CERTIFICATE OF NEED

RESPONSE TO DEFICIENCIES DATED OCTOBER 30, 2015 AND NOVEMBER 12, 2015

Eastern Connecticut Health Network, Inc.
Proposed Asset Purchase by
Prospect Medical Holdings, Inc.

OHCA Docket Number: 15-31216-486
Attorney General Docket Number: 15-486-01

November 23, 2015

WIGGIN AND DANA

Counsellors at Law

Wiggin and Dana LLP
One Century Tower
P.O. Box 1832
New Haven, Connecticut
06508-1832
www.wiggin.com

Melinda A. Agsten
203.498.4362
magsten@wiggin.com

Rebecca A. Matthews
203.498.4502
rmatthews@wiggin.com

November 23, 2015

VIA HAND-DELIVERY

Office of the Attorney General
55 Elm Street
P.O. Box 120
Hartford, Connecticut 06141-0120
Attn: Gary W. Hawes, Assistant Attorney General

Office of Health Care Access
Department of Public Health
410 Capitol Avenue
Hartford, Connecticut 06134
Attn: Steven W. Lazarus, Health Care Analyst

Re: Eastern Connecticut Health Network, Inc.
Proposed Asset Purchase by Prospect Medical Holdings, Inc.
OHCA Docket Number: 15-31216-486
Attorney General Docket Number: 15-486-01

Dear Mr. Hawes and Mr. Lazarus:

Eastern Connecticut Health Network, Inc. and Prospect Medical Holdings, Inc. (the "Applicants") hereby submit the enclosed responses to the completeness questions issued by the Office of the Attorney General and the Office of Health Care Access in two separate letters to the Applicants: the first dated October 30, 2015 and the second dated November 12, 2015.

At your request, one (1) hard copy and one (1) electronic copy have been provided to each Office. Per the instructions in the letter dated October 30, 2015, the information requested in Question 39 of that letter has been provided only in electronic form.

If you have any questions or need anything further, please feel free to contact Rebecca Matthews at (203) 498-4502 or Melinda Agsten at (203) 498-4326. Thank you for your assistance in this matter.

Sincerely,

Wiggin and Dana LLP

By _____
Rebecca A. Matthews
Its Partner

By _____
Melinda A. Agsten
Its Partner

cc: Kevin Hansted, Staff Attorney, Department of Public Health Division of Office of Health Care Access
Kimberly Martone, Director of Operations, Department of Public Health Division of Office of Health Care Access
Perry Zinn Rowthorn, Deputy Attorney General, Office of the Attorney General
Dennis P. McConville, Senior Vice President and Chief Strategy Officer, Eastern Connecticut Health Network, Inc.
Thomas M. Reardon, President, Prospect Medical Holdings-East, Inc.
Frank Saidara, Vice President, Corporate Development, Prospect Medical Holdings, Inc.
Jonathan Spees, Senior Vice President, Corporate Development, Prospect Medical Holdings, Inc.
Joyce Tichy, Senior Vice President and General Counsel, Eastern Connecticut Health Network, Inc.
Michele M. Volpe, Esq., Bershtein, Volpe & McKeon, P.C

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On October 30, 2015 and November 12, 2015, Eastern Connecticut Health Network ("ECHN") and Prospect Medical Holdings ("PMH" and, together with ECHN, the "Applicants") received correspondence from the Office of the Attorney General ("OAG") and the Office of Health Care Access ("OHCA") requesting additional clarification for certain deficiencies identified in the Application submitted on October 13, 2015. The Applicants' response to the deficiencies identified on October 30, 2015 has been provided below; the Applicants' response to the deficiencies identified on November 12, 2015 begins on page 2204:

1. Page 23 of the Application and Section 2.05(b) of the proposed Asset Purchase Agreement ("APA") state that if ECHN obtains, prior to the Closing Date, an assumable loan in an amount not to exceed $45 million to refinance certain of its outstanding bond liabilities (the "Refinancing Loan"), PMH will pay $115 million instead of $105 million for the assets of ECHN, subject to certain adjustments. The same section of the APA states that if ECHN obtains the Refinancing Loan and spends less than $10M on capital projects that could be counted toward the $75 million Commitment Amount under Section 5.18 of the APA, the purchase price of $115 million would be reduced by the difference between $10 million and the amount spent on such capital projects. With respect to these provisions, please answer the following:

    a) Has ECHN obtained the Refinancing Loan and, if not, what is the status of its efforts in this regard and how likely is it that the Refinancing Loan will be obtained before the Closing Date?

    Response:

    ECHN has not obtained the Refinancing Loan. There are no plans to obtain the Refinancing Loan at this time, however ECHN reserves the right to pursue obtaining the proposed Refinancing Loan should the need arise prior to the Closing Date.

    b) If ECHN has obtained the Refinancing Loan, what is the loan amount, how much of the loan amount has been expended on capital projects as of the date of ECHN's response and what is the likelihood that $10 million of the new capital will be expended before the Closing Date?

    Response:

    As stated in the response to Question 1a above, ECHN has not obtained the Refinancing Loan. ECHN is, however, seeking to secure a bank loan of $5 million to cover the cost of planned capital projects and, if received, expects to expend the full amount prior to the Closing Date. If the bank loan is secured, and the planned projects are completed prior to the closing, the purchase price will be

increased by $5 million to reflect the increased value of ECHN that will result from the investment in these planned capital projects and the Commitment Amount would be reduced by $5 Million. If the planned projects have not been completed by the time of the closing of the transaction, then an amount equal to $5 million minus the amount spent on such planned capital projects shall be transferred to PMH. In essence, PMH has agreed to pre-fund a portion of its Commitment Amount.

c) Please provide detail on the improvements to ECHN's OB and Behavioral Health facilities that the $10 million is intended to be expended on.

Response:

In February 2015, four physicians from Mansfield OB/GYN Associates joined the ECHN Medical staff and began performing deliveries at Manchester Memorial Hospital ("MMH"). The added demand for OB services increases the number of annual deliveries expected at MMH to 1,500 per year which has resulted in a need to add capacity to MMH's birthing center. To address this need, MMH has discussed a plan to add three labor delivery recovery and postpartum (LDRP) beds to the fifteen beds currently available. The addition of these LDRP beds will require the coordination of various relocations, including (i) the relocation of existing physician sleep rooms on the birthing unit to an adjacent area that will still provide the physicians with easy accessibility to the birthing center; and (ii) relocation of MMH's Health Information Management staff. The cost for the project has been estimated at $1.7 million. Although ECHN had initially planned to begin the project in the short term and to fund the project with proceeds from the planned Refinancing Loan, a decision has been made to further discuss the plans as part of the overall capital budget to be developed with PMH post-closing. In the meantime, ECHN will continue to utilize the Third West nursing unit as an obstetrics overflow to accommodate postpartum patients when demand for labor and delivery beds on the maternity unit is at or near the unit's capacity.

At Rockville General Hospital ("RGH"), designs have been developed to renovate the former maternity unit to accommodate up to 30 patients with behavioral health conditions. The cost of that project has been estimated to be $5 million. The Department of Public Health was consulted on the design in order to ensure that the unit would be compliant with current building codes to ensure the safety of this patient population. The unit will incorporate the finishes, hardware and security equipment recommended by the Department of Public Health. The renovations will begin in December and are expected to be completed by September 2016.

2. Section 4 of the Letter of Intent ("LOI") states that the joint venture interests of ECHN subject to transfer to PMH, except for Metro Wheelchair Services, Inc., have been valued at a six (6) times multiple of FY2014 EBITDA.

   a) Please explain how and why the parties determined the 6X multiple to be appropriate.

   Response:

   The parties determined the 6X multiple based on their substantial mergers and acquisitions industry experience, independent valuations of similar facilities at other PMH locations, and independent fair market valuations of the joint ventures which were completed by ECHN in 2014.

   b) Please provide the aggregate value of the joint venture assets using this valuation method and the value ascribed to each individual joint venture asset under this methodology.

   Response:

   Please refer to **Exhibit A** for a schedule showing the joint venture valuations as of September 30, 2014.

   c) Please provide an update on the status of the transfer of these interests (e.g., for which joint ventures have the JV partners of ECHN agreed to a transfer if the asset purchase is consummated).

   Response:

   The effort to obtain consents from joint venture partners to sell the joint venture interests of ECHN and its affiliates is ongoing. To date, consents have been obtained from Harford Hospital to permit the transfer of MMH's ownership interests in Ambulance Service of Manchester, LLC, Aetna Ambulance Service, Inc., and Metro Wheelchair Service, Inc.

   For the following joint ventures, meetings are being scheduled to formalize the consents requested by ECHN. Walden Behavioral Care has indicated its consent to the transfer of ECHN's membership in WBC East, LLC and this consent is in the process of being documented. The operating agreement for Evergreen

Endoscopy Center, LLC allows for ECHN to sell its membership in that company. The real estate joint venture members have consented to allow ECHN to sell its memberships in Haynes Street Medical Associates, LLC, Haynes Street Medical Associates II, LLC, Evergreen Medical Associates, LLC and Haynes Street Medical Associates II, LLC. The request for consent to sell ECHN's membership in Connecticut Occupational Partners, LLC (COMP) was raised at its recent Board Meeting and action will be taken at its next meeting.

Meetings for the member representatives of Northeast Regional Radiation Oncology Network, Inc. and the member representatives of Tolland Imaging Center, LLC have been scheduled to decide on the transfer of ownership interests of MMH and RGH in those companies.

3. The LOI at Section 5 and the APA at Section 2.05(d) provide that if, on the Closing Date, ECHN has more than $77 million of liabilities under Scenario A (purchase price of $105 million) or $122 million of liabilities under Scenario B (purchase price of $115 million) other than long-term debt, PMH shall assume such excess liabilities provided it is reimbursed dollar-for-dollar by ECHN from its Available Cash (to the extent the Available Cash exceeds $1 million) and the $4.5 million Indemnity Reserve established under Section 9.8 of the APA. If the Indemnity Reserve is exhausted and there are still additional liabilities to assume, PMH will assume up to an additional $10 million of such liabilities and reduce its $75 million Commitment Amount by that amount. PMH also has the option to assume more than $10 million of ECHN's remaining debt and offset those additional amounts from the Commitment Amount. Please respond to the following questions regarding that option:

   a) Do the figures in Table 8 of the Application (p. 88) reflect all liabilities of ECHN?

      Response:

      The figures presented in Table 8 of the Application reflect both the liabilities to be assumed by PMH and the long-term debt liabilities to be paid off by ECHN at closing. ECHN may be left with some additional liabilities that are not paid at closing, including, for example, liabilities from prior Medicare and Medicaid cost reports. Because these liabilities are not known and are not being assumed by PMH, they are not reflected in the figures in Table 8.

   b) Did the parties consider a cap on reductions to the Commitment Amount?

Response:

It should be noted that if ECHN does not have sufficient cash to discharge all of its liabilities, ECHN will not be in a position to close the transaction. The parties conducted a forecast of cash at closing. Although the parties anticipate sufficient cash to enable ECHN to close, there is a possibility that ECHN will not have sufficient cash at time of the closing if there is a deterioration of ECHN's financial performance during the Certificate of Need and for-profit conversion process. As such the parties discussed and negotiated various alternatives to enable ECHN to close in the event that it did not have sufficient cash. A cap on the reductions to the Commitment Amount was discussed.

c) If the answer to the above question is no, why was no such cap considered? If the answer is yes, why was no cap instituted?

Response:

The Commitment Amount is part of the consideration and the purchase price for the assets of ECHN as described in the APA. Furthermore, any increase in the amount of liabilities assumed by PMH is considered an increase in the consideration and the purchase price for ECHN's assets.

After good faith negotiations between the parties, PMH agreed to increase the purchase price for the assets by $10 million in the event that ECHN does not have sufficient cash to close the transaction, which increase would be offset by a corresponding reduction in the Commitment Amount. This concession by PMH is significant because PMH essentially agreed to pay more for the assets of ECHN in the event that ECHN underperforms on its operations. In essence, PMH has agreed to potentially pay more for assets that would be worth less because of a deteriorating financial condition of ECHN. From an enterprise value perspective, and without taking the Commitment Amount into account, the purchase price offered by PMH exceeds the high value determined by Duff & Phelps by $32 million. If the Commitment Amount is taken into account, the total consideration exceeds the high enterprise value by $107 million. In the event that ECHN's operations deteriorate and, assuming that the enterprise value of ECHN does not change, PMH may potentially pay $42 million above ECHN's value (without taking the Commitment Amount into account). It is only due to an increase in purchase price and the exhaustion of all other sources of cash that the Commitment Amount may be reduced.

It should be noted that PMH views the Commitment Amount as the minimum that it would spend for capital expenditures at ECHN. If there is a need to spend more

on such projects that will contribute to ECHN's growth, PMH plans to make such additional capital investments.

4. Table 8 of the Application provides a net proceeds analysis of the funds payable to ECHN from the asset purchase. Please update the Assumed Liabilities and other line items of the table to reflect the net proceeds analysis under Scenarios A and B as of the date of your response to this Completeness Letter and confirm whether or not the line item for the underfunding of ECHN's pension plan will change between the date of your response and September 30, 2016. Please also:

Response:

An update of the Net Proceeds Analysis (Table 8), including the Assumed Liabilities and other line items, has been provided as **Exhibit B**.

With regard to the pension plan, the Applicants cannot determine at this time if the amount underfunded will increase or decrease between the date of the Applicants' response and September 30, 2016. This is primarily driven by the interest rate market which the Applicants are not able to predict.

a) Describe the cause and estimated amount of any other changes to the Assumed Liabilities line item amounts that may occur between the date of your response and the Closing Date.

Response:

The line items that ECHN expects to change between now and the Closing Date are Capital Leases and Long Term Debt. The budget for fiscal year 2016 has no provision for new debt (although the $5 million loan discussed in the response to Question 1 has been included in the estimates in Table 8 "Scenario B" already) nor does ECHN plan to incur new Capital Lease Obligations over the next fiscal year. ECHN plans to pay down the existing Capital Lease Obligations and Long Term Debt, so the expectation is to have the Capital Leases and Long Term Debt line items decrease between now and the Closing as outstanding principal payments are applied. The other line items to track are the net working capital "true-up" and cash and investments. When one increases the other is expected to decrease and vice versa, however the net of two should remain fairly consistent through the next year as ECHN manages to cash flow neutral. A reliable estimate of any changes to the captive and workers compensation programs is not feasible at this time, but the Applicants do not expect any material change in the amounts projected for these line items.

b) Comment on the likelihood of the $75 million Commitment Amount being substantially reduced under the terms of the APA given ECHN's unfunded pension liabilities, level of debt and declines in cash and cash equivalents as set forth in its FY 2014 financial statements and Table 8 of the Application.

Response:

It is difficult to forecast whether the pension underfunding amount will increase or decrease, but ECHN estimates that the amount of variation from what has been presented in Table 8 is not expected to change materially. In addition, ECHN FY 2016 budget does not include new debt and thus debt (both assumed and paid down at closing) will decrease. If any new debt is incurred, it will be debt that PMH is assuming and also adjusting the price accordingly. Finally, cash flow is budgeted to be neutral in FY 2016. Based on each of these different assumptions and projections, there would be no reduction to the capital commitment as there would be sufficient cash to pay down the outstanding debt not assumed.

c) If the $75 million Commitment Amount is substantially reduced by what means and under what timetable would the proposed capital projects described at page 31 of the Application be funded by PMH?

Response:

The capital projects described on page 31 of the Application are examples of capital projects that may be funded by PMH. After closing, PMH will develop a specific capital plan in consultation with the Local Boards and medical staff. This plan will prioritize capital projects and service improvements given the capital funding available. The goal will be to establish priorities based on maintaining or providing access to needed services that allow for the optimum care and coordination of care within and across the community. The plan and priorities will be evaluated periodically by PMH, and adjustments made based on changes in funding available and capital needs, with input from the Local Board and medical staff.

5. Please provide a copy of PMH's written response to the February 19, 2015 Request For Proposal set forth at Exhibit Q5 to the Application, including, without limitation, the responses to the questions and other items listed at pages 229 to 232 thereof from the Visions

and Operations section to the section entitled Additional Information/Due Diligence Required.

Response:

Please refer **Exhibit C** for a copy of PMH's written response to the February 19, 2015 Request for Proposal.

6. The LOI provides in Section 9 that the parties agree to enter into a Consulting Agreement, to be effective 30 days after the parties have made any required Hart-Scott-Rodino Act filing, pursuant to which PMH "would provide operational support to ECHN's leadership." The parties also state that "ECHN agrees to reasonably consent to make recommended operational changes" pursuant to the Consulting Agreement. Please elaborate on the content and purpose of the Consulting Agreement by providing specific examples of the type of operational support that would be offered, the operational changes PMH is likely to make and provide a copy of the Consulting Agreement if one is available.

Response:

Attached as **Exhibit D** is a draft copy of the proposed Consulting Agreement. The purpose of the Consulting Agreement is to provide additional support to ECHN's management team to improve its operations and to prepare ECHN to implement PMH's Coordinated Regional Care strategy ("CRC"). For a complete description of support services, please refer to the Consulting Agreement. Please note that the Consulting Agreement has not yet commenced.

Under the terms of the Consulting Agreement, ECHN's Board and management will retain full authority over the operations of ECHN prior to Closing, and PMH will not have authority to make any operational changes during that time. PMH may make recommendations to ECHN, and if ECHN believes that the recommendations are reasonable, in the best interests of ECHN, and improve the operations of ECHN, then ECHN may implement such recommendations.

One key area that the parties intend to focus on during the consulting engagement is the foundational work required to implement CRC. CRC is the clinical integration among hospitals, physicians and other medical, social and community providers working closely with strategic partner health plans and other payers under a value-based, global risk reimbursement payment system to achieve the triple aim of improved patient care and experience, better patient health, and lower costs.

In anticipation of implementing CRC in Connecticut, PMH, has established a risk-taking entity called Prospect Health Service CT, Inc. and received licensure for the entity from the Connecticut Department of Insurance as a Preferred Provider Network.

7. The Application at page 97 states that PMH will be seeking property and sales tax abatements post-closing for a transition period and that "such abatement is deemed critical to the overall success of the proposed transaction." In connection with these statements:

a) Please describe the length of the proposed transition period and the particulars of the abatement that will be sought.

Response:

As a for-profit health system, PMH will be expected to pay property taxes, sales taxes and income taxes post-closing. Even though PMH does not have the benefits of tax-exemption, PMH has committed to maintain and adhere to ECHN's current policies regarding charity care, indigent care, community volunteer services and community benefits or to adopt other policies that are at least as favorable to the community as ECHN's policies. In essence, PMH is not only required to provide the benefits generally expected from non-profit hospital operators, but is also required to pay the taxes described above even though similarly situated hospital operators would not be responsible for such taxes.

Although PMH expects that implementation of the CRC model will result in an improved financial outlook for the current ECHN operations, these benefits will take time to realize. If taxes are imposed on PMH before any of these benefits can be obtained, there is a risk that the new tax burden could negatively affect the community in terms of jobs, local vendor payments and other factors which could outweigh the benefits from tax collections. Accordingly, PMH plans to work with the State and local communities to seek temporary relief from the new tax burden. This temporary relief has been deemed appropriate in other states in order to allow a hospital to re-gain its strength for the benefit of its employees and the communities that it serves before taking on the full tax burden.

Seeking temporary tax relief is a process that necessarily involves the participation of all constituents. PMH is aware of pilot programs where cities receive funds from the State because they host non-profit entities. PMH is in the process of gathering facts that are necessary to formulate a fair proposal for all parties. As such, PMH, at this time, does not have any specific proposals that it can share. PMH will update this response once it has formulated a fair proposal.

b) Explain why the abatement is deemed critical to the overall success of the proposed transaction.

Response:

Please refer to the response to Question 7a above for the Applicants' explanation regarding the need for the abatements post-closing.

c) If PMH is unsuccessful in its negotiations for such an abatement, will there be any changes to the Commitment Amount or PMH's commitment, as noted on page 75, to ensure that MMH and RGH each maintains and adheres to ECHN's current policies regarding charity care, indigent care, community volunteer services and community benefits or adopts other policies that are at least as favorable to the community as ECHN's policies?

Response:

PMH is proud of its history of providing health care services to underserved communities. PMH hopes that it will be able to negotiate a fair tax abatement plan that will place all healthcare providers on equal competitive grounds. However, in the event that PMH is not successful in those negotiations, PMH will continue to honor all of its obligations under the APA (including but not limited to the Commitment Amount), to maintain ECHN's current policies regarding charity care and indigent care and will adopt policies that are at least as favorable to the community as ECHN's policies.

8. The LOI provides in Section 10 that Eastern Connecticut Physician Hospital Organization ("ECPHO") and Clinically Integrated Network of Eastern Connecticut ("CINECT") will enter into a 5-year management agreement with Coordinated Regional Care Group, Inc., a subsidiary of PMH, to implement PMH's Coordinated Regional Care ("CRC") strategy. Please provide the number of physicians currently participating in ECPHO and CINECT, respectively, describe any physician participation overlap between these two entities and detail the nature of the management services to be provided by the PMH subsidiary under the agreement. Also, provide a copy of the management agreement if available.

Response:

ECPHO is a nonstock corporation with two members: ECHN and the Eastern Connecticut Individual Provider Group, Inc. ("ECIPG). ECIPG is a separately incorporated nonstock corporation that represents two hundred and two (202) physicians in the communities served by ECHN. ECPHO provides administrative, purchasing and other services to its members, including contracting with insurers.

CINECT is a limited liability company, the sole member of which is ECHN. CINECT was formed in 2014 to address changes in the healthcare environment as a result of healthcare reform. The purpose of CINECT is to implement protocols and programs for healthcare providers that promote quality, coordination and efficiency in the delivery of healthcare and to provide management, purchasing and administrative and other services to subscribing providers. There are currently no physician members of CINECT and no contractual relationship between CINECT and ECIPG, so there is no overlap of any physician participation between ECPHO and CINECT. ECPHO continues to provide the management, administrative and other services to ECIPG and its physician members. ECHN and ECIPG had planned to transition these activities to CINECT to better address changes in the healthcare environment due to healthcare reform, but have put these plans on hold, pending the acquisition of ECHN by PMH.

Although a five-year management agreement among ECPHO, CINECT and the PMH Coordinated Regional Care Group was anticipated at the time the LOI was originally signed, the Applicants have since determined not to proceed with such an arrangement. Instead, PMH has established its own Independent Practice Association entity in Connecticut (Prospect Provider Group CT-ECHN, LLC, "PPGCTE")) and a Preferred Provider Network/Health System Risk Taking entity (Prospect Health Services, CT, Inc.). These two organizations, through management services agreements with Prospect Medical Systems, Inc., will manage physician participation, risk contracting and care management activities for participating members. Physicians currently represented by ECIPG will make individual and independent decisions regarding their participation in PPGCTE.

The Risk Taking Entity and the Independent Practice Association Management Services Agreements have not been drafted at this time.

9. On page 26 of the Application, Applicants describe the CRC model as being "highly successful in aligning physicians with PMH hospitals and improving quality, efficiency and financial performance in California, and local versions of the model have been implemented in Texas and Rhode Island with similar success." The Application also states that the size of PMH's physician network in these three states encompasses approximately 8,900 physicians. With respect to these statements, please provide the following:

    a) How many physicians participate in PMH's physician networks in California, Texas and Rhode Island, respectively?

    Response:

    Please refer to **Exhibit E** for the number of physicians participating in PMH's physician networks in California, Texas and Rhode Island from 2012 to present.

Please note that the number of physicians reflected in this exhibit includes both fully contracted physicians and physicians who have entered into a Memorandum of Understanding ("MOU") with PMH. The MOUs are generally related to limited services by a physician, provide for a limited period of time for the provision of services and/or are limited to a particular patient for physicians who do not wish to be fully contracted with PMH.

PMH's contracting system is not able to distinguish between MOU physicians and fully contracted physicians. In order to determine how many physicians are fully contracted and how many are part of an MOU requires physical inspection of each agreement. Within the past year, such an exercise was performed to determine the approximate number of fully contracted physicians (8,900).

b) Do the physician networks in each of these states operate as independent practice associations ("IPAs") that contract with a management services organization ("MSO") controlled by PMH or, if there are other models used, please describe the models and the states in which they are used.

Response:

The physician networks for risk taking are all IPAs comprised of employed and independent physicians. The IPAs are managed by PMH-owned MSOs.

c) How will the physician network that PMH seeks to establish in Connecticut differ from those developed in these other states?

Response:

PMH will seek to replicate the same model in Connecticut.

d) For the CRC model developed for the Alta Los Angeles Hospitals in California, provide the number of physicians participating in PMH's physician network for each year from 2007 to present;

Response:

PMH manages its physician networks regionally and not by specific hospital. As such, PMH does not have separate networks for Alta Los Angeles Hospitals and Southern California Healthcare System. Please refer to **Exhibit E** for the number

of physicians participating in PMH's physician network in California for each year from 2012 to present.

Please be advised, PMH changed information technology data systems and data for years prior to 2012 are on legacy systems that are not readily available.

e) For the CRC model developed for the Southern California Healthcare System in California, provide the number of physicians participating in PMH's physician network for each year from 2009 to present;

Response:

Please see the Applicants' response to Question 9d above.

f) For the CRC model developed for the Nix Health System in Texas, provide the number of physicians participating in PMH's physician network for each year from 2012 to present; and

Response:

PMH received and implemented a risk-based contract in Texas approximately one year ago. PMH's network in Texas currently consists of 23 primary care practitioners and 594 specialists. The network remained stable and consistent over the past year.

g) For the CRC model developed for the Prospect CharterCare Hospitals in Rhode Island, where applicants state in Exhibit Q58-1 that PMH developed an IPA and recruited 105 primary care physicians and 270 specialists, please state the number of physicians that were affiliated with these hospitals through IPAs or other physician organizations at the inception of the joint venture.

Response:

There was no IPA at the CharterCARE Hospitals at the inception of the joint venture. Of the 375 physicians recruited to the IPA only 18 were employed by the CharterCARE Hospitals at the inception of the joint venture.

10. Elaborate on whether there is a standard CRC business plan that is used by PMH in the development of IPAs and what specific CRC policies, procedures and processes are implemented for recruiting purposes to reach target amounts of affiliated medical professionals.

Response:

PMH does have a standard business plan by which it approaches each new market. The initial plan entails three work streams that PMH begins working on simultaneously and soon after an acquisition Letter of Intent has been agreed upon with a health system such as EHCN. The three work streams are:

- Regulatory Infrastructure
- Provider Network Development
- Health Plan Engagement

The first two work streams are relevant to answering the question posed.

The first work stream addresses investigating and developing the Regulatory Infrastructure necessary in order for providers to assume and manage value-based risk contracts with health plans under our CRC model. In Connecticut that requires a license as a Preferred Provider Network ("PPN"). Prospect Health Services CT, Inc. received its license to transact business as a Preferred Provider Network from the Connecticut Insurance Commissioner on October 21, 2015.

The second work stream is Provider Network Development which entails identifying and beginning to contract with the provider network described in the PPN application and required by health plans in the market for our PPN to enter into value-based risk contracts. A critical component of this work stream is the development of the IPA affiliated with the health system, in this case ECHN. PMH has formed an IPA called Prospect Provider Group CT-ECHN, LLC. (PPCTE), which will be the ECHN-affiliated IPA. PMH is currently developing the participating agreements for the ECHN-affiliated physicians and will begin contracting the physicians into the IPA in the near future.

The PPN application requires that Prospect Health Service CT, Inc. comply with National Committee for Quality Assurance ("NCQA") network adequacy standards, so those are the standards that PMH will use to gauge the number and type of providers needed to contract in the IPA. PMH has identified the physicians affiliated with ECHN, many of whom already participate in another ECHN-affiliated physician organization. When the contracts are approved for use, PMH will begin contracting those physicians into the IPA. PMH will then recruit any additional providers necessary to meet the requirements of the value-based contracts negotiated with the health plans in Connecticut.

11. PMH's prior hospital acquisitions in California, Texas and Rhode Island have been concentrated in high density urban markets. ECHN's service area population for 2020 is projected to be 356,046 residents. Explain how PMH's experience with the CRC model in high density urban markets will be adapted to a more rural market.

Response:

It is important to note that PMH's operations in California are in four separate and distinct markets. The markets are as follows: (a) South Orange County; (b) Central Orange County; (c) Inland Empire; and (d) Los Angeles. While these counties are populous, the population is spread over a very large geographic area. For example, Orange County is over 948 square miles, the Inland Empire covers over 27,000 square miles, and Los Angeles is over 4,000 square miles. PMH provides services to distinct areas within each county and manages approximately 260,000 lives. PMH does not consider a market service area of 356,046 residents to be rural. PMH believes ECHN's service area is a good size and appropriate for implementation of CRC.

12. On page 76 of the Application and in Figure 3, Applicants indicate that from 2012 to 2014, in Texas and California, PMH reduced hospital bed days per thousand from 1,260 to 720, reduced length of stay from 5.1 days to 3.9 days, dropped admissions per thousand from 245 to 182 and reduced hospital readmissions within thirty days from 19% to 13% for Medicare Advantage participants. This data is provided as evidence of PMH's ability to operate its hospitals efficiently through the CRC model while avoiding unnecessary, inefficient and duplicative services and reducing medical errors. Using these same benchmarks (hospital bed days, length of stay, patient admissions and readmissions) please update Figure 3 to show whether similar reductions have been achieved across all patient populations for each of the healthcare systems owned by PMH in California and Texas over the past 3 years and for Prospect CharterCare Hospitals since 2014. Provide data and detailed explanations on the specific programs, policies and procedures under the CRC model that have been implemented in the PMH member hospitals to reduce hospital stays, admissions and medical errors.

Response:

The referenced data above is largely based on PMH's California experience.

In Texas, PMH's risk-based contract under the CRC model was implemented approximately one year ago. Trends are both encouraging and positive, but show room for improvement. CRC development requires education and training of physicians, patients and other providers across the healthcare continuum and takes several years to implement. PMH expects to achieve similar results in Texas to what has been accomplished in California over time.

Please note that results in California were achieved over two to three years. A summary of performance metrics for Texas can be found in the **Exhibit F.**

Please note that in Rhode Island, PMH began medical management under a risk-based contract in September 2015. As such, there is no data to report at this time. However, because of the programs and systems used, PMH is confident it can produce the same results in Rhode Island and Connecticut.

For an overview of PMH's programs and procedures, please see **Exhibit G**.

13. On page 56 of the Application, Applicants state that "the transaction will allow ECHN the ability to adjust to a rapidly changing healthcare delivery environment and reinvest in itself to continuously improve care coordination, address continued improvement in quality and safety, expand and add needed services, recruit and retain physicians, and improve access to services across its service area." Please explain how implementation of the CRC model will facilitate the expansion and addition of needed services and improve access to services. Specifically focus on examples where PMH opened new outpatient facilities and developed new service lines for the hospitals it acquired in California, Rhode Island and Texas.

Response:

Implementation of the CRC model necessarily requires that a full continuum of care be accessible and available to patients. As part of the implementation process, PMH reviews the services offered by its systems and seeks to enhance or expand services over time. To the extent that a PMH-affiliated system does not provide the full range of services, PMH seeks to add such services or to affiliate with other service providers for the provision of such services, as appropriate. PMH's focus initially will be to:

- Invest in Primary Care/Specialty practices through
  - Attractive physician models that reward quality and service
  - Participation in academic-affiliated residency programs

- Expand Ambulatory Offerings, such as
  - Urgent care facilities
  - Out-patient services/service lines
  - Primary care clinics

Examples of development activities in Texas include:

- Formation of an IPA
- Formation of a Multi-Specialty IPA – Including Integration with Behavioral Health doubling the Behavioral Health service capacity

- Expansion of Hospital-Based Outpatient Clinics
- Purchase of a rural hospital resulting in increased access to care
- Establishment of an Emergency Room; and
- Leasing and converting additional space for expansion of services

In Rhode Island PMH has accomplished the following:

- Purchased 28 primary care clinics, expanding access to care;
- Joint ventured on a radiation-oncology center;
- Expanded cardiac catheterization services

California is a mature market for PMH. Efforts to improve access to services that have been recently accomplished (or are about to be accomplished) include the following:

- Purchased a closed hospital in South Orange County (which PMH reopened in September 2015) to better serve patients who are members of our owned or managed IPAs; and
- Will purchase primary care and multi-specialty clinics to increase access to care

All of the above are examples of service line expansions and improving access to care.

14. In reference to the "Local Board" as described on page 30 of the Application, please provide the following:

    a) Elaborate on recommending authority of the respective Local Boards as described in Sections 5.18 (strategic capital plan), 5.21 (clinical quality matters), and 5.26 (strategic business plan) of the APA.

    Response:

    PMH and the management of the Hospitals will provide the respective Local Boards with the necessary information to make informed recommendations to PMH with respect to (i) a strategic capital plan (APA Section 5.18), (ii) clinical quality matters (APA Section 5.21) and (iii) the Strategic Business Plan (APA Section 5.26). PMH will carefully consider the recommendations of the respective Local Boards in its deliberations on those matters, and will collaborate with the Local Boards to ensure that such recommendations are in the best interests of the Hospitals and the System. PMH and the local management of the Hospitals and the System will then seek to implement the recommendations and will provide timely updates to the Local Boards regarding such implementation. The role of the Local Boards will include oversight and responsibility for medical staff credentialing as well as quality matters.

b) Please clarify how each respective Local Boards of MMH and RGH will function collaboratively in providing recommendations to PMH.

Response:

The Local Boards will be appointed upon the closing of the transaction, and it is anticipated that they will begin operations shortly thereafter. Since the time ECHN was formed, the hospital boards of MMH and RGH have met concurrently with the ECHN parent board. This arrangement ensures common focus for the system while also providing the mechanism for each hospital to handle formal governance business individually as necessary. PMH plans to continue this approach for the two Local Boards by appointing the same individuals to each and having them meet concurrently. As is currently the case with the ECHN Board, tenures on the Local Boards will be predetermined and limited in order to ensure that fresh perspectives are continuously present. PMH expects that the Local Boards will be comprised of community physicians who are active parts of the ECHN Medical staff along with other community members who have demonstrated an active commitment to ECHN's mission to enhance the health of its community. PMH will schedule regular standing meetings to update the Local Boards on clinical quality and strategic matters, to allow the Local Boards to provide feedback on health issues of concern to the community, and to provide a forum for the Local Boards to deliberate and formulate recommendations to PMH. Educational sessions will also be scheduled as appropriate and desired by the Local Boards. In order to ensure that the perspectives of the Local Boards are heard, representatives of PMH and the senior local managers of the System will either sit on both of the Local Boards or attend the meetings of both of the Local Boards. In this way the representatives will be able to facilitate coordination and collaboration among the members of the Local Boards with respect to making recommendations to PMH.

15. On page 66 of the Application, Applicants state that "PMH has already begun implementation efforts with respect to its CRC model for ECHN, including formation of an IPA and Board, review of regulatory requirements, discussions with payers and evaluation of the care delivery network." Please provide the following:

a) the status on the formation of the IPA and the Board;

Response:

The IPA legal entity has been formed as a limited liability company called Prospect Provider Group CT-ECHN, LLC. (PPGCTE). The Chair and the Board of the newly formed IPA are being selected currently and the Board will likely begin to meet in

December. Physician contracting will begin as soon as the Board has approved the participating physician agreements.

b) the opportunities and impediments for utilizing the CRC model in Connecticut based on regulatory requirements;

Response:

The primary CRC regulatory requirement for providers assuming and managing value-based risk contracts in Connecticut is licensure as a Preferred Provider Network by the Connecticut Insurance Department. Prospect Health Services CT, Inc. received its license to transact business as a Preferred Provider Network from the Connecticut Insurance Commissioner on October 21, 2015. As such, PMH has already satisfied the main regulatory requirement necessary for implementing the CRC model in Connecticut.

That said, one potential impediment to fully implementing the CRC model across geographies is the restriction on the number of medical foundation entities per health system that exists under Connecticut law. Specifically, pursuant to §33-182bb(f) of the Connecticut medical foundation statute, "a hospital, health system or medical school may organize and be a member of no more than one medical foundation." This statutory restriction does not permit for the formation of separate medical foundation entities by a hospital system that owns multiple hospitals in wholly separate service areas. This restriction is a significant issue for hospital systems that operate in more than one market in that third party payers typically set contract rates, adjudicate claims or limit participation in certain risk sharing arrangements or incentives based on service area. PMH is seeking approval to own three hospitals in two different markets but will have to utilize a single medical foundation even though the professionals employed in the medical foundation will be in two distinct markets. In order to participate in regionalized payer contracts or programs, a medical foundation formed by PMH will need to work with payers to allocate providers under different risk arrangements while maintaining a single tax identification number. Many payors do not have ready systems that can allocate providers to divisions within a single tax identification number, making population health management and risk-based contracting more difficult. There is no easy immediate solution to this problem and PMH's plan is to try to work closely with payers to develop internal tracking mechanisms by the payer and PMH. However these unnecessary added administrative costs may defeat some of the healthcare savings of the risk model.

c) the substance of discussions with payers; and

Response:

PMH has had preliminary discussions with most of the major payers in Connecticut to introduce PMH's CRC model to them. They have all expressed the desire to work with PMH on value-based contracts such as those preferred in PMH's CRC model. To date, the discussions with payers have been introductory, rather than substantive. However, PMH is optimistic that the discussions will result in most payers embracing the skills and expertise that PMH brings to the Connecticut market in its CRC model.

d) any reports on PMH's evaluation of the care delivery network.

Response:

PMH does not have any written evaluations of the care delivery network. However, PMH filed an application for the Preferred Provider Network as a substantial component of the delivery network and PMH received its PPN license last month. PMH is pleased with ECHN's care delivery network and believes it will provide a substantial foundation for PMH's CRC model in Connecticut.

16. On page 75 of the Application, Applicants disclose that "PMH and ECHN representatives have already met with leadership for Connecticut's Medicaid Program and expressed their desire to work under a risk-based arrangement to provide care to Medicaid recipients." Please provide an update on the status of these discussions. What impact, if any, would there be on the proposed asset purchase if Connecticut's Department of Social Services were to decide not to enter into risk-based arrangements with PMH?

Response:

Since the initial meeting with the Department of Social Services, PMH has not met with representatives of that Department. PMH expects to meet with the Department in the near future. The Applicants would be disappointed if the Department of Social Services decided not to enter into a risk-based arrangement with PMH, but it would not have an impact on the proposed asset purchase.

17. In table format, provide historical volumes (three full fiscal years ("FY") and the current year-to-date) for the number of discharges and patient days, by service for MMH and RGH, respectively.

TABLE A
HISTORICAL AND CURRENT DISCHARGES

Manchester Memorial Hospital	**Actual Volume** *(Last 3 Completed FYs)**			
	FY 2013	**FY 2014**	**FY 2015**	**CFY 2016 (October)**
Medical/Surgical	5,433	5,223	4,685	407
Maternity	1,233	1,259	1,406	139
Psychiatric	1,444	1,372	1,313	123
Pediatric**	1,232	1,256	1,402	135
Total	**9,342**	**9,110**	**8,806**	**804**

** Fiscal Year period runs from October 1 to September 30*
***Only reflects patients categorized as "Newborn" in ECHN's internal Daily Census Report*

Rockville General Hospital	**Actual Volume** *(Last 3 Completed FYs)**			
	FY 2013	**FY 2014**	**FY 2015**	**CFY 2016 (October)**
Medical/Surgical	2,567	2,341	2,112	172
Maternity	0	0	0	0
Psychiatric	0	0	0	0
Pediatric	0	0	0	0
Total	**2,567**	**2,341**	**2,112**	**172**

** Fiscal Year period runs from October 1 to September 30*

TABLE B
HISTORICAL AND CURRENT PATIENT DAYS

Manchester Memorial Hospital	**Actual Volume** *(Last 3 Completed FYs)**			
	FY 2013	**FY 2014**	**FY 2015**	**CFY 2016 (October)**
Medical/Surgical	29,363	26,169	22,040	1,799
Maternity	3,369	3,412	3,760	355
Psychiatric	10,277	10,866	10,745	890
Pediatric**	3,657	3,653	4,147	438
Total	**46,666**	**44,100**	**40,692**	**3,482**

** Fiscal Year period runs from October 1 to September 30*
***Only reflects patients categorized as "Newborn" in ECHN's internal Daily Census Report*

Rockville General Hospital	**Actual Volume** *(Last 3 Completed FYs)**			
	FY 2013	**FY 2014**	**FY 2015**	**CFY 2016 (October)**
Medical/Surgical	12,363	11,155	9,873	682
Maternity	0	0	0	0
Psychiatric	0	0	0	0
Pediatric	0	0	0	0
Total	**12,363**	**11,155**	**9,873**	**682**

** Fiscal Year period runs from October 1 to September 30*

18. Complete the following tables for MMH and RGH, respectively, for the first three (full) fiscal years following the proposed asset purchase, if the first year is a partial year, include that as well.

TABLE C
PROJECTED DISCHARGES BY SERVICE

Manchester Memorial Hospital	**Projected Volume with Proposed Asset Purchase***			
	FY 2016	**FY 2017**	**FY 2018**	**FY 2019**
Medical/Surgical	4,665	4,846	4,936	5,027
Maternity	1,538	1,538	1,538	1,538
Psychiatric	1,370	1,370	1,370	1,370
Pediatric**	1,533	1,533	1,533	1,533
Total	**9,043**	**9,224**	**9,314**	**9,405**

** Fiscal Year period runs from October 1 to September 30*
***Only reflects patients categorized as "Newborn" in ECHN's internal Daily Census Report*

Rockville General Hospital	**Projected Volume with Proposed Asset Purchase***			
	FY 2016	**FY 2017**	**FY 2018**	**FY 2019**
Medical/Surgical	2,159	2,191	2,213	2,235
Maternity	0	0	0	0
Psychiatric	0	0	0	0
Pediatric	0	0	0	0
Total	**2,159**	**2,191**	**2,213**	**2,235**

** Fiscal Year period runs from October 1 to September 30*

TABLE D
PROJECTED PATIENT DAYS BY SERVICE

Manchester Memorial Hospital	**Projected Volume with Proposed Asset Purchase***			
	FY 2016	**FY 2017**	**FY 2018**	**FY 2019**
Medical/Surgical	22,040	22,040	22,040	22,040
Maternity	3,760	3,760	3,760	3,670
Psychiatric	10,745	10,745	10,745	10,745
Pediatric**	4,147	4,147	4,147	4,147
Total	**40,692**	**40,692**	**40,692**	**40,692**

** Fiscal Year period runs from October 1 to September 30*
***Only reflects patients categorized as "Newborn" in ECHN's internal Daily Census Report*

Rockville General Hospital	**Projected Volume with Proposed Asset Purchase***			
	FY 2016	**FY 2017**	**FY 2018**	**FY 2019**
Medical/Surgical	9,873	9,873	9,873	9,873
Maternity	0	0	0	0
Psychiatric	0	0	0	0
Pediatric	0	0	0	0
Total	**9,873**	**9,873**	**9,873**	**9,873**

** Fiscal Year period runs from October 1 to September 30*

a) Explain any increases and/or decreases in historical volumes reported in the tables above.

Response:

The decreasing trend in total discharge volume experienced by MMH and RGH from FY 2013 through FY 2015 is, in part, due to an industry-wide trend to shift inpatient care to the outpatient setting.[1] ECHN's struggle to recruit and retain primary care physicians in the communities served by the Hospitals has also contributed to the decline in patient discharges at both facilities. MMH did experience an increase in maternity and pediatric (newborn) discharges and patient days beginning in FY 2015 when an established OB/GYN practice in the region joined ECHN's active medical staff.

Total patient days declined along with the decrease in discharges, but the Hospitals also experienced a decrease in the average length of stay ("LOS") during the same time period which further contributed to the decline in the patient day volume. Ongoing efforts to reduce patient lengths of stay and an industry-wide increase in observation status utilization are primary drivers behind the reduction in the average LOS.[2]

b) Provide a detailed explanation of all assumptions used in the derivation/calculation of the projected volume.

Response:

Inpatient discharges for FY 2016 were based on ECHN's internal budget for the current fiscal year and assumes that inpatient discharges will increase 2.5% from FY 2015 to FY 2016 (3% at MMH and 0% at RGH). The increase in discharges at MMH is directly related to the additional maternity and newborn volume that is expected with the addition of deliveries from the physicians from Mansfield OB/GYN Associations, who joined ECHN's Medical staff midway through FY 2015.

[1] The New Normal? Shift to Outpatient Care, Payer Pressure Hit Hospitals. Modern Healthcare, August 10, 2013. http://www.modernhealthcare.com/article/20130810/MAGAZINE/308109974

[2] Study: Hospital Observation Stays Increase 25 Percent in 3 Years. Kaiser Health News, June 4 2012. http://khn.org/news/study-hospital-observation-stays-increase-25-percent-in-3-years/

As presented in Exhibit Q38-1 (page 1851), with CON approval, total inpatient discharges are anticipated to increase after FY 2016 by the percentages listed below as a result of implementing PMH's CRC model of care delivery:

Entity	Volume Statistics	Projected Growth with CON Authorization		
		FY 2017	FY 2018	FY 2019
PMH ECHN	Inpatient Discharges	1.9%	2.9%	3.9%
	Outpatient Visits	0.1%	0.2%	0.3%
Prospect MMH	Inpatient Discharges	2.0%	3.0%	4.0%
	Outpatient Visits	0.1%	0.2%	0.3%
Prospect RGH	Inpatient Discharges	1.5%	2.5%	3.5%
	Outpatient Visits	0.1%	0.2%	0.4%

The model assumed that increased Medical/Surgical discharges at both facilities will be the primary driver of discharge growth, as both the maternity unit and behavioral health unit are operating at capacity and RGH does not provide either of these services at the present time. Based on this assumption, discharge volume for maternity, pediatric (newborn) and psychiatric services will remain constant at the levels projected for FY 2016 through FY 2019. Medical/Surgical discharges will increase each year, resulting in the overall growth presented in the table above. Efforts currently underway at ECHN, which have historically reduced Medical/Surgical LOS, will continue to reduce patient days through FY 2019 despite the increase in discharges. Based on the continuation of these efforts, it was assumed that patient days would remain at FY 2015 levels throughout the projection period.

19. Please complete the following tables setting forth the number of physicians comprising Active and total members of the medical staffs (Active plus all other staff categories) for both MMH and RGH for the years listed below:

TABLE E
MMH

	2013	**2014**	**2015***
Active Staff	297	308	303
Consulting	13	15	13
Courtesy	49	41	41
Part Time	34	29	36
Allied Health**	**83**	**80**	**93**
Total Physician Staff	**476**	**473**	**486**

** Medical staff totals as of October 31, 2015*

*** Non-physician medical staff personnel (i.e. APRN, Physician Assistant, etc.)*

TABLE F
RGH

	2013	**2014**	**2015***
Active Staff	297	308	303
Consulting	13	15	13
Courtesy	49	41	41
Part Time	34	29	36
Allied Health**	**83**	**80**	**93**
Total Physician Staff	**476**	**473**	**486**

** Medical staff totals as of October 31, 2015*

*** Non-physician medical staff personnel (i.e. APRN, Physician Assistant, etc.)*

Response:

Table E and Table F have been completed to show the number of physicians comprising each medical staff category for ECHN. MMH and RGH have utilized a single medical staff since 1997.

While the overall Medical staff participation total has remained relatively constant year to year, ECHN has struggled to retain individual providers, particularly primary care providers (family medicine and internal medicine):

Specialty	2013		2014		2015*	
	Add	Delete	Add	Delete	Add	Delete
Anesthesiology	4	12	6	5	11	5
Emergency Medicine	5	3	2	4	5	8
Family Medicine	**5**	**6**	**5**	**1**	**2**	**4**
Internal Medicine	**9**	**32**	**14**	**17**	**20**	**18**
Medical Imaging	1	11	3	2	0	1
Obstetrics & Gynecology	2	2	3	7	12	5
Pathology	0	0	0	0	0	0
Pediatrics	2	1	5	3	3	2
Psychiatry	4	4	5	7	2	1
Surgery	6	13	9	12	8	9
TOTAL	**38**	**84**	**52**	**58**	**63**	**53**

20. With respect to ECHN's Medical Foundation, please provide the number of physicians and other allied health professional participants for each year since the inception of the Foundation to the current year to date.

Response:

Table G below provides the number of physicians and other allied health professional participants for ECHN's Medical Foundation since its inception on November 17, 2011. It reflects the number of participants (individuals, not full-time equivalents) as of the calendar-year end-date (December 31) for each year requested.

The decline in the number of participants from 2013 to 2014 is primarily related to ECHN's decision to contract with a third party to provide hospitalist services at the Hospitals.

TABLE G
ECHN's Medical Foundation

	2011	2012	2013	2014	2015
Physicians	60	62	56	40	36
Allied Health Professionals	32	31	36	39	42
Medical Foundation Total	**92**	**93**	**92**	**79**	**78**

** Participant totals as of December 31 of each year except 2015 (totals as of 10/31/2015).*

21. In accordance with the provisions of the Section 5.18 of the APA, PMH may direct some portion of the Commitment Amount to expenditures in support of the recruitment of the Hospitals' medical staff located in the Hospitals' Service Area. Please elaborate on the extent to which ECHN has had difficulty recruiting and/or maintaining medical staff in recent years and how and PMH's experience with the development of its CRC models of care in California, Texas and Rhode Island would demonstrate PMH's ability to effectively grow ECHN's physician network from the 39 community-based physicians and 16 allied health professionals reported to be currently employed by its medical foundation.

Response:

ECHN works continuously to recruit physicians to its medical staff as physicians retire, move away or as needs for physician specialists are identified. The competition among healthcare systems to attract and employ physicians has been intensifying. It is well known that ECHN has been pursuing a transaction to join a larger health care organization. Current medical staff and potential recruits to the medical staff want to know ECHN's future. They want to know that ECHN will be joining an organization that will support their practices. The uncertainty caused by Tenet Healthcare's withdrawal from Connecticut and its planned venture with Yale New Haven Health System to acquire ECHN made an already uncertain healthcare landscape more uncertain. This has made the process of recruiting needed medical staff even more challenging.

Capital investments to support medical staff development are essential to the success of a health system like ECHN. ECHN has been strategic with its deployment of capital to develop medical offices in its communities which help to attract and retain primary and specialty care physicians. Future investments will be needed to develop additional ambulatory sites to house physician practices in the communities served by ECHN. Capital investments in equipment and technology are also important to recruit and support physicians on the medical staff. An example would be ECHN's purchase of robotic technology to assist with surgical procedures, technology that has become expected by today's surgeons.

ECHN has also been creative in establishing programs to recruit physicians. In 2013, ECHN established a Family Practice Graduate Medical Education (GME) Program to help train

primary care physicians with a goal of attracting medical residents to train with the medical staff, become familiar with the communities and practice opportunities at ECHN and encourage them join the medical staff following their post graduate studies. Having sufficient primary care physicians located throughout the service area is critical to effectively addressing the health of the patients served by the network.

For 2013-2014, the ECHN GME program included a total of eleven first year and second year family medicine residents. For 2014-2015, the program included a total of nineteen first year, second year and third year family medicine residents. One of four 2015 graduates joined the ECHN Medical staff. The current 2015-2016 class has a total of twenty-two family medicine residents. It is our hope that some of the six eligible graduates from the current third year class will join the medical staff. It is important to note that PMH supports the continuation of the GME program which will grow in its importance as a resource for primary care providers.

ECHN believes that PMH, through the development of its CRC model, will bring success in meeting the challenges of retaining and recruiting physicians needed for our communities. ECHN considers its physician staff to include all physician and allied health members of the ECHN Medical staff, both employed and independent physicians and allied health professionals, not just those community-based providers currently employed by the Eastern Connecticut Medical Professionals Foundation. The CRC Model will attract and align both employed and independent physicians with the health system and the payer community to the benefit of our patients. CRC is a patient and physician focused model. It is organized to allow for strong physician governance of the Prospect Provider Group CT-ECHN, LLC (PPGCTE) that will result in the physician community having a central role in determining what health services are needed and developed by the health system for patients, as well as overseeing the service and quality of care of delivered to patients by the PPGCTE. In addition to stronger leadership and governance opportunities, physicians will be supported with care management programs to effectively manage their patients with challenging chronic medical conditions, and to keep their patients well in the appropriate care settings. Finally, PMH brings significant value to physicians with its experience and success with risk-based payment arrangements which will continue to expand and replace the fee-for-service payment system healthcare services.

The value that PMH brings to physicians in the form of experience and competencies under risk-based payment arrangements; capital to invest in facilities, equipment, programs and technology; leadership and governance opportunities; and programs to assist in the management of patients will support and grow the ECHN Medical staff.

PMH is a physician friendly company that tries to accommodate physicians' preferences for practicing medicine. Some physicians prefer to be employed, while others wish to remain independent but would like to work in a hospital environment where they know that independent physicians are valued. There is another subset of physicians who would like to remain independent but work in hospital-based clinics. PMH provides the full menu of

options to physicians. Furthermore, as described in the response to Question 10 above, PMH has been very successful at recruiting physicians, including the most recent success in establishing an IPA in Rhode Island with 105 primary care practitioners and 270 specialist physicians. Of the 105 primary care practitioners in Rhode Island, only 18 were previously employed by the CharterCare System.

22. On page 70 of the Application, PMH and its affiliates commit to "continue support the CHNA [Community Health Needs Assessment] implementation plans [of ECHN] as they are rolled out through 2016." With respect to this statement, please respond to the following:

    a) Please address whether PMH intends to conduct CHNAs after the closing and, if so, whether it intends to conduct them in a manner that meets the requirements of IRS Code Section 501(r), including conducting a CHNA at least once every three years and adopting an implementation strategy to address those identified needs.

       Response:

       PMH will support and implement ECHN's CHNA plans through 2016. For subsequent years, PMH will work closely with ECHN's Local Advisory Boards (comprised of local leaders and physicians) to help assess local community needs and develop effective plans to address such needs.

    b) Describe PMH's experience in conducting CHNAs subsequent to acquiring non-profit, tax-exempt hospitals, specifically, those hospitals located in California and Texas;

       Response:

       PMH has not been required by any state to conduct CHNAs. However, PMH works closely with its Local community advisory Boards (comprised of local physicians and community leaders) to help assess local community needs and develop effective plans to address such needs.

    c) In 2013, MMH and RGH jointly conducted a CHNA. The CHNA identified four priority health needs including heart disease incidence, cancer incidence, diabetes incidence and arthritis incidence. Please provide, for years 2013 to present, the dates, locations, and number of free screenings ECHN conducted for the following:

       i. Blood pressure screenings
       ii. Cholesterol and/or body fat screenings
       iii. Cancer screenings

iv. Diabetes glucose testing

Response:

A list of screenings and educational programs conducted by ECHN for each of the four priority health needs identified in the CHNA has been provided in **Exhibit H**.

d) On page 1783 of the Application, ECHN's CHNA identified additional priority needs, including addressing Alzheimer's, Multiple Sclerosis, substance abuse and childhood lead screening, that ECHN was not able to address due to limited resources. Please elaborate how PMH plans to address these additional identified areas of need.

Response:

PMH will reevaluate the healthcare needs of the community with input from the Local Boards as part of its overall planning process post-closing and expects to prioritize capital projects and service improvements based on hospital and community needs. The goal will be to establish priorities based on maintaining or providing access to needed services that allow for the optimum care and coordination of care within and across the community. Plans to address the priority needs in ECHN's service area will be developed post-closing once the priority needs have been confirmed or identified.

23. Reference is made to the chart below concerning the amount of charity care provided by MMH and RGH from FY 2012 to FY 2014:

	FY 2012	**FY 2013**	**FY 2014**
MMH	$4,953,633	$3,908,882	$2,411,263
RGH	$2,192,753	$1,271,767	$1,188,543

** Source: OHCA Annual Report on the Financial Status of Connecticut's Short Term Acute Care Hospitals (Sept. 2015)*

a) Please explain the reasons for the year over year declines in charity care provided by MMH and RGH.

Response:

Charity care amounts reported by hospitals in OHCA's annual filings report the financial assistance provided to a subset of uninsured patients that apply for charity care and qualify per the hospital financial assistance guidelines. With the implementation of the Affordable Care Act ("ACA") and the expansion of Medicaid eligibility, the number of uninsured patients seen by ECHN has decreased. In addition, following implementation of the ACA, ECHN contracted with an outside vendor to improve the identification of Medicaid eligible patients and to assist those patients with the application process. As a result of these factors, the number of patients who were uninsured and qualified for charity care decreased, which contributed to the reduction in charity care amounts reported to OHCA. More than 60% of the hospitals in Connecticut (including MMH and RGH) also reported a decrease in charity care.[3]

It is important to note that the charity care amounts referenced above only reflect gross revenue (charges) for the uninsured patient population treated by the Hospitals. It is also important to note that with more patients covered by the Medicaid Program, the community benefit reported to the IRS for MMH and RGH has increased, reflecting the uncovered costs for providing services to Medicaid beneficiaries. The level of community benefit provided by a nonprofit hospital is based on the expenses associated with financial assistance provided at cost, the unreimbursed Medicaid services, other community benefit and community building activities of the hospital.

The total community benefit amounts reported for FY 2014 increased 30% at MMH and 10% at RGH compared to FY 2012 levels, despite the impact of the ACA. While the amount of total community benefit reported by MMH in FY2014 was less than the totals reported in FY 2013 (a 4% decline), this was due to a change in IRS instructions effective for FY 2014 that required grant revenue to offset grant program costs. Without this change, the MMH Community Building Activities would have been $1,841,362 and the total community benefit amount would have been $17,221,538 (a 5% increase over FY 2013 amounts). Despite this IRS reporting change the community benefit amount reported for the two ECHN hospitals combined shows an increase in the community benefit totals from FY 2013 to FY 2014:

[3] OHCA Annual Report on the Financial Status of Connecticut's Short Term Acute Care Hospitals (Sept 2015), Table 3, page 10.

Total Community Benefit - MMH	**FY 2012**	**FY 2013**	**FY 2014**
Financial Assistance at Cost *IRS 990 Schedule H Part I, 7a*	$1,602,647	$1,162,736	$577,404
Unreimbursed Medicaid Services *IRS 990 Schedule H Part I, 7b*	$6,221,594	$8,753,602	$8,167,609
Other Community Benefits *IRS 990 Schedule H Part I, 7j*	$2,937,827	$4,670,039	$6,635,163
Community Building Activities *IRS 990 Schedule H Part II, 10*	$1,335,251	$1,760,601	$293,406
Total	**$12,097,319**	**$16,336,978**	**$15,673,582**

Total Community Benefit - RGH	**FY 2012**	**FY 2013**	**FY 2014**
Financial Assistance at Cost *IRS 990 Schedule H Part I, 7a*	$742,084	$367,583	$333,537
Unreimbursed Medicaid Services *IRS 990 Schedule H Part I, 7b*	$3,631,357	$3,505,315	$4,675,911
Other Community Benefits *IRS 990 Schedule H Part I, 7j*	$1,500,538	$1,747,298	$1,414,904
Community Building Activities *IRS 990 Schedule H Part II, 10*	$3,244	$2,901	$19,070
Total	**$5,877,223**	**$5,622,997**	**$6,443,422**

Total Community Benefit – ECHN	**$17,974,542**	**$21,959,975**	**$22,117,004**

ECHN treats patients regardless of their ability to pay for services and hospital policies regarding charity care have not changed. The hospitals continue to provide the same level of financial assistance to patients that qualify based on need. PMH has committed to continue these ECHN policies. Medicaid expansion and the availability of low-cost insurance plans through the Health Insurance Exchange (created as a result of the ACA) have reduced the number of patients who qualify for financial assistance at hospitals across Connecticut, including MMH and RGH. Despite this, ECHN has continued to increase the total amount of community benefit that it provides to patients in its service area.

b) Please provide the amount of charity care provided by each hospital for FY 2015.

Response:

In FY 2015, as projected for FY 2015 in Financial Worksheet C, MMH provided charity care in the amount of $2,382,698 and RGH provided charity care in the amount of $1,195,377.

c) Please describe how the proposed asset purchase with PMH can result in an increase in charity care provided by MMH and RGH, respectively, and cite to any examples from PMH's prior non-profit acute care hospital acquisitions where the amount of charity care (not total uncompensated care inclusive of bad debt) has increased from year to year post acquisition.

Response:

With the passage and implementation of the ACA, the amount of charity care for the industry as whole has been declining. As more people are insured, the need for charity care has decreased. PMH remains committed to providing charity care and to maintaining the charity care policies of MMH and RGH.

24. In reference to Table 9 at page 96 of the Application, Applicants identify $27,678 in community based clinical services and $412,862 in health care support services provided by MMH in FY 2014; in reference to Table 10 at page 97, Applicants identify $47,369 in health care support services provided by RGH in FY 2014; and, in reference to Table 11 at page 100, Applicants identify $140,797 and $124,710 in community support and workforce development expenditures by MMH in FY 2014. Please provide the following:

a) A breakout of the services and community building activities associated with each of these amounts;

Response:

A breakout of the services and community building activities associated with the referenced amounts is presented below:

Manchester Memorial Hospital

Community Based Clinical Services

Breast health information and screening events, oversight of the Early Detection Program [4]	$	26,546
Blood pressure and cardiac health screenings	$	204
Diabetic foot screenings	$	928
Total Community Based Clinical Services:	**$**	**27,678**

Health Care Support Services

Expenses associated with transportation for patients to outpatient behavioral health services provided at 150 North Main Street:		
Costs of bus passes and taxi service	$	24,006
Time spent for referrals to other programs for patients residing outside of ECHN service area	$	3,214
2014 Medicaid Referral Calls (70% of expense allocated to MMH)	$	2,305
Lifeline – Free replacement buttons provided to clients	$	148
Nurse and survivorship navigator programs	$	334,474
Staff to assist patients in enrolling in Medicaid and other public assistance programs	$	48,715
Total Health Care Support Services:	**$**	**412,862**

[4] Grant funded program managed by ECHN's Breast Care Collaborative which provides breast screenings and colonoscopies for the uninsured and underinsured.

Community Support

Expenses associated with hosting the Veteran's Day dinner and Veteran's Day ceremony at MMH	$	1,778
Emergency management and disaster preparedness meetings and drills (including simulated situations involving hurricane, bed triage/patient overflow, active shooter, emergency supply, etc.)	$	5,330
Family Development Center Programs *(see the response to Question 24b below for more information on these programs)*	$	133,104
Staff participation in Manchester Chamber of Commerce events and South Windsor Chamber of Commerce board meetings	$	585
Total Community Support:	**$**	**140,797**

Workforce Development

Workforce training, vocational services to residents to obtain integrated competitive employment	$	115,766
Legal department mentoring of interns and volunteers	$	272
Capital Community College Advisory Board Annual Meeting, Rockville High School student and paramedic mock interviews	$	1,738
Career Advancement Program for Manchester High School seniors	$	4,724
Sleep Lab presentations to students and intern rotations	$	1,157
Rockville High School to Business Partnership meeting; orientation for parents of Allied Health Students; interviewing students and parent for Junior Volunteer summer program	$	1,053
Total Workforce Development:	**$**	**124,710**

Please see the response to Question 24c below for more information on the workforce development activities at MMH.

Rockville General Hospital

Health Care Support Services

2014 Medicaid Referral Calls (30% of expense allocated to RGH)	$	988
Lifeline – Free replacement buttons provided to clients	$	183
Staff to assist patients in enrolling in Medicaid and other public assistance programs	$	46,198
Total Health Care Support Services:	**$**	**47,369**

b) Details on the Early Head Start, Family Enrichment Services, Nurturing Families Network programs and the School-based Family Resources Centers' services provided by MMH's Family Development Center; and

Response:

As discussed previously in the Applicants' response to Question 52 of the CON application, MMH's Family Development Center operates programs for families needing support with parenting and other family issues. These programs are funded by state and federal grants. The $133,104 represents the in-kind contributions to the programs made by MMH.[5]

Additional information related to the specific programs has been provided below:

Early Head Start Program

The Early Head Start (EHS) program serves low-income children (birth to age three), pregnant women and their families residing in Manchester and/or Vernon. A Family Development Educator (FDE) provides parent education, child development information and learning activities.

EHS provides families with opportunities to get involved in their child's education.

[5] In-kind contributions refer to the expenses incurred by MMH in support of the program including, but not limited to, rent, administrative overhead (human resources, payroll, accounting, legal, information technology, etc.), insurance and overall program administration.

Positive Parenting Program[6]

Positive Parenting Program (Triple P) is a Connecticut State Department of Children and Families funded grant program. Triple P is suitable for parents with concerns about a child's behavior or who wish to learn a variety of parenting skills that will promote the development and potential of their child or teenager.

Nurturing Families Network Programs

The Nurturing Families Network (NFN) is designed to help new parents and consists of: (i) home visitation which helps first-time parents get off to a great start with a new baby and provides infant development and care information; (ii) Nurturing Connections provides phone support to help first-time parents adjust to their first few weeks home with a new baby; and (iii) organizing parenting groups.

School-based Family Resource Center Services

The ECHN Family Resource Centers (FRC) offer education and support services for the entire family Services included child care, school-age care, parent-child playgroups, parent education, home visits, support for child care providers, positive youth development, adult education, resources and referrals to community services.

c) Details on the Workforce Development activities of MMH.

Response:

The majority of activities related to the Workforce Development activities of MMH are related to the organization's Work Source program. Work Source is a program designed to help people with mental illness and substance abuse achieve vocational success and social and economic independence. The program provides assistance in securing and maintaining competitive employment and educational opportunities.

25. Applicants state that ECHN's present teaching arrangements with the University Of New England College of Medicine for third year medical students, residents, and interns will be maintained. Please explain how these students, residents and interns are deployed within MMH, RGH and the towns served by ECHN to provide healthcare services and whether PMH plans any changes to how such medical students, residents, and interns are utilized.

[6] Family Enrichment Services was renamed Positive Parenting Program by the Department of Children and Families to reflect changes in the program curriculum.

Response:

PMH has committed to maintaining key clinical operations and community support including ECHN's University of New England College of Osteopathic Medicine ("UNECOM") medical student and other health professions teaching programs, and ECHN's graduate medical education programs. PMH does not have any plans to change how the medical students, residents and interns are utilized. Students, residents and interns will continue to be deployed to the Hospitals and communities served by ECHN utilizing a rotation structure that has been developed for each program:

Medical Students - In 2010, ECHN partnered with UNECOM to provide medical education and clinical opportunities at ECHN for sixteen of UNECOM's third year medical students. Students spend their entire third year of medical school in Connecticut and participate in the following clinical rotations:

- Family medicine
- Internal medicine (Hospitalist Service and Critical Care)
- Obstetrics and gynecology
- Pediatrics
- Psychiatry
- Surgery

Medical students also select rotations in the following areas to complete the third-year requirements for their program:

- Emergency medicine (hospital-based)
- Gastroenterology (inpatient and outpatient settings)
- Osteopathic manipulative medicine (outpatient setting)
- Otolaryngology (inpatient and outpatient settings)
- Pathology (inpatient setting)
- Radiology (inpatient setting)

Residents and Interns - In 2013, in response to the growing need for primary care providers, ECHN launched its own graduate medical education (GME) program that includes a family medicine residency program (twenty-four positions) and a rotating internship program (six positions). Residents and interns participate in the following clinical rotations:

- Hospital-based rotations
    - Hospitalist service (Family Medicine Inpatient Service)
    - Critical care
    - Emergency medicine
    - Geriatrics (completed at ECHN's Woodlake at Tolland)
    - Obstetrics

  - Pediatrics - completed at Connecticut Children's Medical Center ("CCMC")
  - Pediatric emergency medicine - completed at CCMC
  - Psychiatry
  - Surgery

- Community-based (outpatient) rotations
  - Cardiology
  - Dermatology
  - Family medicine
  - Gynecology
  - Nephrology
  - Ophthalmology
  - Orthopedics
  - Osteopathic manipulative medicine
  - Otolaryngology
  - Podiatry
  - Rheumatology
  - Sports medicine
  - Surgery

26. On page 63 of the Application, Applicants cite that the "Rockville section of Vernon, where RGH is located, has been designated by the Health Resources and Services Administration as a Medically Underserved Population and the northwestern part of Mansfield has been designated as a Health Professional Shortage Area for Primary Medical Care. RGH, MMH and their System affiliates provide safety net services to this region of the State." Please explain specifically how the proposed transaction with PMH will continue to address the needs of these underserved areas by identifying those programs, services and collaborations with other community organizations that will continue post-closing and provide information on any plans for new programs, services and collaborations that will expand access to health care in these underserved areas.

Response:

Services currently provided by ECHN at RGH and in the surrounding communities address the needs of Rockville's medically underserved population. RGH's emergency department has over 20,000 patient visits annually and nearly half of those patients come from the town of Vernon. The Maternity Care Center, located on the RGH campus, provides free maternity services to uninsured and underinsured women from Vernon and surrounding towns, including Manchester, Ellington, East Hartford and Mansfield. ECHN has established, through its medical foundation, a family medicine practice in Rockville within close proximity to RGH and another practice in Vernon, just a few miles from the Rockville section, to support the primary care needs of the area.

In Tolland, which is only a few miles from the northwestern border of Mansfield, ECHN offers laboratory services and has a number of specialists that see patients in a shared specialty suite at Fieldstone Commons. Also at this location is ECHN's joint venture imaging center Tolland Imaging Center which makes MRI, CT and other medical imaging services available to patients in a convenient outpatient setting. Several independent primary care physicians on the ECHN Medical staff practice at locations in Vernon, Tolland and Coventry, all of which offer a convenient source of primary care services for residents of northwestern Mansfield.

PMH has committed to keeping the Hospitals open for three years and has no plans to eliminate any services. No service line or service location changes are currently planned in connection with the proposed transaction, although it is expected that the ECHN ambulatory network will be expanded and services configured to promote the most efficient delivery of coordinated care following the closing. Through PMH's CRC model, PMH works closely with hospitals and affiliated medical groups for the benefit of every person who comes to them for care, building comprehensive networks of quality healthcare services that are designed to offer patients highly coordinated, personalized care and help them live healthier lives.

PMH will look to work with current service area providers such as Federally Qualified Health Centers in such underserved and health professional shortage areas to support their health care delivery efforts. PMH will also aggressively recruit physicians for these areas. PMH will also seek to expand services in these areas by establishing clinics / urgent care centers and staffing such centers with either independent or employed physicians. There are no definitive plans at this time to add service locations for MMH or RGH. PMH will conduct a planning effort with the Local Boards post-closing to determine where there are opportunities to improve access, enhance services and introduce new programs that address identified health needs.

27. With respect to Exhibits Q42-1, Q42-2 and Q44-1, please address the following:

a) Applicants project no change in Nurse Staff to Patient Ratios or the Average Weekly Hours for Ancillary Caregivers for three years following approval of the asset purchase. Reconcile how the asset purchase will achieve efficiencies and improve quality of care without corresponding adjustments to nurse to patient ratios and the hours of ancillary caregivers.

Response:

PMH expects to implement cost and clinical efficiencies over time utilizing a planned and coordinated approach. Specific plans to address potential areas of opportunity that would impact patient census, patient acuity, staff experience levels and

technology utilized by caregivers have not been developed at this time, so staffing changes that would result related to these factors cannot be reasonably predicted. Furthermore, the parties have been careful to wait for the required antitrust approvals before making any post-closing plans, including any operational or capital plans.

Given these limitations, the projections presented in Exhibit Q42-2 (Staffing Attachment II) and Exhibit Q44-1 (Ancillary Caregiver Staffing Attachment) assumes volume demands (which would impact unit configuration and size), patient acuity, staff experience levels, and technology will remain constant during the projection period. During the first three full fiscal years following approval of the Asset Purchase (FY 2017, FY 2018, and FY 2019) staffing levels may begin to shift as PMH introduces best practices from its other hospitals and implements its CRC model, which is expected eventually to result in changes in patient acuity caused by improving population health and a shift in relative volumes of inpatient and outpatient services. PMH is committed to staffing levels that comply with ratios mandated by Connecticut state law, which implement best industry practices, and which take into account patient safety and acuity, employee safety and facility census.

b) ECHN failed to meet budgeted targets for Average Nursing Hours per Patient Day in several categories yet no changes in Nursing Staff ratios for the first three years following approval of the asset purchase are projected. Explain why this is the case.

Response:

The Nursing Hours per Patient Day (NHPPD) target is a metric used by nursing unit leaders to manage staffing levels and help them to respond to fluctuations in unit census. Unit census changes constantly and can vary significantly from day-to-day and hour-to-hour, making the decision of when to adjust staffing levels (and for how long) challenging. Factors including, but not limited to, the number of patients being admitted to or discharged from a unit, the acuity of patients on the unit and staff experience all influence decisions regarding staffing levels. Whether or not a unit has historically met NHPPD targets does not affect the Nursing Staff ratio guidelines for future years because the ratios are determined by the projected unit census and the Nursing Staff requirements at that census level.

PMH expects to implement cost and clinical efficiencies over time utilizing a planned and coordinated approach. Specific plans to address potential areas of opportunity that would impact patient census, patient acuity, staff experience levels and technology utilized by caregivers have not been developed at this time, so staffing changes that would result related to these factors cannot be reasonably predicted. Furthermore, the parties have been careful to wait for the required antitrust approvals before making any post-closing plans, including any operational or capital plans.

Given these limitations, comparable Staffing ratios were maintained until specific plans are developed

28. Please elaborate on the expected revenue growth for MMH and RGH associated with the use of the CRC model of care and provide specific examples from hospitals currently owned by PMH of actual savings realized post-acquisition in the various operating expense categories set forth in Financial Worksheet (C).

Response:

The implementation of CRC is not expected to cause a reduction in operating expense categories. The goal of CRC is reduce the overall cost of healthcare by increasing preventative care and early interventions, reducing re-admissions, reducing inpatient utilization and reducing emergency room visits. CRC achieves these objectives by incentivizing physicians and patients to appropriately use urgent cares centers and to keep patients compliant with various homebound and other wellness programs, and by keeping patients healthier so as to reduce the overall over-utilization of healthcare services. By achieving these objectives, the cost of healthcare will be reduced, including for such programs as Medicaid and Medicare.

In the state of Rhode Island, PMH projects to reduce the cost of care for a segment of the Medicaid population by 5%.

29. On page 78 of the Application, the Applicants indicate that "PMH has access to an existing corporate level credit facility in addition to its cash on hand." Name the credit facility, provide PMH's current credit rating and elaborate on the process associated with borrowing funds from this credit facility to fund any portion of the $75 million Commitment Amount in lieu of cash from MMH and RGH operations.

Response:

PMH has received credit upgrades by both Moody's and S&P in 2015. Moody's rates PMH's bonds as B1, while S&P rates PMH's bonds as B.

PMH has access to a revolving line of credit with Morgan Stanley that has been pre-approved. In order to draw on this line, PMH simply provides a 24 hour advance verbal notice to the lenders. The line of credit is available to fund the Commitment Amount if necessary.

30. Elaborate on the financial feasibility to fund the $105 million (or $115 million) purchase price given PMH's declines in cash and cash equivalents, operating income, net income, and realized deficits in Stockholder's equity from FY 2012 to 2014 reported in its FY 2014 audited financial statements as set forth at Exhibit Q8-1.

Response:

PMH's financial performance has demonstrated significant growth from 2012 to present:

PMH Financial Performance	2012	9 Months Ending 06/30/2015
Operating Income:	$80 Million	$82.3 Million
Net Income	$26 Million	$32 Million
Stockholders' Equity	$31 Million	$34 Million

The growth in Stockholders' Equity is net of a $100 million dividend paid in November 2012. Please refer to Exhibit Q8-2 of the CON application for more information pertaining PMH's stockholder equity.

Impacting 2014 reported financial and cash flow was the delay in revenue recognition of the California Quality Assurance Fee (SB 239) program. The associated revenue, EBITA and cash receipts could not be recognized until formal Federal approval of the program was received which occurred after the fiscal year-end.

Cash balances from 2012 to 2014 were impacted by the completion of multiple acquisitions paid with existing cash on the balance sheets. The cash consideration for these aquistions totaled in excess of $81 million. Additionally, during this time, the Due from Government payor receivable increased by more than $28 million, primarily due to the delay in funding the California Quality Assurance Fee program for the period of January 2014 to September 2014. Payments related to this program were subsequently received in 2015.

PMH has significant cash on hand to complete the transaction. As of September 30, 2015, PMH on consolidated basis had in excess of $110 million in funds available. Furthermore, PMH generates over $7.5 million in free cash flow per month. The amount of cash necessary to close the ECHN transaction is currently estimated to be approximately $28 million.

31. On page 907 of the Application, in PMH's Condensed Consolidated Statements of Operations, Applicants report significant growth in both Total Net Revenues and Total Operating Expenses for the nine months ending June 30, 2015 as compared to the same reporting period in 2014. Please explain the factors impacting these changes.

Response:

Revenue and expense growth for the nine months ended on June 30, 2015 as compared to the same reporting period in 2014 is due to the acquisition of CharterCARE in the state of Rhode Island and the recognition of payments from the California Quality Assurance Fee (SB 239) program.

32. In reference to the priority capital projects identified by ECHN management on page 82 of the Application, provide their current estimated cost and, as applicable, the years beyond useful life for these assets.

Response:

The following table contains cost estimates for the capital list identified by ECHN management. The years beyond useful life for the assets being replaced indicate the time since the asset was last being depreciated for accounting purposes and does not suggest that the assets are not in good working order.

	Estimated Cost	Estimated Years beyond useful financial life
Upgrades to emergency department for behavioral health patients (MMH)	$1.1M	N/A
Electronic medical record system (MMH & RGH)	$20M	N/A
Upgrades to nursing units (RGH)	$6.6M	N/A
Upgrades to nursing units (MMH)	$11M	N/A
Vessel sealing systems (MMH & RGH)	$0.6M	N/A
MRI replacement (MMH)	$1.6M	4
SPECT scanner replacement (MMH)	$0.4M	10

33. With the understanding that the $75 million Commitment Amount has not been apportioned by hospital or other affiliates, please submit a preliminary capital investment plan that provides an approach on how PMH might distribute the $75 million by capital projects.

Response:

The parties have not yet prepared a capital investment plan. ECHN and PMH have agreed to seek the input of the Local Boards and medical staff to produce a capital plan post-closing that will ultimately determine the capital projects and priorities. The parties have been careful to wait for the required antitrust approvals before making any post-closing plans, including any operational or capital plans.

In order to better position ECHN as a premier choice for healthcare in its community, PMH believes that it will need to continually evaluate the facilities and markets for future capital projects. Immediately post-closing, as a part of the strategic planning process, PMH would consider and evaluate market data and projections, current and proposed regulatory environments, operational and financial requirements, and capital expenditures models in the markets in which ECHN operates. This strategic planning process would be led by the local management team; however the resources of PMH would provide the necessary capital and expertise to enhance existing services and add new service lines.

Working with the local leadership, PMH will identify and prioritize the identified capital projects. PMH's objective is to implement growth initiatives for the benefit of the surrounding communities served by ECHN so long as that care can be delivered in a high quality and financially responsible manner.

34. Provide an updated Exhibit Q8-2, providing PMH's FY 2015 unaudited financial statements to reflect twelve months of financial activity.

Response:

PMH's FY 2015 unaudited financial statements reflecting twelve months of financial activity are not yet available as PMH's year-end financials cannot be disclosed publicly in draft form, particularly in light of the potential investment transaction at PMH corporate level, described more fully below (see response to the deficiencies identified by OAG and OHCA on November 12, 2015, beginning on page 2204, for more information on this investment transaction). The Applicants will provide a copy of the financial statements once the audited financials have been received and they have been publicly disclosed.

35. In reference to Financial Worksheet (C), Exhibit Q37, and the related Assumptions, at Exhibit Q38, for MMH, RGH and ECHN address the following:

a) Provide a revised Financial Worksheet (C) that will include projections of total revenue, expense and volume statistics without, incremental to and with the CON proposal for FYs 2015 and 2016. Provide the assumptions utilized in developing the projections and explain any projected losses from operations;

Response:

Financial Worksheet (C) has been revised to include projections of total revenue, expense and volume statistics without, incremental to and with the CON proposal for FY 2015 and FY 2016.

The FY 2015 projections are annualized statistics based on actual FY 2015 year-to-date amounts through July and were originally provided on pages 1846 and 1847 of the CON application submitted on October 13, 2015. Assumptions utilized in developing the FY 2016 projections can be found on pages 1852 and 1853 of the CON application.

Additionally, after reviewing the detail assembled for other operating revenue (requested in Question 35b below), it was brought to the Applicants' attention that the amounts for Public Support were not removed in the "with CON" scenario. This oversight has been corrected and the revised incremental amounts for other operating revenue are now reflected in the projections with CON approval presented on Financial Worksheet (C).

Please refer to **Exhibit I** for the revised version of Financial Worksheet (C) reflecting the changes described above.

ECHN is projecting declines in net patient revenues in FY 2015 and FY 2016 as a result of payer mix shifts to the exchanges and Medicaid. As discussed on page 36 of the CON application in the Applicants' response to Question 5, increases to the state hospital tax, Medicare wage index changes, and the continued evolution of the health spending accounts are additional factors behind ECHN's projected operating losses.

b) The Assumptions, listed under the other operating revenue section, indicate that joint venture income will increase 2% each year after FY 2016. Provide an itemized schedule of the other operating revenue amounts reported for FYs 2017, 2018 and 2019 without, incremental to and with the CON proposal, inclusive of joint venture income for all three entities; and

Response:

An itemized schedule of the other operating revenue amounts reported for FY 2015 through FY 2019 without, incremental to, and with the CON proposal, inclusive of joint venture income for all three entities has been provided in **Exhibit J**.

c) The Assumptions indicate that the asset purchase by PMH will allow MMH and RGH and their provider affiliates to benefit from economies of scale inherent of a large organization when purchasing supplies and services. In reference to this statement, explain the projected incremental increases in fringe benefits, supplies and drugs, and other expenses reported between FYs 2017 and 2019.

Response:

PMH believes that the costs to provide fringe benefits will decrease in the first full year of operation, because PMH is essentially self-insured for providing benefits and will therefore save on the profit portion of the premium generally paid to third parties in order to provide fringe benefits to employees. PMH estimates, however, that cost of providing fringe benefits will increase over time, as salaries and costs of providing benefits increase each year.

From a supplies perspective, PMH believes that through the economies of scale, the Hospitals will enjoy higher discounts for supplies and drugs as part of a larger organization in the first year. Subsequently, the Hospitals should be entitled to better discounts and pricing through better compliance with purchasing protocols. It should be noted, that if PMH is successful in future hospital acquisitions (whether within the state of Connecticut or outside), the Hospitals should receive better pricing as PMH's purchasing power increases.

36. Please provide updated Financial Measurements/Indicators, Exhibit Q50-1, for the months of July, August and September 2015 and comparable months from the previous fiscal year for MMH and RGH, ECHN and PMH. Provide the methodology utilized to calculate the financial ratios on Sections A through C and an explanation for any decreases or increases that apply to any of the items listed on Section D between YTD FYs 2014 and 2015.

Response:

Please refer to **Exhibit K** for Financial Measurement/Indicators for July, August and September 2015[7] and comparable months from the previous fiscal year for MMH, RGH and ECHN. Financial statistics for the entity which will acquire ECHN (Prospect ECHN, Inc.) are not available as the entity does not currently exist and will not be formed unless the proposed asset purchase is approved.

For the financial ratios on Sections A through C, the Applicants utilized the formulas provided by OHCA in the Twelve-month filing Report 185 to calculate all of the statistics with the exception of the following:

Statistic	Calculation Methodology Used
ECHN's Days Cash on Hand	(Cash + Board Designated Investments +Investments) / (Operating Expenses – Depreciation) x 365 days
ECHN's Average Payment Period	Current Liabilities x 365 days / (Operating Expenses – Depreciation)
ECHN's Long-term Debt to Capitalization	Long-term debt / (Long-term debt + Unrestricted Net Assets)
ECHN's Debt Service Coverage Ratio	(Net Income + Depreciation + Interest Expense + Change in Swap value) / Maximum Annual Debt Service

ECHN saw a deterioration in all of the financial indicators in Section D due mainly to lower government reimbursements, most notably from the State. In addition, ECHN saw a decrease in volume across many of the key inpatient and outpatient services provided by the hospitals which also contributed to the declines observed in these financial indicators.

37. For each of PMH's five most recent acute care hospital acquisitions identified in Exhibit Q58-1 of the Application address the following:

    a) Complete the following table:

[7] Financial statistics provided for September 2015 are based on the unaudited financials for MMH, RGH and ECHN available at the time of this submission. The Applicants will plan to submit an updated version of the September 2015 financials once the year-end audit has been completed and the final audited financial statements for FY 2015 are available.

Name	Total Capital Investments	Describe Improvements in Financial Performance			Total Cost Savings
		Profits	Liquidity	Solvency	

Response:

Please see **Exhibit L** for the completed Table.

b) Describe particular initiatives utilized to achieve the results described above;

Response:

With respect to Los Angeles Community Hospital at Bellflower and Foothill Regional Medical Center, the capital investments were for improvement to the plant and equipment to open the hospitals.

With respect to Nix, PMH made investments in creating an IPA, expanding outpatient clinics, opening an emergency room, expanding behavioral health capacity, and upgrading plant and equipment.

With respect to the CharterCARE, in only its first year of ownership, PMH has made investments in forming an IPA, forming a risk bearing entity, acquiring primary care clinics, and making upgrades to plant and equipment. PMH has committed to spending an additional $20 million on a cancer center, Digestive Diseases Center, expansion and upgrade to the emergency department and additional physician practice acquisitions.

c) Indicate how the financial performance improvements translated into lower health care costs; and

Response:

Initiatives implemented through the development of the CRC model of care will facilitate a more efficient care delivery model. CRC encourages providers to be more clinically integrated with other care givers and enables patients to receive the right care, with the highest levels of quality, in the most appropriate care setting. Through the development of the CRC and the attainment of these objectives, PMH will be successful reducing unnecessary re-admissions, inpatient

utilization, and emergency room visits which will translate into improved outcomes and lower health care costs for patients in the region.

d) Indicate how the cost savings were due to economies of scale inherent of a larger organization; and

Response:

As discussed in response to Question 28 above, the implementation of PMH's CRC will not cause a reduction in operating expense categories at a hospital. The goal of CRC is reduce the overall cost of healthcare by reducing re-admissions, reducing inpatient utilization and reducing emergency room visits. By achieving these objectives, PMH will reduce the cost of healthcare for such government programs as Medicaid and Medicare, but also to commercial insurers who elect to participate in risk-based contracts.

It should be noted that by affiliating with a larger organization, ECHN will benefit from economies of scale due to PMH's overall purchasing power. Post-acquisition, ECHN should realize benefits in lower supply costs, drug costs and costs related to consultants. By having ECHN participate in PMH's Group Purchasing Organization, ECHN will realize lower supply and drug costs. Furthermore, the resources of PMH will be made available to ECHN to assist ECHN in developing and implementing its strategic plans, whereas in the past, ECHN may have employed consultants to aid in such efforts.

e) Since Exhibit Q58-1 contains no discussion of how these acquisitions improved the quality of health care for the hospital's service area, comment on each hospital's performance under the following CMS quality improvement programs since PMH first acquired the hospital (comparison to national, state and local performance standards as well as ECHN's current performance statistics is invited):

i. Hospital Inpatient Quality Reporting Program;
ii. Hospital Outpatient Quality Reporting Program;
iii. Hospital Value-Based Purchasing Program; and
iv. Hospital Readmissions Reduction Program.

Response:

Please see **Exhibit M** for the quality report generated by the State of Rhode Island with respect to the CharterCare CON and conversion process. The report includes the historical quality metrics at the now current PMH hospitals.

Attached in the **Exhibit N** is an update of the quality metrics for 2014. Metrics for MMH and RGH are included in the exhibit. Additionally, please note that 2015 risk adjusted quality metrics have not been published.

Delivering quality care is of utmost importance in operating a hospital as well as the CRC model. As physicians are such an integral part of delivery of care, PMH believes that quality issues should be handled at a local level. The goals of the PMH Quality Program consist of achieving results in each of measures that are better than the national average, with the expectation of continuous improvement. The PMH Quality program is the accomplished through a joint process between the Medical staff leadership and Hospital leadership within each entity with oversight by the Local Governing Board. PMH provides overall leadership, coordination of best practice, and Policy and Procedures for Standardization of protocols.

38. On page 865 of the Application, PMH's FY 2014 audited financial statements, indicate that "*Patients without insurance are offered assistance in applying for Medicaid and other programs they may be eligible for, such as state disability. Patient advocates from the Company's Medical Eligibility Program ("MEP") screen patients in the Hospital and determine potential linkage to financial assistance programs. They also expedite the process of applying for these government programs*." Elaborate on the MEP process and success record. Indicate whether this program will be available at MMH and RGH if the asset purchase is approved and consummated.

Response:

Uninsured patients who receive services at PMH-affiliated hospitals are interviewed by either employees or third party contractors to determine if such patients are entitled to benefits from a variety of financial assistance programs, most notably state Medicaid. With the expansion of Medicaid under the ACA, many patients who present as uninsured are not aware that they could potentially qualify for Medicaid. Through the interview process, PMH hospitals determine if such patients qualify for Medicaid and assist such patients with submitting the appropriate forms to the relevant state agencies. In California, PMH estimates the success rate on assisting patients to qualify for financial assistance programs to be approximately 60%. In Texas, this success rate is approximately 15%. The success rate is lower in Texas because Texas did not opt for Medicaid expansion as part of the ACA. PMH has just

recently instituted our MEP program in Rhode Island. As such, PMH has not had a chance to assess its success in Rhode Island.

39. On page 92, Applicants were asked provide copies of the most recent CMS Statements of Deficiencies and Plans of Correction (CMS Form 2567) for all hospitals owned by PMH. Applicants provided only those statements pertaining to its Rhode Island hospitals. Please provide the requested information for PMH owned hospitals in Texas and California. Provide these documents in an electronic format only. PDF file on a CD to accompany the responses.

Response:

Please see **Exhibit P** for the requested CMS Statements of Deficiencies. Documents have been provided in electronic format only as requested.

40. With respect to the proposed Asset Purchase Agreement, please provide the information contained in the following schedules: Schedule 2.01 (a) Owned Real Property; Schedule 2.01(b) Leased real property; Schedule 3.12 (c) Building Maintenance and Repairs; Schedule 3.12(g) Rent Roll; Schedule 3.12 Tenant Lease Encumbrances; Schedule 3.13(a) Environmental claims; Schedule 3.13 (b) Underground storage tanks and waste disposal; and Schedule 3.18 People in possession of owned property.

Response:

The APA schedules referenced above are documents that will be produced for Closing. Please see **Exhibit O** for responsive information describing ECHN owned real property, leased real property, building maintenance and repairs, rent rolls, tenant lease encumbrances, environmental claims, underground tanks and waste disposal. Schedule 3.18 to the APA (Exhibit Q3-2 of the CON submission, page 127) does not concern owned property; however, responsive information regarding this topic is being made available in **Exhibit O** under the title Owned Real Property. The information in **Exhibit O** is subject to change in the ordinary course of business prior to Closing.

41. Please provide a full and complete listing of both owned and leased real property, including any real estate related to joint ventures.

Response:

Please refer to the responsive information included in **Exhibit O** under the titles Owned Real Property and Leased Real Property for a listing of ECHN's owned and leased property.

The real property leased by the joint ventures is listed in the following table:

Joint Venture	Real Property
Ambulance Service of Manchester, LLC	275 New State Road, Manchester, CT 06042
Aetna Ambulance Service, Inc.	140 Van Block Avenue, Hartford, CT 06114
Connecticut Occupational Medicine Partners, LLC*	2800 Tamarack Avenue, South Windsor, CT 06074
Eastern Connecticut Physician Hospital Organization, Inc.	26 Haynes Street, Manchester, CT 06040
Evergreen Endoscopy Center, LLC	2400 Tamarack Avenue, South Windsor, CT 06074
Evergreen Medical Associates, LLC	2800 Tamarack Avenue, South Windsor, CT 06074
Evergreen Medical Associates II, LLC	2400 Tamarack Avenue, South Windsor, CT 06074 2600 Tamarack Avenue, South Windsor, CT 06074
Haynes Street Medical Associates, LLC	29 Haynes Street, Manchester, CT 06040
Haynes Street Medical Associates II, LLC	100 Haynes Street Manchester, CT 06040
Metro Wheelchair Service, Inc.	275 New State Road, Manchester, CT 06042
Northeast Regional Radiation Oncology Network, Inc.	100 Haynes Street, Manchester, CT 06040 142 Hazard Avenue, Enfield, CT 06082
Tolland Imaging Center, LLC	6 Fieldstone Commons, Tolland, CT 06084
WBC Connecticut East, LLC	2400 Tamarack Avenue, South Windsor, CT 06074

** Connecticut Occupational Medicine Partners, LLC provides management services for Manchester Memorial Hospital's CorpCare Program at this address.*

42. With respect to Question 5, please provide any information and documents that are not attorney/client privileged or are protected by confidentiality agreements relating to any other offers to transfer assets or operations or change control of operations received by ECHN.

Response:

As referenced in response to Question 5 of the Application, ECHN received three responses to its February 19, 2015 Request for Proposal (RFP). One was from a nonprofit system that proposed making a minority investment in ECHN, purchasing its home care agency and providing a management agreement for ECHN. A second was from a national nonprofit organization that was merging with a Connecticut nonprofit system and that proposed a member substitution pursuant to which it would become ECHN's corporate parent. The third proposal was from PMH to acquire all or substantially all of the assets of ECHN. As part of the RFP process, ECHN entered into confidentiality agreements with each of the respondents. As such, ECHN has committed to the respondents (other than PMH who has consented to disclose information about its response in connection with obtaining necessary regulatory approvals) to keep the details of those offers confidential. ECHN is not, therefore, permitted to provide any additional information or documentation on the offers received, other than the offer received from PMH (see response to Question 5 for the complete response received from PMH).

On November 12, 2015, ECHN and PMH received additional correspondence from the OAG and the OHCA requesting additional information regarding reports of a potential sale of PMH. The Applicants' response to the deficiencies received on November 12, 2015 has been provided below:

1. Please confirm or deny the reports identified above and specifically explain the basis for the report.

   Response:

   Neither PMH nor any of its subsidiaries are affiliated with the Deal Pipeline's website or the LBO Wire. Therefore, we cannot explain how or why those particular reports were generated.

   We can confirm, however, that PMH has retained Morgan Stanley to review and assess additional sources of investment to support its overall growth strategy, and that PMH has been in discussions with additional investment groups to evaluate opportunities to partner during this next phase of the company's growth.

   PMH is a growing company that is performing very well and receives inquiries from interested investors. The company is not for sale to a strategic buyer such as another healthcare provider, health plan or health system. PMH is only considering its financial investment and investor options to support its plans for future growth.

2. Please describe Leonard Green & Partners and its present ownership stake and control of PMH.

   Response:

   About Leonard Green & Partners, L.P. ("Leonard Green") - Source: www.leonardgreen.com

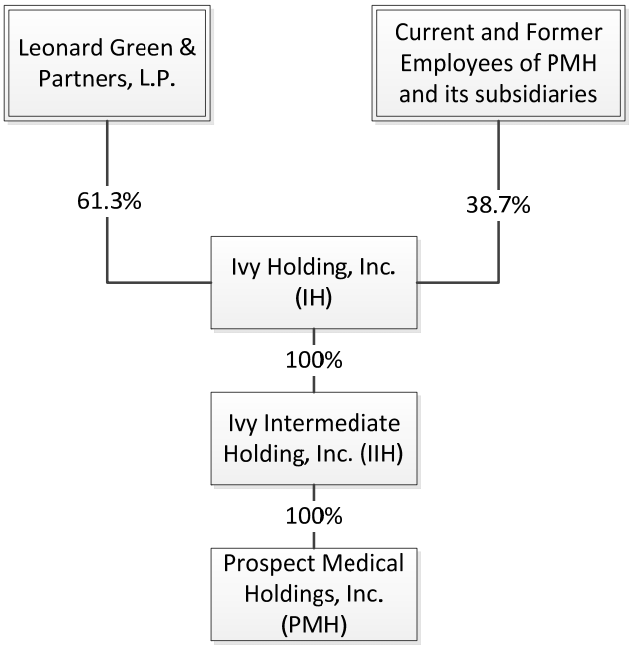
   "Leonard Green is one of the nation's preeminent private equity firms with over $15 billion of private equity capital raised since its inception. Founded in 1989, the firm has invested in 76 companies in the form of traditional buyouts, going-private transactions, recapitalizations, growth capital investments, corporate carve-outs and selective public equity and debt positions. Based in Los Angeles, CA, Leonard Green invests in established companies that are leaders in their markets." [8]

   The affiliated investment funds of Leonard Green own approximately 61.3% of the common stock of Ivy Holding, Inc. ("IH"), a Delaware corporation which owns 100% of the stock in Ivy Intermediate Holding, Inc. ("IIH"). IIH is a Delaware corporation which owns 100% of the stock of PMH. IIH is a holding company for such stock ownership. It has no other assets,

[8] http://www.leonardgreen.com/news/081415-Ellucian-n.pdf

liabilities or operations. Current and former employees of PMH and its subsidiaries own the remaining shares of IH stock.

Figure 1 – Relationship of Leonard Green to PMH



Other healthcare related investments held by Leonard Green include CHG Healthcare Services, RestorixHealth and US Renal Care.

3. If PMH is contemplating a sale, whether for a controlling or non-controlling interest in PMH, please explain the motivation and rationale for the sale.

Response:

PMH is not for sale to a strategic buyer such as another healthcare provider, health plan or health system. PMH is only considering its financial investment and investor options to support its plans for future growth. The rationale for pursuing these potential partnerships is to secure a means of raising additional capital to support its existing operations and for further acquisitions in new and existing markets.

4. If PMH is contemplating a sale, whether for a controlling or non-controlling interest in PMH, please explain the planned timeline for the sale.

Response:

The engagement with Morgan Stanley to review and assess additional sources of investment for PMH will likely conclude within the next year. PMH will only proceed further with any additional investors if we find a partner that supports our current growth strategy. The engagement with Morgan Stanley may not yield any additional investment into the Company. This is an evaluation at this point in time.

5. If PMH is contemplating a sale, whether for a controlling or non-controlling interest in PMH, please explain the anticipated key terms and conditions of the sale.

Response:

At of the date of this response, there is no pending sale of PMH, and as a result, no terms and conditions.

6. If PMH is contemplating a sale, whether for a controlling or non-controlling interest in PMH, please explain how a sale would affect the planned acquisition of ECHN.

Response:

PMH's pursuit of additional investment partners will not affect the planned acquisition of ECHN. Capital funding associated with PMH's acquisition of ECHN is currently available. The rationale for pursuing additional investment partners at this time is to prepare the organization for future growth and to support PMH's overall growth strategy.

7. If PMH is contemplating a sale, whether for a controlling or non-controlling interest in PMH, please explain how the sale would affect the future operations of ECHN.

Response:

PMH's pursuit of additional investment partners will not affect the future operations of ECHN other than to support the overall growth of PMH – which could also benefit ECHN as part of a growing system. PMH's short and long term strategy and focus on transforming the healthcare delivery model will not change. PMH will continue to focus on its current operations and will continue to invest in its hospitals, medical groups, CRC network and related business. The management of PMH will remain unchanged.

RESPONSE TO DEFICIENCIES
EXHIBIT A – Joint Venture Valuations

Joint Venture Valuations

	Ownership/ Membership	ECHN Net Income/(Loss) 9/30/2014	Joint Venture EBITDA 9/30/2014	EBITDA @6X
Metro Wheelchair Service, Inc.	50%	(54,225)	(54,462)	(326,772)
Aetna Ambulance Service, Inc.	50%	188,996	495,936	2,975,616
Ambulance Service of Manchester, LLC	50%	1,026,411	1,355,963	8,135,775
WBC Connecticut East, LLC	16%	(1,455)	10,366	62,195
Evergreen Endoscopy Center, LLC	50%	491,891	565,547	3,393,279
Tolland Imaging Center, LLC	70%	179,810	238,046	1,428,277
Northeast Regional Radiation Oncology Network, Inc.	50%	381,743	506,689	3,040,131
Haynes Street Medical Associates, LLC	23%	20,243	46,896	281,374
Haynes Street Medical Associates II, LLC	15%	65,410	186,919	1,121,513
Evergreen Medical Associates, LLC	20%	108,866	130,389	782,333
Evergreen Medical Associates II, LLC	20%	70,834	205,715	1,234,292
Total		**2,478,524**	**3,688,002**	**22,128,012**

RESPONSE TO DEFICIENCIES

EXHIBIT B - Table 8: Net Proceeds Analysis (Revised 11/4/2015)

Response to Deficiencies Question 4

Table 8: Net Proceeds Analysis

Assumes transaction will close on 09/30/2015

			Scenario B 9/30/2015	Scenario A 9/30/2015
ACQUISITION PRICE (EV)	A		$115,000,000	$105,000,000
ASSUMED LIABILITIES:				
Pension & Retiree Medical			($62,598,000)	($62,598,000)
Captive & Workers Comp.			($1,705,000)	($1,705,000)
Net Working Capital True-up			($9,107,000)	($9,107,000)
"Taxable" Long Term Debt			($45,000,000)	0
Capital Leases, Misc (FIN47)			($8,045,000)	($8,045,000)
TOTAL ACQ LIABILITIES	B		($126,455,000)	($81,455,000)
NET PROCEEDS (CASH to ECHN)	C	A+B	($11,455,000)	$23,545,000
CASH & INVESTMENTS (ECHN)	D		$58,214,000	$58,214,000
TOTAL CASH for DEBT PAYOFF	E	C+D	$46,759,000	$81,759,000
LONG TERM DEBT (Net AWUIL)	F		($42,696,000)	($77,696,000)
SURPLUS after DEBT DEFEASANCE	G	E+F	$4,063,000	$4,063,000
INDEMNITY RESERVE	H		($3,063,000)	($3,063,000)
SURPLUS for COMM. FOUNDATION	I	G+H	$1,000,000	$1,000,000

Updated November 4, 2015

RESPONSE TO DEFICIENCIES
EXHIBIT C - Request for Proposal Response (PMH)

10780 Santa Monica Blvd
Suite 400
Los Angeles, CA 90025
Tel (310) 943-4500
Fax (310) 943-4501

VIA EMAIL ONLY

March 16, 2015

Mr. Dennis P. McConville
Senior Vice President and Chief Strategy Officer
Eastern Connecticut Health Network, Inc.
71 Haynes Street
Manchester, CT 06040

Dear Mr. McConville:

This letter sets forth the non-binding intent of Prospect Medical Holdings, Inc. ("Prospect") with respect to a proposed transaction in which Prospect, or a designated subsidiary, would acquire the assets of Eastern Connecticut Health Network (collectively "ECHN"). The following represents the basic framework of our proposal and, if acceptable to ECHN shall serve as a basis for a more formal Asset Purchase Agreement ("APA").

Pursuant to your request we have attached a revised draft APA and side letter. Please note that the revised draft APA, as well as the side letter, are subject to further diligence, which will require exchange of additional information. Furthermore, should you have any questions or wish to discuss any of the revisions, please do not hesitate to contact us.

Prior to responding to the requested proposal elements, we believe a brief background on Prospect would be helpful.

Prospect is an innovative healthcare services delivery company that is responding to the evolving healthcare environment through meaningful collaboration between physicians and hospitals. Prospect's proven track-record with hospital integration and growth is directly related to its collaborative and cooperative relationships with physicians on a hospital's medical staff to promote the quality and efficiency of patient care. Prospect believes that it will meet ECHN's transaction objectives due to its financial strength, proven population management expertise, and its strong management team of seasoned operating, marketing, contracting, financial and administrative executives that maintain a dedicated "*hands-on*" commitment to the delivery of quality, cost effective healthcare services.

Prospect provides quality, cost-efficient and coordinated healthcare services through our hospitals, clinics and physician networks in Southern California, Texas, and Rhode Island. We are also purchasing an additional hospital in New Jersey.

We conduct our business operations through two complementary segments: the hospital segment and the medical group segment. Through our hospital segment, we own and operate 13 acute care and behavioral hospitals, with a total of approximately 2,258 licensed beds, and a network of 32 specialty and primary care clinics. Our hospitals are located in diverse population areas within Southern California, Texas and Rhode Island and maintain significant market positions in the areas they serve. All of our facilities provide a comprehensive range of services tailored to their specific communities, including other area hospitals, physicians and health plans. We believe that our proven model has a number of competitive advantages, including a data-driven and cost-efficient platform that has enabled us to provide quality care to patients.

Through our medical group segment and hospitals, we manage the provision of healthcare services to approximately 260,000 enrollees of Health Maintenance Organizations (''HMOs'') and other payers in Southern California through a network of approximately 8.900 primary care and specialty physicians. Based on our enrollment, our medical groups have a significant presence in Southern California and have long-term capitated contracts with nearly all major HMOs operating in the region. In addition to the medical group capitated enrollment, we also have contracts with affiliated medical groups and health plans which capitate our hospitals in Southern California for more than 30,000 members bringing our total lives under risk management to more than 300,000.

We align our hospitals and physicians under what we call coordinated regional care ("CRC"). CRC is the clinical integration among hospitals, physicians and other medical, social and community providers working closely with strategic partner health plans and other payers under a value-based, global risk reimbursement payment system to achieve the triple aim of improved patient care and experience, better patient health and lower costs. This has been a highly successful strategy for aligning physicians with our hospitals and improving the volume, quality, efficiency and financial performance of our system in California. We have implemented a similar, local version of the CRC strategy in our Texas and Rhode Island markets and have seen similar success.

We operate both our facilities and medical groups by applying highly disciplined, data-driven management to the provision of quality care to our patients. Through the in-depth analysis and application of various operational and financial metrics, we have been able to achieve a highly efficient cost structure across a diverse mix of payers and have been able to adapt to economic and regulatory changes. We believe the most cost-efficient and quality driven providers will succeed in this rapidly changing economic and regulatory environment. Furthermore, we believe the coordination of our facilities and medical groups creates an efficient healthcare delivery system that positions us well for the future of healthcare delivery.

Prospect currently owns the following hospitals:

- Los Angeles Community Hospital;
- Los Angeles Community Hospital at Bellflower;
- Norwalk Community Hospital;
- Southern California Hospital at Hollywood;
- Southern California Hospital at Van Nuys;
- Southern California Hospital at Culver City;
- Newport Specialty Hospital;
- Roger Williams Medical Center
- Our Lady of Fatima Hospital; and
- Nix Health (four campuses)

Furthermore, we believe that ECHN's vision for the future is compatible with Prospect's objectives in expanding into the Connecticut market. Prospect seeks to establish a quality healthcare delivery system in Connecticut with a continuum of services that would provide access to quality healthcare services to ECHN's surrounding communities on a cost efficient basis. We plan to employ a number of physician alignment strategies that will help ECHN to not only maintain its current market position but to grow its patient care services and enhance its market position. We also believe that Prospect's long and deep experience in population health management and coordinated regional care will make ECHN a leading healthcare provider in the state of Connecticut. Obviously, there is an enormous advantage to early adopters, which we believe we will be in the state of Connecticut.

Our interest in ECHN is based on its location in a very attractive market, its strong presence and commitment to its local community, its reputation for quality and service, and its significant potential for growth. We believe that this is the right opportunity for Prospect and plan to build upon ECHN's significant achievements as an essential community system.

Proposed Transaction

We propose to form one or more new entities to purchase all tangible and intangible assets owned or used by ECHN in the operation of the hospital and health delivery system. We contemplate that the assets would be conveyed and assigned free and clear of all liens, claims, charges or encumbrances. As a part of the transaction, Prospect expects to assume ECHN's pension liabilities.

Assuming that ECHN's consolidated balance sheet at closing would be free of all debt (including pension liabilities) and cash, Prospect is prepared to offer a total consideration of $180 million (based on ECHNS's financial statements as presented to date) for the assets of ECHN as described above. The consideration is broken down as follows:

Consideration for Assets	$105 million
Capital Commitment	$ 75 million
Total	$180 million

Please note that Prospect is amenable to and welcomes other potential transaction structures to be suggested by ECHN. Aside from acquisitions, Prospect has experience, and has had success, in structuring partnerships and joint ventures.

Vision and Operations

1. *How will affiliation with our organization help ECHN achieve its vision and goals?*

In order to better position ECHN as a premier choice for healthcare services in its community, we believe that we must continually evaluate the facilities and markets for future capital projects. Immediately upon the execution of the APA, as a part of our strategic planning process we would consider and evaluate market data and projections, current and proposed regulatory environments, operational and financial requirements, and capital expenditures models in the markets in which ECHN operates. Our strategic planning process would be led by the local management team; however the resources of Prospect would provide the necessary capital and expertise to enhance existing services and to add new service lines. Although we have not yet had an opportunity to review ECHN's strategic plan, we believe that we will build upon ECHN's plans.

We will form an integrated healthcare delivery system through the CRC model which will necessarily involve a physician engagement strategy with the goal of providing high quality care in an efficient manner. We plan to implement, as necessary and appropriate, value-based payments, bundled payments, accountable care, and clinical integration with physicians and other providers. This is a model we have successfully implemented in Southern California for many years and are in process of exporting to other markets such as Texas, Rhode Island and New Jersey. It is a model we would seek to establish in Connecticut.

2. *Based on your vision of the market, how can you help us improve the range of healthcare services available within the communities ECHN serves and access to those services?*

We recognize that meeting the long-term needs of ECHN's service area would require constant evaluation of the market to identify needed services to enhance growth. Growth strategies begin with a detailed assessment of the market to identify opportunities to add or expand healthcare services. ECHN's service lines would be identified and evaluated. Working with the local management team, and in consultation with local advisory boards, we will identify and prioritize the growth initiatives that make the most sense. It would be our objective to initiate growth initiatives for the benefit of the surrounding communities of the hospitals operated by ECHN so long as that care can be delivered in a high quality and financially responsible manner.

One of the key components of the CRC model is to build a coordinated network of providers that deliver the full range of services to a population for a value based payment. Of course it is preferable to have as many services delivered by owned and operated facilities as possible. However, it generally isn't possible or feasible to provide all services for such a population. We would use the CRC network development process to assist in the evaluation of those existing and new services best provided by ECHN and those that could be provided more advantageously by others.

As an example, since the closing of our transaction in Rhode Island on June 20, 2014, we have achieved the following in building our CRC model:

a. Formed a multi-specialty IPA with over 100 primary care providers;
b. Recruited a highly skilled team of vascular surgeons and bariatric surgeons;
c. Expanded the base of employed physicians;
d. Entered into a joint venture for outpatient radiation oncology;
e. Expanded out-patient clinics to outside our service area; and
f. Re-opened a closed Cath Lab.

In addition to the above, we are in the process of developing a digestive disease center, exploring the establishment of a hospital based surgical center, and developing a neurosciences center.

Prospect commits to spend $75 million in capital expenditures over 5 years to expand and enhance ECHN's market presence and growth. Such capital expenditures will be consistent with the strategic plan described in Question #1 above. We plan to commit sufficient funds in order to maintain and improve the physical plant and equipment at ECHN. Finally, we plan to commit sufficient capital to implement physician engagement strategies to align the incentives of physicians and ECHN.

As Prospect's first hospitals in Connecticut, our incentives are perfectly aligned to make ECHN the provider of choice in its service areas. As healthcare reform focuses on quality care delivered efficiently, ECHN is well positioned; and with Prospect's capital and resource commitments, ECHN will have the ability to expand on the quality healthcare services it provides to its surrounding communities.

3. *If you have facilities in ECHN's primary and secondary services areas or within the city of Hartford, how do you envision ECHN working with these facilities? What services, if any would you anticipated growing, adding, or eliminating at the local community level?*

As stated above, ECHN will be Prospect's first hospitals in the state of Connecticut. As such, we do not anticipate eliminating any services. In fact, our goal would be enhance and grow ECHN's service lines and market position within its communities.

4. *What governance or other changes would you propose to make to our medical staffs?*

Prospect would work with local advisory boards and ECHN's medical staff members to preserve the existing staff membership and the current privileges of each physician as well as the medical staff leadership. Furthermore, we believe that the delivery of quality healthcare services depends on quality physicians. It is our intention to attract and recruit quality physicians (both primary and specialty) in order to form a CRC network.

We intend to develop a network of healthcare clinics and independent physician associations to support, enhance and implement the mission and vision of ECHN and to implement the coordinated regional care model. The establishment of a strong physician network necessarily requires the recruitment of high quality physicians to ECHN's medical staff. We intend to use our experience and physician alignment strategies in order to form lasting physician relationships.

Furthermore, we intend to support any existing initiatives and provide additional quality and safety expertise and protocols, as necessary, to achieve high satisfaction among patients, physicians, employees and volunteers. A commitment to excellence is of paramount importance to Prospect. Our desired culture is an environment which rewards teamwork, communication, accountability, learning and respect. Recent reimbursement changes and the advent of value-based purchasing programs emphasize the importance of quality and satisfaction across all constituents.

5. *What governance or other changes would you make to the medical foundation? What level of local governance or other changes would you make to the medical foundation? What level of local governance or influence would ECHN based providers or ECHN management has in the medical foundation*?

We believe that the delivery of healthcare is local in nature. As such we plan to organize and empower local governance boards comprised of local leaders and physicians to assist ECHN post transaction in the delivery of health care services. We anticipate that the local advisory boards would have oversight over the strategic direction and quality of health care services provided at ECHN facilities including the services provided by the physicians employed by the medical foundation. In addition, we will use our experience in working with physicians to improve the performance of the medical foundation. Finally, we will use the foundation as a cornerstone of our CRC strategy to improve the financial performance of the Foundation. Also see generally the response to question #4, above.

6. *How would a strategic transaction with your organization enhance ECHN's ability to attract and retain high quality physicians to the medical staff in ECHN's service area? Please discuss:*
    - *Your organization's processes and capabilities regarding physician recruitment and retention,*

- *Your organization's strategy for fostering clinical integration and alignment with employed and independent medical staff.*

Prospect does not have a standardized approach to physician recruitment and retention. We consider Prospect to be a physician friendly service operator. As such, we listen to our physicians and accommodate them to the extent reasonable. For example, certain physicians prefer to be employed. As such we will use the Medical Foundation for their employment. Some physicians prefer to remain independent in their practices, but would like to be free of the non-clinical aspects of running a practice. For such physicians, in our other markets have established hospital-based clinics to accommodate such physicians. We also form Independent Physician Associations ("IPAs"). Through our IPAs, both employed and independent physicians join together with the health system to contract with payers and participate in capitation, bundled payments and other value-based payment methodologies to improve their practice environment, performance and financial results. We use the health system aligned IPA as the vehicle for clinical and financial integration. Through value-based and risk contracting, we achieve financial integration between the health system and its aligned physicians. Through utilization review, quality improvement, clinical guideline development, pay for performance and data sharing and integration, we achieve clinic integration between the health system and its aligned physicians.

Clinical excellence and quality of care are the cornerstone of Prospect's philosophy with respect to the delivery of healthcare services. Prospect believes that quality healthcare services must be provided in a cost efficient manner. We believe that such model of a healthcare delivery system necessarily requires the input and participation of quality physicians who practice evidence-based medicine. Therefore, regardless of the physician engagement model, we incentivize physicians to provide high quality services through "pay-for-performance" standards that stress clinical integration and quality of services. We would employ the same approach at ECHN.

7. *How would the proposed affiliation enhance clinical quality, safety, service and patient satisfaction? Please describe the ways in which you measure quality and safety. Discuss how your hospitals perform in terms of CMS quality indicators and patient satisfaction.*

As stated above, quality of care is of paramount importance to Prospect. Attached for your convenience, is a list of quality awards that our hospitals and medical groups have recently received.

We intend to foster an environment that not only encourages quality of care but also rewards it.

Furthermore, as stated above, Prospect would work with local advisory boards to support any existing initiatives, develop new strategies and provide additional quality and safety expertise and protocols, as necessary, to enhance the quality of services at ECHN. The delivery of quality healthcare services requires constant and unwavering focus from all constituents. Through the

leadership of the local advisory boards and the local management team, we expect a tenacious focus on quality at ECHN post transaction.

As an example of our commitment to quality, we have attached a recent article regarding our cancer center in Rhode Island. The Cancer Center at Roger Williams Medical Center was recently classified by the Commission on Cancer as an Academic Comprehensive Cancer Care Program. Only 13% of the cancer programs accredited by the Commission on Cancer receive such designation.

The local advisory board, management and physician leaders at Roger Williams Medical Center thought that it was important for Roger Williams to earn such distinction. Prospect not only encouraged the pursuit of the designation, but also facilitated and provided all resources necessary to achieve such designation.

Finally, implementing the coordinated regional care model aligns physicians with the health system and measures the improvement in population health management as a result of the implementing value-based, risk contracts with payers. We integrate processes between the hospitals and its aligned physicians under those value-based contracts with payers that measure, manage and improve quality, utilization and efficiency metrics.

8. *Please describe your anticipated operational approach to ECHN, including anticipated operating efficiencies and cost avoidance, if any, resulting from the proposed transaction and any savings associated with such efficiencies/avoidance.*

We anticipate that by joining with Prospect, we can use our increased size in order to reduce costs related to supplies, pharmaceuticals and purchased services at ECHN. However, this transaction is not about the reduction of such costs or the elimination of duplicate services in order to avoid costs. We believe the true opportunity in this proposed business combination, aside from reductions in expenses, to be in the shared vision of the parties and the combined capabilities and expertise to execute on that vision and in particular growth opportunities.

As described above, Prospect has a well-developed integrated healthcare delivery network with a successful track record in population health management and accepting risk-based contracts, while delivering quality healthcare service. ECHN is a healthcare delivery network with all the necessary pieces to take the next steps in its evolution to accept more risk contracts and to immerse itself more in population health management. We believe that the synergies between the parties and the potential to implement best practices of each party across the Prospect-ECHN system will present far greater market growth opportunities.

As such, we intend to invest in ECHN's infrastructure and to develop scalable tools and technology to effectively manage the health of the population served by ECHN. It is our goal that ECHN to not only remain viable but be a leader in providing high safety and quality healthcare services at low cost to the community for the long-term. We will endeavor to form an integrated healthcare delivery model which will necessarily involve a physician engagement

strategy with the goal of providing high quality care in an efficient manner. We plan to implement, as necessary and appropriate, health reform required changes including, but not limited to: value-based payment, bundled payment, accountable care, and clinical integration with physicians and other providers.

9. *Please discuss the governance structure and continuing role of ECHN and/or the ECHN Board in the governance of the Health System, and if applicable, at your health system corporate level. Please describe your willingness to commit to the following roles as part of an affiliation agreement. Examples of comparable transactions where you have employed the proposed structure would be helpful.*

Prospect believes that the delivery of health care is local in nature and as such, Prospect depends on meaningful input from local community and physician leaders. Prospect is extremely flexible on issues relating to local governance. We propose to form a local advisory board comprised of local community members and physicians. To that end, we welcome and encourage the continued involvement of the exiting board members of ECHN with the advisory board. Generally, post-transaction, the Board of Directors for ECHN will receive input from a local advisory board. Pending further discussions with the current ECHN board, we propose the following:

(A) Board Representation. Post-transaction, Prospect will appoint a local community advisory board. A significant and pre-determined number of the local advisory board shall be members of the local community and practicing physicians. Prospect would prefer that at least some members of the Board of Directors of ECHN agree to serve on such advisory boards at the local hospitals. A member of the board of directors of ECHN post transaction shall be a member of the local community governing advisory board. That way there is a direct communication between the advisory boards and the board of directors.

(B) Roles and Responsibilities of the Advisory Board. The local community governing advisory board shall serve in an advisory capacity to board of directors post transaction. The roles and responsibilities of the advisory board shall be as follows:

(i) make recommendations and suggestions with respect to medical staff credentialing;

(ii) provide input on policies and clinical programs;

(iii) provide input in the development and review of strategic plans;

(iv) provide input on operating and capital budgets;

(v) provide input and support physician recruitment efforts;

(vi) provide input on succession plans for executive leadership at the hospital;

(vii) promote community health initiatives; and

(viii) monitor the commitment to maintain and improve quality indicators.

As stated above, since we value local input into operations, in addition to the above, we are amenable to other suggestions and/or proposals that the current ECHN Board of Directors may have regarding input and influence post business combination.

In our most recent transaction in Rhode Island, each of the hospitals that were part of the transaction has local advisory boards. The compositions of the local advisory boards are local physicians and local community leaders. The local advisory boards have been indispensable in our efforts in Rhode Island. We welcome ECHN's input on this matter.

10. *Please indicate the senior management positions you would anticipate having at ECHN, as well as the roles and positions these individuals would have in the organization post-affiliation.*

We do not foresee any changes in the management of ECHN. It has been our practice and preference to rely on the existing strong management in place at the time of the transaction. In addition, Prospect will make all of its resources (both financial and human capital) available to ECHN management team in order to execute on the strategic plan and develop a healthcare delivery system with population health management and accountable care capabilities.

11. *Please describe your willingness, if requested, to commit to the following service enhancements and capital investments as part of an affiliation agreement. To the extent that some of these commitments are in the future and subject to changes in the market/context, please describe the requirements these initiatives have to meet in order to be implemented (e.g., an ROI within a period of time requirement, system Board approval, etc.). Additionally, to the extent there are capital investments required, please describe the structure of the capital pool(s) that these programs would be accessing and the mechanism for accessing them (e.g., would you segregate a certain capital pool for these programs over a period of time, would these programs be competing for capital with other facilities in your system, etc.).*

- ***Service Enhancements***

i. In addition to maintaining the services outlined in its template Agreement, ECHN anticipates developing, expanding or enhancing service in the following clinical areas. Please comment on how affiliation with your organization would support and enable clinical program development and/or

expansion, how you approach medical staffing, and/or facility and equipment enhancements for the following services:

1. *Enhancing and expanding Primary Care capabilities, in existing and new markets*
2. *Cardiovascular Services, including diagnostic and interventional catheterization, electrophysiology and pacemaker programs*
3. *Cancer Care, including medical oncology and specialty oncologic surgery*
4. *Bariatric Surgery*
5. *Orthopedics, with an emphasis on spine surgery and joint replacement surgery*
6. *Pain Management Service/Program*

ii. Maintaining joint ventures such as Tolland Imaging Center, Evergreen Endoscopy Center, Community Cancer Care and others.

- ***Capital Investments***
  - *i. Electronic Medical Record system replacement and implementation*
  - *ii. New care management capabilities and systems*
  - *iii. Building an ambulatory surgery center*
  - *iv. Transitioning capacity to private rooms*
  - *v. Upgrading and expanding OB and neonatal nursery*
  - *vi. Upgrading and expanding the inpatient operating rooms*
  - *vii. Renovating and expanding the radiology suite*
  - viii. *Investing in medical equipment*

It should be noted at the outset that hospitals and regional networks within the Prospect system do not compete against each other for capital. It is Prospect's practice to fund capital expenditures as are reasonable and necessary to foster an environment of growth and provision of quality healthcare services in each region. Therefore, how much Prospect spends on capital expenditures in its other regions will never have an impact on ECHN.

Furthermore, there is no set formula for approving of capital expenditures. We recognize a healthcare company's need to continually re-invest in its property, plant, equipment, and information systems. As stated above, immediately after the closing, we would embark on a strategic planning process involving the local management team and the local board. We understand that all of the items noted above are part of ECHN's strategic plan. We have not as of yet has the opportunity to review the plan. However, we intend to collaborate with the local management to prioritize ECHN's growth plans and capital expenditure needs and will use at a minimum the funds committed ($75 million) to fund such programs and improvements to

ECHN's infrastructure. If there's a need to spend more on such projects that will contribute to ECHN's growth, Prospect will make such an investment.

In addition please see our response to question #2 above illustrating the initiatives underway in Rhode Island for a transaction that closed on June 20, 2014 (less than one year ago)

12. *Please provide a detailed list of additional information required if selected to proceed with further due diligence.*

Attached please find a copy of due diligence request list.

13. *Please indicate the names of the financial, legal or other advisors who will be engaged in connection with the transaction.*

We have not yet hired any financial or legal advisors with respect to this transaction. We are in process of interviewing appropriate firms to assist us in this transaction. We will inform you of the firms that we ultimately hire as we move forward in this process.

14. *Upon the selection of a preferred acquirer/partner, ECHN intends to promptly negotiate a Definitive Agreement and consummate the transaction. Please discuss any corporate approvals required to complete the transaction, the time required for those approvals and any potential risks that could increase the time required or stop the process.*

Typically, we are able to complete our due diligence process within 30-45 days of receipt of all items requested in our due diligence list. Our process involves an in depth review of material documents, interviews with management and site visits by key personnel at Prospect.

This indication of interest has been approved by Prospect's senior management. Execution of a definitive agreement and completion of a transaction will require approval by the Prospect Board of Directors. Furthermore, the execution of the APA is subject to satisfactory completion of due diligence at Prospect's sole discretion and the closing of the proposed transaction is subject to any necessary and customary regulatory approvals.

15. *Please indicate any financing or other contingencies or material conditions to the consummation of the transaction, including any key assumptions in your valuation of ECHN that, if revised, could have a significant impact on the financial terms.*

Our proposal is not subject to any financing contingency. Prospect has the funds to consummate the proposed transaction.

16. *Describe the religious or ethical restrictions in detail.*

None

17. *Explain how ECHN would continue to meet the needs of its community in the event the restrictions apply.*

Does not apply.

We recognize that choosing a transaction partners involves more than financial considerations and legal structures. Our proposal is about preserving and enhancing a community resource in a way that honors ECHN's stated mission and vision.

Prospect is unique in the market place and is uniquely positioned to meet the challenges of the ever changing healthcare environment and thrive under healthcare reform. Although noted above, we believe it is important to reiterate that what distinguishes Prospect in the marketplace is its CRC model with the proven ability to effectively and profitably manage risk and value-based reimbursement, and bundled payments on behalf of our hospitals and medical groups while at the same time delivering a high quality of care. This unique structure allows managed care plans to focus on marketing; physicians to focus on patient care; and Prospect to coordinate population health management that ensures quality and efficiency.

This indication of interest is confidential and subject to the terms and conditions of our Confidentiality Agreement dated February 20, 2015.

The contacts for questions regarding our indication of interest are as follows:

Steve Aleman, Chief Financial Officer (steve.aleman@prospectmedical.com)
Frank Saidara Vice President (frank.saidara@prospectmedical.com)

Mr. Aleman and Mr. Saidara can be reached at 310.943.4500.

If you have any questions, please feel free to contact Messrs. Saidara or Aleman, or me.

We look forward to working with you.

Very truly yours,
PROSPECT MEDICAL HOLDINGS, INC.

Samuel S. Lee
Chief Executive Officer

Quality Awards

PROSPECT MEDICAL HOLDINGS, INC.
HOSPITAL QUALITY AWARDS
Wednesday, March 4, 2015
PROSPECT MEDICAL
California Association of Physician Groups – Standards of Excellence Program – Elite Status (2012-2014)
Citizens Choice Healthplan, HMO, Shooting Star Award Top Performer (2012)
Circle of Care Award from CalOptima (Health Plan), Health Educator, Paul Montanchez (2012)
Certificate of Outstanding Performance from Integrated Healthcare Association: 1. IT Enabled Systemness for groups Genesis, Prospect Medical Group, NWOC, Gateway Medical Group (2010) 2. Diabetes Registry and related activities for groups Genesis, Professional Care, NWOC, Gateway Medical Group (2010) 3.Meaningful Use of Health IT for groups – Genesis, Professional Care, NWOC, Gateway Medical Group (2011)
City of Anaheim recognized Prospect Medical for Community Service (2011)
Integrated Healthcare Association AMVI Medical Group - Pay for Performance (P4P) "Most Improved" award winner (2012)
Integrated Healthcare Association AMVI Medical Group - Certificate of Outstanding Performance - Meaningful Use of Health IT (2012)
DHMC - AMVI Medical Group, awarded a Certificate of Excellent HEDIS scores related to cardiovascular disease and diabetes (2012)
PROMED HEALTHCARE ADMINISTRATORS
California Association of Physician Groups – Standards of Excellence Program – Elite (2012)
Integrated Healthcare Association Pomona Valley Medical Group - Certificate of Outstanding Performance - Patient Assessment Survey (2012)
Dr. Prasad
Corporate Honorary Chair of the Arthritis Foundation I.E. Walk (June 2013)
LA Business Journal Healthcare Leadership Awards (Healthcare Advocate Award, Dr. Prasad was a finalist in the Healthcare Executive category). (April 2013)
LOS ANGELES Community Hospital/NORWALK Community Hospital (combined licensure)
Healthgrades Awards
America's Best 100 Hospitals
One of Healthgrades America's 100 Best Hospitals for Pulmonary Care (2013)
One of Healthgrades America's 100 Best Hospitals for Gastrointestinal Care (2013)
One of Healthgrades America's 100 Best Hospitals for Stroke Care (2014)
One of Healthgrades America's 100 Best Hospitals for General Surgery (2014)
Cardiac
Five-Star Recipient for Treatment of Heart Failure for 5 Years in a Row (2010 – 2014)
Neurosciences
Stroke Care Excellence Award for 7 Years in a Row (2008 – 2014)

Top 5% in the Nation for Treatment of Stroke for 5 Years in a Row (2010 – 2014)	
Five-Star Recipient for Treatment of Stroke for 7 Years in a Row (2008 – 2014)	
Orthopedic	
Five-Star Recipient for Hip Fracture Treatment (2014)	
Pulmonary	
Pulmonary Care Excellence Award for 2 Years in a Row (2013-2014)	
Top 5% in the Nation for Overall Pulmonary Care Services for 2 Years in a Row (2013-2014)	
Ranked #6 in California for Overall Pulmonary Services (2013)	
Top 10 in California for Overall Pulmonary Services (Ranked 6 in 2013)	
Five-Star Recipient for Overall Pulmonary Services (2013)	
Five-Star Recipient for Treatment of COPD for 10 Years in a Row (2005 – 2014)	
Five-Star Recipient for Treatment of Pneumonia for 2 Years in a Row (2013-2014)	
Gastrointestinal	
Gastrointestinal Care Excellence Award (2013)	
Top 5% in the Nation for Overall GI Services (2013)	
Ranked #6 in California for GI Services (2013)	
Top 10 in California for GI Services in 2013 (Ranked 6 in 2013)	
Five-Star Recipient for Treatment of GI Bleed for 2 Years in a Row (2013-2014)	
Five-Star Recipient for Treatment of Pancreatitis for 5 Years in a Row (2009 – 2013)	
Five-Star Recipient for Cholecystectomy (2013)	
General Surgery Excellence Award (2014)	
Top 5% in the Nation for General Surgery (2014)	
Five-Star Recipient for Esophageal/Stomach Surgeries (2014)	
Appendectomy	
Five-Star Recipient for Appendectomy for 2 Years in a Row (2013-2014)	
Critical Care	
Five-Star Recipient for Treatment of Sepsis for 9 Years in a Row (2006 – 2014)	
Five-Star Recipient for Treatment of Diabetic Acidosis and Coma (2013)	
Five-Star Recipient for Treatment of Respiratory Failure (2014)	
Maternity Care	
Five-Star Recipient for Maternity Care for 2 Years in a Row (2011 – 2012)	
GYN Surgery	
Five-Star Recipient for Gynecological Surgery (2012)	

CareChex Awards
Stroke Care - Top 10% Nationwide (2012)
Women's Health - Top 15% Nationwide (2012)
Gastrointestinal Care - Top 15% Nationwide (2012)
Bruce Grimshaw
2010 ACHE Regents Leadership Award
2013 ACHE Service Award
SOUTHERN CALIFORNIA HOSPITAL AT HOLLYWOOD
Healthgrades Awards
Pulmonary
Pulmonary Care Excellence Award for 10 Years in a Row (2005 – 2014)
Top 5% in the Nation for Overall Pulmonary Services for 2 Years in a Row (2013-2014)
Five-Star Recipient for Overall Pulmonary Services for 11 Years in a Row (2003 – 2013)
Five-Star Recipient for Treatment of COPD for 12 Years in a Row (2003 – 2014)
Five-Star Recipient for Treatment of Pneumonia (2013)
Gastrointestinal
Five-Star Recipient for Esophageal/Stomach Surgeries (2014)
Critical Care
Five-Star Recipient for Treatment of Sepsis for 9 Years in a Row (2006 – 2014)
CareChex Awards
Stroke Care - Top 15% Nationwide (2012)
Vascular Surgery - Top 10% Nationwide (2014)
SOUTHERN CALIFORNIA HOSPITAL AT CULVER CITY
Healthgrades Awards
Cardiac
Five-Star Recipient for Treatment of Heart Failure (2013)
Gastrointestinal
Five-Star Recipient for Treatment of Pancreatitis for 2 Years in a Row (2013-2014)
Critical Care
Five-Star Recipient for Treatment of Sepsis for 6 Years in a Row (2008 – 2013)

GYN Surgery	
Five-Star Recipient for Gynecological Surgery for 2 Years in a Row (2011 – 2012)	
Orthopedic	
Five-Star Recipient for Hip Fracture Treatment (2014)	
CareChex Awards	
Women's Health - Top 10% Nationwide (2012)	
NIX HEALTH	
Healthgrades Awards	
Hospital-Wide	
Outstanding Patient Experience Award (2012)	
Top 10% in the Nation for Outstanding Patient Experience (2012)	
Appendectomy	
Five-Star Recipient for Appendectomy for 4 Years in a Row (2010 – 2013)	
Cardiac	
Five-Star Recipient for Treatment of Heart Attack for 5 Years in a Row (2010 – 2014)	
Critical Care	
Five-Star Recipient for Treatment of Sepsis for 5 Years in a Row (2009 – 2013)	
Gastrointestinal	
Gastrointestinal Care Excellence Award (2015)	
Gastrointestinal Care Excellence Award (2014)	
Top 5% in the Nation for GI Medical Treatment (2014)	
Top 10% in the Nation for Overall GI Services (2014)	
Five-Star Recipient for Treatment of Bowel Obstruction (2014)	
Five-Star Recipient for Gallbladder Removal Surgery for 4 Years in a Row (2011-2014)	
Five-Star Recipient for Cholecystectomy for 3 Years in a Row (2011 – 2013)	
Neurosciences	
Five-Star Recipient for Treatment of Stroke for 4 Years in a Row (2011 – 2014)	
Pulmonary	
Five-Star Recipient for Treatment of COPD for 2 Years in a Row (2012 – 2013)	
Joint Commission's Top Performers on Key Quality Measures™ (2012)	

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Bariatric
Bariatric Surgery Center of Excellence by The American Society for Bariatric Surgery's (2011-2014)
OptumHealth Center of Excellence Designation for Bariatric Centers of Excellence Network (2011)
Five-Star for Bariatric Surgery (2010/2011, 2009/2010, 2008/2009, 2007/2008)
Five-Star Recipient for Overall Bariatric Surgery by Healthgrades (2013)
Bariatric Quality Program Accredited by The Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program (MBSAQIP) 2014
Cardiovascular
Get with the Guidelines Gold Achievement Award by the American Heart Association (2010-2013)
CareChex Awards
Overall Hospital Care - Top 15% Nationwide (2012)
Overall Medical Care - Top 15% Nationwide (2012)
General Surgery - Top 10% San Antonio (2014)
Emergency Medicine
Dr. Gregory Roth, MD, CPE became a Certified Physician Executive (2014)
Executive Women's International San Antonio
Firm of the Year Award (2013)
Hospital-Wide
Top Improver Award Winner by Press Ganey Associates, Inc. (2011)
Bronze Award by Texas Hospital Quality Improvement Award (2014)
General Surgery Excellence Award (2015)
General Surgery Excellence Award (2014)
Texas Medical Foundation Health Quality Institute - Hospital Quality Improvement Award (2014)
Above and Beyond Award - Employer Support of the Guard and Reserve (2014)
Hyperbaric Medicine
Accreditation with Distinction from the Undersea and Hyperbaric Medical Society (2009-2014)
John Strieby
Graduate of the Masters in Leadership Program (2008)
Orthopedics
Blue Distinction Center for Knee and Hip Replacement® by Blue Cross and Blue Shield of Texas (2009-2013)

Institute of Quality Orthopedic Care for Total Joint Replacement by Aetna (2012-2013)	
San Antonio Business Journal - Health Care Heroes	
Elizabeth Llanas, RN, Health Care Heroes Health Care Provider (2013)	
Peggy Perry, Health Care Heroes Volunteer (2012)	
Adele Giles, Health Care Heroes Administrative Excellence (2011)	
Sr. Stephanie Morales, Health Care Heroes Health Care Advocate (2011)	
Dr. Robert Jimenez, Health Care Heroes Lifetime Achievement Award (2010)	
Senior Health Center	
Patient-Centered Medical Home, National Committee for Quality Assurance (2014)	
Surgical Care	
Joint Commission's Top Performers on Key Quality Measures™ (2012)	
FATIMA/ST. JOSEPH	
Patient Care Services	
Director of Permformance Improvement is one of 21 contributors from across the country to the Nursing 2015 Drug Handbook	
Joint Commission Accredited Hospital, (2015)	
Joint Commission Accredited Hospital, 3 years (9/2011)	
Joint Commission Certified for Advanced Primary Stroke Center, 2 years (9/2013)	
Joint Commission Certified for Advanced Diabetes Center, 2 years (9/2013)	
Joint Commission Disease Specific Certification for Diabetes (2014)	
Joint Commission Certified for Joint Replacement-Hip, 2 years (9/2013)	
Joint Commission Certified for Joint Replacement-Knee, 2 years (9/2013)	
NDNQI (National Database of Nursing Quality Indicators from the American Nurses Association) for outstanding commitment to quality patient care (2014)	
Designated a NICHE hospital, Nursing Improving the Care of Hospitalized Elders (2014)	
Joint Commission Certified for Advanced Diabetes Center, 2 years (2014)	
Pathway to Excellence Certification by the American Nurses Association (1/2015)	
NICHE "Exemplar" status (2015)	
Emergency Department	
First senior-friendly emergency department opened (3/2013)	
Rehabilitation	
Comprehensive Integrated Inpatient Rehabilitation awarded January, 2012; expires January 2015	
Stroke Specialty Program awarded January, 2012; expires January, 2015	

Commission on the Accreditation of Rehabilitation Facilities (CARF) (recertified 2014) Commission on the Accreditation of Rehabilitation Facilities (CARF) Stroke designation (2014)	
Cancer Services	
Cancer Services is STAR (Survivorship Training and Rehab) certified by Oncology Rehab Partners (3/2014)	
Cancer Services – American College of Surgeons, Commission on Cancer Accredited (level to be determined) from March 2014 – March 2017	
Infusion Therapy – All nurses certified by the Oncology Nursing Society for chemotherapy infusion, (4/2014)	
Blood Bank	
Certified by American Association of Blood Banks, AABB 4/1/14 – 3/31/16	
College of American Pathologists (CAP), 2 years (9/13)	
Infection Protection and Control Department	
Marlene Fishman honored as a Knowledge Bar Expert at 41st APIC Annual Conference (6/2014)	
Certificate of Improvement presented by Healthcentric Advisors to Our Lady of Fatima Hospital for 25% or Greater Relative Improvement Rate for *Clostridium difficile* Infection (CDI) LabID (June 2014)	
Certificate of Participation presented by Healthcentric Advisors to Our Lady of Fatima Hospital for Participation in the CMS 10th Statement of Work (June 2014)	
Rhode Island Department of Health recognition for supporting and contributing to the Department Quality Improvement efforts – to Marlene Fishman (2014)	
Patient Safety Champion Award for joint efforts to decrease harm and improve the care delivered within St. Joseph Health Services of Rhode Island – to Marlene Fishman (2014)	
Rhode Island Department of Health Certificates of Appreciation for participation in the Influenza Hospitalization Surveillance Network – to Our Lady of Fatima Infection Control Practitioners (2012 – 2013)	
APIC Heroes of Infection Prevention Award for having successfully reduced infection, raised awareness, and improved the health and well-being of patients, healthcare workers, and the public - to Marlene Fishman Wolpert (2012)	
ROGER WILLIAMS MEDICAL CENTER	
Patient Care Services	
Joint Commission Accredited Hospital, 3 years (9/2011)	
Joint Commission Certified as Advanced Primary Stroke Center, 2 years (9/2013)	
American Heart/Stroke Association's Silver Award for Advanced Primary Stroke Center's composite performance (3/2013)	
Stroke and US News and World Report , "Best Hospitals" issue. (3/2013)	
NDNQI (National Database of Nursing Quality Indicators) for outstanding commitment to Quality Patient Care (10/2013)	
Palliative Care Program survey scheduled for June 13, 2014 to be first in state for certification by the Joint Commission (9/2013)	

Emergency Department
Emergency Department, the states first senior-friendly emergency department (3/2013)
Bariatrics
Bariatric Surgery Center of Excellence by ASMBS (American Society for Metabolic and Bariatric Surgery) and SRC (Surgical Review Corporation) (12/2013)
Endoscopy
First hospital in RI to perform Endobronchial Ultrasound (EBUS) (8/2013)
Third hospital in the nation to offer Sedationless Colonoscopy (9/2013)
Orthopaedics
The Joint Commissions Gold Seal of Approval, total hip and knee replacement programs (2/2014)
Blue Cross/Blue Shield Blue Distinction Total Value Center for Spine Surgery and Hip & Knee Surgery (1/2014)
First hospital in RI to launch the American Orthopaedic Association's "Own the Bone program" (1/2014)
Cancer Center
18 Surg/Onc fellowship training programs, one of only two in New England (7/2013)
Cancer Program accreditation with commendation by the Commission on Cancer of the American College of Surgeons (10/2012)
National Marrow Donor Program approved Transplant Center (1/2014)
Foundation for the Accreditation of Cellular Therapy Accreditation for the Bone Marrow Unit
Commission on Cancer CCP Community Cancer program (October 2012 - October 2015)
National Accreditation Program for Breast Centers April 2013 – April 2016
Quality Oncology Practice Initiative Certification, American Society of Clinical Oncology October 2013 – October 2016
STAR Program Certification from Oncology Rehab Partners (2014)
Designated as a Academic Comprehensive Cancer Center (2/2015)
Behavioral Medicine
Optum Health recognition for ACE (Achievements in Clinical Excellence) program Behavioral Health (7/2013)
Optum Health - 2013 Achievements in Clinical Excellence in Behavioral Health Silver Level (7/2013)
Addiction Medicine
States only level 4 inpatient detox
American Hospital Association recognition for hosting Rally 4 Recovery Program (1/2014)
Geriatrics
Successfully pass annual FDA-MQSA (Mammography Quality Standards Act) facility inspection (8/2013)
Re-established Cardiac Catheterization Services (8/2013)
Redesignated as a NICHE (Nurses Improving Care for Healthsystem Elders) Hospital (9/2013)

OR
First hospital in state to conduct a Fire safety training with evacuation in the Operating Room, a training video has been developed from this session (10/2013)
Diagnostic Wing
ACR accreditation for CT Scanner (2/2014)
Certified as a Radiation Injury Treatment Network (8/2013)
Breast Health Clinic received American College of Radiology 3-year re-accreditation (8/2013)
Successfully pass annual FDA-MQSA (Mammography Quality Standards Act)
Re-established Cardiac Catheterization Services.
Pharmacy
Phaseal Safety Award: Pharmacy recognition of Chemotherapy Compounding Safety in the Northeast (10/2012)
Laboratory
CAP (College of American Pathologists) Certified, 2 years (12/2014)
AABB (American Association of Blood Bank), 3 years (10/2012)
Radiology
Accredited in Computed Tomography (CT) by the American College of Radiology (ACR) 3 years (2014)
ELMHURST
Joint Commission Accredited Hospital, 3 years (9/2014)

Article re Quality

HEALTH CARE

Cancer Center at Roger Williams Medical Center receives new designation

ROGER WILLIAMS Medical Center's Cancer Center has been classified by the Commission on Cancer as an Academic Comprehensive Cancer Center Program.

By PBN Staff
Twitter: @ProvBusNews (http://twitter.com/ProvBusNews)

2/27/15

PROVIDENCE – The Cancer Center at Roger Williams Medical Center has been classified by the Commission on Cancer as an Academic Comprehensive Cancer Center Program, placing it among a select group of cancer centers in New England to hold the designation.

According to information from CharterCare Health Partners, of which Roger Williams Medical Center is an affiliate, 13 percent of the more than 1,500 Commission on Cancer-accredited cancer programs nationwide hold this designation.

Roger Williams met the following criteria from the Commission on Cancer to achieve the new classification:

- Provides postgraduate medical education in at least four program areas, including internal medicine and general surgery
- Records more than 500 newly diagnosed cancer cases each year
- Full range of diagnostic and treatment services either on-site or by referral
- Participates in cancer-related clinical research either by enrolling patients in cancer-related clinical trials or by referring patients for enrollment at another facility or through a physician's office.

"This designation is a reflection of both our academic and clinical efforts to provide better treatment for cancer patients in our region," Dr. N. Joseph Espat, director of the Cancer Center at Roger Williams, said in a statement. "More patients are coming to our cancer program, our residency and fellowship programs continue to provide excellent training for the next generation of physicians and our clinical trials are advancing research into diagnosis and treatment of cancer."

Kimberly O'Connell, president of Roger Williams, said the entire oncology team - including those involved with cancer teaching and research programs - has been involved is reaching this designation.

Dr. Steven Katz, chairman of the Roger Williams' Cancer Committee, said "innovative research programs" played a role in enabling the recognition.

"Our immunotherapy platforms promise to bring novel treatments to patients with limited options. We look forward to launching several new T cell trials for liver tumors in the coming year," Katz said.

The Commission on Cancer, a program of the American College of Surgeons, recognizes cancer care programs for their commitment to providing comprehensive patient-centered care. In Rhode Island, The Miriam Hospital and Rhode Island Hospital are also designated Academic Comprehensive Cancer Centers by the Commission on Cancer.

Due Diligence Document Checklist

Entity: ECHN & Affiliates (including JVs)

		GENERAL CORPORATE
A		**Minutes**
	1	Stockholders'/partnership meetings
	2	Board of Directors
	3	Board committees
B		**Charter Documents**
	1	Certificate of Incorporation/Partnership, as amended
	2	By-laws, as amended
C		**Corporate Organization**
	1	Officer & director lists
	2	Management structure organization chart
	3	Organization chart showing the Group, each subsidiary and affiliated partnership
	4	Stockholder or partnership list, including number of shares or units held
	5	Information regarding any subsidiaries of affiliated entities, i.e., ownership; management arrangement; acquisition documents
	6	Information regarding joint ventures or partnerships
	7	Agreements related to earnouts and contingency payments
	8	Material covenants against competition or exclusivity arrangements
	9	Shareholder agreements
D		**Capital Stock/Partnership Units**
	1	Stock records, stock ledgers
	2	Agreements relating to the purchase, repurchase, sale or issuance of securities/partnership units, including oral commitments to sell or issue securities/partnership units
	3	Agreements relating to voting of securities/partnership units and restrictive transfers
	4	Agreements relating to preemptive or other preferential rights to acquire securities/partnership units and any waivers thereof
	5	Documents relating to any conversion, recapitalization, reorganization or significant restructuring of the Group
E		**Business**
	1	Marketing or strategic plans
	2	Marketing brochures
	3	Policies and procedures
	4	List of any trademarks, trade names, copyrights, patents, service marks or other intellectual property rights, owned by or used in the business

Due Diligence Document Checklist

		Entity: ECHN & Affiliates (including JVs)
	5	Description of IT Systems
	6	List of physicians/providers by site& specialty
	7	Health plan audits & CAPs for last 12 months
F		**PHYSICIAN INFORMATION**
	1	Physician and physician extender census including name, hire date, status (full or part time), specialty
	2	Curriculum vitae (must include SSN, DOB, Medical School & year graduated)
	3	Copy of license & DEA for each physician
	4	Shareholder/Partner/Employed physician contracts
	5	Current IPA physician compensation arranagement and contracts
	6	Physician productivity reports for last fiscal year and current year: Gross charges & visits
	7	Physician and physician extender W-2s for last completed calendar year
	8	IPA physician contracts
	9	Encounter data by physician - Last two full calendar years
G		**MANAGEMENT & EMPLOYEES**
	1	Employment agreements and all other agreements with employees
	2	Consulting contracts
	3	Confidentiality or non-competition agreements
	4	List of all employees, headcount by function, describe current salary and wage program, including pay scales and forthcoming increases
	5	All employee compensation, bonus, profit-sharing plans, including deferred compensation, incentive, retirement, benefit or similar plans
	6	Description of all perquisites
	7	Employee manuals, handbooks, and other personnel policies
	8	Documents relating to any receivables from or payables to any employees/partners of the the Group
	9	Contracts with unions and other labor agreements
	10	Correspondence with any federal, state or local agencies regarding compliance with the U.S. Occupational Safety and Health Act or similar
H		**FINANCIAL & STATISTICAL**
	1	**Financial Statements**
	a	Audited statements, most recent three years

Due Diligence Document Checklist

	Entity: ECHN & Affiliates (including JVs)
b	Most recent unaudited interim financial statements (and the statements for the corresonding period of the previous fiscal year)
c	Last fiscal year and YTD detailed financial statements (income statement, balance sheet)
d	Detailed revenue breakdown for last fiscal year and current YTD, if not included above
e	Current year budget, including capital expenditure budget
f	Long range strategic/financial plan
g	Any reports, studies, and projections prepared internal or externally on the Group's finanical condition or planned operations
h	Significant correspondence with independent public accountants, including management letters in the last three years
i	Shared risk reconciliation reports and accrual schedules by HMO
j	IBNR analysis/lag study
k	Claims run: Dates of service 1/1/05 to 12/31/05 paid to date
l	Depreciation and amortization schedule
m	Aged accounts receivable schedule by payor
n	Aged accounts payable schedule
o	Accrued vacation and sick leave schedule
p	Complete inventory/asset listing
2	**Debt Financing**
a	All debt instruments, credit agreements and guarantees entered into by the Group and any of its affiliates, including lease financing, which are currently in effect
b	All material correspondence with lenders, including all compliance reports submitted by the Group or its designees
c	Any loans and guarantees of third party obligations
3	**Tax Matters**
a	Tax returns, most recent three years
b	Correspondence or notice from any foreign, federal, state or local taxing authority regarding any filed tax return (or any failure to file) including copies of all audit reports and descriptions of any pending tax audits by the IRS or other
c	Rulings, concessions, or the like which have been obtained from any federal or state taxing authority and which may apply to the Group's current or future operations
4	**Statistical & Other**
a	Last fiscal year and current YTD monthly HMO enrollment and capitation by plan
b	Last calendar year and current YTD inpatient days/1000 and SNF days/1000 for commercial, senior, and MediCal

Due Diligence Document Checklist

	Entity: ECHN & Affiliates (including JVs)
c	RAF Scores - Last two full calendar years
d	Encounter data submission
e	Pended claims report
f	Denials
g	Open auths report
h	P4P Reports
I	**CONTRACTS AND OTHER DOCUMENTS**
1	HMO, PPO or other third-party payor agreements, all other managed care agreements, and all proposals to enter into such agreements
2	Status/description of pending contractual changes related to the above
3	Hospital contracts- Include description of risk sharing agreements
4	Significant ancillary provider or professional services contracts
5	List of outside provider contracts with rates
6	Significant vendor contracts requiring more than $10,000 annual payments
7	Maintenance contracts for equipment, as well as all supply or service contracts and purchasing agreements
8	Outstanding guarantees, indemnities, or other similar agreements
J	**REAL PROPERTY**
1	Deeds
2	Leases of real property
3	Completed environmental surveys and assessments for all real property owned, leased or operated by the Group
4	Equipment financing documents, including leases
K	**RISK MANAGEMENT**
1	All insurance policies
2	List of all current or pending professional liability claims
3	List of closed claims for the past five years
4	Loss run reports from all insurance carriers for the past five years--Indicate closed claims
5	List of all current or pending workers' compensation claims
6	List of all current or pending litigation or investigation
7	Consent decrees, judgments, orders or settlement agreements which provided for ongoing covenants
8	Description of any outstanding judgments against the Group

Due Diligence Document Checklist

	Entity: ECHN & Affiliates (including JVs)
9	Actual and/or pending accusations, investigations and/or records of disciplinary action(s) by the Medical Board of California
10	Actual or pending hospital medical staff action
11	Information on any investigations, pending or threatened by any federal, state or local authority
12	Counsel's evaluation of pending litigation and any current litigation
13	Attorneys' letters to auditors
L	**REGULATORY INFORMATION**
1	All governmental (federal, state or local) licenses, titles, certificates, franchises, and permits necessary for the Group to conduct its business in compliance with applicable law, with expirations and renewal dates
2	List of all accreditations received by the Group and all professional or trade association memberships
3	Correspondence with any governmental agency requiring action by the Group which has not been taken or completed

RESPONSE TO DEFICIENCIES
EXHIBIT D - Interim Consulting Agreement (DRAFT)

INTERIM CONSULTING AGREEMENT

THIS INTERIM CONSULTING AGREEMENT (this "Agreement") is made and entered into as of the ___ day of October, 2015 (the "Effective Date") by and between Prospect Medical Holdings, Inc., a Delaware corporation ("Prospect," and collectively with its Affiliates (as defined below), "Advisor"), and Eastern Connecticut Health Network, Inc. a Connecticut non-stock corporation ("ECHN").

RECITALS

A. ECHN, together with its Affiliates (collectively, the "Company"), operate The Manchester Memorial Hospital and The Rockville General Hospital (the "Hospitals") which serve the needs of residents of the greater Manchester, Connecticut area.

B. On June 25, 2015, Advisor entered into a Letter of Intent with the Company, as amended by that certain Amendment No. 1 to Letter of Intent dated October ___, 2015 (as so amended, the "Letter of Intent"), which sets forth certain terms and conditions pursuant to which Advisor, or an Affiliate of Advisor, would acquire the businesses of the Company pursuant to the terms of a definitive Asset Purchase Agreement to be negotiated and entered into by ECHN and Advisor, the form of which is being filed in connection with the parties' application for a CON (as defined below) (the "Purchase Agreement"). Defined terms used but not defined herein shall have the meanings set forth in the Letter of Intent. References contained herein to Sections and Section numbers of the Purchase Agreement shall be deemed to refer to any successor provisions thereto, as the case may be.

C. The Letter of Intent provides, among other things, that the term of the Letter of Intent shall continue in effect until the earlier of (w) the execution by both parties of a definitive purchase agreement with respect to the matters set forth in the LOI, (x) thirty (30) days following the receipt by the parties of the proposed conditions or proposed settlement for certificate of need approval for the Hospitals by the Office of Healthcare Access of the Connecticut Department of Public Health ("OHCA"), (y) either the application for approval of the certificate of need by OHCA or the application for approval of the conversion of the Hospitals to a for-profit entity by the Attorney General of the State of Connecticut is withdrawn, and (z) June 30, 2016 (the "Expiration Date"). The Letter of Intent further provides that notwithstanding the foregoing, Prospect shall have the right (an "Extension Right"), exercisable upon prior written notice to ECHN and with the consent of ECHN, such consent to not be unreasonably withheld, to extend the Expiration Date by up to an additional thirty (30) days, if the foregoing regulatory approvals have not been received on or prior to thirty (30) days prior to the Expiration Date, in a form that Prospect has determined in good faith is on terms reasonably satisfactory to Prospect, and such failure to receive such approvals in satisfactory form is for reasons beyond the reasonable control of Prospect and without any fault on the part of Prospect. In addition, the Letter of Intent provides Prospect the right to exercise up to an aggregate of three (3) Extension Rights if the foregoing conditions to such exercise (including such consent of ECHN) are satisfied, and the Letter of Intent further states that the ECHN Board of Trustees shall be entitled to deny (i.e. withhold the required consent of ECHN) an Extension Right if it makes a good faith determination that the transaction is unlikely to close in the 90-Day period following June 30, 2016.

D. The Purchase Agreement is expected to set forth various conditions to Closing (including regulatory approvals), but pursuant to Connecticut law, the Purchase Agreement cannot be executed by the parties until receipt by the parties of the certificate of need approval for the Hospitals by OHCA and approval for the conversion of the Hospitals to a for-profit entity by the Office of the Attorney General of the State of Connecticut (the "CON Approvals").

E. Given the contracting restrictions imposed upon the parties by the State of Connecticut, the parties seek to confirm in writing that this Agreement is intended to continue until the closing of the transactions contemplated in the Letter of Intent (and, more specifically, in the Purchase Agreement) and that should this Agreement terminate, Advisor shall be entitled to be paid its Consulting Service Fees (as defined below) in accordance with, and to the extent provided by, Section 6.5 hereof.

F. Advisor, through its executives and other personnel, has certain experience and expertise in the management, operations, financial and administrative aspects of businesses like that of the Company.

G. Advisor is willing to provide certain consulting services, as described on Exhibit A hereto (the "Consulting Services"), with the objective of improving and otherwise benefitting the operations of the Company and the Hospitals during the time period from the Effective Date through the Closing of the Purchase Agreement, pursuant to the terms and conditions contained in this Agreement.

H. The Company seeks to confirm in writing Advisor's agreement to provide the Company with the Consulting Services between the Effective Date and the Closing Date (unless this Agreement is sooner terminated in accordance with the provisions of ARTICLE VI below).

NOW, THEREFORE, in consideration of the premises and mutual covenants set forth herein and other valuable consideration, the receipt and sufficiency of which are hereby acknowledged, and for their mutual reliance, the parties agree as follows:

ARTICLE I
RECITALS; AFFILIATES

1.1 Recitals. The recitals set forth above are hereby incorporated into this Agreement as if fully set forth in this ARTICLE I.

1.2 Affiliate. As used herein, "Affiliate" means, as to ECHN or Prospect, any person or entity that directly or indirectly controls, is controlled by, or is under common control with, as applicable, ECHN or Prospect and any successors or assigns of such person or entity; and the term "control" means possession, directly or indirectly, of the power to direct or cause the direction of the management and policies of, as applicable, ECHN or Prospect whether through ownership of voting securities, by appointment of trustees, directors, and/or officers, by contract or otherwise.

ARTICLE II
OFFER OF CONSULTING SERVICES

2.1 Appointment; Provision of Services. For and during the Term (as defined in ARTICLE V below), the Company retains Advisor to provide the Consulting Services, and Advisor shall provide to the Company, with respect to the operation of the Hospitals and other programs and services carried on by the Company (collectively, the "Business"), those Consulting Services described on Exhibit A, as it may be amended from time to time, upon the terms and conditions as set forth herein.

2.2 Acceptance. Advisor hereby accepts such appointment by the Company and agrees that it will faithfully perform its duties and responsibilities hereunder.

2.3 Maintenance of Control. The Consulting Services entail recommendations to the Company regarding how to improve the operations and financial condition of the Company's Business. The Company agrees to reasonably consent to make operational changes recommended by Advisor. Nothing in this Agreement is intended to alter, weaken, displace or modify the authority of either (i) the Board of Trustees of the Company with respect to the ultimate oversight and governance of the Company, or (ii) the executive leadership of the Company with respect to day-to-day management of the Business and the assets and affairs of the Company. During the Term, the Board of Trustees of the Company shall exercise ultimate authority, supervision, direction and control over the business, policies, operation and assets of the Company, and shall retain the ultimate authority and responsibility regarding the powers, duties and responsibilities vested in the Board of Trustees of the Company by any and all applicable laws and regulations. The parties mutually acknowledge and agree that any Consulting Services provided pursuant to this Agreement are intended to constitute assistance and support to the Company's Board of Trustees and executive leadership, and are not intended and shall not be construed to grant Advisor any rights or interests in, nor decision-making authority with respect to, the Company or the Business, and the rights and interests of Advisor shall be limited to those expressly set forth herein or in the Purchase Agreement.

2.4 Input Into Company's Strategic Business Decisions. The Company, through its Chief Executive Officer, shall make Advisor aware of key strategic business decisions facing the Company that could compromise the Company's economic viability, marketability or competitive potential and shall elicit input from Advisor on said decisions.

2.5 Consulting Services Fee. During the Term, Fees payable to Advisor for the Consulting Services furnished hereunder shall accrue in an amount equal to two (2) percent of the Company's net patient revenue per month (cumulatively, the "Consulting Services Fee"). The Consulting Services Fee shall be deferred and payable to Consultant if and only if the Closing under the Purchase Agreement fails to occur as a result of a breach of the Purchase Agreement or Letter of Intent by the Company where such breach is willful and intentional by the Company and based on factors within the Company's control, in which such case the Consulting Services Fee shall be paid to Advisor pursuant to Section 6.5 hereunder. Notwithstanding anything to the contrary in this Agreement, the Consulting Services Fee shall be forgiven in its entirety and shall not be payable in any circumstance other than as set forth in the

immediately preceding sentence. If the Closing under the Purchase Agreement takes place, payment of the Consulting Services Fee shall be waived.

2.6 Company's Commitments. The Company shall provide Advisor with sufficient working space and other reasonable physical accommodations at the Facilities as appropriate to the Consulting Services, including access to telephones, facsimile machines, internet connections and copiers, to enable Advisor to fulfill its duties and responsibilities hereunder. The Company and its management staff shall provide timely responses to Advisor's requests for information (and other inquiries) to enable Advisor to perform the Consulting Services hereunder, and shall fully cooperate with Advisor in the fulfillment of Advisor's duties hereunder, including, without limitation, attending meetings and providing information, feedback and input to Advisor.

2.7 Liaisons. Advisor shall direct all inquiries regarding the Consulting Services, and provide all recommendations, reports and other matters relating to the Consulting Services, to Peter J. Karl, the Company's Chief Executive Officer, and/or such person(s) as he may from time to time designate. The Company shall direct all inquiries regarding the Consulting Services to Von Crockett at Prospect, and/or such person(s) as he may from time to time designate.

2.8 Access of Advisor; Patient Records.

(a) During the Term, Advisor shall be given complete access to the Company's records (including Patient Records as defined below), offices and Facilities, in order that it may carry out its obligations hereunder, subject to the confidentiality requirements relating to Patient Records and Confidential Information (as defined below).

(b) The Company shall maintain, to the fullest extent of the law, sole and exclusive responsibility for the preparation, storage and destruction of all patient medical records, clinical treatment plans, charts and similar documents generated in connection with the operation of the Business (collectively, the "Patient Records"). The Company shall assure that the Patient Records are prepared in compliance with all applicable federal, state and local laws and regulations. All Patient Records will be maintained by the Company and shall remain the property of the Company.

(c) To the extent permitted by law including, but not limited to, the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and the standards or regulations promulgated thereunder, including the Privacy Standards and the Security Standards, as well as the federal Health Information Technology for Economic and Clinical Health Act (including any and all standards and regulations promulgated thereunder) and professional ethics regarding confidentiality and disclosure of medical information, the Company shall make such information available to Advisor to enable Advisor to perform its duties hereunder and for any and all other reasonable purposes. For the purposes of this Section 2.8, Advisor shall be referred to as the Company's Business Associate ("Business Associate"). As a Business Associate, Advisor agrees to enter into the Business Associate Agreement with the Company, attached hereto as Exhibit B.

ARTICLE III
[RESERVED]

ARTICLE IV
CONFIDENTIALITY; PROPRIETARY RIGHTS

4.1 Due to the highly competitive nature of the health care industry, disclosure of certain nonpublic, confidential or proprietary information – including but not limited to Advisor's Proprietary Rights (as defined below), the Company's Proprietary Rights (as defined below), analyses, compilations, summaries, memoranda, studies, policy and procedure documentation/information, quality assurance materials or other documents prepared by the Company or Advisor in connection with this Agreement or the Consulting Services provided hereunder (collectively, the "Confidential Information") – would be extremely damaging to the party that owns or has the right to such Confidential Information. The parties therefore agree to maintain the confidentiality of the other party's Confidential Information and to protect as a trade secret any portion of the other party's Confidential Information by using reasonable efforts to prevent any unauthorized disclosure, copying, use, distribution, or transfer of possession of such Confidential Information. Each party agrees to maintain at least the same procedures regarding the other party's Confidential Information that it maintains with respect to its own Confidential Information, but in no event less than a reasonable standard of care. For purposes of this Agreement, Confidential Information shall not be deemed to include information and data: (a) rightfully previously known or acquired by either party from a third party without a continuing restriction on use; (b) that is or becomes a part of the public domain through no breach of this Agreement by either party; (c) approved for release by written authorization by the party who owns or has rights to the Confidential Information; (d) that is required to be disclosed by law; or (e) independently developed by either party.

4.2 The manuals, software, systems, methods, procedures, policies, controls, documents and pricing and the information relating thereto (including, without limitation, purchase orders and all form documents) and all information relating to Advisor and its Affiliates learned, acquired or obtained by the Company and its Affiliates pursuant to this Agreement, including without limitation the financial condition, marketing plans, regulatory affairs and business strategies of Advisor or its Affiliates, employed or obtained by Advisor or its Affiliates, and all trademarks, service marks, trade names, copyrights and other proprietary rights in which Advisor or any of its Affiliates has any interest (collectively, "Advisor's Proprietary Rights") are proprietary to Advisor and shall remain the property of Advisor or its Affiliates and are not, at any time during the Term or thereafter, to be utilized, distributed, disseminated, copied or otherwise employed or acquired by the Company, any of the Company's Affiliates, or their respective officers, directors, trustees, consultants, members, employees, shareholders, and agents, except as authorized by Advisor in writing.

4.3 The manuals, software, systems, methods, procedures, policies, controls, documents and pricing and the information relating thereto (including, without limitation, purchase orders and all form documents) and all information relating to the Company and its

Affiliates learned, acquired or obtained by Advisor and its Affiliates pursuant to this Agreement, including without limitation the financial condition, marketing plans, regulatory affairs and business strategies of the Company or its Affiliates, employed or obtained by the Company or its Affiliates, and all trademarks, service marks, trade names, copyrights and other proprietary rights in which the Company or any of its Affiliates has any interest (collectively, "Company's Proprietary Rights") are proprietary to the Company and shall remain the property of the Company or its Affiliates and are not, at any time during the Term or thereafter, to be utilized, distributed, disseminated, copied or otherwise employed or acquired by Advisor, any of Advisor's Affiliates, or their respective officers, directors, trustees, contractors, members, employees, shareholders, and agents, except as authorized by the Company in writing.

4.4 Each party acknowledges that the breach of the provisions of this ARTICLE IV would cause irreparable injury to the non-breaching party that could not be adequately compensated by money damages. Accordingly, the non-breaching party may obtain a restraining order, injunction or other equitable relief prohibiting a breach or threatened breach of the provisions of this ARTICLE IV without the necessity of posting any bond or security whatsoever, in addition to any other legal or equitable remedies that may be available. In the event of a breach or threatened breach by either party of any of its obligations under this ARTICLE IV, the other party shall have the right, in addition to any other remedies that may be available to it, to obtain specific performance of the terms of this Agreement without posting any security or bond whatsoever.

4.5 If requested by court order or other legal process to disclose any information constituting Confidential Information, Advisor's Proprietary Rights or Company's Proprietary Rights, the party so requested shall promptly give notice of such request or requirement to the other party so that such party may, at its own cost and expense, seek an appropriate protective order or, in the alternative, waive compliance to the extent necessary to comply with such request if a protective order is not obtained. If a protective order or waiver is granted, the party to whom the request was made may disclose such information only to the extent required by such court order or other legal process or to the extent permitted by such waiver.

4.6 The provisions of this ARTICLE IV shall survive the termination of this Agreement, provided, however, this provision shall terminate upon the Closing of the Purchase Agreement. In that event, however, the parties shall continue to be subject to the terms and conditions of that certain Confidentiality and Non-Disclosure Agreement dated as of February 19, 2015, which shall remain in full force and effect in accordance with its terms.

ARTICLE V
TERM

The term of this Agreement shall commence on the Effective Date and shall continue until the Closing of the Purchase Agreement (the "Term"), unless sooner terminated in accordance with the provisions of ARTICLE VI below.

ARTICLE VI
TERMINATION

6.1 Termination by Either Party for Cause. If either party materially defaults in the performance of any material covenant, agreement, term or provision of this Agreement or the Letter of Intent to be performed by it and such material default continues for a period of thirty (30) days after written notice is delivered to the breaching party from the other party stating the specific default, then the non-breaching party may terminate this Agreement by giving written notice thereof to the breaching party; provided, however, that the non-breaching party shall not have the right to terminate under this Section 6.1 at the end of such thirty (30) day period so long as the breaching party has commenced a cure within such thirty (30) day period and thereafter diligently pursues such cure to completion, which shall be no later than sixty (60) days after the initial written notice.

6.2 Termination Upon Bankruptcy, Etc. If either party shall apply for or consent to the appointment of a receiver, trustee or liquidator for it or for all or substantially all of its assets, file a voluntary petition in bankruptcy or admit in writing its inability to pay its debts as they become due, make a general assignment for the benefit of creditors, file a petition or any answer seeking reorganization or arrangement with creditors or to take advantage of any insolvency law, or if an order, judgment or decree shall be entered by a court of competent jurisdiction, on the application of a creditor, adjudicating either party to be bankrupt or appointing a receiver, trustee or liquidator of either party with respect to all or substantially all of the assets of either party, and such order, judgment or decree shall continue unstayed and in effect for any period of ninety (90) consecutive days, then this Agreement shall automatically terminate.

6.3 Termination Upon Dissolution of the Company, Termination of Letter of Intent or Termination of Purchase Agreement. This Agreement shall terminate immediately and automatically upon the first to occur of the following events:

(a) the Company files for voluntary dissolution;

(b) the Letter of Intent expires by it terms or is otherwise terminated; and

(c) the Purchase Agreement is terminated (in accordance with the provisions thereof) prior to a Closing of the transactions contemplated therein.

6.4 Regulatory Matters. If the performance by either party of any material covenant, agreement, term or provision of this Agreement would (a) result in the de-certification of a Hospital under any federal or state government program or by any other regulatory agency that would have a material adverse effect on the operation of the Business, (b) result in the loss of a Hospital's accreditation, or (c) be in violation of any statute or regulation, or for any other reason be or become illegal and such violation or illegality would have a material adverse effect on the operation of the Business, and in any such event, the reason therefore cannot be corrected by good faith negotiations and effort of the parties hereto within sixty (60) days after written notice thereof (with the objective of keeping the financial intent of the parties hereunder materially the same), then either party may at its option terminate this Agreement.

6.5 Certain Rights Upon Termination.

(a) In the event of any of the following:

(i) upon the receipt of the CON Approvals, if (x) Advisor has executed a purchase agreement in the form of the Purchase Agreement and (y) ECHN willfully and intentionally fails to execute such purchase agreement within ten (10) days after Advisor's execution thereof; or

(ii) the parties having both executed a purchase agreement in substantially the form of the Purchase Agreement, if (x) all conditions to Closing (other than those that by their terms are to be satisfied by the actions to be taken at the Closing) have been satisfied by Advisor, but ECHN willfully and intentionally fails to close the transactions pursuant to Section 8.01 of the Purchase Agreement where such failure is based on factors within ECHN's control, or (y) ECHN willfully and intentionally breaches its obligations under Section 5.23 of the Purchase Agreement;

then, Advisor shall be paid by ECHN, within sixty (60) days after such termination and receipt of an invoice therefor, any accrued and unpaid Consulting Service Fees. For the avoidance of doubt, in all other event, including in the event a Closing occurs under the Purchase Agreement, Advisor shall not be entitled to receive any Consulting Service Fee hereunder.

(b) Subject always to the provision of Section 6.5(a), the termination of this Agreement for any reason shall be without prejudice to any payments or obligations that may have accrued or become due hereunder prior to the effective date of termination or that may become due after such termination.

6.6 Cessation of Use of Proprietary Rights Upon Termination. Upon termination of this Agreement, each party shall immediately discontinue the use of, and shall promptly return to the other party, as applicable, all Confidential Information (to the extent in tangible format) that was made available to such party by reason of its participation in this Agreement, including any copies that it may have in its possession or control.

6.7 Failure to Terminate. Failure to terminate this Agreement shall not waive any breach of this Agreement.

6.8 Survival. To the extent expressly set forth or contemplated in this Agreement, provisions of this Agreement shall survive the termination of this Agreement.

ARTICLE VII
LIABILITY, INDEMNIFICATION, PROFITABILITY AND INDEPENDENT CONTRACTOR

7.1 Limitation of Liability. Except for Advisor's gross negligence or willful misconduct, Advisor shall not by reason of this Agreement or any Consulting Services rendered pursuant to this Agreement have any liability in connection with the operation of the Business or

be deemed to have assumed any liabilities associated with or incident to the operation of the Business. All such liabilities shall remain with the Company. Without limiting the generality of the foregoing, Advisor shall have no liability for any breach of any obligation under this Agreement unless such breach shall constitute gross negligence or willful misconduct; it being understood that in such case of a breach of an obligation that does not constitute gross negligence or willful misconduct, the Company's sole remedies shall be to obtain damages pursuant to Section 15.1 below and/or to terminate this Agreement as provided herein.

7.2 Indemnification.

(a) The Company hereby agrees to defend, indemnify and hold harmless Advisor and its Affiliates, and their respective officers, directors, contractors, members, employees, shareholders, agents, successors and assigns (each, an "Advisor Indemnified Party"), from and against any and all liabilities, causes of action, damages, losses, demands, claims, penalties, judgments, costs and expenses (including, without limitation, reasonable attorneys' fees and related costs) of any kind or nature whatsoever that may be sustained or suffered by any Advisor Indemnified Party arising out of or resulting from (i) any breach by the Company of any of its representations, warranties, covenants, obligations or duties under this Agreement or (ii) the Company's gross negligence or willful misconduct.

(b) Advisor hereby agrees to defend, indemnify and hold harmless the Company, and its Affiliates, and their respective officers, directors, trustees, contractors, members, employees, shareholders, agents, successors and assigns (each a "Company Indemnified Party"), from and against any and all liabilities, causes of action, damages, losses, demands, claims, penalties, judgments, costs and expenses (including, without limitation, reasonable attorneys' fees and related costs) of any kind or nature whatsoever that may be sustained or suffered by any Company Indemnified Party arising out of or resulting from (i) the violation of state, federal, or local law, rules or regulations by Advisor, its directors, officers, agents, independent contractors and employees, which results in bodily injury or physical or actual and material damages or the imposition of a fine, penalty or other charge; or (ii) any breach by the Advisor, its directors, officers, agents, independent contractors or employees of any of its representations, warranties, covenants, obligations or duties under this Agreement; or (iii) the gross negligence or willful misconduct of Advisor, its directors, officers, agents, independent contractors or employees.

(c) The provisions of this Section 7.2 shall survive the termination of this Agreement.

7.3 No Representation of Profitability, Etc. Advisor does not guarantee or represent that operation of the Business will be profitable, or have a certain amount of revenues or cash flow. Except as otherwise expressly provided herein, Advisor shall not be liable for the Company's losses, whether from operation of the Business or otherwise.

7.4 Independent Contractor Status. Advisor does not under this Agreement act in any capacity other than as an independent contractor and does not, under this Agreement, act as principal in the operation of the Business, the Hospitals or any other facilities of the Company.

ARTICLE VIII
NON-SOLICITATION

8.1 Covenant Not To Solicit. During the Term and for a period of two (2) years after the Term (the "Non-Solicit Period"), each party shall not, and shall cause its Affiliates not to, directly or indirectly, (a) take any action that may induce any customer, employee, agent, contractor, or vendor of the other party (either individually or in the aggregate) to discontinue his, her or its affiliation with such other party, or (b) solicit or hire the employees or independent contractors of the other party or any Affiliate thereof without the prior written consent of such other party.

8.2 Equitable Relief. In the event of a breach or threatened breach by a party or any of its Affiliates of any of the obligations under this ARTICLE VIII, the other party shall be entitled, upon application to any court of proper jurisdiction, to a temporary restraining order or preliminary injunction to restrain and enjoin the breaching party and/or its Affiliates from such violation without prejudice as to any other remedies the non-breaching party may have at law or in equity. Each party agrees that, in the event of a violation by such party or an Affiliate thereof, it would be virtually impossible for the other party to calculate its monetary damages and that such other party would be irreparably harmed. If the non-breaching party seeks a temporary restraining order or preliminary injunction, such non-breaching party shall not be required to post any bond or other security with respect thereto, or, if, nonetheless, a bond is required, it may be posted without surety thereon. If any restriction contained in this ARTICLE VIII is held by any court to be unenforceable, or unreasonable, as to time, geographic area or business limitation, the parties agree that such provisions shall be and are hereby reformed to the maximum time, geographic area or business limitation permitted by applicable laws. The parties further agree that the remaining restrictions contained in this ARTICLE VIII shall be severable and shall remain in effect and shall be enforceable independently of each other. Each party specifically acknowledges, represents and warrants that the covenants set forth in this ARTICLE VIII are reasonable, necessary, and enforceable to protect the legitimate interests of the other party, and that such other party would not have entered into this Agreement in the absence of such covenants.

ARTICLE IX
REPRESENTATIONS AND WARRANTIES

9.1 Of Advisor. Advisor represents and warrants to the Company as follows:

(a) Advisor has been duly organized and validly exists as a corporation in good standing under the laws of the State of Delaware, with full corporate power to own its properties and to conduct its business under such laws.

(b) Advisor has the full corporate power and authority to execute and deliver this Agreement and to perform its obligations hereunder, and all necessary actions for the due authorization, execution, delivery and performance of this Agreement by Advisor have been duly taken. The individual executing this Agreement on behalf of Advisor is duly authorized and has the requisite power and authority to execute this Agreement.

(c) Neither the execution of this Agreement, the performance by Advisor under this Agreement, nor compliance by Advisor with any provision of this Agreement will conflict with or violate Advisor's articles of incorporation or bylaws, any agreements to which Advisor is a party, or any material provision of applicable federal, state and local laws, rules and regulations.

(d) Upon Advisor's execution of this Agreement, this Agreement shall constitute a valid and binding obligation of Advisor, enforceable in accordance with its terms.

(e) Neither Advisor, nor its Affiliates, employees, and agents (i) is currently excluded, debarred or otherwise ineligible to participate in any federal or state health care program, (ii) has been convicted of a criminal offense related to the provision of healthcare items and services, (iii) is under investigation or otherwise aware of any circumstances which may result in Advisor or any of its Affiliates, employees, or agents being excluded from participation in any federal or state health care program, (iv) is listed in the HHS/OIG List of Excluded Individuals (http://www.oig.hhs.gov/exclusions) ("LIEE"), the General Services Administration's List of Parties Excluded from Federal Programs (http://www.epls.gov), the National Practitioner Data Bank, or any similar federal or state database indicating that such individual is ineligible to perform the Consulting Services under this Agreement, or (v) is a Specially Designated National or a Blocked Person by the Office of the Foreign Asset Control of the U.S. Department of Treasury.

(f) Advisor will not employ or otherwise obtain the services of any individual to perform Consulting Services under this Agreement who is not legally authorized to work in the United States in the capacity indicated. In furtherance thereof, Advisor certifies that all persons assigned to work under this Agreement are legally authorized to work in the United States in the capacity they are serving under this Agreement and will provide any and all written documentation to support such certification. Advisor agrees that if the status of any such person changes during the term of the Agreement, it shall remove such person from performing Consulting Services under this Agreement. On no less than a monthly basis, Advisor shall screen each individual performing the Consulting Services under this Agreement in the manner recommended by the HHS/OIG May 8, 2013 Special Advisory Bulletin on the Effect of Exclusion from Participation in Federal Health Care Programs, and shall maintain a record of each such screening.

(g) Advisor will abide by any and all applicable federal and/or state employment statutes, rules and regulations including, without limitation, Title VII of the Civil Rights Act of 1964, the Equal Opportunity Act of 1972, the Age Discrimination in Employment Act of 1967, the Equal Pay Act of 1963, the National Labor Relations Act, the Fair Labor Standards Act, the Rehabilitation Act of 1973, and the Occupational Safety and Health Act of 1970, all as may be from time to time modified or amended.

(h) Advisor shall cooperate with the Company corporate compliance audits, reviews and investigations that relate to the services provided by Advisor under this Agreement. Advisor acknowledges that the Company has established a Corporate Compliance Plan ("CCP") and promotes a culture that fosters prevention, detection and resolution of instances of misconduct. Advisor shall cause all Advisor personnel performing the Consulting Services for the Company

to participate in the Company's initial corporate compliance and privacy training no later than thirty (30) days from the date such individual commences performing Services under this Agreement, and additionally in the Company's annual compliance and privacy training thereafter. The failure to complete such training within the designated time frame shall be cause for removal under this Agreement. Advisor shall additionally require all Advisor personnel furnishing the Consulting Services to sign and furnish to the Company the Certification and Acknowledgement attached to the ECHN Code of Conduct stating that such individual has read the ECHN Code of Conduct (available on the ECHN website at www.ECHN.org, About ECHN) and agrees to comply with all of its provisions.

(i) Advisor shall immediately notify ECHN's Compliance Officer of any violation of any applicable law, regulation, third party payor requirements or breach of ECHN's CCP of which Advisor or any of its employees or agents become aware of during the term hereof. Advisor shall instruct its employees and agents of this requirement.

(j) Advisor shall maintain and actively support, at all times during the term of this Agreement, a corporate compliance program that has been reasonably designed, implemented and enforced so that it generally will be effective in preventing and detecting criminal conduct and ethical lapses by Advisor, its agents and employees.

(k) Advisor shall cooperate with the Company in responding to or resolving any complaint, investigation, inquiry, or review initiated by a governmental agency or otherwise. Advisor shall cooperate with any insurance company providing protection to the Company in connection with the foregoing and shall, consistent with applicable law, fully follow the directions of the Company.

(l) Advisor has all rights, authorizations, and licenses necessary to provide any material furnished by Advisor to the Company, and that the material and the Company's use thereof, as authorized by this Agreement, shall not infringe, misappropriate, or otherwise violate the rights of any third party.

(m) Each of Advisor's employees, agents, or representatives assigned to perform under the Agreement shall have the proper skill, training, and background so as to be able to perform in a professional and workmanlike manner and that all work will be so performed in a manner compatible with Advisor's business operations at its premises.

(n) Advisor will not introduce into Advisor software, computer hardware or data any software that contains any "time-bombs," "usage authorization codes," or other codes or programming devices that might or might be used to access, modify, delete, damage, deactivate, or disable any of the Company's software, computer hardware, or data; nor will Advisor cause any of the Company's software, computer hardware or data to be infected with any "worms", "viruses", "Trojan horses" or other programs or programming devices that might be used to modify, delete, damage, deactivate or disable any of the Company's software, computer hardware or data.

9.2 Of the Company. The Company represents and warrants to Advisor as follows:

(a) The Company has been duly organized and validly exists as a not-for-profit corporation in good standing under the laws of the State of Connecticut, with full limited power to own its properties and to conduct its business under such laws.

(b) The Company has the full corporate power and authority as a company to execute and deliver this Agreement and to perform its obligations hereunder, and all necessary actions for the due authorization, execution, delivery and performance of this Agreement by the Company have been duly taken. The individual executing this Agreement on behalf of the Company is duly authorized and has the requisite power and authority to execute this Agreement.

(c) Neither the execution of this Agreement, the performance by the Company under this Agreement, nor compliance by the Company with any provision of this Agreement will conflict with or violate the Company's articles of incorporation, bylaws, any agreements to which the Company is a party, or any material provision of applicable federal, state and local laws, rules and regulations.

(d) Upon the Company's execution of this Agreement, this Agreement shall constitute a valid and binding obligation of the Company, enforceable in accordance with its terms.

(e) Neither the Company, nor its Affiliates, employees, and agents (i) is currently excluded, debarred or otherwise ineligible to participate in any federal or state health care program, (ii) has been convicted of a criminal offense related to the provision of healthcare items and services, or (iii) is a Specially Designated National or a Blocked Person by the Office of the Foreign Asset Control of the U.S. Department of Treasury.

ARTICLE X
INSURANCE

10.1 Advisor's Required Coverage. During the Term hereof, Advisor shall maintain, at its own expense, workers' compensation coverage in accordance with statutory requirements for Advisor's employees who provide services under this Agreement, and commercial general liability insurance and commercial auto insurance in an amount not less than One Million Dollars ($1,000,000) per occurrence and Three Million Dollars ($3,000,000) in the annual aggregate with insurance carriers duly licensed to conduct business in the State of Connecticut. In addition, Advisor shall maintain professional liability insurance and cyber liability insurance, each in an amount not less than One Million Dollars ($1,000,000) per occurrence and Three Million Dollars ($3,000,000) in the annual aggregate with insurance carriers duly licensed to conduct business in the State of Connecticut. The limits above may be satisfied by any combination of self insurance or umbrella policies, and Advisor may carry any insurance required by this Agreement under a blanket policy.

10.2 The Company's Required Coverage. The Company shall maintain, at the Company's expense, at all times during the Term: (a) workers' compensation coverage in accordance with statutory requirements for the Company's employees; (b) commercial property

damage and fire/hazard insurance written on full replacement value basis for all of the Company's assets and real property; (c) professional liability insurance covering the Company's employees who perform any work, duties, or obligations against claims for bodily injury, death, malpractice and property damage, which insurance shall provide coverage on a claims-made or occurrence basis with a per occurrence limit of not less than One Million Dollars ($1,000,000) per occurrence and Three Million Dollars ($3,000,000) in the annual aggregate; and (d) comprehensive commercial general liability insurance in an amount not less than One Million Dollars ($1,000,000) per occurrence and Three Million Dollars ($3,000,000) in the annual aggregate. The above limits may be satisfied by any combination of primary and excess or umbrella policies. The Company may carry any insurance required by this Agreement under a blanket policy. Advisor shall be an additional named insured under the Company's general liability insurance policy.

10.3 Certificates of Insurance. On the Effective Date and at any time upon request, each party shall provide the other party certificates of insurance evidencing the coverages required hereby, and shall notify the other party immediately of the cancellation, termination, or non-renewal of, or material change in, such insurance coverage.

ARTICLE XI
ARMS-LENGTH BARGAINING

The parties agree that the compensation provided herein has been determined in arm's-length bargaining and is consistent with fair market value in arm's length transactions and is not and has not been determined in a manner that takes into account the volume or value of any referrals or business otherwise generated for or with respect to the Hospitals or other facilities of the Company or between the parties or any of the undersigned persons or equity holders thereof for which payment may be made in whole or in part under Medicare or any state health care program or under any other payor program.

ARTICLE XII
ASSIGNMENT

Neither party shall, directly or indirectly, assign or otherwise transfer this Agreement, or any interest herein or obligation hereunder, without the prior written consent of the other party, which may be withheld in such other party's sole discretion. In no event may a party assign this Agreement unless the assignee shall have executed and delivered to the other party a written assumption of this Agreement in form and substance satisfactory to such other party in its sole discretion. Notwithstanding the foregoing, Advisor shall be permitted, without the consent of the Company, to assign this Agreement to any Affiliate of Advisor, but Advisor shall remain liable to the Company for the performance and satisfaction of all undertakings and commitments set forth herein.

ARTICLE XIII
NOTICES

All notices required or permitted hereunder shall be given in writing by actual delivery or by certified mail, postage prepaid or by nationally recognized overnight courier service. Notice shall be deemed given upon delivery, or if given by mail, upon receipt or if sent by next day delivery by a nationally recognized overnight courier service, on the next business day. Notice shall be delivered or mailed to the parties at the following addresses or at such other places as a party shall designate in writing:

If to the Company:	Eastern Connecticut Health Network, Inc. 71 Haynes Street Manchester, CT 06040 Attn: Peter J. Karl, President and Chief Executive Officer phone: e-mail:
with a copy (which shall not constitute notice) to:	Ropes & Gray LLP Prudential Tower 800 Boylston Street Boston, MA 02199-3600 Attn: Anne Ogilby Fax: 617-235-0234 Email: anne.ogilby@ropesgray.com
If to Advisor:	Prospect Medical Holdings, Inc. 10780 Santa Monica Boulevard, Suite 400 Los Angeles, CA 90025 Attention: Legal Department
with a copy (which shall not constitute	Epstein Becker & Green, P.C. One Gateway Center

notice) to: Newark, NJ 07102
Attention: Gary W. Herschman, Esq.
phone: (973) 642-1900
email: gherschman@ebglaw.com
Attention: David E. Weiss, Esq.
phone: (212) 351-4500
email: dweiss@ebglaw.com

ARTICLE XIV
RECORD ACCESS AND RETENTION

14.1 Access to Records. Each party hereto shall permit, and shall ensure that any subcontractor retained by it permits, the United States Department of Health and Human Services and General Accounting Office, or their authorized representatives, to review appropriate books and records relating to the performance hereunder to the extent required under Section 1861(v)(1) of the Social Security Act, 42 U.S.C. Section 1395x(v)(1)(I), or any successor law or regulation for a period of four (4) years following the last day Advisor provided services hereunder. The access shall be provided in accordance with the provisions of Title 42, Code of Federal Regulations, Part 420, Subpart D.

14.2 Notification. Each party shall notify the other party immediately of the nature and scope of any request for access to books and records described above and shall provide copies of any books, records or documents to the other party prior to the provision of same to any governmental agent to give such other party an opportunity to lawfully oppose such production of documents. Nothing herein shall be deemed to be a waiver of any applicable privilege (such as the attorney-client privilege) by either party.

ARTICLE XV
MISCELLANEOUS

15.1 Choice of Law; Dispute Resolution; Venue.

(a) Choice of Law. The parties agree that this Agreement shall be governed by and construed in accordance with the Laws of the State of Connecticut, without giving effect to any choice or conflict of law provision or rule thereof that would require the application of any other law.

(b) Dispute Resolution. Except as provided in Section 15.2 below, in the event that any dispute, controversy or claim arises among the parties with respect to this Agreement, including as to the breach, termination or invalidity hereof (a "Dispute"), the parties shall attempt in good faith to resolve such Dispute promptly by negotiation (including at least one in-person meeting) over a period of not less than thirty (30) days, commencing upon one party's delivery of a written notice of Dispute to the other party.

(c) Venue. In the event that any Dispute is not resolved through good faith negotiations as provided in Section 15.1(b) above, either party may submit the matter to a court

of law or equity through the filing of a claim. The Parties agree that, except as otherwise expressly provided in Section 15.2 below, venue for any and all claims associated with a Dispute between the Parties shall rest with the state courts of the State of Connecticut.

(d) Waiver of Jury Trial. EXCEPT AS PROVIDED IN SECTION 15.2 BELOW, EACH PARTY HEREBY IRREVOCABLY WAIVES ALL RIGHT TO TRIAL BY JURY IN ANY ACTION, PROCEEDING OR COUNTERCLAIM (WHETHER BASED ON CONTRACT, TORT OR OTHERWISE) ARISING OUT OF OR RELATING TO THIS AGREEMENT OR THE TRANSACTIONS CONTEMPLATED HEREBY OR THEREBY.

15.2 Injunctive Relief. Notwithstanding anything to the contrary contained herein, each party acknowledges and agrees that a party may seek, from a court of competent jurisdiction in the State of Connecticut, injunctive relief against a breaching party pursuant to Sections 4.4 and 8.2 above, without posting any bond or other undertaking.

15.3 Severability. Should any provision of this Agreement be found void or unenforceable, the remainder hereof nevertheless shall continue in full force and effect. A new provision shall be amended to this Agreement that is similar to the provision found unenforceable but which is enforceable.

15.4 Approval or Consent. Except as otherwise provided herein, whenever under any provisions of this Agreement, the approval or consent of either party is required, such approval or consent shall not be unreasonably withheld, conditioned or delayed.

15.5 Entire Agreement. This Agreement contains the entire agreement between the parties with respect to the subject matter hereof, and the parties expressly agree that this Agreement supersedes and rescinds any prior agreement between them (verbal or written) pertaining to the subject matter hereof.

15.6 No Third Party Beneficiary. Except as expressly provided in this Agreement, no person or entity that is not a party to this Agreement shall be a third party beneficiary of any rights or obligations hereunder or be entitled to enforce any of said rights or obligations.

15.7 Interpretation. The article and paragraph headings contained herein are for convenience of reference only, do not constitute part of this Agreement, and are not intended to define, limit or describe the scope of intent of any provision of this Agreement. All gender references used in this Agreement shall include all genders, and the singular shall include the plural and the plural shall include the singular whenever and as often as may be appropriate.

15.8 Force Majeure. Advisor shall not be deemed to be in violation of this Agreement, and shall not be liable for any resulting claims, losses, damages, expenses and liabilities if it is prevented, hindered or delayed, either directly or indirectly, from performing any of its obligations hereunder for any reason beyond its reasonable control, including without limitation labor disputes, fires, storms, earthquakes, acts of God, or any statute, regulation or rule of the federal government, any state or local government or any agency thereof.

15.9 Amendments; Course of Dealing. This Agreement may be amended or supplemented only in a writing signed by both parties. The failure of any party to enforce at any time any of the provisions of this Agreement shall in no way be construed to be a waiver of any such provision, nor in any way to affect the validity of this Agreement or any part hereof or the right of any party thereafter to enforce each and every such provision. No waiver of any breach of this Agreement shall be held to be a waiver of any other or subsequent breach.

15.10 Cooperation; Further Assistance. From time to time, as and when reasonably requested by either party hereto, the other party will (at the expense of the requesting party) execute and deliver, or cause to be executed or delivered, all such documents, instruments and consents and will use reasonable efforts to take all such action as may be reasonably requested or necessary to carry out the intent and purpose of this Agreement.

15.11 Execution of this Agreement. The parties may execute this Agreement in counterparts, each of which shall be deemed an original and both of which together shall constitute but one and the same instrument. A signature delivered by facsimile or PDF shall be sufficient for all purposes between the parties.

[*signature page follows*]

IN WITNESS WHEREOF, the parties have executed this Agreement, through their duly authorized representatives, effective as of the date first above written.

ADVISOR:

PROSPECT MEDICAL HOLDINGS, INC., a Delaware corporation

By:_____
Name:
Title:

THE COMPANY:

EASTERN CONNECTICUT HEALTH NETWORK, INC., a Connecticut non-stock corporation

By:_____
Name:
Title:

EXHIBIT A
LIST OF CONSULTING SERVICES

In consideration of the payments to be made hereunder, Advisor shall from time to time and as appropriate provide, either directly or indirectly through one or more of its Affiliates, the following services to the Company:

1. Advise the Company regarding trends in the industry, make recommendations regarding new and/or expanded services and programs, physician alignment & recruitment, IT/EMR capabilities and improvements, technology implementation, ACOs and other reform-driven approaches, and managed care approaches.

2. Review, assess and provide recommendations regarding potential service consolidation and restructurings to achieve efficiencies.

3. Review, assess and provide recommendations regarding new clinical service lines, programs and locations.

4. Review, assess and provide recommendations regarding physician-alignment strategies, joint ventures and other strategic initiatives.

5. Advise the Company regarding expenditure and spending patterns, evaluate standard procurement lifecycle methodologies including working cash vs. discount modeling, invoice synchronization and vendor payment management. Such expenditures and contracts would include without limitation:

    - Third party service providers
    - Supply contracts
    - Contracts with outside contractors or consultants
    - Preventive maintenance with respect to equipment and building
    - Upkeep and maintenance of the physical facilities

6. Advise the Company regarding third-party reimbursement issues and consultation on such issues and compliance with all applicable reimbursement rules.

7. Assist the Company to develop, implement and maintain a compliance program that is committed to promoting, preventing, detecting and resolving instances of conduct that do not conform to federal or state laws.

8. Assist the Company to develop plans with respect to labor relations matters.

9. Review, assess and provide recommendations regarding a physician-led and focused clinical documentation program.

10. Review, assess and provide recommendations regarding the Company's case management program and length of stay initiatives.

11. Assist the Company to develop strategies with respect to cost accounting processes.

12. Provide other Consulting Services as mutually agreed upon in writing by the parties from time to time.

EXHIBIT B
BUSINESS ASSOCIATE AGREEMENT

THIS BUSINESS ASSOCIATE AGREEMENT (the "Business Associate Agreement") is made and entered into as of _____, 20____ (the "Effective Date"), by and between ("Business Associate"), and Eastern Connecticut Health Network, Inc. by and on behalf of its covered entity subsidiaries, affiliates and related organizations (collectively, the "Covered Entity").

RECITALS

WHEREAS, the Business Associate and Covered Entity have entered into and may enter into one or more agreements (the "Agreement(s)") under which the Business Associate performs or assists the Covered Entity with a function or activity involving the Use or Disclosure of Individually Identifiable Health Information;

WHEREAS, the Covered Entity and the Business Associate desire to comply with the requirements of regulations promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

WHEREAS, the HIPAA Standards require that the Covered Entity obtain satisfactory assurances that the Business Associate will appropriately safeguard the Individually Identifiable Health Information Used or Disclosed by the Business Associate in the course of performing services pursuant to the Agreement(s).

NOW, THEREFORE, in consideration of the foregoing and the mutual promises and covenants herein contained, the parties agree as follows:

1. Definitions

a) HIPAA Rules shall mean the Privacy, Security, Breach Notification and Enforcement Rules at 45 C.F.R. Part 160 and Part 164.

b) The following terms Used in this business Associate Agreement shall have the same meaning as those terms defined in the HIPAA Standards: Business Associate, Covered Entity, Breach, Data Aggregation, Designated Record Set, Disclosure, Health Care Operations, Individual, Minimum Necessary, Notice of Privacy Practices, Protected Health Information, Required By Law, Secretary, Security Incident, Subcontractor, Unsecured Protected Health Information, and Use.

c) The Covered Entity and the Business Associate acknowledge and agree that capitalized terms Used, but not otherwise defined, herein are as defined in the HIPAA Standards;

2. Obligations and Activities of Business Associate

a) Business Associate shall not Use or further Disclose Protected Health Information other than as permitted or required by this Business Associate Agreement or as required by law.

b) Business Associate shall Use appropriate safeguards and comply with Subpart C of 45 C.F.R. Part 164 with respect to electronic protected health information, to prevent Use or Disclosure of the Protected Health Information not provided for by this Business Associate Agreement.

c) Business Associate shall immediately report to Covered Entity any Use or Disclosure of Protected Health Information or individually identifiable information not provided for by this Business Associate Agreement, including without limitation any Breach of Protected Health Information or Unsecured Protected Health Information as required and any Security Incident of which the Business Associate becomes aware. Business Associate shall take any reasonable action necessary or requested by the Covered Entity to mitigate, to the extent practicable, any harmful effect that is known to Business Associate.

d) In the event of a Breach of Protected Health Information or Unsecured Protected Health Information, Business Associate's notice to Covered Entity of such Breach shall include, to the extent possible, the identification of each Individual whose Protected Health Information has been, or is reasonably believed to have been, accessed, acquired, or disclosed. Business Associate shall also provide Covered Entity any other available information that the Covered Entity is required to include in the notification to the Individual, even if such information becomes available after notification to the Individual, or take any reasonable action necessary as requested by the Covered Entity to assist Covered Entity in complying with any applicable Breach notification requirements.

e) Business Associate shall ensure that any agent of the Business Associate, including a subcontractor that creates, maintains transmits, or receives Protected Health Information on behalf of Covered Entity agrees to the same restrictions, conditions and requirements that apply through to Business Associate with respect to such information.

f) If the Business Associate maintains Protected Health Information in a Designated Record Set, the Business Associate shall:

(i) provide access or make available to Covered Entity Protected Health Information in a Designated Record Set, to Covered Entity or to an Individual, per Covered Entity's direction in order to meet the requirements under 45 C.F.R. § 164.524; and

(ii) make any amendment(s) to Protected Health Information in a Designated Record Set that the Covered Entity directs or agrees to pursuant to 45 C.F.R. § 164.526 at the request of Covered Entity or an Individual in the time and manner designated by Covered Entity, or take other measures as necessary to satisfy Covered Entity's obligations under 45 C.F.R. 164.526.

g) Business Associate shall maintain and make available to Covered Entity information pertaining to Disclosures of Protected Health Information by Business Associate to permit Covered Entity to respond to a request by an Individual for an accounting of Disclosures of Protected Health Information in accordance with 45 C.F.R. § 164.528. In the event that Business Associate receives a direct request from an Individual for an accounting of Disclosures of Protected Health Information made by Business Associate, Business Associate agrees to provide the Individual with such an accounting in accordance with 45 C.F.R. § 164.528.

h) To the extent Business Associate is to carry out one or more of Covered Entity's obligation(s) under Subpart E of 45 C.F.R. Part 164, Business Associate shall comply with the requirements of Subpart E that apply to Covered Entity in the performance of such obligation(s); and

i) Business Associate shall make internal practices, books, and records relating to the Use and Disclosure of Protected Health Information received from, or created, maintained or received by Business Associate on behalf of Covered Entity available to the Covered Entity or the Secretary, in a time and manner designated by the Covered Entity or the Secretary, for purposes of the Secretary determining Covered Entity's or Business Associate's compliance with the HIPAA Rules.

j) Business Associate shall implement and maintain safeguards as necessary to ensure that all Protected Health Information is Used or Disclosed only as authorized under the HIPAA Rules and this Business Associate Agreement. Business Associate agrees to assess potential risks and vulnerabilities to Protected Health Information in its possession and develop, implement and maintain the administrative, physical and technical safeguards required by the HIPAA Rules that protect the confidentiality, availability and integrity of the Protected Health Information that Business Associate creates, receives, maintains or transmits on behalf of the Covered Entity. These measures must be documented and kept current, and must include, at a minimum, those measures that fulfill the requirements outlined in the HIPAA Rules. Business Associate also agrees to implement policies and procedures that address Business Associate's compliance with applicable HIPAA Rules and its efforts to detect, prevent and mitigate the risks of identity theft resulting from the improper Use and/or Disclosure of an Individual's information.

k) In the event that Business Associate has knowledge of Covered Entity's breach of the HIPAA Rules, Business Associate agrees to notify Covered Entity and take reasonable steps to cure such breach.

l) Business Associate acknowledges that if it violates any of the requirements provided under this Business Associate Agreement, Business Associate will be subject to the same civil and criminal penalties that a Covered Entity would be subject to if such Covered Entity violated the same requirements.

3. Permitted Uses and Disclosures by Business Associate

a) Business Associate may Use or Disclose Protected Health Information to perform functions, activities, or services for, or on behalf of, Covered Entity as specified in the Agreement(s), provided that such Use or Disclosure would not violate the HIPAA Rules if done by Covered Entity.

b) Business Associate may Use Protected Health Information for the proper management and administration of the Business Associate or to carry out the legal responsibilities of the Business Associate.

c) Business Associate may Disclose Protected Health Information for the proper management and administration of the Business Associate, provided that Disclosures are Required by Law, or Business Associate obtains reasonable assurances from the person to whom the information is Disclosed that it will remain confidential and will be Used or further Disclosed only as Required by Law or for the purpose for which it was initially Disclosed to the recipient, and the recipient notifies the Business Associate of any instances of which it is aware in which the confidentiality of the information has been breached.

d) Except as otherwise permitted by the HIPAA Rules, when using or disclosing Protected Health Information or responding to a request for Protected Health Information, Business Associate must limit such Protected Health Information, to the extent practicable, to a Limited Data Set, or if more information than a Limited Data Set is required, Business Associate agrees to make Uses and Disclosures and requests for protected health information consistent with the Minimum Necessary to accomplish the intended purpose of such Use, Disclosure, or request.

e) Except as otherwise permitted by the HIPAA Rules, Business Associate agrees that it will not directly or indirectly receive remuneration in exchange for any Protected Health Information unless Covered Entity has obtained from an Individual a valid authorization that includes a specification of whether the Protected Health Information can be further exchanged for remuneration by the entity receiving the Individual's Protected Health Information. When the Secretary issues the regulations that address the requirements of this Section and such regulations become effective, Business Associate shall comply with such regulations with respect to receiving remuneration in exchange for any Protected Health Information.

f) If an Individual requests that Business Associate restrict the Disclosure of the Individual's Protected Health Information to carry out treatment, payment, or health care operations, Business Associate agrees that it will comply with the requested restriction if, except as otherwise required by law, the Disclosure is to a health plan for purposes of carrying out payment or health care operations (and is not for purposes of carrying out treatment), and the Protected Health Information pertains solely to a health care item or service for which the health care provider involved has been paid out of pocket in full.

g) Except as otherwise limited in this Business Associate Agreement, Business Associate may Use and Disclose Protected Health Information to provide Data Aggregation services to Covered Entity as permitted by 42 C.F.R. § 164.504(e)(2)(i)(B).

4. Obligations of Covered Entity

a) Covered Entity shall provide Business Associate with the Notice of Privacy Practices that Covered Entity produces in accordance with 45 C.F.R. § 164.520, as well as provide any changes to such Notice and the Business Associate shall comply with such Notice of Privacy Practices.

b) Covered Entity shall provide Business Associate with any changes in, or revocation of, permission by Individual to Use or Disclose Protected Health Information, if such changes affect Business Associate's permitted or required Uses and Disclosures.

c) Covered Entity shall notify Business Associate of any restriction to the Use or Disclosure of Protected Health Information that Covered Entity has agreed to in accordance with 45 C.F.R. § 164.522.

d) Covered Entity shall not request Business Associate to Use or Disclose Protected Health Information in any manner that would not be permissible under the HIPAA Rules if done by Covered Entity.

5. Term and Termination

a) Term. The Term of this Business Associate Agreement shall be effective as of the Effective Date and shall terminate when all of the Protected Health Information provided by Covered Entity to Business Associate, or created, maintained, or received by Business Associate on behalf of Covered Entity, is destroyed or returned to Covered Entity, or, if it is infeasible to return or destroy Protected Health Information, protections are extended to such information, in accordance with the termination provisions in this Section.

b) Termination for Cause. Upon Covered Entity's knowledge of a material breach of this Business Associate Agreement by Business Associate, Covered Entity shall provide an opportunity for Business Associate to cure the breach or end the violation. Covered Entity shall terminate the Business Associate Agreement if Business Associate does not cure the breach or end the violation within the time specified by Covered Entity. Covered Entity may immediately terminate the Business Associate Agreement if Business Associate has breached a material term of this Business Associate Agreement and cure is not possible, as determined by the Covered Entity in its reasonable discretion.

c) Effect of Termination.

(i) Except as provided in this subsection, upon termination of the Agreement(s) or this Business Associate Agreement, for any reason, Business Associate shall return or destroy all Protected Health Information received from Covered Entity, or created, maintained or received by Business Associate on behalf of Covered Entity that the Business Associate still maintains in any form. This provision shall apply to Protected Health Information that is in the possession of subcontractors or agents of Business Associate. Business Associate shall retain no copies of the Protected Health Information.

(ii) In the event that Business Associate determines that returning or destroying the Protected Health Information is infeasible, Business Associate shall provide to Covered Entity notification of the conditions that make return or destruction infeasible. Upon mutual agreement of the parties that return or destruction of Protected Health Information is infeasible, Business Associate shall extend the protections of this Business Associate Agreement to such Protected Health Information and limit further Uses and Disclosures of such Protected Health Information to those purposes that make the return or destruction infeasible, for so long as Business Associate maintains such Protected Health Information.

(iii) The parties hereto understand and agree that the terms of this Business Associate Agreement are reasonable and necessary to protect the interests of the Covered Entity and the Business Associate. The parties further agree that the Covered Entity would suffer irreparable harm if the Business Associate breached this Business Associate Agreement. Thus, in addition to any other rights or remedies, all of which shall be deemed cumulative, the Covered Entity shall be entitled to obtain injunctive relief to enforce the terms of this Business Associate Agreement.

(iv) Survival. The obligations of Business Associate under this Section shall survive the termination of this Business Associate Agreement.

6. Miscellaneous

a) Interpretation. Any ambiguity in this Business Associate Agreement shall be interpreted in a manner that permits the parties to comply with the HIPAA Rules.

b) No Private Cause of Action. This Business Associate Agreement is not intended to and does not create a private cause of action by any individual, other than the parties to this Business Associate Agreement, as a result of any claim arising out of the breach of this Business Associate Agreement, the HIPAA Standards or other state or federal law or regulation relating to privacy or confidentiality.

c) Amendment. Either party shall have the right to amend this Business Associate Agreement by providing written notice to the other party in order to bring it into compliance with any law or regulation enacted or promulgated regarding the protection of health information that is any way inconsistent with the terms of this Business Associate Agreement or interferes with either parties' obligations with respect to the protection of health information.

d) Application of State Law. Where any applicable provision of Connecticut State law relates to the privacy of health information and is not preempted by HIPAA, as determined by application of the HIPAA Rules, the parties shall comply with the applicable provisions of Connecticut State law.

e) Severability. If any provision of this Business Associate Agreement shall be declared invalid or illegal for any reason whatsoever, then notwithstanding such invalidity or illegality, the remaining terms and provisions of this Business Associate Agreement shall remain in full force and effect in the same manner as if the invalid or illegal provision had not been contained herein, and such invalid, unenforceable or illegal provision shall be valid, enforceable and legal to the maximum extent permitted by law.

f) Governing Law. This Business Associate Agreement shall be interpreted, construed and governed according to the laws of the State of Connecticut. The parties agree that venue shall lie in Federal and State courts in the State in which the Covered Entity maintains its principal place of business, without regard to its conflicts of law principles, regarding any and all disputes arising from this Business Associate Agreement.

g) Notices. Any notice or other communication given pursuant to this Business Associate Agreement must be in writing and (i) delivered personally, (ii) delivered by overnight express, or (iii) sent by registered or certified mail, postage prepaid, to the address set forth below and shall be considered given upon delivery.

Chief Compliance and Privacy Officer

Eastern Connecticut Health Network

71 Haynes Street

Manchester, CT 06040

h) Indemnification. Without limitation to any indemnification obligation that Business Associate may have under the Agreement(s), Business Associate shall indemnify, hold harmless and defend Covered Entity from and against any and all claims, losses, liabilities, costs and other expenses resulting from, or relating to, the acts or omissions of Business Associate, its employees, agents, and subcontractors, in connection with any Use or Disclosure of Protected Health Information, Unsecured Protected Health Information, or an Individual's information not provided for by this Business Associate Agreement, including without limitation any Breach of Protected Health Information, Unsecured Protected Health Information, or an Individual's information or any expenses incurred by Covered Entity in providing required breach notifications.

IN WITNESS WHEREOF, the parties hereto have caused this Business Associate Agreement to be executed and delivered as of the day and year first above written.

COVERED ENTITY:	BUSINESS ASSOCIATE:
EASTERN CONNECTICUT HEALTH NETWORK, INC.	PROSPECT MEDICAL HOLDINGS, INC.
BY: _____	BY: _____
NAME: _____	NAME: _____
ITS: _____	ITS: _____
DATE_____	DATE: _____

RESPONSE TO DEFICIENCIES
EXHIBIT E - Number of Physicians in PMH Network

Number of Physicians Participating in PMH's Physician Network by State

	Owned			
	2012	2013	2014	2015
Total PCP's (Contracted Only) - California	852	903	913	882
Total SP's (Contracted Only) - California	8,264	9,273	10,607	12,402
Total PCP's (Contracted Only) - Rhode Island				105
Total SP's (Contracted Only) - Rhode Island				270
Total PCP's (Contracted Only) - Texas				23
Total SP's (Contracted Only) - Texas				594
TOTAL PCP'S AND SP'S	**9,116**	**10,176**	**11,520**	**14,276**

Please note that the above data includes all fully contracted physicians and physicians who Prospect has Memorandum of Understandings for limited services and/or for a limited period of time and/or

PCP = Primary Care Physician

SP = Specialist

RESPONSE TO DEFICIENCIES
EXHIBIT F - PMH Performance Metrics (Texas)

Prospect Medical

12 Month Bed-Day Report - HMO Product Summary

Health Plan : ALL HEALTH PLANS

Location : PROSPECT HEALTH SERVICES-TEXAS

GOAL:

Senior: (900 / K)
Commercial: (125 / K)
Medi-Cal: (250 / K)
SPD: (400 / K)

PROSPECT HEALTH SERVICES-TEXAS

HMO Product		2015-01	2015-02	2015-03	2015-04	2015-05	2015-06	2015-07	2015-08	2015-09	2015-10	2015-11	2015-12	Total
SENIOR														
ACUTE	**Membership:**	1,617	1,611	1,626	1,465	1,439	1,430	1,378	1,320	1,317	1,339	0	0	14,542
	Admits:	31	28	32	20	24	22	23	17	18	14	0	0	229
	Days:	172	149	179	148	143	143	194	104	154	91	0	0	1,477
	Admits / 1000:	226	227	232	166	196	187	197	152	166	123	0	0	189
	Days / 1000:	1,252	1,206	1,296	1,229	1,170	1,217	1,658	928	1,423	800	0	0	1,218
	ALOS:	5.5	5.3	5.6	7.4	6.0	6.5	8.4	6.1	8.6	6.5	0	0	6.4
NON-ACUTE	**Membership:**	1,617	1,611	1,626	1,465	1,439	1,430	1,378	1,320	1,317	1,339	0	0	14,542
	Admits:	8	5	1	4	4	6	7	6	2	3	0	0	46
	Days:	219	200	137	103	120	93	181	173	54	50	0	0	1,330
	Admits / 1000:	58	40	7	33	33	51	60	54	18	26	0	0	38
	Days / 1000:	1,595	1,618	992	855	982	791	1,547	1,543	499	440	0	0	1,096
	ALOS:	27.4	40.0	137.0	25.8	30.0	15.5	25.9	28.8	27.0	16.7	0	0	28.9

RESPONSE TO DEFICIENCIES
EXHIBIT G - PMH Programs and Procedures

PROSPECT MEDICAL
Quality Service ~ Quality Care

The Next Generation Healthcare System

THE PROSPECT MEDICAL DIFFERENCE: CARE PLUS

Care Management– Care Plus

What is Quality?

- Simply put, health care quality is: “getting the right care to the right patient at the right time – every time.”

Statement by: Carolyn Clancy MD, Director Agency for Health care Research and Quality, US Department of HHS.

Before: Committee on Finance, Subcommittee on Health Care; US Senate. Wednesday March 18, 2009.

http://www.hhs.gov/asl/testify/2009/03/t20090318b.html

Care Management– Care Plus

- What we do:
  - We improve patient outcomes & save lives with our innovative Care Plus Model for care coordination.
  - We embed specialized care teams into PCP practices & into the communities where our high-risk patients live.
  - Our medical-behavioral-social care model is executed across the care-continuum: any place of service, any time.
  - Seamless optimal care coordination & care transitions.
  - Leverage Complex Case Management, Palliative Care, Medication Therapy Management, & Home-based Care.
  - High-touch, high-service patient-centered approach.
  - Single operating platform with NCQA certified workflow.
  - Full Implementation with measurable results in 120 days.

Care Management– Care Plus

- What makes us special:
  - Our Care Model approach is Innovative & Effective.
  - Our Care Model drives Value.
  - Our Leaders are national experts in Care Coordination.
  - We are able to do this with all types of patients.
  - We specialize in highest-risk patients: chronic conditions, frail, disabled, homebound, severe mental illness, & end-of-life.
  - We also do this in all locations, geographies, & states.
  - We do this quickly, with minimum up-front investment.
  - We can reproduce, scale, & sustain.
  - Our results are compelling for all of our stakeholders.
  - Others are unable to replicate.

Care Management– Care Plus

- What this provides:

BETTER OUTCOMES

  - Improved patient safety.
  - Improved clinical quality of care.
  - Saves lives due to care coordination.
  - Better patient experience with improved satisfaction & retention.
  - Better physician experience with improved satisfaction & retention.
  - Dramatic reductions in avoidable hospital admissions.
  - Dramatic reductions in hospital re-admissions.
  - Dramatic reductions in population cost.
  - Decrease in medical loss ratio (MLR): 70% - 85%.
  - Increased savings from institutional & professional risk pools.

Care Management– Care Plus

- What this provides:

PATIENT VIEW

  - VIP Concierge patient experience.
  - I am healthier, safer, & living longer.
  - Available caring PCP on any day that I need him/ her.
  - Dedicated caring nurse to assist me whenever I need.
  - Assistance in my home with medications, treatments, questions, or concerns; day or night or weekend or holiday.
  - Transportation, appointments, community support, when I need.
  - My care team knows me, & communicate with each other about my care needs and preferences.
  - I will always get my care here.
  - I will recommend Prospect to all of my family & friends.

Care Management– Care Plus

- What this provides:

PCP VIEW

  - Improved clinical quality of care due to care coordination.
  - Easier to care for complex patients.
  - PCP is leader of care coordination team.
  - Always available CM nurse, NP, social worker, pharmacist, or behavioral health (BH) specialist.
  - Programs: Complex CM, Integrated BH, Inpatient CM (Hospital & SNF), Palliative Care, Homebound, Institutionalized (Long-term care).
  - Transportation, medication delivery, care givers, community support
  - Better care transitions to & from PCP.
  - Better PCP experience with improved satisfaction & retention.
  - Dramatic reduction in avoidable hospital admissions & re-admissions.
  - Increased bonus & capitation payments to PCP.

Care Management– Care Plus

- What this provides:

HOSPITAL VIEW

  - Improved patient safety.
  - Improved clinical quality of care due to care coordination.
  - Improved hospital throughput due to care coordination.
  - Partners in moving from fee-for-service to value-based payment.
  - Better alignment of physicians & health plans.
  - Increased admissions from aligned physician referrals.
  - Increased admissions from out-of-network hospital transfers.
  - Better patient experience with improved satisfaction.
  - Dramatic reductions in hospital re-admissions.
  - Increased shared savings from institutional risk pools.

Care Management– Care Plus

- What this provides:

HEALTHPLAN VIEW

  - Improved clinical quality of care due to care coordination.
  - Partners in population health management.
  - Better alignment of physicians & hospitals.
  - Delegate care coordination to Prospect, reduce G&A costs.
  - Dramatic reductions in population cost.
  - Reduced patient appeals & grievances.
  - Decrease in medical loss ratio (MLR): 85%.
  - Fixed budget & costs.
  - Shift financial risk to Prospect

PROSPECT MEDICAL
Quality Service ~ Quality Care

Prospect Medical Group

Integrated Care Coordination Program

2287

Care *Plus*-
High Intensity Care Management

- 24/7 Direct Telephonic Access
- Identification of patient “admission drivers” with development of specific actions plans
- Patient and Family Engagement of Care Plans
- Integrated Social Service coordination for members with psychosocial issues and placement issues
- Integrated Behavioral Health Management
- Disease Specific Action Plans and Self-Management
- Advance Care Planning
- Coordination of Ancillary Services/Physician Referrals

Care *Plus*- Palliative Care

- Outpatient Palliative Care Program
- Multidisciplinary team of physicians, RN, SW, chaplain, & pharmacist available 24/7
- Objectives are symptom management & reduce readmits
- Integrated with Prospect Care*Plus* Programs
- Goal to maximize care in home, then transition to hospice
- Screening LTC patients for palliative care & hospice

Care *Plus*-
Hospital Case Management

- Aggressive patient management & oversight
- Expectation of close monitoring of patients by rounding 2x per day until patient is discharged
- Medical Director rounds with CM & Hospitalist 2x per day
- Ability to direct patients from acute to preferred SNFs
- Ability to direct patients from acute to early Post DC Visit
- Close collaboration between Inpatient CM, SNF CM, Pharmacy, NP & PCP

Care *Plus*-
SNF Case Management

- Aggressive patient management
- Monitoring of patients by rounding 3-5x per week until patient is stable, then 2-3x per week
- Physician rounds supplemented by Prospect NPs
- Medical Director rounds with CM & SNFist 2x per week
- If patient's status deteriorates, transfer to network hospital
- Ability to direct patients from acute setting to preferred SNFs
- Direct patients from home or ED to preferred SNF for Therapy
- Close collaboration between Inpatient CM, SNF CM, Pharmacy, NP & PCP

Care *Plus*- Institutional (Long-Term Care)

- Patients to be seen weekly by Prospect SNFist/ NP
- Each facility assigned a dedicated SNFist & NP
- Each facility assigned a dedicated CM to assist in coordination of care
- Proactively manage ambulatory care sensitive conditions
  - Treat at SNF by converting patients from custodial to skilled LOC
  - Discontinue the practice of sending otherwise stable patients to hospital (IV Hydration, IV Antibiotics, Wound Care, etc.)
  - Advance Care Planning (DNR, DNH)

Care *Plus*- Utilization Management/ Referrals

- UM Program, Annual UM Plan, & UM Committee
- Utilization Measures, and related financial measures
  - Hospital Bed-days, Admits, ALOS
  - SNF Bed-days, Admits, ALOS
  - ER Visits
  - Specialty Referrals
  - Ambulatory Surgery Center Referrals
  - CT, MRI, PET Referrals
- Aggregate all data from provider referrals and claims, then analyze for improvement opportunities
- Detailed metric reporting for utilization & cost improvement
- Stream-lined, Effective process for provider requests for services, Referral review, Authorization, and Claims payment

Care *Plus*- Performance Programs/ QM

- Health Plan and Government based Quality Measures, and associated incentive payments
  - HEDIS
  - STARS
  - CMS ACO
  - CAHPS/ HOS
  - HCC/ RAF
- Collect data from health plans, labs, pharmacies, radiology, provider EHRs, and hospitals' EHRs
- Aggregate all data, then analyze for improvement opportunities
- Detailed metric reporting for quality & RAF improvement
- Quality Program, Annual Quality Plan, & QM Committee

Care *Plus*- Homebound Program

- Mid-level providers NPs) with patient panels
- 24/7 direct telephonic access
- Expedited interventions for Pneumonia, COPD, CHF, Dehydration, & Cellulitis
- Hospital post-DC follow-up visits within 24 hr
- Same day urgent visits
- HCC risk assessment and STAR quality assessment
- NP Visit Notes to PCP
- Phone Communication with PCP & SCP for intervention

Care *Plus*- Pharmacy Program

- 24/7 Direct Telephonic Access with Pharmacist
- Telephonic Medication Therapy Management
- Disease Management Programs (DM & Anticoagulation)
- Post DC In-Home Medication Therapy Management
- LTC Medication Therapy Management
- Integrated with Inpatient & Outpatient Clinical Teams
- Patient Education and Assessment of Non Adherence

PROSPECT MEDICAL
Quality Service ~ Quality Care

Coordinated-Regional-Care: The Next Generation Healthcare System

Prospect Medical Directors

Care *Plus*-
High Intensity Case Management

PROSPECT MEDICAL DIRECTOR'S RESPONSIBILITIES

- High Intensity CM Case Rounds 2x weekly
- Target high risk patients: readmits, multiple co morbid conditions, functional impairment, cognitive decline, psychosocial issue
- Identify admission drivers, barriers and develop care plans with multidisciplinary team
- Use Care Plus programs: palliative or hospice team, pharmacy, high risk clinic, home visits or LTC visits by NP
- Focus on avoidance of ER visits or Hospital Admits
- Provide Strategic input to CM program

Care *Plus*- Palliative Care

PROSPECT MEDICAL DIRECTOR'S RESPONSIBILITIES

- Palliative Care Team Rounds 1x Weekly
- Palliative Care Physician consults, as needed
- Discuss Admits, Discharges, 'Change of Condition' cases
- Recognize barriers, then develop home-based care plans
- Focus on Advance Care Planning & Hospice Conversions
- Focus on Symptom management
- Focus on avoidance of ER visits or Hospital Admits
- Provide Strategic input to Palliative Care programs

Care *Plus*- Hospital Case Management

PROSPECT MEDICAL DIRECTOR'S RESPONSIBILITIES

- Rounds AM and PM with Prospect concurrent review nurse
- Rounds daily with Hospitalists. Monthly Hospitalist JOCs.
- Focus on appropriateness of –
  - Level of Care. Need for Inpatient Stay (OBS, IP, SNF, etc.).
  - Preferred Hospital (Low or high DRG, Per Diem, etc.)
  - Identify DC barriers. **Use Care Plus programs**.
  - Identify service delays: facility with payment denials vs provider
- Participate in Core Hospital JOCs
- Approve Tertiary Hospital transfers; then daily oversight
- Out-of-Network Hospital Rounds daily; Repatriation if able
- Provide Strategic input to Hospitalist & CM programs

Care *Plus*-
SNF Case Management

PROSPECT MEDICAL DIRECTOR'S RESPONSIBILITIES

- Biweekly SNF Rounds with Case Managers, NPs, & SNFists
- Quarterly JOC with Core SNFs. Develop higher standards for level of care & service in SNFs.
- Monthly SNFist Meetings
- DC planning for care transitions; Use of Care Plus programs
- Advance Care planning (ACP)
- Long Term Care planning (LTC)
- Provide Strategic input to SNF & LTC programs

Care *Plus*- UM & QI

PROSPECT MEDICAL DIRECTOR'S RESPONSIBILITIES

- Phone call discussions with physicians on specific requests
  - PCP**s**
  - Specialists
- Educational support to providers on EBM Standards & Goals
- Participate or Chair UM Committee
- Claims Review for key questions re: payment authorization
- Review Appeals & Grievances for authorization denials
- Provide Strategic input to Utilization Management program

Care *Plus*- Performance Programs & QM

PROSPECT MEDICAL DIRECTOR'S RESPONSIBILITIES

- Referral Review for a targeted complex service requests
- Office Meetings & Phone call discussions with physicians on Performance Programs
  - PCP**s**
  - Specialists
- Educational support to providers on Standards & Goals
  - Quality Measures (Pay4Performance, HEDIS, STARS, ACO)
  - Clinical Documentation for HCC/ RAF Scores
  - Tools for providers (Ascender, Reports, Training materials, Contacts)
  - Specific opportunities for Performance Improvement
- Participate or Chair QM Committee
- Provide Strategic input to Performance Programs

RESPONSE TO DEFICIENCIES
EXHIBIT H - ECHN Screenings and Educational Programs

Identified Community Health Need: Heart Disease Incidence

Fiscal Year 2013

Date	Screening/Education	Location	Number of People Served
Oct/Nov 2012	**Free blood pressure and cholesterol screenings** to employees	Manchester/Vernon	751
11/5/12	Free education program: "Keep the Beat: Lifestyle & Heart Health"	Manchester	16
11/29/12	Free education program: "Sodium Savvy: Making Health Choices	Manchester	13
2/1/13	**Free blood pressure/risk factor screening**	Manchester	30
2/1/13	**Free blood pressure/risk factor screening**	Vernon	20
2/27/13	Free education program: "Heart Health for Women"	Manchester	23
4/27/13	**Free blood pressure/risk factor screening**	South Windsor	25

Fiscal Year 2014

Date	Screening/Education	Location	Number of People Served
10/18/13	**Free blood pressure screenings at AHA Heart Walk**		undetermined
Oct/Nov 2013	**Free blood pressure and cholesterol screenings** to employees	Manchester/Vernon	691
2/7/14	**Free blood pressure/risk factor screening**	Vernon	30
2/10/14	Free education program: "Let's Talk About Your Ticker!"	Manchester	28
2/19/14	Free education program: "Understanding Hypertension: Break the Silence"	South Windsor	14
2/24/14	Free education program: "Heart Healthy Living in Children"	Manchester	60
6/1/14	**Free blood pressure screenings at health fair**	Manchester	55

Fiscal Year 2015

Date	Screening/Education	Location	Number of People Served
Oct/Nov 2014	**Free blood pressure and cholesterol screenings** to employees	Manchester/Vernon	850
11/15/14	**Free blood pressure, cholesterol & body mass screening**	Manchester	undetermined
11/18/14	**Free blood pressure, cholesterol & body mass screening**	East Hartford	undetermined
FY 2015	Heart Talk Support Group (meets monthly)	Vernon	

Identified Community Health Need: Cancer Incidence

Fiscal Year 2013

Date	Screening/Education	Location	Number of People Served
10/12/12	Free education program: "Nothing to Fear: The Truth About Colonoscopy Prep & Procedure"	Manchester	9
10/9/12	**Free mammogram screening to uninsured & underinsured women**	Vernon	51
10/9/12	**Free prostate screening**	Vernon	42
10/21/12	**Free mammogram event with Tolland Imaging Center & Big Y**	Tolland	10
10/24/12	Free education program: "Hereditary Cancer Genetics"	Manchester	19
2/19/13	Free education program: "Head & Neck Cancer: Early Detection is Key"	Manchester	9
3/4/13	Free education program: "Women & Colon Cancer"	Manchester	20
3/6/13	Free education program: "Prostate Screening: New Recommendation"	Manchester	19
4/27/13	**Free mammogram screenings to uninsured & underinsured woman**		53
5/6/13	**Free skin cancer screening**		48
5/17/13	Free program: Cancer Survivors Day Celebration	South Windsor	308
FY 2013	**Free breast and cervical screenings** (through Early Detection grant)		80
FY 2013	Free Smoking Prevention Outreach to middle schools	Vernon, Manchester, Tolland and Ellington	1,351

Fiscal Year 2014

Date	Screening/Education	Location	Number of People Served
Fall	Smoking cessation program: "Freedom From Smoking"	Manchester	11
10/1/2013	Free education program: "HPV & Oral Cancer: What's the Connection?"	South Windsor	10
10/19/13	**Free mammogram event with Tolland Imaging Center & Big Y**	Tolland	15
10/26/13	**Free mammogram screening**	South Windsor	17
11/18/13	Free education program: "I Have Dense Breasts: Now What?" (screening education)	South Windsor	27
Winter	Smoking cessation program: "Freedom From Smoking"	Manchester	3
3/12/14	Free education program: "Colon-ary Fun for Colon Cancer Awareness" (cooking demonstration)	Manchester	43

Date	Screening/Education	Location	Number of People Served
4/22/14	**Free mammogram screening event**	Glastonbury	1
5/7/14	**Free mammogram screening event**	South Windsor	1
5/21/14	**Free mammogram screening event**	Manchester	2
6/1/14	Free program: Cancer Survivors Day Celebration	Windsor	127
6/5/14	**Free mammogram screening event**	Vernon	1
FY 2014	**Free breast and cervical screenings** (through Early Detection grant)		234
FY 2014	Free Smoking Prevention Outreach to middle schools	Vernon, Manchester, Tolland and Ellington	478

Fiscal Year 2015

Date	Screening/Education	Location	Number of People Served
Fall	Smoking cessation program: "Freedom From Smoking"	Manchester/South Windsor	8
10/9/14	Free education program: "Emotional & Spiritual Self-Care	Manchester	25
10/23/14	Free education program: "Spirituality"	Manchester	21
Winter	Smoking cessation program: "Freedom From Smoking"	Manchester	6
4/1/15	Free education program: "Feeding the Body, Feeding the Soul"	Manchester	9
5/28/15	**Free mammography screening**	South Windsor	21
6/3/15	Free education program: "The Nuts and Bolts of Cancer Caregiving"	Manchester	3
6/7/15	Free program: Cancer Survivors Day Celebration	Windsor	372
6/17/15	Free education program: "When Cancer Can't Be Cured"	Manchester	9
8/6/15	Free education program: "Skin Lesions: Identification & Treatment Options"	South Windsor	35
FY 2015	**Free breast and cervical screenings** (through Early Detection grant)		143
FY 2015	Prostate Cancer Support Group (meets monthly)	Manchester	undertermined

Fiscal Year 2016

Date	Screening/Education	Location	Number of People Served
10/5/15	Free education program: "Encouraging Wellness in the Midst of Cancer"	Manchester	13
10/15/15	**Free Mammography screening**	South Windsor	55
Fall	Smoking cessation program: "Freedom From Smoking"	Manchester	3
10/26/15	Free education program: "Painting From the Heart" (for cancer patients and caregivers)	Manchester	12
11/2/15	Free education program: "Journaling Through the Cancer Journey"	Manchester	11
11/9/15	Free education program: "Creating Sacred Spaces" (for cancer patients and caregivers)	Manchester	
11/16/15	Free education program: "Skin Cancer: Detection, Prevention & Treatment Options"	South Windsor	
11/16/15	Free education program: "Palliative Cancer Care"	Manchester	

Identified Community Health Need: Diabetes Incidence

Fiscal Year 2013

Date	Screening/Education	Location	Number of People Served
10/17/12	Free education program: "Pre-diabetes: Making Changes That Will Last a Lifetime"	Manchester	64
Oct/Nov 2012	**Free glucose testing** for employees	Manchester/Vernon	751
11/4/12	**Free diabetic foot screening**	Manchester	16
11/8/12	Free education program: "Diabetes and the Eye"	South Windsor	11
2/18/13	**Free diabetic foot screening**	Manchester	15
4/9/13	Free education program at Manchester Senior Center	Manchester	75
5/6/13	**Free diabetic foot screening**	Manchester	18
8/5/13	**Free diabetic foot screening**	Manchester	15
FY 2013	Diabetes support group "Sweet Talk" - meets monthly	Manchester	undetermined

Fiscal Year 2014

Date	Screening/Education	Location	Number of People Served
10/9/13	Free education program: "Pre-Diabetes: Making Changes That Last a Lifetime"	Manchester	48
Oct/Nov 2013	**Free glucose testing** for employees	Manchester/Vernon	691
11/4/13	**Free diabetic foot screening**	Manchester	5
1/29/14	Free education program: "Pre-Diabetes: Making Changes That Last a Lifetime"	Manchester	42
3/8/14	**Free diabetic screening**	Manchester	13
6/9/14	**Free diabetic screening**	Manchester	20
8/6/2014	Free education program: "Pre-Diabetes: Making Changes That Last a Lifetime"	Manchester	38
9/15/14	**Free diabetic foot screening**	Manchester	18
FY 2014	Diabetes support group "Sweet Talk" - meets monthly	Manchester	undetermined

Fiscal Year 2015

Date	Screening/Education	Location	Number of People Served
10/14/14	Free education program: "Diabetes & Eye Health"	South Windsor	19
Oct/Nov 2014	**Free glucose testing** for employees	Manchester/Vernon	850
11/15/14	**Free glucose screening**	Manchester	undetermined
11/18/14	**Free glucose screening**	East Hartford	undetermined
12/3/14	Free education program: "Pre-Diabetes: Let's Take Action!"	South Windsor	53
12/8/14	**Free diabetic foot screening**	Manchester	13
3/3/15	Free education program: "Diabetes Made Simple!"	South Windsor	39
3/16/15	**Free diabetic foot screening**	Manchester	14
4/1/15	Free education program: "Pre-Diabetes: Let's Take Action!"	South Windsor	40
6/22/15	**Free diabetic foot screening**	Manchester	18
FY 2015	Diabetes support group "Sweet Talk" - meets monthly	Manchester	undetermined

Fiscal Year 2016

Date	Screening/Education	Location	Number of People Served
10/5/15	**Free diabetic foot screening**	Manchester	15
11/12/15	Free education program: "Just Keep Swimming: Dive In and Find Success Managing Your Diabetes"	Manchester	
12/9/15	Free education program: "Pre-Diabetes: Let's Take Action!"	South Windsor	

Identified Community Health Need: Arthritis Incidence

Fiscal Year 2013

Date	Screening/Education	Location	Number of People Served
5/22/13	Free education program: "Water Exercises for Arthritic Conditions"	Ellington	17
6/5/2013	Free education program: "Hip & Knee Arthritis: New Trends & Current Concepts"	Manchester	25

Fiscal Year 2014

Date	Screening/Education	Location	Number of People Served
10/30/13	Free education program: "Hip & Knee Arthritis: New Trends & Current Concepts"	Manchester	25
5/21/14	Free education program: "Understanding Rheumatoid Arthritis"	Manchester	30
6/19/14	Free education program: "Massage and Reiki for Arthritis Sufferers"	South Windsor	63

RESPONSE TO DEFICIENCIES
EXHIBIT I - Financial Worksheet C (Revised)

Sale of Non-Profit Hosptal to For-Profit Entity - REVISED

Name Entity: ECHN

Financial Worsheet (C):

Please provide one year of actual results and three years of projections of **Total Entity** revenue, expense and volume statistics without, incremental to and with the CON proposal in the following reporting format:

		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)	(14)	(15)	(16)
LINE	**Total Entity:**	**FY 2014 Actual**	**FY 2015 Projected**	**FY 2015 Projected**	**FY 2015 Projected**	**FY 2016 Projected**	**FY 2016 Projected**	**FY 2016 Projected**	**FY 2017 Projected**	**FY 2017 Projected**	**FY 2017 Projected**	**FY 2018 Projected**	**FY 2018 Projected**	**FY 2018 Projected**	**FY 2019 Projected**	**FY 2019 Projected**	**FY 2019 Projected**
	Description	**Results**	**W/out CON**	**Incremental**	**With CON**	**W/out CON**	**Incremental**	**With CON**	**W/out CON**	**Incremental**	**With CON**	**W/out CON**	**Incremental**	**With CON**	**W/out CON**	**Incremental**	**With CON**
A.	**OPERATING REVENUE**																
1	Total Gross Patient Revenue	$929,318,695	$919,861,607	$0	$919,861,607	$911,417,931	$0	$911,417,931	$927,844,907	$17,635,006	$945,479,913	$945,508,033	$28,243,993	$973,752,026	$964,300,815	$38,852,980	$1,003,153,795
2	Less: Allowances	$613,774,825	$605,465,288	$0	$605,465,288	$599,410,635	$0	$599,410,635	$611,398,847	$12,229,890	$623,628,737	$623,626,824	$19,589,415	$643,216,239	$636,099,361	$26,948,940	$663,048,301
3	Less: Charity Care	$4,833,207	$4,778,075	$0	$4,778,075	$4,730,294	$0	$4,730,294	$4,824,900	$75,815	$4,900,715	$4,921,398	$122,094	$5,043,492	$5,019,826	$168,374	$5,188,200
4	Less: Other Deductions	$739,349	$689,936	$0	$689,936	$683,037	$0	$683,037	$696,698	$0	$696,698	$710,632	$0	$710,632	$724,844	$0	$724,844
	Net Patient Service Revenue	**$309,971,314**	**$308,928,308**	**$0**	**$308,928,308**	**$306,593,965**	**$0**	**$306,593,965**	**$310,924,462**	**$5,329,301**	**$316,253,763**	**$316,249,179**	**$8,532,484**	**$324,781,663**	**$322,456,784**	**$11,735,666**	**$334,192,450**
5	Medicare	$112,234,172	$115,287,873	$0	$115,287,873	$114,416,727	$0	$114,416,727	$116,032,810	$1,955,888	$117,988,698	$118,019,923	$3,134,443	$121,154,366	$120,336,517	$4,313,000	$124,649,517
6	Medicaid	$48,469,631	$49,459,392	$0	$49,459,392	$49,085,664	$0	$49,085,664	$49,778,976	$776,499	$50,555,475	$50,631,462	$1,234,950	$51,866,412	$51,625,299	$1,693,402	$53,318,701
7	CHAMPUS & TriCare	$1,895,490	$1,860,705	$0	$1,860,705	$1,846,645	$0	$1,846,645	$1,872,728	$19,948	$1,892,676	$1,904,799	$31,962	$1,936,761	$1,942,188	$43,975	$1,986,163
8	Other	$0	$0	$0	$0	$0	$0	$0		$0	$0		$0	$0		$0	$0
	Total Government	**$162,599,293**	**$166,607,970**	**$0**	**$166,607,970**	**$165,349,036**	**$0**	**$165,349,036**	**$167,684,514**	**$2,752,335**	**$170,436,849**	**$170,556,184**	**$4,401,355**	**$174,957,539**	**$173,904,004**	**$6,050,377**	**$179,954,381**
9	Commercial Insurers	$137,108,151	$133,386,403	$0	$133,386,403	$132,378,500	$0	$132,378,500	$134,248,284	$2,485,974	$136,734,258	$136,547,345	$3,984,510	$140,531,855	$139,227,611	$5,483,046	$144,710,657
10	Uninsured	$666,816	$526,077	$0	$526,077	$522,102	$0	$522,102	$529,477	$11,120	$540,597	$538,544	$17,931	$556,475	$549,115	$24,741	$573,856
11	Self Pay	$4,893,477	$4,051,067	$0	$4,051,067	$4,020,456	$0	$4,020,456	$4,077,244	$0	$4,077,244	$4,147,068	$0	$4,147,068	$4,228,470	$0	$4,228,470
12	Workers Compensation	$4,507,382	$4,058,179	$0	$4,058,179	$4,027,514	$0	$4,027,514	$4,084,401	$79,872	$4,164,273	$4,154,348	$128,687	$4,283,035	$4,235,893	$177,502	$4,413,395
13	Other	$196,195	$298,613	$0	$298,613	$296,357	$0	$296,357	$300,543	$0	$300,543	$305,689	$0	$305,689	$311,690	$0	$311,690
	Total Non-Government	**$147,372,021**	**$142,320,339**	**$0**	**$142,320,339**	**$141,244,929**	**$0**	**$141,244,929**	**$143,239,949**	**$2,576,966**	**$145,816,915**	**$145,692,994**	**$4,131,128**	**$149,824,122**	**$148,552,779**	**$5,685,289**	**$154,238,068**
	Net Patient Service Revenue[a] (Government+Non-Government)	**$309,971,314**	**$308,928,309**	**$0**	**$308,928,309**	**$306,593,965**	**$0**	**$306,593,965**	**$310,924,463**	**$5,329,301**	**$316,253,764**	**$316,249,178**	**$8,532,483**	**$324,781,661**	**$322,456,783**	**$11,735,666**	**$334,192,449**
14	Less: Provision for Bad Debts	$10,216,094	$6,060,538	$0	**$6,060,538**	$5,999,933	$0	**$5,999,933**	$6,059,932	$112,360	**$6,172,292**	$6,181,131	$180,494	**$6,361,625**	$6,304,753	$248,637	**$6,553,390**
	Net Patient Service Revenue less provision for bad debts	**$299,755,220**	**$302,867,770**	**$0**	**$302,867,770**	**$300,594,032**	**$0**	**$300,594,032**	**$304,864,530**	**$5,216,941**	**$310,081,471**	**$310,068,048**	**$8,351,990**	**$318,420,038**	**$316,152,031**	**$11,487,029**	**$327,639,060**
15	Other Operating Revenue	$28,166,459	$16,802,913	$0	**$16,802,913**	$15,925,913	$0	**$15,925,913**	$15,972,139	($1,417,903)	**$14,554,236**	$16,019,290	($1,417,903)	**$14,601,387**	$16,067,383	($1,417,903)	**$14,649,480**
17	Net Assets Released from Restrictions	$833,650	$913,370	$0	**$913,370**	$913,370	$0	**$913,370**	$913,370	($913,370)	**$0**	$913,370	($913,370)	**$0**	$913,370	($913,370)	**$0**
	TOTAL OPERATING REVENUE	**$328,755,329**	**$320,584,053**	**$0**	**$320,584,053**	**$317,433,315**	**$0**	**$317,433,315**	**$321,750,039**	**$2,885,668**	**$324,635,707**	**$327,000,708**	**$6,020,717**	**$333,021,425**	**$333,132,784**	**$9,155,756**	**$342,288,540**
B.	**OPERATING EXPENSES**																
1	Salaries and Wages	$162,727,445	$156,292,474	$0	$156,292,474	$150,021,693	$0	$150,021,693	$150,778,127	$1,410,518	$152,188,645	$153,793,689	$2,257,113	$156,050,802	$156,869,563	$3,103,708	$159,973,271
2	Fringe Benefits	$43,859,398	$47,762,750	$0	$47,762,750	$50,610,250	$0	$50,610,250	$49,260,250	($284,122)	$48,976,128	$49,710,250	$324,373	$50,034,623	$50,160,250	$639,204	$50,799,454
3	Physicians Fees	$14,478,331	$14,605,651	$0	$14,605,651	$14,605,651	$0	$14,605,651	$15,043,821	$0	$15,043,821	$15,495,135	$0	$15,495,135	$15,959,989	$0	$15,959,989
4	Supplies and Drugs	$34,194,649	$34,974,486	$0	$34,974,486	$35,324,231	$0	$35,324,231	$35,677,473	($913,733)	$34,763,740	$36,034,248	($474,183)	$35,560,065	$36,394,590	($34,635)	$36,359,955
5	Depreciation and Amortization	$12,196,877	$11,958,956	$0	$11,958,956	$11,958,956	$0	$11,958,956	$11,958,956	$714,285	$12,673,241	$11,958,956	$1,428,571	$13,387,527	$11,958,956	$2,142,857	$14,101,813
6	Provision for Bad Debts-Other[b]	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
7	Interest Expense	$3,764,488	$3,570,511	$0	$3,570,511	$3,570,511	$0	$3,570,511	$3,570,511	($2,847,514)	$722,997	$3,570,511	($2,925,174)	$645,337	$3,570,511	($2,978,049)	$592,462
8	Malpractice Insurance Cost	$3,807,147	$3,845,218	$0	$3,845,218	$3,883,671	$0	$3,883,671	$3,922,507	$0	$3,922,507	$3,961,732	$0	$3,961,732	$4,001,350	$0	$4,001,350
9	Lease Expense	$6,622,257	$6,245,578	$0	$6,245,578	$6,308,033	$0	$6,308,033	$6,371,114	$0	$6,371,114	$6,434,825	$0	$6,434,825	$6,499,173	$0	$6,499,173
10	Other Operating Expenses	$44,932,012	$44,334,273	$0	$44,334,273	$44,883,620	$0	$44,883,620	$45,412,457	($451,595)	$44,960,862	$45,946,581	($3,616)	$45,942,965	$46,486,047	$444,362	$46,930,409
	TOTAL OPERATING EXPENSES	**$326,582,604**	**$323,589,897**	**$0**	**$323,589,897**	**$321,166,616**	**$0**	**$321,166,616**	**$321,995,216**	**($2,372,161)**	**$319,623,055**	**$326,905,927**	**$607,084**	**$327,513,011**	**$331,900,429**	**$3,317,447**	**$335,217,876**
	Provision for Income Taxes[c]		$0	$0	**$0**	$0	$0	**$0**	$0	$2,426,950	**$2,426,950**	$0	$2,635,170	**$2,635,170**		$3,344,235	**$3,344,235**
	Earnings Before Interest, Taxes, Depreciation & Amortization **(EBITDA)**	**$18,134,090**	**$12,523,623**	**$0**	**$12,523,623**	**$11,796,166**	**$0**	**$11,796,166**	**$15,284,290**	**$3,124,600**	**$18,408,890**	**$15,624,248**	**$3,917,030**	**$19,541,278**	**$16,761,822**	**$5,003,117**	**$21,764,939**
	INCOME / (LOSS) FROM OPERATIONS	**$2,172,725**	**($3,005,844)**	**$0**	**($3,005,844)**	**($3,733,301)**	**$0**	**($3,733,301)**	**($245,177)**	**$2,830,879**	**$2,585,702**	**$94,781**	**$2,778,463**	**$2,873,244**	**$1,232,355**	**$2,494,074**	**$3,726,429**
	NON-OPERATING INCOME / REVENUE	($2,125,751)	($2,394,868)	$0	**($2,394,868)**	($1,500,000)	$0	**($1,500,000)**	($500,000)	$0	**($500,000)**	($500,000)	$0	**($500,000)**	($500,000)	$0	**($500,000)**
	NET INCOME / EXCESS (DEFICIENCY) OF REVENUE OVER EXPENSES	**$46,974**	**($5,400,712)**	**$0**	**($5,400,712)**	**($5,233,301)**	**$0**	**($5,233,301)**	**($745,177)**	**$2,830,879**	**$2,085,702**	**($405,219)**	**$2,778,463**	**$2,373,244**	**$732,355**	**$2,494,074**	**$3,226,429**

Sale of Non-Profit Hosptal to For-Profit Entity - REVISED

Name Entity: ECHN

Financial Worsheet (C):

Please provide one year of actual results and three years of projections of **Total Entity** revenue, expense and volume statistics without, incremental to and with the CON proposal in the following reporting format:

LINE	Total Entity:	(1) FY 2014 Actual Results	(2) FY 2015 Projected W/out CON	(3) FY 2015 Projected Incremental	(4) FY 2015 Projected With CON	(5) FY 2016 Projected W/out CON	(6) FY 2016 Projected Incremental	(7) FY 2016 Projected With CON	(8) FY 2017 Projected W/out CON	(9) FY 2017 Projected Incremental	(10) FY 2017 Projected With CON	(11) FY 2018 Projected W/out CON	(12) FY 2018 Projected Incremental	(13) FY 2018 Projected With CON	(14) FY 2019 Projected W/out CON	(15) FY 2019 Projected Incremental	(16) FY 2019 Projected With CON
	Description																
C.	Retained Earnings/ Net Assets, beginning of year	$85,849,149	$77,693,789	$0	$77,693,789	$72,293,077	$0	$72,293,077	$67,059,776	$0	$67,059,776	$66,314,599	$2,830,879	$69,145,478	$65,909,381	$5,609,341	$71,518,722
	Retained Earnings / Net Assets, end of year	$77,693,789	$72,293,077	$0	$72,293,077	$67,059,776	$0	$67,059,776	$66,314,599	$2,830,879	$69,145,478	$65,909,381	$5,609,341	$71,518,722	$66,641,736	$8,103,415	$74,745,151
	Principal Payments	$7,235,595	$7,086,082	$0	$7,086,082	$7,163,415	$0	$7,163,415	$6,382,582	($6,382,582)	$0	$6,771,353	($6,771,353)	$0	$6,058,092	($6,058,092)	$0
D.	PROFITABILITY SUMMARY																
1	Hospital Operating Margin	0.7%	-0.9%	0.0%	-0.9%	-1.2%	0.0%	-1.2%	-0.1%	98.1%	0.8%	0.0%	46.1%	0.9%	0.4%	27.2%	1.1%
2	Hospital Non Operating Margin	-0.7%	-0.8%	0.0%	-0.8%	-0.5%	0.0%	-0.5%	-0.2%	0.0%	-0.2%	-0.2%	0.0%	-0.2%	-0.2%	0.0%	-0.1%
3	Hospital Total Margin	0.0%	-1.7%	0.0%	-1.7%	-1.7%	0.0%	-1.7%	-0.2%	98.1%	0.6%	-0.1%	46.1%	0.7%	0.2%	27.2%	0.9%
E.	FTEs	2,298	2,240	-	2,240	2,117	-	2,117	2,117	21	2,138	2,117	32	2,149	2,117	44	2,161
F.	VOLUME STATISTICS[d]																
1	Inpatient Discharges	11,451	10,927	-	10,927	11,202	-	11,202	11,202	213	11,415	11,202	325	11,527	11,202	438	11,640
2	Outpatient Visits	2,052,425	2,085,348	-	2,085,348	2,085,348	-	2,085,348	2,085,348	2,170	2,087,518	2,085,348	4,340	2,089,688	2,085,348	6,510	2,091,858
	TOTAL VOLUME	2,063,876	2,096,275	0	2,096,275	2,096,550	0	2,096,550	2,096,550	2,383	2,098,933	2,096,550	4,665	2,101,215	2,096,550	6,948	2,103,498

[a]Total amount should equal the total amount on cell line "Net Patient Revenue" Row 14.

[b]Provide the amount of any transaction associated with Bad Debts not related to the provision of direct services to patients. For additional information, refer to FASB, No.2011-07, July 2011.

[c]Provide the amount of income taxes as defined by the Internal Revenue Services for for-profit entities.

[d]Provide projected inpatient and/or outpatient statistics for any new services and provide actual and projected inpatient and/or outpatient statistics for any existing services which will change due to the proposal.

Sale of Non-Profit Hosptal to For-Profit Entity - REVISED

Name Entity: MMH

Financial Worsheet (C):

Please provide one year of actual results and three years of projections of **Total Entity** revenue, expense and volume statistics without, incremental to and with the CON proposal in the following reporting format:

LINE	Total Entity:	(1) FY 2014 Actual Results	(2) FY 2015 Projected W/out CON	(3) FY 2015 Projected Incremental	(4) FY 2015 Projected With CON	(5) FY 2016 Projected W/out CON	(6) FY 2016 Projected Incremental	(7) FY 2016 Projected With CON	(8) FY 2017 Projected W/out CON	(9) FY 2017 Projected Incremental	(10) FY 2017 Projected With CON	(11) FY 2018 Projected W/out CON	(12) FY 2018 Projected Incremental	(13) FY 2018 Projected With CON	(14) FY 2019 Projected W/out CON	(15) FY 2019 Projected Incremental	(16) FY 2019 Projected With CON
	Description																
A.	**OPERATING REVENUE**																
1	Total Gross Patient Revenue	$601,959,668	$594,394,400	$0	$594,394,400	$588,450,456	$0	$588,450,456	$596,688,762	$13,369,792	$610,058,554	$606,832,471	$20,855,080	$627,687,551	$618,362,288	$28,340,367	$646,702,655
2	Less: Allowances	$421,521,668	$411,650,321	$0	$411,650,321	$407,533,818	$0	$407,533,818	$413,239,291	$9,259,305	$422,498,596	$420,264,359	$14,443,273	$434,707,632	$428,249,382	$19,627,240	$447,876,622
3	Less: Charity Care	$2,411,263	$2,382,698	$0	$2,382,698	$2,358,871	$0	$2,358,871	$2,391,895	$53,594	$2,445,489	$2,432,557	$83,600	$2,516,157	$2,478,776	$113,606	$2,592,382
4	Less: Other Deductions	$0	$0	$0	$0	$0	$0	$0	$0		$0	$0	$0	$0	$0	$0	$0
	Net Patient Service Revenue	**$178,026,737**	**$180,361,381**	**$0**	**$180,361,381**	**$178,557,767**	**$0**	**$178,557,767**	**$181,057,576**	**$4,056,893**	**$185,114,469**	**$184,135,555**	**$6,328,207**	**$190,463,762**	**$187,634,130**	**$8,599,521**	**$196,233,651**
5	Medicare	$63,378,038	$65,429,033	$0	$65,429,033	$64,774,743	$0	$64,774,743	$65,681,589	$1,471,704	$67,153,293	$66,798,176	$2,295,660	$69,093,836	$68,067,341	$3,119,617	$71,186,958
6	Medicaid	$27,585,570	$28,409,212	$0	$28,409,212	$28,125,120	$0	$28,125,120	$28,518,872	$639,012	$29,157,884	$29,003,692	$996,773	$30,000,465	$29,554,763	$1,354,534	$30,909,297
7	CHAMPUS & TriCare	$664,283	$668,944	$0	$668,944	$662,255	$0	$662,255	$671,526	$15,047	$686,573	$682,942	$23,471	$706,413	$695,918	$31,895	$727,813
8	Other	$0	$0	$0	$0	$0	$0	$0	$0		$0	$0	$0	$0	$0	$0	$0
	Total Government	**$91,627,891**	**$94,507,189**	**$0**	**$94,507,189**	**$93,562,117**	**$0**	**$93,562,117**	**$94,871,987**	**$2,125,763**	**$96,997,750**	**$96,484,811**	**$3,315,904**	**$99,800,715**	**$98,318,022**	**$4,506,046**	**$102,824,068**
9	Commercial Insurers	$83,212,124	$83,015,701	$0	$83,015,701	$82,185,544	$0	$82,185,544	$83,336,142	$1,867,283	$85,203,425	$84,752,856	$2,912,711	$87,665,567	$86,363,160	$3,958,139	$90,321,299
10	Uninsured	$413,470	$343,512	$0	$343,512	$340,077	$0	$340,077	$344,838	$7,727	$352,565	$350,700	$12,053	$362,753	$357,364	$16,378	$373,742
11	Self Pay	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
12	Workers Compensation	$2,773,252	$2,494,979	$0	$2,494,979	$2,470,029	$0	$2,470,029	$2,504,610	$56,120	$2,560,730	$2,547,188	$87,539	$2,634,727	$2,595,585	$118,959	$2,714,544
13	Other	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
	Total Non-Government	**$86,398,846**	**$85,854,192**	**$0**	**$85,854,192**	**$84,995,650**	**$0**	**$84,995,650**	**$86,185,589**	**$1,931,130**	**$88,116,719**	**$87,650,744**	**$3,012,303**	**$90,663,047**	**$89,316,108**	**$4,093,476**	**$93,409,584**
	Net Patient Service Revenue[a] (Government+Non-Government)	**$178,026,737**	**$180,361,381**	**$0**	**$180,361,381**	**$178,557,767**	**$0**	**$178,557,767**	**$181,057,576**	**$4,056,893**	**$185,114,469**	**$184,135,555**	**$6,328,207**	**$190,463,762**	**$187,634,130**	**$8,599,522**	**$196,233,652**
14	Less: Provision for Bad Debts	$5,822,470	$3,643,728	$0	**$3,643,728**	$3,607,291	$0	**$3,607,291**	$3,657,793	$81,969	**$3,739,762**	$3,719,975	$127,845	**$3,847,820**	$3,790,655	$173,731	**$3,964,386**
	Net Patient Service Revenue less provision for bad debts	**$172,204,267**	**$176,717,653**	**$0**	**$176,717,653**	**$174,950,476**	**$0**	**$174,950,476**	**$177,399,783**	**$3,974,924**	**$181,374,707**	**$180,415,579**	**$6,200,362**	**$186,615,941**	**$183,843,475**	**$8,425,790**	**$192,269,265**
15	Other Operating Revenue	$16,853,888	$11,023,919	$0	**$11,023,919**	$10,633,672	$0	**$10,633,672**	$10,846,346	($735,367)	**$10,110,979**	$11,063,272	($735,367)	**$10,327,905**	$11,284,538	($735,367)	**$10,549,171**
17	Net Assets Released from Restrictions	$486,908	$646,366	$0	**$646,366**	$776,365	$0	**$776,365**	$776,365	($776,365)	**$0**	$776,365	($776,365)	**$0**	$776,365	($776,365)	**$0**
	TOTAL OPERATING REVENUE	**$189,545,063**	**$188,387,937**	**$0**	**$188,387,937**	**$186,360,513**	**$0**	**$186,360,513**	**$189,022,494**	**$2,463,192**	**$191,485,686**	**$192,255,217**	**$4,688,630**	**$196,943,847**	**$195,904,378**	**$6,914,058**	**$202,818,436**
B.	**OPERATING EXPENSES**																
1	Salaries and Wages	$83,606,297	$82,578,386	$0	$82,578,386	$79,275,251	$0	$79,275,251	$80,068,003	$1,080,696	$81,148,699	$81,669,364	$1,685,741	$83,355,105	$83,302,751	$2,290,786	$85,593,537
2	Fringe Benefits	$25,720,253	$27,704,116	$0	$27,704,116	$29,366,363	$0	$29,366,363	$28,485,372	($186,999)	$28,298,373	$28,770,225	$330,795	$29,101,020	$29,057,928	$554,925	$29,612,853
3	Physicians Fees	$9,813,958	$10,038,473	$0	$10,038,473	$10,038,473	$0	$10,038,473	$10,339,627	$0	$10,339,627	$10,649,816	$0	$10,649,816	$10,969,310	$0	$10,969,310
4	Supplies and Drugs	$25,775,974	$23,929,618	$0	$23,929,618	$24,168,914	$0	$24,168,914	$24,410,603	($901,009)	$23,509,594	$24,654,709	($593,572)	$24,061,137	$24,901,256	($286,136)	$24,615,120
5	Depreciation and Amortization	$7,116,905	$7,114,038	$0	$7,114,038	$7,114,038	$0	$7,114,038	$7,114,038	$488,896	$7,602,934	$7,114,038	$977,792	$8,091,830	$7,114,038	$1,466,689	$8,580,727
6	Provision for Bad Debts-Other[b]	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
7	Interest Expense	$2,589,201	$2,451,251	$0	$2,451,251	$2,353,201	$0	$2,353,201	$2,353,201	($2,175,156)	$178,045	$2,353,201	($2,252,816)	$100,385	$2,353,201	($2,305,691)	$47,510
8	Malpractice Insurance Cost	$2,774,065	$2,801,806	$0	$2,801,806	$2,829,824	$0	$2,829,824	$2,858,122	$0	$2,858,122	$2,886,703	$0	$2,886,703	$2,915,570	$0	$2,915,570
9	Lease Expense	$2,328,809	$2,207,010	$0	$2,207,010	$2,229,080	$0	$2,229,080	$2,251,371	$0	$2,251,371	$2,273,885	$0	$2,273,885	$2,296,623	$0	$2,296,623
10	Other Operating Expenses	$25,584,097	$25,294,474	$0	$25,294,474	$25,547,418	$0	$25,547,418	$25,802,892	($419,554)	$25,383,338	$26,060,921	($94,582)	$25,966,339	$26,321,531	$230,389	$26,551,920
	TOTAL OPERATING EXPENSES	**$185,309,559**	**$184,119,170**	**$0**	**$184,119,170**	**$182,922,561**	**$0**	**$182,922,561**	**$183,683,229**	**($2,113,126)**	**$181,570,103**	**$186,432,862**	**$53,358**	**$186,486,220**	**$189,232,208**	**$1,950,962**	**$191,183,170**
	Provision for Income Taxes[c]		$0	$0	**$0**	$0	$0	**$0**		$4,254,950	**$4,254,950**		$4,482,606	**$4,482,606**		$5,030,134	**$5,030,134**
	Earnings Before Interest, Taxes, Depreciation & Amortization **(EBITDA)**	**$13,941,610**	**$13,834,056**	**$0**	**$13,834,056**	**$12,905,191**	**$0**	**$12,905,191**	**$14,806,503**	**$2,890,058**	**$17,696,561**	**$15,289,594**	**$3,360,248**	**$18,649,842**	**$16,139,409**	**$4,124,094**	**$20,263,503**
	INCOME / (LOSS) FROM OPERATIONS	**$4,235,504**	**$4,268,767**	**$0**	**$4,268,767**	**$3,437,952**	**$0**	**$3,437,952**	**$5,339,265**	**$321,368**	**$5,660,633**	**$5,822,355**	**$152,666**	**$5,975,021**	**$6,672,171**	**($67,038)**	**$6,605,133**
	NON-OPERATING INCOME / REVENUE	($1,743,322)	($1,672,972)	$0	**($1,672,972)**	($1,140,000)	$0	**($1,140,000)**	($380,000)		**($380,000)**	($380,000)		**($380,000)**	($380,000)		**($380,000)**
	NET INCOME / EXCESS (DEFICIENCY) OF REVENUE OVER EXPENSES	**$2,492,182**	**$2,595,795**	**$0**	**$2,595,795**	**$2,297,952**	**$0**	**$2,297,952**	**$4,959,265**	**$321,368**	**$5,280,633**	**$5,442,355**	**$152,666**	**$5,595,021**	**$6,292,171**	**($67,038)**	**$6,225,133**

Sale of Non-Profit Hosptal to For-Profit Entity - REVISED

Name Entity: MMH

Financial Worsheet (C):

Please provide one year of actual results and three years of projections of **Total Entity** revenue, expense and volume statistics without, incremental to and with the CON proposal in the following reporting format:

LINE	Total Entity:	(1) FY 2014 Actual Results	(2) FY 2015 Projected W/out CON	(3) FY 2015 Projected Incremental	(4) FY 2015 Projected With CON	(5) FY 2016 Projected W/out CON	(6) FY 2016 Projected Incremental	(7) FY 2016 Projected With CON	(8) FY 2017 Projected W/out CON	(9) FY 2017 Projected Incremental	(10) FY 2017 Projected With CON	(11) FY 2018 Projected W/out CON	(12) FY 2018 Projected Incremental	(13) FY 2018 Projected With CON	(14) FY 2019 Projected W/out CON	(15) FY 2019 Projected Incremental	(16) FY 2019 Projected With CON
	Description																
C.	**Retained Earnings/ Net Assets, beginning of year**	$37,731,740	$24,798,417	$0	$24,798,417	$27,394,212	$0	$27,394,212	$29,692,165	$0	$29,692,165	$34,651,429	$321,368	$34,972,797	$40,093,784	$474,034	$40,567,818
	Retained Earnings / Net Assets, end of year	$24,798,417	$27,394,212	$0	$27,394,212	$29,692,165	$0	$29,692,165	$34,651,429	$321,368	$34,972,797	$40,093,784	$474,034	$40,567,818	$46,385,955	$406,996	$46,792,951
	Principal Payments	$4,145,905	$4,883,195	$0	$4,883,195	$4,924,258	$0	**$4,924,258**	$4,234,565	($4,234,565)	**$0**	$4,781,812	($4,781,812)	**$0**	$4,061,758	($4,061,758)	**$0**
D.	**PROFITABILITY SUMMARY**																
1	Hospital Operating Margin	**2.3%**	**2.3%**	**0.0%**	**2.3%**	**1.9%**	**0.0%**	**1.9%**	**2.8%**	**13.0%**	**3.0%**	**3.0%**	**3.3%**	**3.0%**	**3.4%**	**-1.0%**	**3.3%**
2	Hospital Non Operating Margin	**-0.9%**	**-0.9%**	**0.0%**	**-0.9%**	**-0.6%**	**0.0%**	**-0.6%**	**-0.2%**	**0.0%**	**-0.2%**	**-0.2%**	**0.0%**	**-0.2%**	**-0.2%**	**0.0%**	**-0.2%**
3	Hospital Total Margin	**1.3%**	**1.4%**	**0.0%**	**1.4%**	**1.2%**	**0.0%**	**1.2%**	**2.6%**	**13.0%**	**2.8%**	**2.8%**	**3.3%**	**2.8%**	**3.2%**	**-1.0%**	**3.1%**
E.	**FTEs**	**1,177**	**1,140**	**0**	**1,140**	**1,052**	**0**	**1,052**	**1,052**	**16**	**1,068**	**1,052**	**24**	**1,076**	**1,052**	**33**	**1,085**
F.	**VOLUME STATISTICS**[d]																
1	Inpatient Discharges	9,110	8,768	0	**8,768**	9,043	0	**9,043**	9,043	181	**9,224**	9,043	271	**9,314**	9,043	362	**9,405**
2	Outpatient Visits	1,631,301	1,651,094	0	**1,651,094**	1,651,094	0	**1,651,094**	1,651,094	1,640	**1,652,734**	1,651,094	3,280	**1,654,374**	1,651,094	4,920	**1,656,014**
	TOTAL VOLUME	**1,640,411**	**1,659,862**	**0**	**1,659,862**	**1,660,137**	**0**	**1,660,137**	**1,660,137**	**1,821**	**1,661,958**	**1,660,137**	**3,551**	**1,663,688**	**1,660,137**	**5,282**	**1,665,419**

[a]Total amount should equal the total amount on cell line "Net Patient Revenue" Row 14.

[b]Provide the amount of any transaction associated with Bad Debts not related to the provision of direct services to patients. For additional information, refer to FASB, No.2011-07, July 2011.

[c]Provide the amount of income taxes as defined by the Internal Revenue Services for for-profit entities.

[d]Provide projected inpatient and/or outpatient statistics for any new services and provide actual and projected inpatient and/or outpatient statistics for any existing services which will change due to the proposal.

Sale of Non-Profit Hosptal to For-Profit Entity - REVISED

Name Entity: RGH
Financial Worsheet (C):

Please provide one year of actual results and three years of projections of **Total Entity** revenue, expense and volume statistics without, incremental to and with the CON proposal in the following reporting format:

LINE	Total Entity:	(1) FY 2014 Actual Results	(2) FY 2015 Projected W/out CON	(3) FY 2015 Projected Incremental	(4) FY 2015 Projected With CON	(5) FY 2016 Projected W/out CON	(6) FY 2016 Projected Incremental	(7) FY 2016 Projected With CON	(8) FY 2017 Projected W/out CON	(9) FY 2017 Projected Incremental	(10) FY 2017 Projected With CON	(11) FY 2018 Projected W/out CON	(12) FY 2018 Projected Incremental	(13) FY 2018 Projected With CON	(14) FY 2019 Projected W/out CON	(15) FY 2019 Projected Incremental	(16) FY 2019 Projected With CON
	Description																
A.	**OPERATING REVENUE**																
1	Total Gross Patient Revenue	$227,300,072	$229,450,128	$0	$229,450,128	$228,302,877	$0	$228,302,877	$231,499,118	$4,265,214	$235,764,332	$235,434,603	$7,388,913	$242,823,516	$239,907,860	$10,512,613	$250,420,473
2	Less: Allowances	$154,781,564	$159,804,700	$0	$159,804,700	$159,005,677	$0	$159,005,677	$161,231,756	$2,970,585	$164,202,341	$163,972,696	$5,146,142	$169,118,838	$167,088,177	$7,321,700	$174,409,877
3	Less: Charity Care	$1,188,543	$1,195,377	$0	$1,195,377	$1,189,400	$0	$1,189,400	$1,206,052	$22,221	$1,228,273	$1,226,555	$38,494	$1,265,049	$1,249,859	$54,768	$1,304,627
4	Less: Other Deductions	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
	Net Patient Service Revenue	**$71,329,965**	**$68,450,051**	**$0**	**$68,450,051**	**$68,107,801**	**$0**	**$68,107,801**	**$69,061,310**	**$1,272,408**	**$70,333,718**	**$70,235,352**	**$2,204,277**	**$72,439,629**	**$71,569,824**	**$3,136,145**	**$74,705,969**
5	Medicare	$25,494,325	$26,046,989	$0	$26,046,989	$25,916,754	$0	$25,916,754	$26,279,589	$484,184	$26,763,773	$26,726,342	$838,783	$27,565,125	$27,234,142	$1,193,383	$28,427,525
6	Medicaid	$7,614,784	$7,396,197	$0	$7,396,197	$7,359,216	$0	$7,359,216	$7,462,245	$137,487	$7,599,732	$7,589,103	$238,177	$7,827,280	$7,733,296	$338,868	$8,072,164
7	CHAMPUS & TriCare	$300,295	$263,667	$0	$263,667	$262,349	$0	$262,349	$266,022	$4,901	$270,923	$270,544	$8,491	$279,035	$275,684	$12,080	$287,764
8	Other	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
	Total Government	**$33,409,404**	**$33,706,853**	**$0**	**$33,706,853**	**$33,538,319**	**$0**	**$33,538,319**	**$34,007,855**	**$626,572**	**$34,634,427**	**$34,585,989**	**$1,085,451**	**$35,671,440**	**$35,243,123**	**$1,544,331**	**$36,787,454**
9	Commercial Insurers	$36,237,003	$33,282,888	$0	$33,282,888	$33,116,474	$0	$33,116,474	$33,580,104	$618,691	$34,198,795	$34,150,966	$1,071,799	$35,222,765	$34,799,834	$1,524,907	$36,324,741
10	Uninsured	$252,693	$182,539	$0	$182,539	$181,626	$0	$181,626	$184,169	$3,393	$187,562	$187,300	$5,878	$193,178	$190,859	$8,363	$199,222
11	Self Pay	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
12	Workers Compensation	$1,430,865	$1,277,771	$0	$1,277,771	$1,271,382	$0	$1,271,382	$1,289,181	$23,752	$1,312,933	$1,311,098	$41,148	$1,352,246	$1,336,008	$58,543	$1,394,551
13	Other	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
	Total Non-Government	**$37,920,561**	**$34,743,198**	**$0**	**$34,743,198**	**$34,569,482**	**$0**	**$34,569,482**	**$35,053,455**	**$645,836**	**$35,699,291**	**$35,649,363**	**$1,118,825**	**$36,768,188**	**$36,326,701**	**$1,591,813**	**$37,918,514**
	Net Patient Service Revenue[a] (Government+Non-Government)	**$71,329,965**	**$68,450,051**	**$0**	**$68,450,051**	**$68,107,801**	**$0**	**$68,107,801**	**$69,061,310**	**$1,272,408**	**$70,333,718**	**$70,235,352**	**$2,204,276**	**$72,439,628**	**$71,569,824**	**$3,136,144**	**$74,705,968**
14	Less: Provision for Bad Debts	$2,801,283	$1,643,173	$0	**$1,643,173**	$1,626,741	$0	**$1,626,741**	$1,649,516	$30,391	**$1,679,907**	$1,677,558	$52,649	**$1,730,207**	$1,709,431	$74,906	**$1,784,337**
	Net Patient Service Revenue less provision for bad debts	**$68,528,682**	**$66,806,878**	**$0**	**$66,806,878**	**$66,481,059**	**$0**	**$66,481,059**	**$67,411,794**	**$1,242,017**	**$68,653,811**	**$68,557,795**	**$2,151,628**	**$70,709,423**	**$69,860,393**	**$3,061,239**	**$72,921,632**
15	Other Operating Revenue	$6,342,519	$2,128,076	$0	**$2,128,076**	$2,052,742	$0	**$2,052,742**	$2,093,797	($112,743)	**$1,981,054**	$2,135,673	($112,743)	**$2,022,930**	$2,178,387	($112,743)	**$2,065,644**
17	Net Assets Released from Restrictions	$49,147	$78,358	$0	**$78,358**	$91,337	$0	**$91,337**	$77,636	($77,636)	**$0**	$77,636	($77,636)	**$0**	$77,636	($77,636)	**$0**
	TOTAL OPERATING REVENUE	**$74,920,348**	**$69,013,312**	**$0**	**$69,013,312**	**$68,625,139**	**$0**	**$68,625,139**	**$69,583,227**	**$1,051,638**	**$70,634,865**	**$70,771,104**	**$1,961,249**	**$72,732,353**	**$72,116,415**	**$2,870,860**	**$74,987,275**
B.	**OPERATING EXPENSES**																
1	Salaries and Wages	$32,460,253	$30,649,768	$0	$30,649,768	$29,423,777	$0	$29,423,777	$29,718,015	$329,822	$30,047,837	$30,312,375	$571,372	$30,883,747	$30,918,622	$812,922	$31,731,544
2	Fringe Benefits	$9,360,797	$10,423,090	$0	$10,423,090	$11,048,475	$0	$11,048,475	$10,717,021	($97,123)	$10,619,898	$10,824,191	($6,422)	$10,817,769	$10,932,433	$84,279	$11,016,712
3	Physicians Fees	$3,728,005	$4,310,255	$0	$4,310,255	$4,310,255	$0	$4,310,255	$4,439,562	$0	$4,439,562	$4,572,749	$0	$4,572,749	$4,709,932	$0	$4,709,932
4	Supplies and Drugs	$9,776,421	$9,560,149	$0	$9,560,149	$9,655,751	$0	$9,655,751	$9,752,308	($12,724)	$9,739,584	$9,849,831	$119,389	$9,969,220	$9,948,330	$251,501	$10,199,831
5	Depreciation and Amortization	$3,281,014	$3,234,649	$0	$3,234,649	$3,234,649	$0	$3,234,649	$3,234,649	$225,389	$3,460,038	$3,234,649	$450,779	$3,685,428	$3,234,649	$676,168	$3,910,817
6	Provision for Bad Debts-Other[b]	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
7	Interest Expense	$689,882	$700,373	$0	$700,373	$672,358	$0	$672,358	$672,358	($672,358)	($0)	$672,358	($672,358)	($0)	$672,357.89	($672,358)	($0)
8	Malpractice Insurance Cost	$1,033,082	$1,043,413	$0	$1,043,413	$1,053,847	$0	$1,053,847	$1,064,385	$0	$1,064,385	$1,075,029	$0	$1,075,029	$1,085,780	$0	$1,085,780
9	Lease Expense	$1,013,626	$1,188,827	$0	$1,188,827	$1,200,715	$0	$1,200,715	$1,212,722	$0	$1,212,722	$1,224,849	$0	$1,224,849	$1,237,098	$0	$1,237,098
10	Other Operating Expenses	$10,816,575	$8,901,262	$0	$8,901,262	$8,990,275	$0	$8,990,275	$9,080,177	($32,041)	$9,048,136	$9,170,979	$90,966	$9,261,945	$9,262,689	$213,973	$9,476,662
	TOTAL OPERATING EXPENSES	**$72,159,655**	**$70,011,785**	**$0**	**$70,011,785**	**$69,590,101**	**$0**	**$69,590,101**	**$69,891,198**	**($259,035)**	**$69,632,163**	**$70,937,011**	**$553,726**	**$71,490,737**	**$72,001,890**	**$1,366,485**	**$73,368,375**
	Provision for Income Taxes[c]		$0	$0	**$0**	$0	$0	**$0**		$419,357	**$419,357**		$607,900	**$607,900**		$766,359	**$766,359**
	Earnings Before Interest, Taxes, Depreciation & Amortization **(EBITDA)**	**$6,731,589**	**$2,936,549**	**$0**	**$2,936,549**	**$2,942,045**	**$0**	**$2,942,045**	**$3,599,036**	**$863,704**	**$4,462,740**	**$3,741,100**	**$1,185,944**	**$4,927,044**	**$4,021,532**	**$1,508,185**	**$5,529,717**
	INCOME / (LOSS) FROM OPERATIONS	**$2,760,693**	**($998,473)**	**$0**	**($998,473)**	**($964,962)**	**$0**	**($964,962)**	**($307,971)**	**$891,316**	**$583,345**	**($165,908)**	**$799,623**	**$633,715**	**$114,525**	**$738,016**	**$852,541**
	NON-OPERATING INCOME / REVENUE	($378,564)	($468,022)	$0	**($468,022)**	($315,000)	$0	**($315,000)**	($105,000)		**($105,000)**	$105,000		**$105,000**	$105,000		**$105,000**
	NET INCOME / EXCESS (DEFICIENCY) OF REVENUE OVER EXPENSES	**$2,382,129**	**($1,466,495)**	**$0**	**($1,466,495)**	**($1,279,962)**	**$0**	**($1,279,962)**	**($412,971)**	**$891,316**	**$478,345**	**($60,908)**	**$799,623**	**$738,715**	**$219,525**	**$738,016**	**$957,541**

Sale of Non-Profit Hosptal to For-Profit Entity - REVISED

Name Entity: RGH
Financial Worsheet (C):

Please provide one year of actual results and three years of projections of **Total Entity** revenue, expense and volume statistics without, incremental to and with the CON proposal in the following reporting format:

		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)	(14)	(15)	(16)
LINE	**Total Entity:**	**FY 2014**	**FY 2015**	**FY 2015**	**FY 2015**	**FY 2016**	**FY 2016**	**FY 2016**	**FY 2017**	**FY 2017**	**FY 2017**	**FY 2018**	**FY 2018**	**FY 2018**	**FY 2019**	**FY 2019**	**FY 2019**
		Actual	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**
	Description	**Results**	**W/out CON**	**Incremental**	**With CON**	**W/out CON**	**Incremental**	**With CON**	**W/out CON**	**Incremental**	**With CON**	**W/out CON**	**Incremental**	**With CON**	**W/out CON**	**Incremental**	**With CON**
C.	**Retained Earnings/ Net Assets, beginning of year**	**$31,052,463**	**$28,334,302**	**$0**	**$28,334,302**	**$26,867,807**	**$0**	**$26,867,807**	**$25,587,845**	**$0**	**$25,587,845**	**$25,174,874**	**$891,316**	**$26,066,190**	**$25,113,967**	**$1,690,939**	**$26,804,906**
	Retained Earnings / Net Assets, end of year	**$28,334,302**	**$26,867,807**	**$0**	**$26,867,807**	**$25,587,845**	**$0**	**$25,587,845**	**$25,174,874**	**$891,316**	**$26,066,190**	**$25,113,967**	**$1,690,939**	**$26,804,906**	**$25,333,492**	**$2,428,955**	**$27,762,447**
	Principal Payments	$874,828	$881,957	$0	**$881,957**	$926,631	$0	**$926,631**	$984,173	($984,173)	**$0**	$1,110,055	($1,110,055)	**$0**	$1,132,025		**$1,132,025**
D.	**PROFITABILITY SUMMARY**																
1	Hospital Operating Margin	**3.7%**	**-1.5%**	**0.0%**	**-1.5%**	**-1.4%**	**0.0%**	**-1.4%**	**-0.4%**	**84.8%**	**0.8%**	**-0.2%**	**40.8%**	**0.9%**	**0.2%**	**25.7%**	**1.1%**
2	Hospital Non Operating Margin	**-0.5%**	**-0.7%**	**0.0%**	**-0.7%**	**-0.5%**	**0.0%**	**-0.5%**	**-0.2%**	**0.0%**	**-0.1%**	**0.1%**	**0.0%**	**0.1%**	**0.1%**	**0.0%**	**0.1%**
3	Hospital Total Margin	**3.2%**	**-2.1%**	**0.0%**	**-2.1%**	**-1.9%**	**0.0%**	**-1.9%**	**-0.6%**	**84.8%**	**0.7%**	**-0.1%**	**40.8%**	**1.0%**	**0.3%**	**25.7%**	**1.3%**
E.	**FTEs**	**405**	**377**	**0**	**377**	**348**	**0**	**348**	**348**	**5**	**353**	**348**	**8**	**356**	**348**	**11**	**359**
F.	**VOLUME STATISTICS[d]**																
1	Inpatient Discharges	2,341	2,159	0	**2,159**	2,159	0	**2,159**	2,159	32	**2,191**	2,159	54	**2,213**	2,159	76	**2,235**
2	Outpatient Visits	421,124	434,254	0	**434,254**	434,254	0	**434,254**	434,254	530	**434,784**	434,254	1,060	**435,314**	434,254	1,590	**435,844**
	TOTAL VOLUME	**423,465**	**436,413**	**0**	**436,413**	**436,413**	**0**	**436,413**	**436,413**	**562**	**436,975**	**436,413**	**1,114**	**437,527**	**436,413**	**1,666**	**438,079**

[a]Total amount should equal the total amount on cell line "Net Patient Revenue" Row 14.
[b]Provide the amount of any transaction associated with Bad Debts not related to the provision of direct services to patients. For additional information, refer to FASB, No.2011-07, July 2011.
[c]Provide the amount of income taxes as defined by the Internal Revenue Services for for-profit entities.
[d]Provide projected inpatient and/or outpatient statistics for any new services and provide actual and projected inpatient and/or outpatient statistics for any existing services which will change due to the proposal.

RESPONSE TO DEFICIENCIES
EXHIBIT J - Other Operating Revenue Detail

Other Operating Revenue Detail

Entity Name: ECHN

	FY 2015 Projected W/out CON	FY 2015 Projected Incremental	FY 2015 Projected With CON	FY 2016 Projected W/out CON	FY 2016 Projected Incremental	FY 2016 Projected With CON	FY 2017 Projected W/out CON	FY 2017 Projected Incremental	FY 2017 Projected With CON	FY 2018 Projected W/out CON	FY 2018 Projected Incremental	FY 2018 Projected With CON	FY 2019 Projected W/out CON	FY 2019 Projected Incremental	FY 2019 Projected With CON
Adolescent Education	$1,990,410	$0	$1,990,410	$1,990,410	$0	$1,990,410	$1,990,410	$0	$1,990,410	$1,990,410	$0	$1,990,410	$1,990,410	$0	$1,990,410
Behavioral Health	$408,035	$0	$408,035	$408,035	$0	$408,035	$408,035	$0	$408,035	$408,035	$0	$408,035	$408,035	$0	$408,035
Biomed Service Contract w/ Tolland Imaging (JV)	$140,667	$0	$140,667	$140,667	$0	$140,667	$140,667	$0	$140,667	$140,667	$0	$140,667	$140,667	$0	$140,667
Cafeteria Income	$965,455	$0	$965,455	$965,455	$0	$965,455	$965,455	$0	$965,455	$965,455	$0	$965,455	$965,455	$0	$965,455
Cancer Services - Salary Recovery from NRRON (JV)	$195,500	$0	$195,500	$195,500	$0	$195,500	$195,500	$0	$195,500	$195,500	$0	$195,500	$195,500	$0	$195,500
ECHN Allocation	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
ECMPF Revenue	$371,634	$0	$371,634	$371,634	$0	$371,634	$371,634	$0	$371,634	$371,634	$0	$371,634	$371,634	$0	$371,634
ECMPF Sound Revenue	$338,800	$0	$338,800	$338,800	$0	$338,800	$338,800	$0	$338,800	$338,800	$0	$338,800	$338,800	$0	$338,800
EHR Initiative Program	$868,039	$0	$868,039	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Gift Shop	$647,433	$0	$647,433	$647,433	$0	$647,433	$647,433	$0	$647,433	$647,433	$0	$647,433	$647,433	$0	$647,433
Grant Income	$1,741,542	$0	$1,741,542	$1,741,542	$0	$1,741,542	$1,741,542	$0	$1,741,542	$1,741,542	$0	$1,741,542	$1,741,542	$0	$1,741,542
HR - Wellness Program & Medicare Part D Subsidy	$468,715	$0	$468,715	$468,715	$0	$468,715	$468,715	$0	$468,715	$468,715	$0	$468,715	$468,715	$0	$468,715
Lab Services - Eastern CT Pathology	$1,313,440	$0	$1,313,440	$1,313,440	$0	$1,313,440	$1,313,440	$0	$1,313,440	$1,313,440	$0	$1,313,440	$1,313,440	$0	$1,313,440
Maintanance Cost Recovery Woodlake	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Miscellaneous Income	$95,627	$0	$95,627	$86,666	$0	$86,666	$86,666	$0	$86,666	$86,666	$0	$86,666	$86,666	$0	$86,666
MPP Billing Revenue	$2,305,526	$0	$2,305,526	$2,305,526	$0	$2,305,526	$2,305,526	$0	$2,305,526	$2,305,526	$0	$2,305,526	$2,305,526	$0	$2,305,526
Nursing/Perinatal Education	$69,584	$0	$69,584	$69,584	$0	$69,584	$69,584	$0	$69,584	$69,584	$0	$69,584	$69,584	$0	$69,584
Physician Hospital Organization	$331,559	$0	$331,559	$331,559	$0	$331,559	$331,559	$0	$331,559	$331,559	$0	$331,559	$331,559	$0	$331,559
Radiology Directorship - Tolland Imaging (JV)	$89,645	$0	$89,645	$89,645	$0	$89,645	$89,645	$0	$89,645	$89,645	$0	$89,645	$89,645	$0	$89,645
Rental Income	$350,197	$0	$350,197	$350,197	$0	$350,197	$350,197	$0	$350,197	$350,197	$0	$350,197	$350,197	$0	$350,197
UNECOM - Medical Education	$237,480	$0	$237,480	$237,480	$0	$237,480	$237,480	$0	$237,480	$237,480	$0	$237,480	$237,480	$0	$237,480
VNHSC (Flu Clinic/Health Promotions)	$66,508	$0	$66,508	$66,508	$0	$66,508	$66,508	$0	$66,508	$66,508	$0	$66,508	$66,508	$0	$66,508
Joint Venture Income	$2,311,296	$0	$2,311,296	$2,311,296	$0	$2,311,296	$2,357,522	$0	$2,357,522	$2,404,672	$0	$2,404,672	$2,452,766	$0	$2,452,766
Public Support	$1,265,801	$0	$1,265,801	$1,265,801	$0	$1,265,801	$1,265,801	($1,265,801)	$0	$1,265,801	($1,265,801)	$0	$1,265,801	($1,265,801)	$0
Realized Gains	$0	$0	$0	$0	$0	$0	$36,261	$0	$36,261	$36,261	$0	$36,261	$36,261	$0	$36,261
Interest Income	$230,020	$0	$230,020	$230,020	$0	$230,020	$193,759	($152,102)	$41,657	$193,759	($152,102)	$41,657	$193,759	($152,102)	$41,657
Total Other Operating Revenue	**$16,802,913**	**$0**	**$16,802,913**	**$15,925,913**	**$0**	**$15,925,913**	**$15,972,139**	**($1,417,903)**	**$14,554,236**	**$16,019,290**	**($1,417,903)**	**$14,601,387**	**$16,067,383**	**($1,417,903)**	**$14,649,480**

Other Operating Revenue Detail

Entity Name: MMH

	FY 2015 Projected W/out CON	FY 2015 Projected Incremental	FY 2015 Projected With CON	FY 2016 Projected W/out CON	FY 2016 Projected Incremental	FY 2016 Projected With CON	FY 2017 Projected W/out CON	FY 2017 Projected Incremental	FY 2017 Projected With CON	FY 2018 Projected W/out CON	FY 2018 Projected Incremental	FY 2018 Projected With CON	FY 2019 Projected W/out CON	FY 2019 Projected Incremental	FY 2019 Projected With CON
Adolescent Education	$1,790,410	$0	$1,790,410	$1,790,410	$0	$1,790,410	$1,826,218	$0	$1,826,218	$1,862,743	$0	$1,862,743	$1,899,997	$0	$1,899,997
Behavioral Health	$376,535	$0	$376,535	$376,535	$0	$376,535	$384,066	$0	$384,066	$391,747	$0	$391,747	$399,582	$0	$399,582
Biomed Service Contract w/ Tolland Imaging (JV)	$140,667	$0	$140,667	$140,667	$0	$140,667	$143,480	$0	$143,480	$146,350	$0	$146,350	$149,277	$0	$149,277
Cafeteria Income	$873,648	$0	$873,648	$873,648	$0	$873,648	$891,121	$0	$891,121	$908,943	$0	$908,943	$927,122	$0	$927,122
Cancer Services - Salary Recovery from NRRON (JV)	$195,500	$0	$195,500	$195,500	$0	$195,500	$199,410	$0	$199,410	$203,398	$0	$203,398	$207,466	$0	$207,466
ECHN Allocation	$901,129	$0	$901,129	$901,129	$0	$901,129	$919,152	$0	$919,152	$937,535	$0	$937,535	$956,285	$0	$956,285
ECMPF Revenue	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
ECMPF Sound Revenue	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
EHR Initiative Program	$429,536	$0	$429,536	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Gift Shop	$613,616	$0	$613,616	$613,616	$0	$613,616	$625,888	$0	$625,888	$638,406	$0	$638,406	$651,174	$0	$651,174
Grant Income	$1,529,803	$0	$1,529,803	$1,529,803	$0	$1,529,803	$1,560,399	$0	$1,560,399	$1,591,607	$0	$1,591,607	$1,623,439	$0	$1,623,439
HR - Wellness Program & Medicare Part D Subsidy	$468,715	$0	$468,715	$468,715	$0	$468,715	$478,089	$0	$478,089	$487,651	$0	$487,651	$497,404	$0	$497,404
Lab Services - Eastern CT Pathology	$1,313,441	$0	$1,313,441	$1,313,441	$0	$1,313,441	$1,339,711	$0	$1,339,711	$1,366,504	$0	$1,366,504	$1,393,834	$0	$1,393,834
Maintanance Cost Recovery Woodlake	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Miscellaneous Income	$29,342	$0	$29,342	$68,631	$0	$68,631	$85,706	$0	$85,706	$103,123	$0	$103,123	$120,888	$0	$120,888
MPP Billing Revenue	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Nursing/Perinatal Education	$69,584	$0	$69,584	$69,584	$0	$69,584	$70,976	$0	$70,976	$72,395	$0	$72,395	$73,843	$0	$73,843
Physician Hospital Organization	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Radiology Directorship - Tolland Imaging (JV)	$89,645	$0	$89,645	$89,645	$0	$89,645	$91,438	$0	$91,438	$93,267	$0	$93,267	$95,132	$0	$95,132
Rental Income	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
UNECOM - Medical Education	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
VNHSC (Flu Clinic/Health Promotions)	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Joint Venture Income	$1,417,219	$0	$1,417,219	$1,417,219	$0	$1,417,219	$1,445,563	$0	$1,445,563	$1,474,475	$0	$1,474,475	$1,503,964	$0	$1,503,964
Public Support	$595,242	$0	$595,242	$595,242	$0	$595,242	$595,242	($595,242)	$0	$595,242	($595,242)	$0	$595,242	($595,242)	$0
Realized Gains	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Interest Income	$189,887	$0	$189,887	$189,887	$0	$189,887	$189,887	($140,125)	$49,762	$189,887	($140,125)	$49,762	$189,887	($140,125)	$49,762
Total Other Operating Revenue	**$11,023,919**	**$0**	**$11,023,919**	**$10,633,672**	**$0**	**$10,633,672**	**$10,846,346**	**($735,367)**	**$10,110,979**	**$11,063,272**	**($735,367)**	**$10,327,905**	**$11,284,538**	**($735,367)**	**$10,549,171**

Other Operating Revenue Detail

Entity Name: RGH

	FY 2015 Projected W/out CON	FY 2015 Projected Incremental	FY 2015 Projected With CON	FY 2016 Projected W/out CON	FY 2016 Projected Incremental	FY 2016 Projected With CON	FY 2017 Projected W/out CON	FY 2017 Projected Incremental	FY 2017 Projected With CON	FY 2018 Projected W/out CON	FY 2018 Projected Incremental	FY 2018 Projected With CON	FY 2019 Projected W/out CON	FY 2019 Projected Incremental	FY 2019 Projected With CON
Adolescent Education	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Behavioral Health	$31,500	$0	$31,500	$31,500	$0	$31,500	$32,130	$0	$32,130	$32,773	$0	$32,773	$33,428	$0	$33,428
Biomed Service Contract w/ Tolland Imaging (JV)	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Cafeteria Income	$208,628	$0	$208,628	$208,628	$0	$208,628	$212,801	$0	$212,801	$217,057	$0	$217,057	$221,398	$0	$221,398
Cancer Services - Salary Recovery from NRRON (JV)	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
ECHN Allocation	$355,646	$0	$355,646	$355,646	$0	$355,646	$362,759	$0	$362,759	$370,014	$0	$370,014	$377,414	$0	$377,414
ECMPF Revenue	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
ECMPF Sound Revenue	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
EHR Initiative Program	$438,503	$0	$438,503	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Gift Shop	$33,817	$0	$33,817	$33,817	$0	$33,817	$34,493	$0	$34,493	$35,183	$0	$35,183	$35,887	$0	$35,887
Grant Income	$193,670	$0	$193,670	$193,670	$0	$193,670	$197,543	$0	$197,543	$201,494	$0	$201,494	$205,524	$0	$205,524
HR - Wellness Program & Medicare Part D Subsidy	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Lab Services - Eastern CT Pathology	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Maintanance Cost Recovery Woodlake	$139,548	$0	$139,548	$139,548	$0	$139,548	$142,339	$0	$142,339	$145,186	$0	$145,186	$148,089	$0	$148,089
Miscellaneous Income	$13,964	$0	$13,964	$377,134	$0	$377,134	$387,184	$0	$387,184	$397,435	$0	$397,435	$407,892	$0	$407,892
MPP Billing Revenue	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Nursing/Perinatal Education	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Physician Hospital Organization	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Radiology Directorship - Tolland Imaging (JV)	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Rental Income	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
UNECOM - Medical Education	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
VNHSC (Flu Clinic/Health Promotions)	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Joint Venture Income	$587,431	$0	$587,431	$587,431	$0	$587,431	$599,180	$0	$599,180	$611,163	$0	$611,163	$623,386	$0	$623,386
Public Support	$100,766	$0	$100,766	$100,766	$0	$100,766	$100,766	($100,766)	$0	$100,766	($100,766)	$0	$100,766	($100,766)	$0
Realized Gains	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Interest Income	$24,602	$0	$24,602	$24,602	$0	$24,602	$24,602	($11,977)	$12,625	$24,602	($11,977)	$12,625	$24,602	($11,977)	$12,625
Total Other Operating Revenue	**$2,128,076**	**$0**	**$2,128,076**	**$2,052,742**	**$0**	**$2,052,742**	**$2,093,797**	**($112,743)**	**$1,981,054**	**$2,135,673**	**($112,743)**	**$2,022,930**	**$2,178,387**	**($112,743)**	**$2,065,644**

RESPONSE TO DEFICIENCIES
EXHIBIT K - OHCA Financial Statistics Report
(ECHN – July, August, September)

OHCA Financial Statistics Report (July FY 2015 and July FY 2014)

	Manchester Memorial Hospital				Rockville General Hospital				Eastern CT Health Network			
	MTD		YTD		MTD		YTD		MTD		YTD	
	July FY 2015	July FY 2014	July FY 2015	July FY 2014	July FY 2015	July FY 2014	July FY 2015	July FY 2014	July FY 2015	July FY 2014	July FY 2015	July FY 2014
A. Operating Performance												
Operating Margin	4.12%	3.32%	2.51%	3.23%	-3.13%	0.81%	-2.72%	1.05%	3.71%	0.89%	-0.98%	0.34%
Non-Operating Margin	-1.21%	-1.76%	-0.89%	-0.88%	-1.20%	-1.71%	-0.69%	-0.45%	-0.92%	-1.36%	-0.67%	-0.59%
Total Margin	2.91%	1.56%	1.62%	2.35%	-4.32%	-0.90%	-3.41%	0.60%	2.80%	-0.47%	-1.65%	-0.25%
Bad Debt as % of Gross Revenue	0.58%	0.38%	-0.61%	-0.66%	0.99%	0.35%	-0.72%	-0.63%	-0.76%	0.48%	-0.65%	-0.75%
B. Liquidity												
Current Ratio	1.16	1.31	1.16	1.31	1.54	1.50	1.54	1.50	1.38	1.40	1.38	1.40
Days Cash on Hand	19	28	13	20	66	61	45	45	65	70	65	70
Days in Net Accounts Receivable	53	59	38	43	62	55	42	41	52	55	38	40
Average Payment Period	62	54	43	39	48	47	32	34	64	70	64	70
C. Leverage and Capital Structure												
Long-term Debt to Equity	2.07	1.64	2.07	1.64	0.91	0.74	0.91	0.74	1.11	0.93	1.11	0.93
Long-term Debt to Capitalization	67	62	67	62	48	42	48	42	67	59	67	59
Unrestricted Cash to Debt	1.30	0.90	10.83	12.60	0.08	0.43	2.49	9.86	1.37	0.49	4.36	7.21
Times Interest Earned Ratio	6.75	5.72	5.82	6.03	2.44	4.94	2.99	6.96	7.70	4.40	3.49	4.46
Debt Service Coverage Ratio	N/A	N/A	1.42	1.83	N/A	N/A	0.92	2.66	N/A	N/A	1.40	1.16
Equity Financing Ratio	16.17	21.64	16.17	21.64	35.23	41.31	35.23	41.31	28.11	32.92	28.11	32.92
D. Additional Statistics												
Income from Operations	$633,053	$520,994	$3,919,130	$5,079,849	($166,895)	$49,602	($1,534,668)	$637,755	$1,033,957	$251,617	($2,648,012)	$961,199
Revenue Over/(Under) Expense	$446,906	$244,365	$2,524,988	$3,695,991	($230,700)	($55,083)	($1,924,686)	$362,997	$778,733	($133,319)	($4,472,987)	($691,635)
EBITDA	$1,413,261	$1,163,486	$11,890,204	$13,184,731	$149,301	$305,483	$1,744,517	$4,002,648	$2,291,661	$1,335,849	$10,337,145	$14,344,707
Cash from Operations	$14,290,215	$15,719,667	$144,426,487	$146,614,120	$5,527,405	$6,707,356	$57,671,830	$58,437,110	$24,789,135	$27,474,495	$250,965,459	$255,093,461
Cash and Cash Equivalents	$9,163,954	$13,849,738	$9,163,954	$13,849,738	$11,726,452	$12,105,457	$11,726,452	$12,105,457	$46,307,239	$51,231,181	$46,307,239	$51,231,181
Net Working Capital	$4,709,127	$8,495,203	$4,709,127	$8,495,203	$4,519,871	$4,689,471	$4,519,871	$4,689,471	$18,060,122	$20,490,665	$18,060,122	$20,490,665
Unrestricted Assets	$10,376,011	$19,815,466	$10,376,011	$19,815,466	$20,665,705	$26,324,679	$20,665,705	$26,324,679	$54,034,965	$71,217,658	$54,034,965	$71,217,658
Credit Ratings (S&P, FITCH, and Moody's)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

OHCA Financial Statistics Report (August FY 2015 and August FY 2014)

	Manchester Memorial Hospital				Rockville General Hospital				Eastern CT Health Network			
	MTD		YTD		MTD		YTD		MTD		YTD	
	August FY 2015	August FY 2014	August FY 2015	August FY 2014	August FY 2015	August FY 2014	August FY 2015	August FY 2014	August FY 2015	August FY 2014	August FY 2015	August FY 2014
A. Operating Performance												
Operating Margin	4.05%	-3.59%	2.65%	2.64%	-2.38%	-0.70%	-2.69%	0.90%	-0.94%	-4.14%	-0.97%	-0.05%
Non-Operating Margin	-1.66%	-0.44%	-0.96%	-0.84%	-1.58%	-0.17%	-0.76%	-0.43%	-1.29%	-0.29%	-0.73%	-0.56%
Total Margin	2.39%	-4.03%	1.69%	1.80%	-3.96%	-0.87%	-3.46%	0.47%	-2.23%	-4.43%	-1.70%	-0.61%
Bad Debt as % of Gross Revenue	1.22%	-0.66%	-0.44%	-0.66%	1.21%	-0.84%	-0.55%	-0.65%	0.96%	-0.79%	-0.51%	-0.75%
B. Liquidity												
Current Ratio	1.19	1.19	1.19	1.19	1.48	1.69	1.48	1.69	1.36	1.39	1.36	1.39
Days Cash on Hand	23	27	15	19	72	62	46	43	66	67	66	67
Days in Net Accounts Receivable	56	64	39	44	64	63	42	44	57	60	39	41
Average Payment Period	67	61	45	44	52	44	34	30	65	67	65	67
C. Leverage and Capital Structure												
Long-term Debt to Equity	2.14	1.74	2.14	1.74	0.92	0.77	0.92	0.77	1.14	0.97	1.14	0.97
Long-term Debt to Capitalization	68	64	68	64	48	44	48	44	67	61	67	61
Unrestricted Cash to Debt	1.20	0.06	11.86	12.11	0.06	0.77	2.55	10.84	0.30	(0.08)	4.60	7.04
Times Interest Earned Ratio	6.91	1.53	6.41	5.64	2.68	5.33	2.96	6.81	3.45	0.91	3.49	4.16
Debt Service Coverage Ratio	N/A	N/A	1.50	1.68	N/A	N/A	0.91	2.72	N/A	N/A	1.41	1.06
Equity Financing Ratio	15.99	20.58	15.99	20.58	34.93	41.46	34.93	41.46	27.76	32.38	27.76	32.38
D. Additional Statistics												
Income from Operations	$597,835	($531,932)	$4,516,964	$4,547,917	($119,527)	($40,468)	($1,654,194)	$597,288	($240,325)	($1,110,535)	($2,888,337)	($149,336)
Revenue Over/(Under) Expense	$353,116	($597,128)	$2,878,103	$3,098,864	($198,666)	($50,522)	($2,123,350)	$312,476	($570,339)	($1,188,772)	($5,043,326)	($1,880,407)
EBITDA	$1,400,713	$316,488	$13,088,122	$13,501,219	$156,631	$307,715	$1,901,150	$4,310,364	$1,003,678	$275,706	$11,340,823	$14,620,413
Cash from Operations	$13,850,383	$14,385,361	$158,276,870	$160,999,481	$5,606,279	$5,677,456	$63,278,109	$64,114,566	$24,438,646	$24,966,839	$275,404,105	$280,060,300
Cash and Cash Equivalents	$10,094,581	$12,933,064	$10,094,581	$12,933,064	$11,578,760	$11,103,202	$11,578,760	$11,103,202	$47,023,731	$49,069,770	$47,023,731	$49,069,770
Net Working Capital	$5,603,489	$5,450,496	$5,603,489	$5,450,496	$4,023,147	$5,397,747	$4,023,147	$5,397,747	$17,639,012	$19,611,711	$17,639,012	$19,611,711
Unrestricted Assets	$10,308,640	$18,971,156	$10,308,640	$18,971,156	$20,279,098	$26,051,748	$20,279,098	$26,051,748	$53,344,364	$70,108,676	$53,344,364	$70,108,676
Credit Ratings (S&P, FITCH, and Moody's)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

OHCA Financial Statistics Report (September FY 2015 and September FY 2014)

DRAFT BASED ON UNAUDITED RESULTS

	Manchester Memorial Hospital				Rockville General Hospital				Eastern CT Health Network			
	MTD		YTD		MTD		YTD		MTD		YTD	
	September FY 2015	September FY 2014	September FY 2015	September FY 2014	September FY 2015	September FY 2014	September FY 2015	September FY 2014	September FY 2015	September FY 2014	September FY 2015	September FY 2014
A. Operating Performance												
Operating Margin	17.81%	-1.98%	4.00%	2.26%	-0.66%	26.83%	-2.53%	3.70%	9.21%	2.28%	-0.13%	0.15%
Non-Operating Margin	0.00%	-1.87%	-0.87%	-0.93%	-1.44%	-1.16%	-0.82%	-0.51%	-0.30%	-1.37%	-0.69%	-0.63%
Total Margin	17.82%	-3.85%	3.13%	1.33%	-2.11%	25.67%	-3.35%	3.20%	8.91%	0.91%	-0.82%	-0.48%
Bad Debt as % of Gross Revenue	0.75%	-4.49%	-0.34%	-0.97%	0.50%	-7.75%	-0.46%	-1.23%	0.85%	0.66%	-0.39%	-0.64%
B. Liquidity												
Current Ratio	1.12	1.17	1.12	1.17	1.94	1.59	1.94	1.59	1.37	1.37	1.37	1.37
Days Cash on Hand	30	36	21	29	75	66	54	50	73	78	73	78
Days in Net Accounts Receivable	48	64	39	40	58	73	42	47	55	64	41	39
Average Payment Period	78	67	54	54	41	47	30	36	69	71	69	71
					0							
C. Leverage and Capital Structure												
Long-term Debt to Equity	3.72	2.03	3.72	2.03	1.08	0.83	1.08	0.83	1.37	1.06	1.37	1.06
Long-term Debt to Capitalization	79	67	79	67	52	45	52	45	76	65	76	65
Unrestricted Cash to Debt	4.26	(0.06)	15.48	11.20	0.38	6.98	3.05	17.41	2.43	0.88	6.76	7.68
Times Interest Earned Ratio	21.38	2.24	7.04	5.38	4.14	42.56	3.06	9.24	14.05	7.45	4.27	4.38
Debt Service Coverage Ratio	N/A	N/A	1.79	1.60	N/A	N/A	0.97	3.99	N/A	N/A	1.27	1.36
Equity Financing Ratio	8.83	16.28	8.83	16.28	30.95	37.96	30.95	37.96	22.08	28.81	22.08	28.81
D. Additional Statistics												
Income from Operations	$2,980,224	($312,411)	$7,497,189	$4,235,507	($35,560)	$2,163,409	($1,689,753)	$2,760,694	$2,461,753	$658,388	($426,584)	$509,052
Revenue Over/(Under) Expense	$2,980,415	($606,680)	$5,858,519	$2,492,184	($113,096)	$2,069,656	($2,236,445)	$2,382,130	$2,381,332	$263,708	($2,661,994)	($1,616,699)
EBITDA	$3,743,274	$440,393	$17,034,191	$13,941,613	$250,620	$2,421,228	$2,151,771	$6,774,667	$3,666,884	$1,850,004	$15,007,707	$16,470,417
Cash from Operations	$14,563,917	$14,901,325	$172,840,787	$175,900,806	$5,514,418	$5,768,359	$68,792,527	$69,882,925	$24,854,112	$25,589,485	$300,258,217	$305,649,785
Cash and Cash Equivalents	$13,188,728	$18,856,818	$13,188,728	$18,856,818	$13,081,652	$12,735,604	$13,081,652	$12,735,604	$53,111,506	$58,713,876	$53,111,506	$58,713,876
Net Working Capital	$4,127,089	$5,986,254	$4,127,089	$5,986,254	$6,725,388	$5,392,746	$6,725,388	$5,392,746	$21,095,237	$20,280,901	$21,095,237	$20,280,901
Unrestricted Assets	$1,126,292	$11,344,473	$1,126,292	$11,344,473	$16,813,993	$24,211,838	$16,813,993	$24,211,838	$42,021,427	$59,544,869	$42,021,427	$59,544,869
Credit Ratings (S&P, FITCH, and Moody's)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

RESPONSE TO DEFICIENCIES
EXHIBIT L - PMH Capital Investments and Cost Savings Table

Table from Question 37a - Capital Investments and Cost Savings Table

Hospital	Describe Improvements in Financial Performance									
	Investments since Acquistion		Profitability		Liquidity		Solvency		Cost Savings	
Los Angeles Community Hospital at Bellflower	$ 3,646,633		N//A	(a)	N/A	(a)	N/A	(a)	N/A	(a)
Foothill Regional Medical Center	$ 7,912,807		N/A	(a)	N/A	(a)	N/A	(a)	N/A	(a)
Our Lady of Fatima Hospital	$ 11,321,376	(f)	$ 15,184,000	(g)	$ 4,976,828	(c)	$ 67,475,613	(c)	Marginal Cost per day reduced to $1,493 from $1,542	(d)
Roger Williams Medical Center	$ 11,321,376	(f)	$ 15,184,000	(g)	$ 4,976,828	(c)	$ 67,475,613	(c)	Marginal Cost per day reduced to $2,271 from $2,263	(d)
Nix Health System	$ 33,350,077		$ 20,867,000	(h)	$ 15,882,118		$ 63,789,134		Total Costs per day decreased to $1,444 from $1,584	(e)

(a) Both Los Angeles Community Hospital at Bellflower (Bellflower) and Foothill Regional Medical Center (Foothill) were closed prior to PMH acquisition
Bellflower re-opened in July 2015 and Foohill re-opened in September 2015. Both facilities were purchased in May 2014.

(b) Los Angeles Community Hospital at Bellflower is under common corporate ownership structure and license as Los Angeles Community Hospital and
Los Angeles Community Hospital at Norwalk. As such, liquidity and solvency for this campus includes financial information for all three campuses combined

(c) The profitability, liquidity and solvency of Our Lady of Fatima and Roger Williams Medical Center are reported on a consoldiated basis for the CharterCARE system
Prior to the acquisition, the liquidity of CharterCARE system was approximately a negative $2.5 million
Profitability is measured on an EBITDA basis and reported on a consolidated basis for the CharterCARE system

(d) Measured from June 2014 to May 2015

(e) Measured from Dember 2011 to September 2015. Prior to acquisition Nix did not compute Marginal cost per day.

(f) Total capital investment in Our Lay of Fatima and Roger Williams Medical Center (which comprise CharterCARE) is reported on a combined basis.
In addition to the amount already spent, we have committed to spend $20 million in addtion to what has already been spent
on (i) cancer center; (ii) Digestive Diseases Center; (iii) Emergency Department and (iv) physician practice acquisitions.

RESPONSE TO DEFICIENCIES
EXHIBIT M - PMH Quality Report from Rhode Island CON

CharterCare and Prospect Holdings Quality Review

Health Services Council

April 8, 2014

Mary Reich Cooper MD JD

No Conflicts of Interest

Statutory Authority and Background

RIGL 23-17-14.3 "Licensing of Health Care Facilities"

- The character, commitment, competence, and standing in the community of the proposed owners, operators, or directors of the health care facility;
- In cases of initial licensure or of proposed change in owner, operator, or lessee, the extent to which the facility will provide or will continue to provide, without material effect on its viability at the time of initial licensure or of change of owner, operator, or lessee, safe and adequate treatment for individuals receiving the health care facility's services;
- The extent to which the facility will provide or will continue to provide safe and adequate treatment for individuals receiving the health care facility's services; and
- The extent to which the facility will provide or will continue to provide appropriate access with respect to traditionally underserved populations and in consideration of the proposed continuation or termination of health care services by the health care facility.

Hospital Conversion Act 23-17.14-3 and 23-17.14-4

- Assure the viability of a safe, accessible, and affordable healthcare system that is available to all of the citizens of the state.
- Establish a process to review whether for-profit hospitals will maintain, enhance or disrupt the delivery of healthcare in the state and to monitor hospital performance to assure that standards for community benefit continue to be met.

Hospital Conversion Act 23-17.14-8

- Whether the character, commitment, competence, and standing in the community or any other proposed communities served by the proposed transacting parties is satisfactory.
- Whether sufficient safeguards are included to assure the affected community continued access to affordable care.

Hospital Conversion Act 23-17.14-8

- Whether the transacting parties have provided clear and convincing evidence that the new hospital will provide health care and appropriate access with respect to traditionally underserved populations in the affected community.
- Whether the conversion demonstrates that the public interest will be served considering the essential medical services needed to provide safe and adequate treatment, appropriate access and balanced health care delivery to the residents of the state.

Scope of Review

- Review of CEC Application
- Review of HCA Filing
- Internet Research and Review of Findings
  - WhyNotTheBest.org (aggregating medicare.gov/hospitalcompare)
  - Kaiser Family Foundation (kff.org)
  - Qualitycheck.org (Joint Commission), DNV.org, NursingHomeCompare, homehealthcompare
  - Other public documents
- Interviews with Leadership

Roger Williams

Roger Williams Medical Center is a general medical and surgical hospital in Providence, RI, with 177 beds. It is also a teaching hospital. Survey data for the latest year available shows 165,058 outpatient visits. The hospital had a total of 7,233 admissions. Its physicians performed 2,133 inpatient and 3,082 outpatient surgeries.

http://health.usnews.com/best-hospitals/area/ri/roger-williams-medical-center-6150160 accessed April 2, 2014 and file:///C:/Users/Mary/Downloads/Free_Hospital_Look_up___Roger_Williams_Medical_Center%20(1).pdf accessed April 6 2014

St. Joseph's

St. Joseph Health Services is a general medical and surgical hospital in North Providence, RI, with 231 beds. Survey data for the latest year available shows 229,153 outpatient visits. The hospital had a total of 7,924 admissions. Its physicians performed 1,694 inpatient and 5,426 outpatient surgeries.

http://health.usnews.com/best-hospitals/area/ri/st-joseph-health-services-6150091 accessed April 2, 2014 and file:///C:/Users/Mary/Downloads/Free_Hospital_Look_up__St_Joseph_Health_Services_of_Rhode_Island.pdf accessed April 6, 2014

Nix Health System

Nix Medical Center is a general medical and surgical hospital in San Antonio, TX, with 173 beds. Survey data for the latest year available shows that the hospital had a total of 7,751 admissions. Outpatient visits totaled 131, 709 Its physicians performed 1,775 inpatient and 3,546 outpatient surgeries.

http://health.usnews.com/best-hospitals/area/tx/nix-medical-center-6743070 accessed April 2, 2014 and file:///C:/Users/Mary/Downloads/Free_Hospital_Look_up__Nix_Health_Care_System.pdf accessed April 6, 2014

Nix Community Hospital

Community General Hospital is a general medical and surgical hospital in Dilley, TX, with 18 beds. Survey data for the latest year available shows that 5,383 outpatient visits. The hospital had a total of 647 admissions.

http://health.usnews.com/best-hospitals/area/tx/community-general-hospital-6740286 and file:///C:/Users/Mary/Downloads/Free_Hospital_Look_up___Nix_Community_General_Hospital.pdf accessed April 6, 2014

SoCal Culver City

(Brotman) is a general medical and surgical hospital in Culver City, CA, with 239 beds. Survey data for the latest year available shows 30,622 outpatients. The hospital had a total of 9,255 admissions. Its physicians performed 788 inpatient and 1,189 outpatient surgeries.

http://health.usnews.com/best-hospitals/area/ca/brotman-medical-center-6930540/details accessed March 30, 2014 and file:///C:/Users/Mary/Downloads/Free_Hospital_Look_up__Southern_California_Hospital_at_Culver_City.pdf accessed April 6, 2014

SoCal Hollywood

Hollywood Community Hospital (SoCal Hollywood) is a general medical and surgical hospital in Los Angeles, CA, with 45 beds, 3,081 admissions, and 5,668 outpatient visits.

http://health.usnews.com/best-hospitals/area/ca/hollywood-community-hospital-6930072 accessed April 2, 2014 and file:///C:/Users/Mary/Downloads/Free_Hospital_Look_up___Southern_California_Hospital_at_Hollywood.pdf accessed April 6 2014

SoCal Van Nuys

"SoCal Van Nuys located in Van Nuys, California is a 60-bed psychiatric hospital that provides acute inpatient and outpatient psychiatric services on a voluntary basis."

http://www.altacorp.com/altacorp/ accessed April 3, 2014

LA Community

LA Community is a general medical and surgical hospital in Los Angeles, CA, with 180 beds. Survey data for the latest year available shows that there were 23,337 outpatient visits. The hospital had a total of 8,393 admissions and 1586 births.

http://health.usnews.com/best-hospitals/area/ca/los-angeles-community-hospital-6930060 accessed April 2, 2014 and file:///C:/Users/Mary/Downloads/Free_Hospital_Look_up___Los_Angeles_Community_Hospital_at_Los_Angeles.pdf accessed April 6 2014

Norwalk Community

"Our hospital located in Norwalk, California is a 50-bed community hospital that offers a comprehensive range of medical and surgical services, including general acute care hospital services, inpatient and outpatient surgery, emergency room and general medical/surgical care and intensive care."

http://www.altacorp.com/altacorp/
accessed April 3, 2014

Framework: Institute of Medicine

- Safety
- Access
- Patient Centered Care
- Effectiveness
- Timeliness
- Efficiency

Crossing the Quality Chasm 2001

Accreditation

Review accreditation decisions for hospitals held by the transacting parties and determine if any adverse accreditation reviews have been identified and corrected.

Accreditation Decisions

- CharterCare
  - **St. Josephs: Joint Commission**
    - Hospital accredited 12/17/2011
    - Advanced Inpatient Diabetes 12/08/2012 1/75
    - Advanced Primary Stroke 12/04/2012 1/1024
    - Hip Replacement 12/12/2012 1/376
    - Knee Replacement 12/12/2012 1/379

http://www.qualitycheck.org/qualityreport.aspx?hcoid=5647 accessed 3/29/2014

Accreditation Decisions

- CharterCare
  - **Roger Williams: Joint Commission**
    - Hospital accredited 09/24/2011
    - Home Care 09/21/2011
    - Nursing Care Center 09/23/2011
    - Advanced Primary Stroke 03/21/2014 1/1024
    - Hip Replacement 02/11/2014 1/376
    - Knee Replacement 02/11/2014 1/379

    - Special Quality Awards
      - 2013 AHCA/NCAL Bronze - Commitment to Quality
      - 2013 Silver Get With The Guidelines - Stroke

http://www.qualitycheck.org/qualityreport.aspx?hcoid=5652# accessed 3/29/2014

Accreditation Decisions

- Prospect Medical Holdings
  - **Nix Health Care System: DNV**
    - Health System accredited 11/25/2013
  - **TX DSHS**
    - Behavioral Health through 12/31/2015
    - Health Care System through 12/31/2015
    - Specialty Health Center through 12/31/2015

http://dnvglhealthcare.com/hospitals?q=&c=&c=19211&prSubmit=Search&page=4 accessed April 2, 2014

http://www.dshs.state.tx.us/HFP/apps.shtm#hosp_gen_spec accessed March 30, 2014

Accreditation Decisions

- Prospect Medical Holdings
  - **Nix Community Hospital: Joint Commission (TJC)**
    - Hospital accredited 08/08/2013
  - **TX DSHS**
    - Community Hospital through 4/30/2015

http://www.qualitycheck.org/qualityreport.aspx?hcoid=546980 accessed March 30, 2014

http://www.dshs.state.tx.us/HFP/apps.shtm#hosp_gen_spec accessed March 30, 2014

Accreditation Decisions

- Prospect Medical Holdings
  - **SoCal Hollywood: DNV**
    - Hospital accredited 1/12/2014
  - **TJC**
    - Laboratory program accredited 9/13/2013
  - **CA DPH**: licensed through 2/24/2015

https://hfcis.cdph.ca.gov/LongTermCare/Facility.aspx?fac=930000064 accessed March 30 2014

http://dnvglhealthcare.com/hospitals?q=&c=&c=19173&prSubmit=Search&page=2 accessed April 2, 2014

http://www.qualitycheck.org/Consumer/searchResults.aspx?zip=90028&Select1=-1&dist=-1&provId=2&provIdtracker=2 accessed March 30, 2014

Accreditation Decisions

- Prospect Medical Holdings
  - **Los Angeles Community/Norwalk Community: DNV**
    - Hospital accredited 1/7/2014
  - **TJC** Laboratory accreditation 7/12/2013
  - **CA DPH** licensed through 3/14/2015

https://hfcis.cdph.ca.gov/LongTermCare/Facility.aspx?fac=930000085 accessed March 30, 2014

http://dnvglhealthcare.com/hospitals?q=&c=&c=19173&prSubmit=Search&page=2 accessed March 30, 2014

http://www.qualitycheck.org/qualityreport.aspx?hcoid=9923 accessed March 30 2014

Accreditation Decisions

- Prospect Medical Holdings
  - **SoCal Culver City: DNV**
    - Hospital accredited 1/12/2014
  - **TJC** No accreditations found; none necessary
  - **CA DPH** licensed through 2/24/2015

https://hfcis.cdph.ca.gov/LongTermCare/Facility.aspx?fac=930000015 accessed April 3, 2014

http://dnvglhealthcare.com/hospitals?q=&c=&c=19173&prSubmit=Search accessed March 30, 2014

http://www.qualitycheck.org/Consumer/searchPage2.aspx?zip=90232&Select1=-1&dist=-1 accessed March 30, 2014

Accreditation Decisions

- Prospect Medical Holdings
  - **Van Nuys: DNV**
    - Effective Date of Accreditation 1/12/2014
  - **TJC**: Laboratory Accreditation 9/13/2013
  - **CA DPH** licensed through 2/24/2015

https://hfcis.cdph.ca.gov/LongTermCare/Facility.aspx?fac=930000492 accessed April 3, 2014

http://dnvglhealthcare.com/hospitals?q=&c=&c=19173&prSubmit=Search&page=2 accessed March 30, 2014

http://www.qualitycheck.org/Consumer/searchResults.aspx?zip=91401&Select1=-1&dist=-1&provGrpId=2&provGrpIdtracker=2 accessed March 30, 2014

Quality Metrics

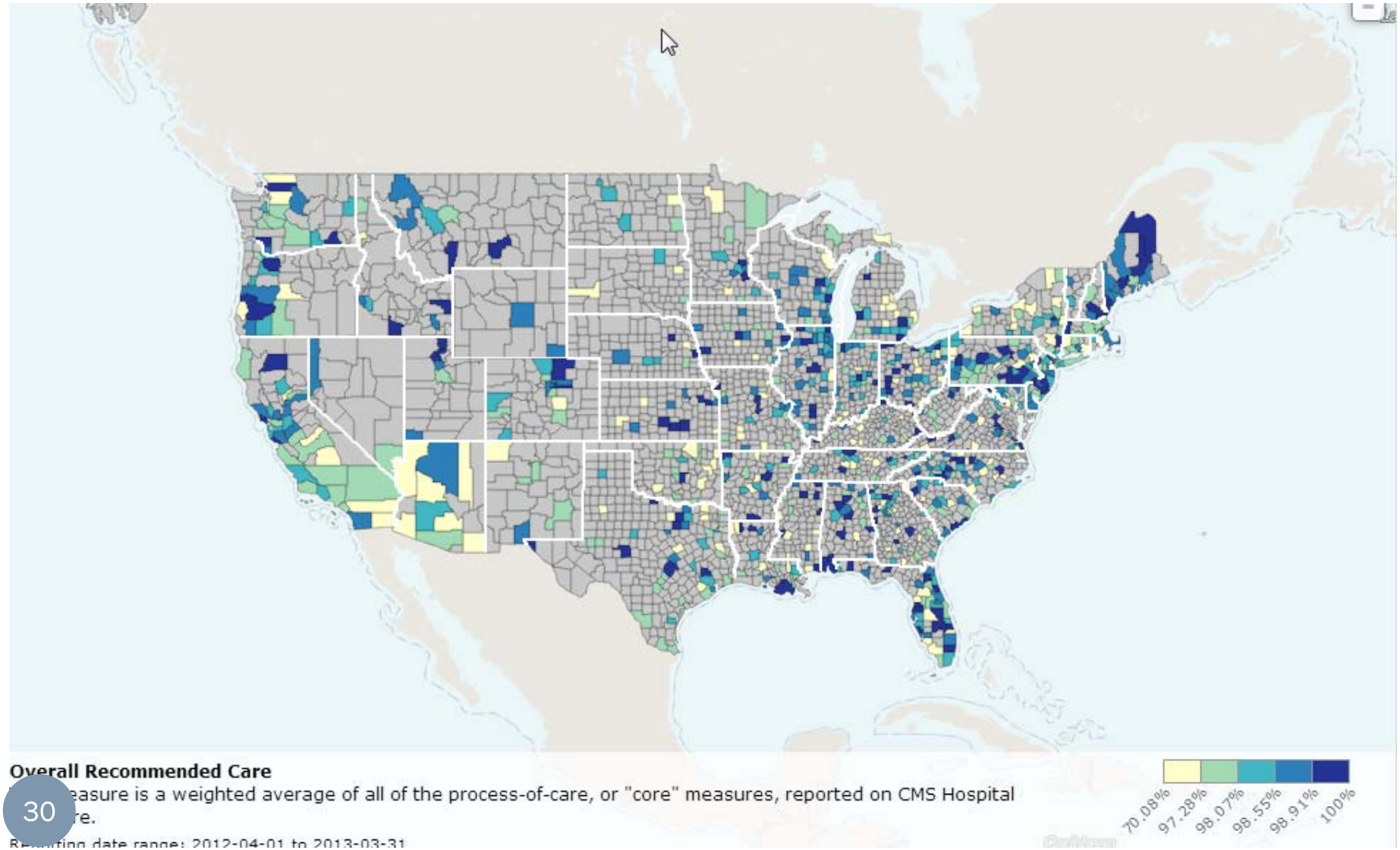
Review HospitalCompare Reports including federal measures of outcomes, patient satisfaction, efficiency, and safety, and benchmark using the Commonwealth Fund's benchmarking information, Why Not the Best®?

Data and Benchmarks
Overall Quality

WhyNotTheBest.org, accessed March 17, 2014, and April 2, 2014 based on data from hospitalcompare.medicare.gov through March 2013

THE COMMONWEALTH FUND
A Private Foundation Working Toward a High Performance Health System

Overall quality: national

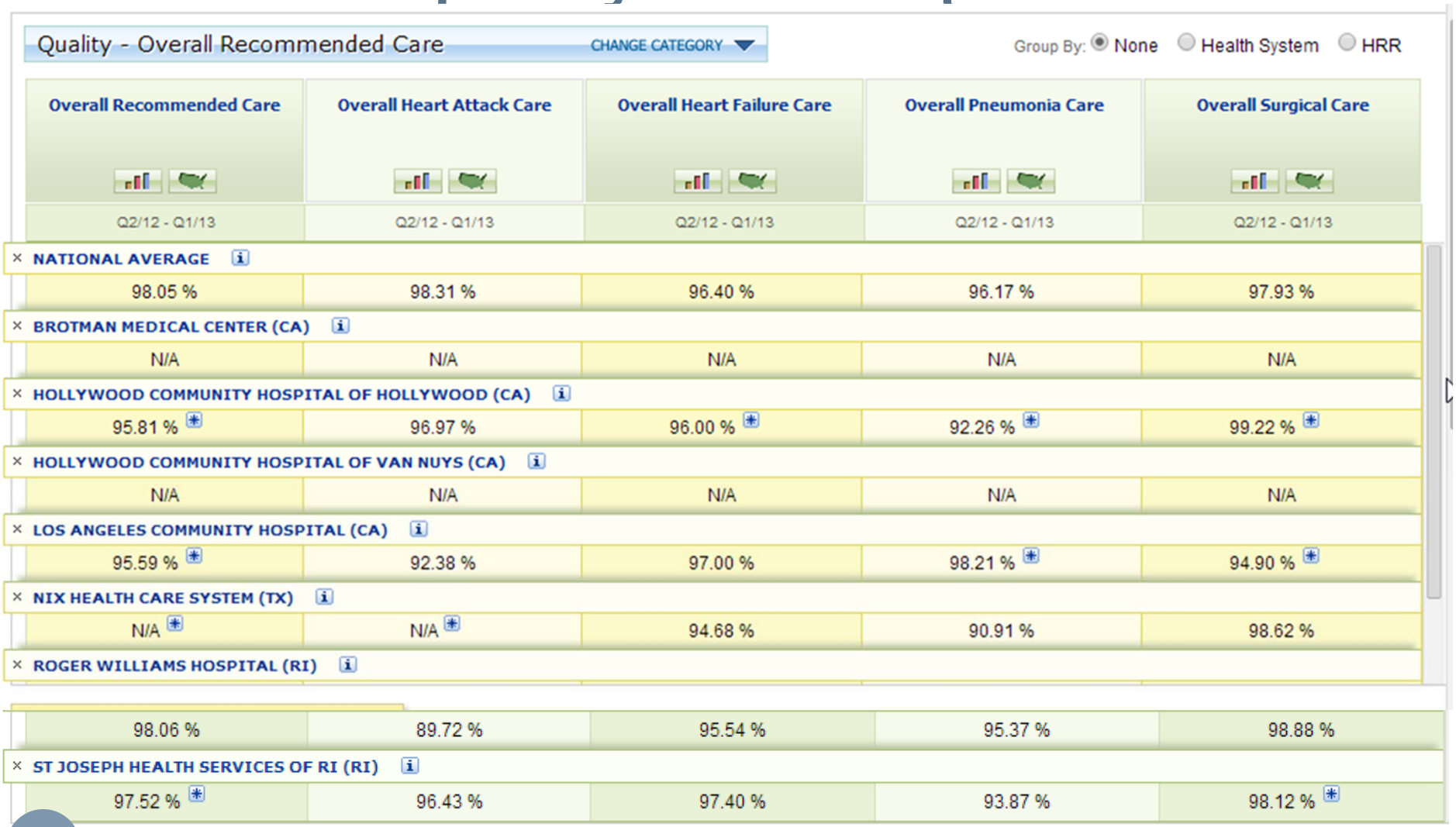


Overall quality: RI, CA, TX

Quality - Overall Recommended Care CHANGE CATEGORY

Overall Recommended Care	Overall Heart Attack Care	Overall Heart Failure Care	Overall Pneumonia Care	Overall Surgical Care
Q2/12 - Q1/13	Q2/12 - Q1/13	Q2/12 - Q1/13	Q2/12 - Q1/13	Q2/12 - Q1/13
NATIONAL AVERAGE				
98.05 %	98.31 %	96.40 %	96.17 %	97.93 %
NATIONAL TOP 10%				
99.55 %	100.00 %	100.00 %	99.58 %	99.63 %
CALIFORNIA (CA)				
97.91 %	98.29 %	96.80 %	96.58 %	97.74 %
RHODE ISLAND (RI)				
97.62 %	96.24 %	96.32 %	96.02 %	98.28 %
TEXAS (TX)				
98.21 %	97.99 %	96.39 %	96.24 %	98.01 %

Overall quality: All Hospitals



Quality - Overall Recommended Care CHANGE CATEGORY

Group By: None Health System HRR

	Overall Recommended Care	Overall Heart Attack Care	Overall Heart Failure Care	Overall Pneumonia Care	Overall Surgical Care
	Q2/12 - Q1/13	Q2/12 - Q1/13	Q2/12 - Q1/13	Q2/12 - Q1/13	Q2/12 - Q1/13
NATIONAL AVERAGE	98.05 %	98.31 %	96.40 %	96.17 %	97.93 %
BROTMAN MEDICAL CENTER (CA)	N/A	N/A	N/A	N/A	N/A
HOLLYWOOD COMMUNITY HOSPITAL OF HOLLYWOOD (CA)	95.81 %	96.97 %	96.00 %	92.26 %	99.22 %
HOLLYWOOD COMMUNITY HOSPITAL OF VAN NUYS (CA)	N/A	N/A	N/A	N/A	N/A
LOS ANGELES COMMUNITY HOSPITAL (CA)	95.59 %	92.38 %	97.00 %	98.21 %	94.90 %
NIX HEALTH CARE SYSTEM (TX)	N/A	N/A	94.68 %	90.91 %	98.62 %
ROGER WILLIAMS HOSPITAL (RI)					
	98.06 %	89.72 %	95.54 %	95.37 %	98.88 %
ST JOSEPH HEALTH SERVICES OF RI (RI)	97.52 %	96.43 %	97.40 %	93.87 %	98.12 %

Overall quality: Roger Williams

Roger Williams Hospital
825 CHALKSTONE AVENUE
Providence, RI 02908

Quality - Overall Recommended Care CHANGE CATEGORY

	Q2/12-Q1/13	Q4/11-Q3/12	Q3/11-Q2/12	Q2/11-Q1/12	Q1/11-Q4/11	Q4/10-Q3/11	Q3/10-Q2/11	Q2/10-Q1/11
OVERALL RECOMMENDED CARE	98.06 %	97.39 %	96.34 % *	96.01 % *	95.19 % *	94.55 % *	94.59 % *	94.67 % *
OVERALL HEART ATTACK CARE	89.72 %	89.22 %	89.42 %	87.37 %	91.07 %	93.29 %	93.11 %	94.94 %
OVERALL HEART FAILURE CAR...	95.54 %	90.55 %	88.80 %	88.52 %	89.42 %	88.89 %	89.90 %	92.07 %
OVERALL PNEUMONIA CARE	95.37 %	95.38 %	96.15 %	97.35 %	90.74 % *	90.05 % *	90.40 % *	88.34 % *
OVERALL SURGICAL CARE	98.88 %	98.30 %	97.25 % *	97.02 % *	97.15 % *	96.54 % *	96.39 % *	96.42 % *

Overall quality: St. Joseph

St Joseph Health Services Of Ri
200 HIGH SERVICE AVENUE
North Providence, RI 02904

Quality - Overall Recommended Care CHANGE CATEGORY

	Q2/12-Q1/13	Q4/11-Q3/12	Q3/11-Q2/12	Q2/11-Q1/12	Q1/11-Q4/11	Q4/10-Q3/11	Q3/10-Q2/11	Q2/10-Q1/11
OVERALL RECOMMENDED CARE	97.52 %	N/A	N/A	95.44 %	95.01 %	93.48 %	93.27 %	93.09 %
OVERALL HEART ATTACK CARE	96.43 %	N/A	N/A	93.44 %	97.31 %	97.80 %	98.52 %	99.42 %
OVERALL HEART FAILURE CAR...	97.40 %	94.42 %	91.27 %	89.09 %	89.02 %	89.62 %	89.88 %	90.64 %
OVERALL PNEUMONIA CARE	93.87 %	94.86 %	95.54 %	93.46 %	91.32 %	87.54 %	88.08 %	88.93 %
OVERALL SURGICAL CARE	98.12 %	97.79 %	97.96 %	96.97 %	97.15 %	96.22 %	95.50 %	94.75 %

Overall quality: Nix

Nix Health Care System
414 NAVARRO
San Antonio, TX 78205

Quality - Overall Recommended Care CHANGE CATEGORY

	Q2/12-Q1/13	Q4/11-Q3/12	Q3/11-Q2/12	Q2/11-Q1/12	Q1/11-Q4/11	Q4/10-Q3/11	Q3/10-Q2/11	Q2/10-Q1/11
OVERALL RECOMMENDED CARE	N/A*	N/A*	N/A*	N/A*	98.10 %*	97.66 %*	96.74 %*	N/A*
OVERALL HEART ATTACK CARE	N/A*	N/A*	N/A*	N/A*	96.75 %	97.41 %*	97.37 %*	N/A*
OVERALL HEART FAILURE CAR...	94.68 %	95.43 %	96.47 %	95.98 %	96.25 %	96.75 %*	96.50 %*	92.90 %*
OVERALL PNEUMONIA CARE	90.91 %	93.33 %	N/A*	93.75 %	96.30 %	94.77 %*	94.08 %*	93.83 %*
OVERALL SURGICAL CARE	98.62 %	98.72 %	99.03 %	98.40 %	98.35 %*	97.96 %*	96.97 %*	96.36 %*

Overall quality: SoCal Hollywood

Hollywood Community Hospital Of Hollywood
6245 DE LONGPRE AVE
Hollywood, CA 90028

Quality - Overall Recommended Care CHANGE CATEGORY

	Q2/12-Q1/13	Q4/11-Q3/12	Q3/11-Q2/12	Q2/11-Q1/12	Q1/11-Q4/11	Q4/10-Q3/11	Q3/10-Q2/11	Q2/10-Q1/11
OVERALL RECOMMENDED CARE	95.81 %	N/A	N/A	N/A	N/A	N/A	N/A	N/A
OVERALL HEART ATTACK CARE	96.97 %	N/A	N/A	N/A	N/A	N/A	N/A	N/A
OVERALL HEART FAILURE CAR...	96.00 %	87.65 %	80.95 %	77.66 %	81.75 %	86.51 %	87.07 %	87.07 %
OVERALL PNEUMONIA CARE	92.26 %	85.42 %	87.88 %	N/A	67.28 %	62.23 %	59.53 %	60.00 %
OVERALL SURGICAL CARE	99.22 %	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Overall quality: LA Community

Los Angeles Community Hospital
4081 E OLYMPIC BLVD
Los Angeles, CA 90023

Quality - Overall Recommended Care CHANGE CATEGORY

	Q2/12-Q1/13	Q4/11-Q3/12	Q3/11-Q2/12	Q2/11-Q1/12	Q1/11-Q4/11	Q4/10-Q3/11	Q3/10-Q2/11	Q2/10-Q1/11
OVERALL RECOMMENDED CARE	95.59 %	94.68 %	85.62 %	75.97 %	71.44 %	65.69 %	65.32 %	66.28 %
OVERALL HEART ATTACK CARE	92.38 %	94.49 %	80.95 %	67.19 %	53.28 %	52.47 %	52.60 %	51.66 %
OVERALL HEART FAILURE CAR...	97.00 %	96.32 %	86.63 %	76.31 %	73.47 %	70.15 %	71.78 %	74.62 %
OVERALL PNEUMONIA CARE	98.21 %	94.12 %	91.00 %	90.32 %	76.70 %	63.08 %	60.00 %	56.25 %
OVERALL SURGICAL CARE	94.90 %	92.63 %	83.26 %	71.12 %	71.53 %	67.83 %	65.42 %	69.35 %

Overall quality: SoCal Culver City

Brotman Medical Center
3828 DELMAS TERRACE
Culver City, CA 90232

Quality - Overall Recommended Care — CHANGE CATEGORY

	Q4/11-Q3/12	Q3/11-Q2/12	Q2/11-Q1/12	Q1/11-Q4/11	Q4/10-Q3/11	Q3/10-Q2/11	Q2/10-Q1/11	Q1/10-Q4/10
OVERALL RECOMMENDED CARE	98.29 %	96.24 %	92.35 %	89.36 %	82.05 %	80.25 %	79.36 %	78.98 %
OVERALL HEART ATTACK CARE	100.00 %	98.94 %	96.15 %	95.67 %	91.35 %	90.23 %	91.82 %	92.55 %
OVERALL HEART FAILURE CAR...	100.00 %	97.89 %	95.41 %	87.44 %	81.02 %	80.33 %	81.04 %	82.08 %
OVERALL PNEUMONIA CARE	100.00 %	98.88 %	94.27 %	89.59 %	77.22 %	76.69 %	77.35 %	78.14 %
OVERALL SURGICAL CARE	96.55 %	94.33 %	89.81 %	88.48 %	84.73 %	81.72 %	78.29 %	74.61 %

Overall quality: SoCal Van Nuys

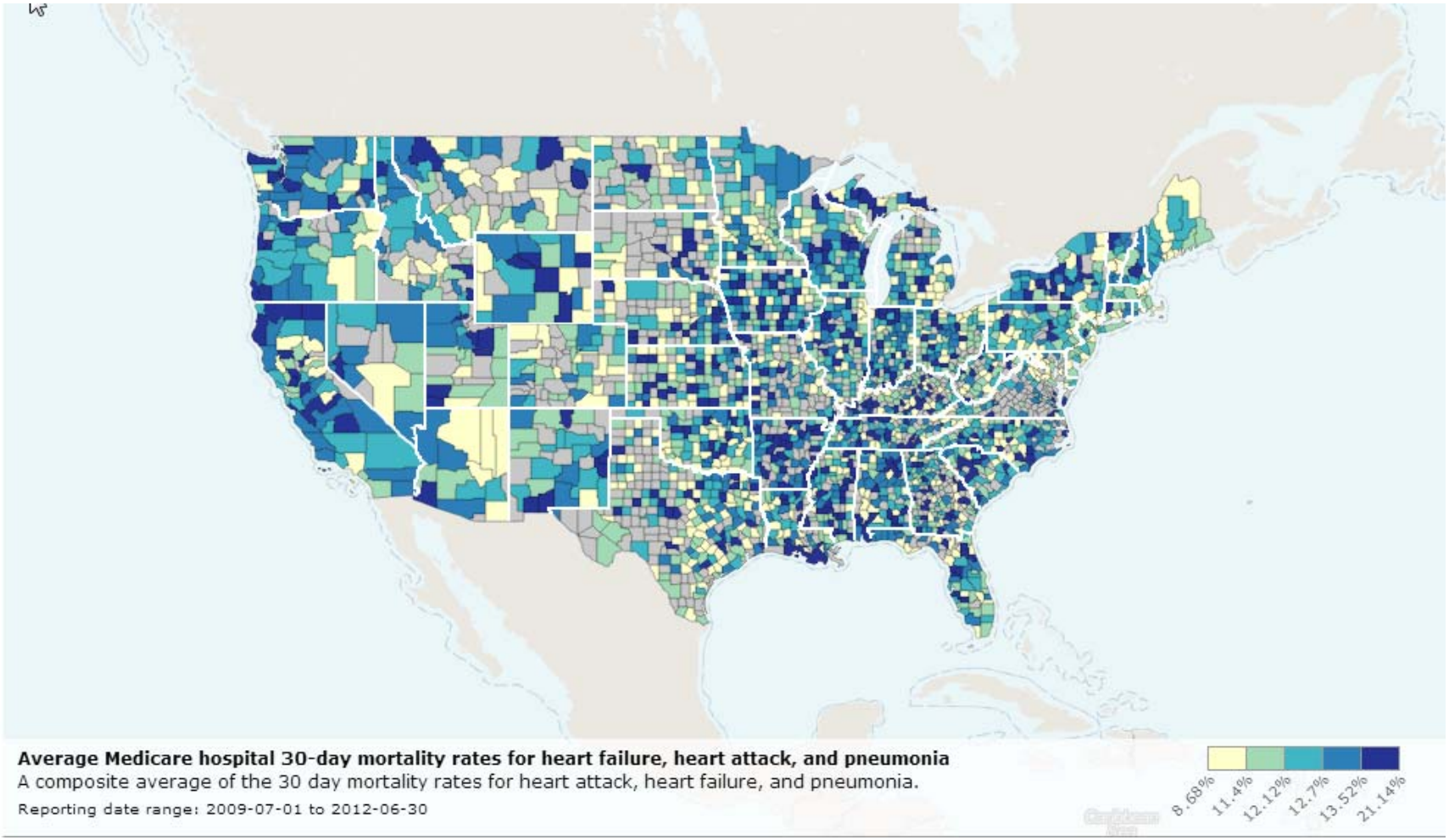
No Data Available: Psychiatric Hospital Does Not Require Reporting

Data and Benchmarks
Mortality

WhyNotTheBest.org, accessed March 17, 2014 and April 2, 2014 based on data from hospitalcompare.medicare.gov through June 2012

THE COMMONWEALTH FUND
A Private Foundation Working Toward a High Performance Health System

Mortality: national



Average Medicare hospital 30-day mortality rates for heart failure, heart attack, and pneumonia
A composite average of the 30 day mortality rates for heart attack, heart failure, and pneumonia.
Reporting date range: 2009-07-01 to 2012-06-30

Mortality: RI, CA, TX

Mortality Rates — CHANGE CATEGORY

	Average Medicare hospital 30-day mortality rates for heart fail...	Heart Attack 30-Day Mortality Rate	Heart Failure 30-Day Mortality Rate	Pneumonia 30-Day Mortality Rate
	Q3/09 - Q2/12	Q3/09 - Q2/12	Q3/09 - Q2/12	Q3/09 - Q2/12
NATIONAL AVERAGE	12.31 %	15.20 %	11.70 %	11.90 %
NATIONAL TOP 10%	10.61 %	13.30 %	9.90 %	9.90 %
CALIFORNIA (CA)	12.01 %	14.89 %	11.23 %	11.68 %
RHODE ISLAND (RI)	12.38 %	14.48 %	12.12 %	11.85 %
TEXAS (TX)	12.09 %	15.39 %	11.61 %	11.69 %

*Value is a simple average of all the risk-adjusted rates for entities reporting within this region

Mortality: All Hospitals

Mortality Rates — CHANGE CATEGORY

Group By: None | Health System | HRR

Average Medicare hospital 30-day mortality rates for heart fail...	Heart Attack 30-Day Mortality Rate	Heart Failure 30-Day Mortality Rate	Pneumonia 30-Day Mortality Rate
Q3/09 - Q2/12	Q3/09 - Q2/12	Q3/09 - Q2/12	Q3/09 - Q2/12
NATIONAL AVERAGE			
12.31 % *	15.20 %	11.70 %	11.90 %
BROTMAN MEDICAL CENTER (CA)			
10.63 %	15.00 %	10.30 %	9.60 %
HOLLYWOOD COMMUNITY HOSPITAL OF HOLLYWOOD (CA)			
9.47 %	N/A *	10.10 %	9.20 %
HOLLYWOOD COMMUNITY HOSPITAL OF VAN NUYS (CA)			
N/A	N/A	N/A	N/A
LOS ANGELES COMMUNITY HOSPITAL (CA)			
9.30 %	14.40 %	9.50 %	7.40 % *
NIX HEALTH CARE SYSTEM (TX)			
10.54 %	13.90 %	10.00 %	9.70 %
ROGER WILLIAMS HOSPITAL (RI)			
12.06 %	16.10 %	10.90 %	10.90 %
ST JOSEPH HEALTH SERVICES OF RI (RI)			
12.88 %	15.50 %	11.90 %	13.00 %

Mortality: Roger Williams

Roger Williams Hospital
825 CHALKSTONE AVENUE
Providence, RI 02908

Mortality Rates CHANGE CATEGORY

	Q3/09-Q2/12	Q3/08-Q2/11	Q3/07-Q2/10	Q3/06-Q2/09
AVERAGE MEDICARE HOSPITAL...	12.06 %	12.21 %	12.37 %	N/A
HEART ATTACK 30-DAY MORTA...	16.10 %	16.30 %	17.50 %	16.00 %
HEART FAILURE 30-DAY MORT...	10.90 %	10.80 %	10.50 %	10.10 %
PNEUMONIA 30-DAY MORTALIT...	10.90 %	11.60 %	11.80 %	13.60 %

Mortality: St Joseph

St Joseph Health Services Of Ri
200 HIGH SERVICE AVENUE
North Providence, RI 02904

Mortality Rates — CHANGE CATEGORY

	Q3/09-Q2/12	Q3/08-Q2/11	Q3/07-Q2/10	Q3/06-Q2/09
AVERAGE MEDICARE HOSPITAL...	12.88 %	13.49 %	12.65 %	N/A
HEART ATTACK 30-DAY MORTA...	15.50 %	15.50 %	14.70 %	17.20 %
HEART FAILURE 30-DAY MORT...	11.90 %	11.90 %	12.10 %	12.30 %
PNEUMONIA 30-DAY MORTALIT...	13.00 %	14.60 %	12.50 %	11.90 %

Mortality: Nix

Nix Health Care System
414 NAVARRO
San Antonio, TX 78205

Mortality Rates CHANGE CATEGORY

	Q3/09-Q2/12	Q3/08-Q2/11	Q3/07-Q2/10	Q3/06-Q2/09
AVERAGE MEDICARE HOSPITAL...	10.54 %	10.65 %	11.08 %	N/A
HEART ATTACK 30-DAY MORTA...	13.90 %	14.00 %	14.30 %	13.90 %
HEART FAILURE 30-DAY MORT...	10.00 %	9.90 %	9.70 %	9.80 %
PNEUMONIA 30-DAY MORTALIT...	9.70 %	9.90 %	11.10 %	9.90 %

Mortality: SoCal Hollywood

Hollywood Community Hospital Of Hollywood

6245 DE LONGPRE AVE
Hollywood, CA 90028

Mortality Rates — CHANGE CATEGORY

	Q3/09-Q2/12	Q3/08-Q2/11	Q3/07-Q2/10	Q3/06-Q2/09
AVERAGE MEDICARE HOSPITAL...	9.47 %	10.50 %	10.41 %	N/A
HEART ATTACK 30-DAY MORTA...	N/A *	N/A *	N/A *	N/A
HEART FAILURE 30-DAY MORT...	10.10 %	N/A *	10.20 %	10.20 %
PNEUMONIA 30-DAY MORTALIT...	9.20 %	10.50 %	10.50 %	11.00 %

Mortality: LA Community

Los Angeles Community Hospital
4081 E OLYMPIC BLVD
Los Angeles, CA 90023

Mortality Rates — CHANGE CATEGORY

	Q3/09-Q2/12	Q3/08-Q2/11	Q3/07-Q2/10	Q3/06-Q2/09
AVERAGE MEDICARE HOSPITAL...	9.30 %	9.77 %	9.56 %	N/A
HEART ATTACK 30-DAY MORTA...	14.40 %	N/A *	N/A *	N/A
HEART FAILURE 30-DAY MORT...	9.50 %	8.90 %	9.00 %	10.00 %
PNEUMONIA 30-DAY MORTALIT...	7.40 % *	9.10 %	10.10 %	10.30 %

Mortality: SoCal Culver City

Brotman Medical Center
3828 DELMAS TERRACE
Culver City, CA 90232

Mortality Rates — CHANGE CATEGORY

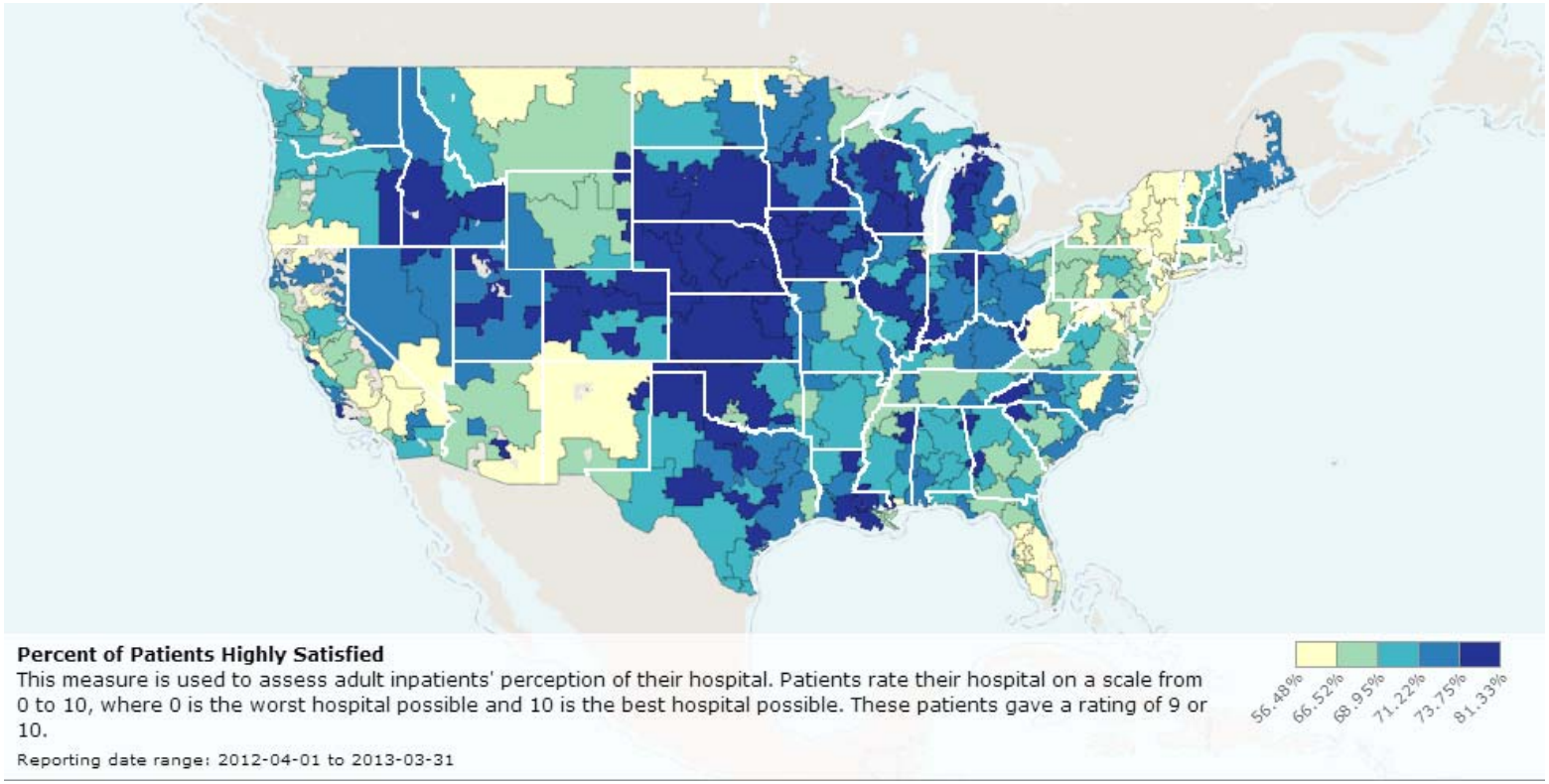
	Q3/09-Q2/12	Q3/08-Q2/11	Q3/07-Q2/10	Q3/06-Q2/09
AVERAGE MEDICARE HOSPITAL...	10.63 %	10.40 %	11.47 %	N/A
HEART ATTACK 30-DAY MORTA...	15.00 %	14.80 %	16.20 %	16.30 %
HEART FAILURE 30-DAY MORT...	10.30 %	9.50 %	11.00 %	10.30 %
PNEUMONIA 30-DAY MORTALIT...	9.60 %	9.70 %	10.00 %	9.90 %

Data and Benchmarks
Patient Experience

WhyNotTheBest.org, accessed March 17, 2014 and April 2, 2014 based on data from hospitalcompare.medicare.gov through March 2013

THE COMMONWEALTH FUND
A Private Foundation Working Toward a High Performance Health System

Patient Experience: national



Patient Experience: RI, CA, TX

Patient Experience (HCAHPS) CHANGE CATEGORY

	Percent of Patients Highl...	Doctors Always Communicat...	Nurses Always Communicate...	Patients Always Received ...	Staff Always Explained Ab...	Pain Was Always Well Cont...	Patient's Room Always Kep...	Patient's Room and Bathro...	Patients Given Informatio...	Patients Would Definitely...
	Q2/12 - Q1/13	Q2/12 - Q1/13	Q2/12 - Q1/13	Q2/12 - Q1/13	Q2/12 - Q1/13	Q2/12 - Q1/13	Q2/12 - Q1/13	Q2/12 - Q1/13	Q2/12 - Q1/13	Q2/12 - Q1/13
× NATIONAL AVERAGE	70.06 %	81.37 %	78.42 %	67.03 %	63.80 %	70.56 %	60.59 %	72.87 %	84.82 %	70.78 %
× NATIONAL TOP 10%	81.00 %	88.00 %	85.00 %	79.00 %	72.00 %	77.00 %	73.00 %	83.00 %	90.00 %	82.00 %
× CALIFORNIA (CA)	67.31 %	77.65 %	73.95 %	61.21 %	60.85 %	68.41 %	50.87 %	70.33 %	82.89 %	69.53 %
× RHODE ISLAND (RI)	68.64 %	80.09 %	79.09 %	65.91 %	60.82 %	71.18 %	54.00 %	73.45 %	85.18 %	71.64 %
× TEXAS (TX)	72.60 %	83.28 %	79.23 %	68.93 %	65.67 %	72.54 %	67.98 %	74.25 %	84.58 %	72.93 %

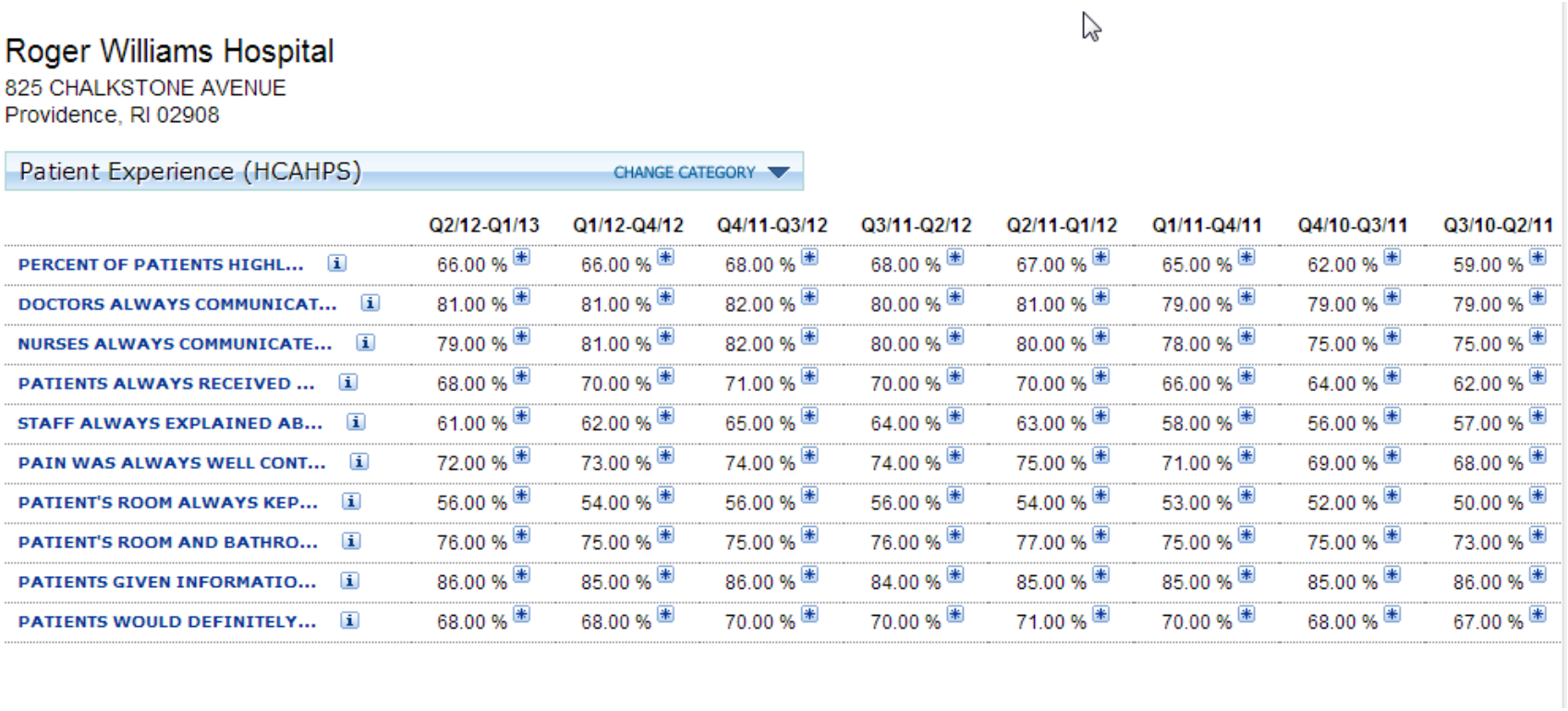
Patient Experience: All Hospitals

Patient Experience (HCAHPS) CHANGE CATEGORY

Group By: None Health System HRR

	Percent of Patients Highl...	Doctors Always Communicat...	Nurses Always Communicate...	Patients Always Received ...	Staff Always Explained Ab...	Pain Was Always Well Cont...	Patient's Room Always Kep...	Patient's Room and Bathro...	Patients Given Informatio...	Patients Would Definitely...
	Q2/12 - Q1/13	Q2/12 - Q1/13	Q2/12 - Q1/13	Q2/12 - Q1/13	Q2/12 - Q1/13	Q2/12 - Q1/13	Q2/12 - Q1/13	Q2/12 - Q1/13	Q2/12 - Q1/13	Q2/12 - Q1/13
NATIONAL AVERAGE	70.06 %	81.37 %	78.42 %	67.03 %	63.80 %	70.56 %	60.59 %	72.87 %	84.82 %	70.78 %
BROTMAN MEDICAL CENTER (CA)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
HOLLYWOOD COMMUNITY HOSPITAL OF HOLLYWOOD (CA)	44.00 %	55.00 %	54.00 %	42.00 %	35.00 %	50.00 %	44.00 %	59.00 %	72.00 %	48.00 %
HOLLYWOOD COMMUNITY HOSPITAL OF VAN NUYS (CA)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
LOS ANGELES COMMUNITY HOSPITAL (CA)	47.00 %	64.00 %	61.00 %	45.00 %	47.00 %	58.00 %	40.00 %	56.00 %	70.00 %	43.00 %
NIX HEALTH CARE SYSTEM (TX)	75.00 %	84.00 %	79.00 %	58.00 %	67.00 %	72.00 %	65.00 %	78.00 %	82.00 %	75.00 %
ROGER WILLIAMS HOSPITAL (RI)	66.00 %	81.00 %	79.00 %	68.00 %	61.00 %	72.00 %	56.00 %	76.00 %	86.00 %	68.00 %
ST JOSEPH HEALTH SERVICES OF RI (RI)	66.00 %	80.00 %	82.00 %	68.00 %	63.00 %	73.00 %	60.00 %	68.00 %	89.00 %	65.00 %

Patient Experience: Roger Williams



Roger Williams Hospital
825 CHALKSTONE AVENUE
Providence, RI 02908

Patient Experience (HCAHPS) CHANGE CATEGORY

	Q2/12-Q1/13	Q1/12-Q4/12	Q4/11-Q3/12	Q3/11-Q2/12	Q2/11-Q1/12	Q1/11-Q4/11	Q4/10-Q3/11	Q3/10-Q2/11
PERCENT OF PATIENTS HIGHL...	66.00 %	66.00 %	68.00 %	68.00 %	67.00 %	65.00 %	62.00 %	59.00 %
DOCTORS ALWAYS COMMUNICAT...	81.00 %	81.00 %	82.00 %	80.00 %	81.00 %	79.00 %	79.00 %	79.00 %
NURSES ALWAYS COMMUNICATE...	79.00 %	81.00 %	82.00 %	80.00 %	80.00 %	78.00 %	75.00 %	75.00 %
PATIENTS ALWAYS RECEIVED ...	68.00 %	70.00 %	71.00 %	70.00 %	70.00 %	66.00 %	64.00 %	62.00 %
STAFF ALWAYS EXPLAINED AB...	61.00 %	62.00 %	65.00 %	64.00 %	63.00 %	58.00 %	56.00 %	57.00 %
PAIN WAS ALWAYS WELL CONT...	72.00 %	73.00 %	74.00 %	74.00 %	75.00 %	71.00 %	69.00 %	68.00 %
PATIENT'S ROOM ALWAYS KEP...	56.00 %	54.00 %	56.00 %	56.00 %	54.00 %	53.00 %	52.00 %	50.00 %
PATIENT'S ROOM AND BATHRO...	76.00 %	75.00 %	75.00 %	76.00 %	77.00 %	75.00 %	75.00 %	73.00 %
PATIENTS GIVEN INFORMATIO...	86.00 %	85.00 %	86.00 %	84.00 %	85.00 %	85.00 %	85.00 %	86.00 %
PATIENTS WOULD DEFINITELY...	68.00 %	68.00 %	70.00 %	70.00 %	71.00 %	70.00 %	68.00 %	67.00 %

Patient Experience: St Joseph

St Joseph Health Services Of Ri
200 HIGH SERVICE AVENUE
North Providence, RI 02904

Patient Experience (HCAHPS) CHANGE CATEGORY

	Q2/12-Q1/13	Q1/12-Q4/12	Q4/11-Q3/12	Q3/11-Q2/12	Q2/11-Q1/12	Q1/11-Q4/11	Q4/10-Q3/11
PERCENT OF PATIENTS HIGHL...	66.00 %	64.00 %	61.00 %	60.00 %	56.00 %	57.00 %	58.00 %
DOCTORS ALWAYS COMMUNICAT...	80.00 %	81.00 %	81.00 %	81.00 %	81.00 %	78.00 %	78.00 %
NURSES ALWAYS COMMUNICATE...	82.00 %	81.00 %	79.00 %	78.00 %	78.00 %	76.00 %	74.00 %
PATIENTS ALWAYS RECEIVED ...	68.00 %	68.00 %	64.00 %	63.00 %	63.00 %	61.00 %	59.00 %
STAFF ALWAYS EXPLAINED AB...	63.00 %	64.00 %	65.00 %	62.00 %	62.00 %	57.00 %	56.00 %
PAIN WAS ALWAYS WELL CONT...	73.00 %	72.00 %	72.00 %	71.00 %	72.00 %	71.00 %	68.00 %
PATIENT'S ROOM ALWAYS KEP...	60.00 %	61.00 %	58.00 %	56.00 %	55.00 %	52.00 %	51.00 %
PATIENT'S ROOM AND BATHRO...	68.00 %	70.00 %	71.00 %	71.00 %	75.00 %	70.00 %	67.00 %

Patient Experience: Nix

Nix Health Care System
414 NAVARRO
San Antonio, TX 78205

Patient Experience (HCAHPS) CHANGE CATEGORY

	Q2/12-Q1/13	Q1/12-Q4/12	Q4/11-Q3/12	Q3/11-Q2/12	Q2/11-Q1/12	Q1/11-Q4/11	Q4/10-Q3/11	Q3/10-Q2/11
PERCENT OF PATIENTS HIGHL...	75.00 %	75.00 %	74.00 %	75.00 %	74.00 %	72.00 %	72.00 %	72.00 %
DOCTORS ALWAYS COMMUNICAT...	84.00 %	84.00 %	82.00 %	82.00 %	81.00 %	81.00 %	83.00 %	84.00 %
NURSES ALWAYS COMMUNICATE...	79.00 %	80.00 %	78.00 %	78.00 %	76.00 %	77.00 %	78.00 %	80.00 %
PATIENTS ALWAYS RECEIVED ...	58.00 %	59.00 %	60.00 %	63.00 %	62.00 %	64.00 %	66.00 %	66.00 %
STAFF ALWAYS EXPLAINED AB...	67.00 %	67.00 %	66.00 %	66.00 %	64.00 %	64.00 %	62.00 %	64.00 %
PAIN WAS ALWAYS WELL CONT...	72.00 %	72.00 %	70.00 %	71.00 %	70.00 %	72.00 %	73.00 %	74.00 %
PATIENT'S ROOM ALWAYS KEP...	65.00 %	65.00 %	65.00 %	66.00 %	67.00 %	68.00 %	68.00 %	69.00 %
PATIENT'S ROOM AND BATHRO...	78.00 %	79.00 %	78.00 %	82.00 %	81.00 %	81.00 %	80.00 %	79.00 %
PATIENTS GIVEN INFORMATIO...	82.00 %	83.00 %	85.00 %	85.00 %	85.00 %	85.00 %	84.00 %	83.00 %
PATIENTS WOULD DEFINITELY...	75.00 %	74.00 %	73.00 %	74.00 %	73.00 %	73.00 %	74.00 %	74.00 %

Patient Experience: SoCal Hollywood

Hollywood Community Hospital Of Hollywood

6245 DE LONGPRE AVE
Hollywood, CA 90028

Patient Experience (HCAHPS) CHANGE CATEGORY

	Q2/12-Q1/13	Q1/12-Q4/12	Q4/11-Q3/12	Q3/11-Q2/12	Q2/11-Q1/12	Q1/11-Q4/11	Q4/10-Q3/11	Q3/10-Q2/11
PERCENT OF PATIENTS HIGHL...	44.00 %	42.00 %	39.00 %	42.00 %	36.00 %	38.00 %	42.00 %	40.00 %
DOCTORS ALWAYS COMMUNICAT...	55.00 %	57.00 %	56.00 %	60.00 %	64.00 %	57.00 %	61.00 %	60.00 %
NURSES ALWAYS COMMUNICATE...	54.00 %	54.00 %	53.00 %	59.00 %	55.00 %	50.00 %	54.00 %	53.00 %
PATIENTS ALWAYS RECEIVED ...	42.00 %	42.00 %	42.00 %	35.00 %	28.00 %	30.00 %	31.00 %	31.00 %
STAFF ALWAYS EXPLAINED AB...	35.00 %	35.00 %	30.00 %	41.00 %	45.00 %	29.00 %	33.00 %	34.00 %
PAIN WAS ALWAYS WELL CONT...	50.00 %	52.00 %	49.00 %	45.00 %	44.00 %	42.00 %	45.00 %	46.00 %
PATIENT'S ROOM ALWAYS KEP...	44.00 %	44.00 %	51.00 %	53.00 %	51.00 %	50.00 %	48.00 %	44.00 %
PATIENT'S ROOM AND BATHRO...	59.00 %	59.00 %	61.00 %	60.00 %	58.00 %	57.00 %	59.00 %	59.00 %
PATIENTS GIVEN INFORMATIO...	72.00 %	71.00 %	66.00 %	69.00 %	65.00 %	62.00 %	65.00 %	67.00 %
PATIENTS WOULD DEFINITELY...	48.00 %	48.00 %	47.00 %	47.00 %	45.00 %	43.00 %	49.00 %	49.00 %

Patient Experience: LA Community

Los Angeles Community Hospital
4081 E OLYMPIC BLVD
Los Angeles, CA 90023

Patient Experience (HCAHPS) CHANGE CATEGORY

	Q2/12-Q1/13	Q1/12-Q4/12	Q4/11-Q3/12	Q3/11-Q2/12	Q2/11-Q1/12	Q1/11-Q4/11	Q4/10-Q3/11	Q3/10-Q2/11
PERCENT OF PATIENTS HIGHL...	47.00 %	44.00 %	43.00 %	42.00 %	43.00 %	41.00 %	43.00 %	42.00 %
DOCTORS ALWAYS COMMUNICAT...	64.00 %	65.00 %	61.00 %	60.00 %	58.00 %	56.00 %	58.00 %	56.00 %
NURSES ALWAYS COMMUNICATE...	61.00 %	57.00 %	53.00 %	52.00 %	53.00 %	48.00 %	48.00 %	46.00 %
PATIENTS ALWAYS RECEIVED ...	45.00 %	45.00 %	49.00 %	50.00 %	42.00 %	40.00 %	42.00 %	40.00 %
STAFF ALWAYS EXPLAINED AB...	47.00 %	47.00 %	44.00 %	44.00 %	37.00 %	37.00 %	43.00 %	39.00 %
PAIN WAS ALWAYS WELL CONT...	58.00 %	55.00 %	48.00 %	47.00 %	47.00 %	45.00 %	48.00 %	45.00 %
PATIENT'S ROOM ALWAYS KEP...	40.00 %	42.00 %	50.00 %	54.00 %	52.00 %	47.00 %	47.00 %	42.00 %
PATIENT'S ROOM AND BATHRO...	56.00 %	59.00 %	67.00 %	69.00 %	64.00 %	61.00 %	62.00 %	64.00 %
PATIENTS GIVEN INFORMATIO...	70.00 %	68.00 %	66.00 %	64.00 %	66.00 %	69.00 %	69.00 %	66.00 %
PATIENTS WOULD DEFINITELY...	43.00 %	41.00 %	44.00 %	46.00 %	46.00 %	43.00 %	43.00 %	44.00 %

Patient Experience: SoCal Culver City

Brotman Medical Center
3828 DELMAS TERRACE
Culver City, CA 90232

Patient Experience (HCAHPS) CHANGE CATEGORY

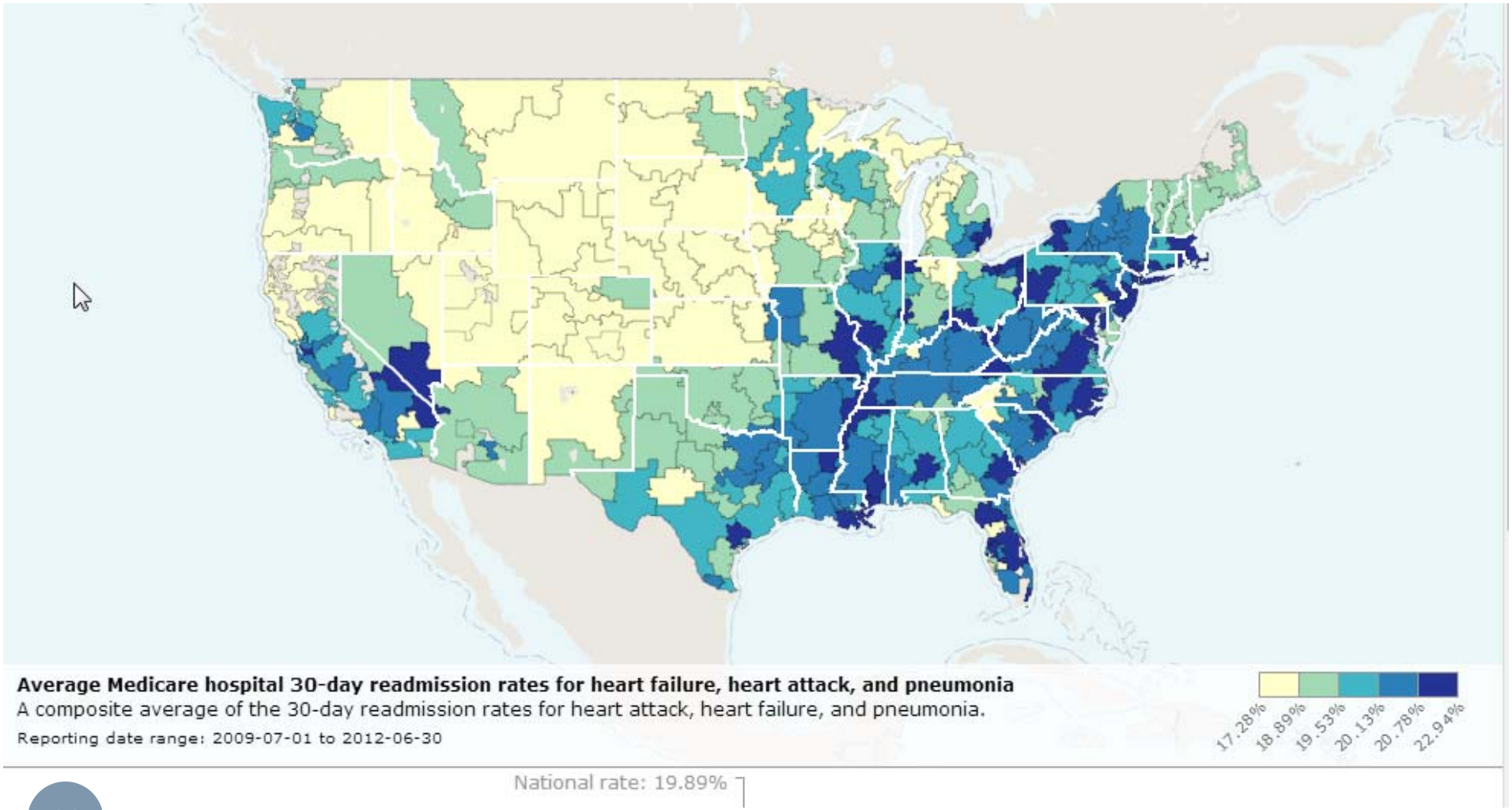
	Q4/11-Q3/12	Q3/11-Q2/12	Q2/11-Q1/12	Q1/11-Q4/11	Q4/10-Q3/11	Q3/10-Q2/11	Q2/10-Q1/11	Q1/10-Q4/10
PERCENT OF PATIENTS HIGHL...	48.00 %	46.00 %	44.00 %	43.00 %	42.00 %	44.00 %	45.00 %	48.00 %
DOCTORS ALWAYS COMMUNICAT...	68.00 %	67.00 %	67.00 %	69.00 %	67.00 %	68.00 %	69.00 %	67.00 %
NURSES ALWAYS COMMUNICATE...	62.00 %	59.00 %	58.00 %	59.00 %	57.00 %	56.00 %	57.00 %	55.00 %
PATIENTS ALWAYS RECEIVED ...	45.00 %	43.00 %	39.00 %	39.00 %	36.00 %	35.00 %	38.00 %	39.00 %
STAFF ALWAYS EXPLAINED AB...	47.00 %	44.00 %	42.00 %	41.00 %	38.00 %	39.00 %	40.00 %	42.00 %
PAIN WAS ALWAYS WELL CONT...	59.00 %	56.00 %	56.00 %	56.00 %	57.00 %	59.00 %	59.00 %	56.00 %
PATIENT'S ROOM ALWAYS KEP...	47.00 %	44.00 %	43.00 %	46.00 %	43.00 %	45.00 %	46.00 %	44.00 %
PATIENT'S ROOM AND BATHRO...	58.00 %	56.00 %	55.00 %	56.00 %	56.00 %	57.00 %	59.00 %	58.00 %
PATIENTS GIVEN INFORMATIO...	68.00 %	66.00 %	65.00 %	64.00 %	62.00 %	63.00 %	64.00 %	67.00 %
PATIENTS WOULD DEFINITELY...	48.00 %	45.00 %	45.00 %	44.00 %	42.00 %	43.00 %	45.00 %	48.00 %

Data and Benchmarks
Readmissions

WhyNotTheBest.org, accessed March 17, 2014 and April 2, 2014 based on data from hospitalcompare.medicare.gov through March 2013

THE COMMONWEALTH FUND
A Private Foundation Working Toward a High Performance Health System

Readmissions: national



Readmissions: RI, CA, TX

Readmission Rates — CHANGE CATEGORY

	Average Medicare hospital 30-day readmission rates for heart fa...	Heart Attack Patients Readmitted to Hospital Within 30 Days	Heart Failure Patients Readmitted to Hospital Within 30 Days	Pneumonia Patients Readmitted to Hospital Within 30 Days
	Q3/09 - Q2/12	Q3/09 - Q2/12	Q3/09 - Q2/12	Q3/09 - Q2/12
NATIONAL AVERAGE	19.89 %	18.30 %	23.00 %	17.60 %
NATIONAL TOP 10%	17.80 %	16.90 %	20.90 %	15.90 %
CALIFORNIA (CA)	19.94 %	18.25 %	22.85 %	17.47 %
RHODE ISLAND (RI)	21.11 %	18.46 %	24.30 %	18.17 %
TEXAS (TX)	19.73 %	18.17 %	22.83 %	17.32 %

Readmissions: All Hospitals

Readmission Rates — CHANGE CATEGORY

Group By: None | Health System | HRR

	Average Medicare hospital 30-day readmission rates for heart fa...	Heart Attack Patients Readmitted to Hospital Within 30 Days	Heart Failure Patients Readmitted to Hospital Within 30 Days	Pneumonia Patients Readmitted to Hospital Within 30 Days
	Q3/09 - Q2/12	Q3/09 - Q2/12	Q3/09 - Q2/12	Q3/09 - Q2/12
NATIONAL AVERAGE	19.89 % *	18.30 %	23.00 %	17.60 %
BROTMAN MEDICAL CENTER (CA)	N/A	N/A	N/A	N/A
HOLLYWOOD COMMUNITY HOSPITAL OF HOLLYWOOD (CA)	18.60 %	18.80 %	22.40 %	16.90 %
HOLLYWOOD COMMUNITY HOSPITAL OF VAN NUYS (CA)	N/A	N/A	N/A	N/A
LOS ANGELES COMMUNITY HOSPITAL (CA)	21.71 %	18.40 %	25.80 %	19.20 %
NIX HEALTH CARE SYSTEM (TX)	20.29 %	18.00 %	22.90 %	17.00 %
ROGER WILLIAMS HOSPITAL (RI)	19.66 %	18.00 %	23.50 %	16.90 %
ST JOSEPH HEALTH SERVICES OF RI (RI)	22.54 %	19.30 %	25.20 %	20.30 %

Readmissions: Roger Williams

Roger Williams Hospital
825 CHALKSTONE AVENUE
Providence, RI 02908

Readmission Rates CHANGE CATEGORY

	Q3/09-Q2/12	Q3/08-Q2/11	Q3/07-Q2/10	Q3/06-Q2/09
AVERAGE MEDICARE HOSPITAL...	19.66 %	20.80 %	21.30 %	N/A
HEART ATTACK PATIENTS REA...	18.00 %	19.00 %	19.60 %	18.80 %
HEART FAILURE PATIENTS RE...	23.50 %	26.10 %	25.10 %	27.60 %
PNEUMONIA PATIENTS READMI...	16.90 %	16.90 %	18.20 %	18.70 %

Readmissions: St Joseph

St Joseph Health Services Of Ri
200 HIGH SERVICE AVENUE
North Providence, RI 02904

Readmission Rates CHANGE CATEGORY

	Q3/09-Q2/12	Q3/08-Q2/11	Q3/07-Q2/10	Q3/06-Q2/09
AVERAGE MEDICARE HOSPITAL...	22.54 %	23.56 %	22.89 %	N/A
HEART ATTACK PATIENTS REA...	19.30 %	20.10 %	21.00 %	22.00 %
HEART FAILURE PATIENTS RE...	25.20 %	26.70 %	25.90 %	25.80 %
PNEUMONIA PATIENTS READMI...	20.30 %	20.30 %	19.30 %	19.40 %

Readmissions: Nix

Nix Health Care System
414 NAVARRO
San Antonio, TX 78205

Readmission Rates — CHANGE CATEGORY

	Q3/09-Q2/12	Q3/08-Q2/11	Q3/07-Q2/10	Q3/06-Q2/09
AVERAGE MEDICARE HOSPITAL...	20.29 %	21.13 %	19.66 %	N/A
HEART ATTACK PATIENTS REA...	18.00 %	19.70 %	18.50 %	19.60 %
HEART FAILURE PATIENTS RE...	22.90 %	24.00 %	21.70 %	23.80 %
PNEUMONIA PATIENTS READMI...	17.00 %	18.10 %	17.90 %	17.60 %

Readmissions: SoCal Hollywood

Hollywood Community Hospital Of Hollywood

6245 DE LONGPRE AVE
Hollywood, CA 90028

Readmission Rates — CHANGE CATEGORY

	Q3/09-Q2/12	Q3/08-Q2/11	Q3/07-Q2/10	Q3/06-Q2/09
AVERAGE MEDICARE HOSPITAL...	18.60 %	19.72 %	21.10 %	N/A
HEART ATTACK PATIENTS REA...	N/A	N/A *	N/A *	N/A
HEART FAILURE PATIENTS RE...	22.40 %	25.70 %	26.10 %	26.20 %
PNEUMONIA PATIENTS READMI...	16.90 %	17.50 %	18.90 %	18.70 %

Readmissions: LA Community

Los Angeles Community Hospital
4081 E OLYMPIC BLVD
Los Angeles, CA 90023

Readmission Rates CHANGE CATEGORY

	Q3/09-Q2/12	Q3/08-Q2/11	Q3/07-Q2/10	Q3/06-Q2/09
AVERAGE MEDICARE HOSPITAL...	21.71 %	24.63 %	25.20 %	N/A
HEART ATTACK PATIENTS REA...	18.40 %	N/A *	N/A *	N/A
HEART FAILURE PATIENTS RE...	25.80 %	28.10 %	28.30 %	25.60 %
PNEUMONIA PATIENTS READMI...	19.20 %	21.30 %	21.90 %	20.30 %

Readmissions: SoCal Culver City

Brotman Medical Center
3828 DELMAS TERRACE
Culver City, CA 90232

Readmission Rates — CHANGE CATEGORY

	Q3/08-Q2/11	Q3/07-Q2/10	Q3/06-Q2/09
AVERAGE MEDICARE HOSPITAL...	22.49 %	22.75 %	N/A
HEART ATTACK PATIENTS REA...	19.80 %	19.10 %	20.20 %
HEART FAILURE PATIENTS RE...	24.40 %	26.30 %	28.50 %
PNEUMONIA PATIENTS READMI...	21.50 %	20.60 %	19.10 %

Additional Quality Areas

Assessment and Findings

Review the service lines and clinical services delivered by the hospital to ascertain whether adequate resources will continue to be available for those services.

Assessment and Findings

Review bed availability, staffing, occupancy and maintenance of adequate resources to provide care.

Assessment and Findings

- Review Information Technology, including
  - Electronic Health Records' Platforms and Investments
  - Access to Health Information Exchanges
  - Meaningful Use Cert.
  - HIMSS Analytics

US EMR Adoption Model[sm]

Stage	Cumulative Capabilities	2006 Year End	2013 Q3
Stage 7	Complete EMR, CCD transactions to share data; Data warehousing; Data continuity with ED, ambulatory, OP	0.0%	2.2%
Stage 6	Physician documentation (structured templates), full CDSS (variance & compliance), full R-PACS	0.1%	11.1%
Stage 5	Closed loop medication administration	0.5%	20.9%
Stage 4	CPOE, Clinical Decision Support (clinical protocols)	3.1%	15.1%
Stage 3	Nursing/clinical documentation (flow sheets), CDSS (error checking), PACS available outside Radiology	18.7%	31.9%
Stage 2	CDR, Controlled Medical Vocabulary, CDS, may have Document Imaging; HIE capable	40.0%	8.4%
Stage 1	Ancillaries - Lab, Rad, Pharmacy - All Installed	17.4%	3.5%
Stage 0	All Three Ancillaries Not Installed	20.4%	6.9%

Data from HIMSS Analytics® Database © 2013 HIMSS Analytics N = 4237 N = 5437

HIMSS Analytics

Assessment and Findings

Review Public Health Indicators for the population served, including Kaiser Family Foundation, California Health Care Foundation, and other public data.

Assessment and Findings

Review additional external certifications such as Magnet, Baby Friendly, CARF, and Disease Management Certifications such as stroke, diabetes, et al.

Assessment and Findings

Review any available public citations for fraud and abuse as they pertain to provision of care.

Assessment and Findings

Review external grading agency reports as available, including but not limited to US News, Healthgrades, Leapfrog, and Consumer Reports.

Assessment and Findings

Review PSO participation and any public or submitted information about adverse events.

Assessment and Findings

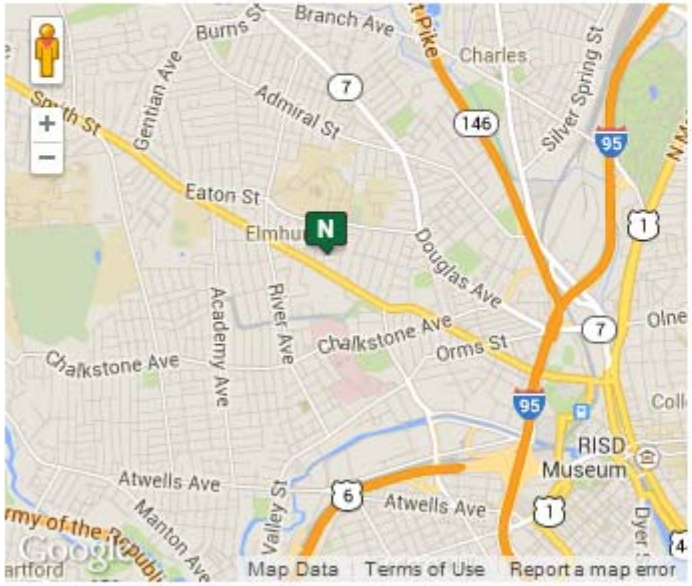
For any wholly-owned or affiliated nursing homes and other post-acute hospital care organizations, review nursing home compare, homecare compare and any submitted information.

Elmhurst Extended Care Facility

ELMHURST EXTENDED CARE FACILITY

50 MAUDE STREET
PROVIDENCE, RI 02908
(401) 456-2600

Add to my Favorites
Map and Directions



Nursing home information

- 206 Certified Beds
- Participates in : Medicare and Medicaid
- Ownership : Non profit - Corporation
- Automatic Sprinkler Systems in All Required Areas: Yes
- Not in a Continuing Care Retirement Community (CCRC)
- Not in a Hospital
- Resident Council Only

Star Rating Summary

Overall Rating	Above Average
Health Inspection	Below Average
Staffing	Above Average
Quality Measures	Much Above Average

http://www.medicare.gov/nursinghomecompare/results.html#s...xlat=0&lng=0&AspxAutoDetectCookieSupport=1
accessed April 3 2014

CharterCare Home Health Services

- **CharterCare Home Health Services performed at or above the national average for Home Health Care Agencies in all categories.**

http://www.medicare.gov/homehealthcompare/profile.html#profTab=2&ID=417029&state=RI&lat=0&lng=0&name=CharterCare accessed April 6 2014

Assessment and Findings

Review status of ACGME or AOA oversight and accreditation or citations of any training programs that exist.

Assessment and Findings

Review Quality Improvement activities.

Conclusion

Based on my review of all available material, my role and experience as an expert consultant in the six domains of Quality, and my review of the statutory requirements for a Change in Effective Control and Hospital Conversion, my opinion is that the transacting parties satisfy all the requirements identified in RIGL 23-17-14.3 "Licensing of Health Care Facilities" and HCA 23-17.14-3, 23-17.14-4 and 23-17.14-8 that pertain to a quality review.

RESPONSE TO DEFICIENCIES
EXHIBIT N - Quality Metrics for 2014

Prospect Medical Holdings

Outcome Measures

For the period of 1/1/14 - 12/31/14
Source: www.medicare.gov/hospitalcompare

Readmissions & Deaths Tab

Readmissions Reduction Program Measures: (Risk Adjusted)

	Rate of Unplanned Readmission by Medical Condition					
	COPD	**AMI**	**CHF**	**Pneumonia**	**Stroke**	**Hospital Wide**
LACH	No Diff	No Diff	No Diff	No Diff	No Diff	No Diff
SCH	No Diff	No Diff	No Diff	No Diff	No Diff	No Diff
Nix	No Diff	No Diff	No Diff	No Diff	No Diff	No Diff
RW	No Diff	No Diff	No Diff	No Diff	No Diff	No Diff
OLF	No Diff	No Diff	No Diff	No Diff	No Diff	No Diff
National Avg	20.2%	17.0%	22.0%	16.9%	12.7%	15.2%
MGH	No Diff	No Diff	No Diff	No Diff	No Diff	No Diff
RGH	No Diff	N/A(3)	No Diff	No Diff	No Diff	No Diff

30-Day Mortality: (Risk Adjusted)

	Death Rate by Medical Condition				
	COPD	**AMI**	**CHF**	**Pneumonia**	**Stroke**
LACH	No Diff	No Diff	No Diff	Better (2)	No Diff
SCH	Better (1)	No Diff	No Diff	Better (2)	No Diff
Nix	No Diff	No Diff	No Diff	No Diff	No Diff
RW	No Diff	No Diff	No Diff	No Diff	No Diff
OLF	No Diff	No Diff	No Diff	No Diff	No Diff
National Avg	7.7%	14.2%	11.6%	11.5%	14.8%
MGH	No Diff	No Diff	No Diff	No Diff	No Diff
RGH	No Diff	No Diff	No Diff	No Diff	No Diff

Complications Tab

Complications: (Risk Adjusted)

	Hip/Knee Surgery	Serious Complication	Deaths/Treat Comp.
LACH	N/A(3)	No Diff	No Diff
SCH	N/A(3)	No Diff	No Diff
Nix	No Diff	No Diff	No Diff
RW	No Diff	No Diff	No Diff
OLF	No Diff	No Diff	Worse
National Avg	3.1%	0.8%	11.8%
MGH	No Diff	No Diff	No Diff
RGH	No Diff	No Diff	N/A(3)

Healthcare-associated Infections: (Risk Adjusted)

	Central Line	Catherter	Surgical Site:Colon	MRSA	Intestinal
LACH	No Diff	Better	N/A	Worse	Better
SCH	No Diff	No Diff	No Diff	No Diff	No Diff
Nix	No Diff	Worse	No Diff	No Diff	Better
RW	No Diff	Worse	No Diff	No Diff	No Diff
OLF	No Diff	No Diff	No Diff	No Diff	No Diff
MGH	No Diff	No Diff	No Diff	No Diff	Better
RGH	No Diff	No Diff	N/A(4)	N/A(4)	No Diff

Key:

LAC - Los Angeles Community Hospital, and Norwalk Campus, CA
SCH - Southern California Hospital, Culver City, Hollywood and Van Nuys Campuses, CA
NIX - Nix Health System, TX
RW - Roger Williams Medical Center, RI
OLF - Our Lady of Fatima, RI
MGH - Manchester General Hospital, CT
RGH - Rockville General Hospital, CT

Prospect Medical Holdings

Timely and Effective Care Measures

For the period of 1/1/14 - 12/31/14

Source: www.medicare.gov/hospitalcompare

Timely and Effective Care Tab

Timely and Effective Care - Heart Attack and Pneumonia Care

	Asprin at Discharge - AMI	Statin At Discharge - AMI	Appr. Antibiotics - Pnem
LACH	100%	91%	73%
SCH	100%	100%	N/A(4)
Nix	100%	98%	92%
RW	98%	86%	100%
OLF	100%	85%	97%
National Avg	99.0%	99.0%	96.0%
MGH	100%	94%	95%
RGH	N/A(4)	N/A(4)	97%

Timely and Effective Care - Surgical Care

	O/P Antibiotic w/hour	I/P Antibiotic w/hour	Antibiotics stopped w/24 post	Trt to Prevent Blood Clots	Continue Beta Blockers	Removal of Urinary Cath
LACH	N/A(4)	71%	97%	76%	95%	100%
SCH	98%	96%	81%	98%	98%	96%
Nix	100%	99%	97%	100%	97%	95%
RW	95%	100%	98%	99%	97%	96%
OLF	98%	100%	99%	100%	99%	99%
National Avg	98.0%	99.0%	98.0%	100.0%	98.0%	98.0%
MGH	98%	99%	99%	100%	98%	100%
RGH	97%	100%	100%	100%	100%	100%

Timely and Effective Care - Emergency Department Care

	Avg wait time/Broken Bone	Left before being seen
LACH	56 minutes	1%
SCH	68 minutes	4%
Nix	41 minutes	4%
RW	69 minutes	3%
OLF	75 minutes	1%
National Avg	54 minutes	2%
MGH	60	3%
RGH	50	1%

Timely and Effective Care - Preventive Care

	Patients given Flue Shot	Health Workers Flue Shot
LACH	76%	74%
SCH	92%	64%
Nix	98%	95%
RW	80%	90%
OLF	92%	90%
National Avg	93.0%	84.0%
MGH	95%	94%
RGH	94%	97%

Timely and Effective Care - Stroke Care

	Preventive Anti-Clot/2 days	Anti-clot/2 days	Anti-Clot prior/discharge	Medicine to Lower CHL	Eval for Rehab
LACH	88%	87%	96%	86%	93%
SCH	100%	100%	100%	99%	100%
Nix	98%	91%	100%	88%	100%
RW	100%	91%	100%	95%	95%
OLF	98%	91%	98%	92%	95%

National Avg	98.0%	97.0%	99.0%	96.0%	98.0%
MGH	98%	91%	100%	97%	94%
RGH	100%	93%	100%	100%	100%

Timely and Effective Care - Blood Clot Prevention & Treatment

	Trx on same day	Trx on Day +1 ICU	Pat who did not receive Trx	Trx X2 Thinners	Written Edu. Materials
LACH	82%	93%	17%	93%	100%
SCH	91%	97%	0%	100%	100%
Nix	80%	81%	20%	97%	100%
RW	84%	93%	N/A(4)	94%	N/A(4)
OLF	86%	98%	8%	98%	100%
National Avg	92.0%	96.0%	6.0%	95.0%	89.0%
MGH	97%	98%	N/A(4)	98%	76%
RGH	94%	99%	N/A(4)	100%	88%

Use of Medical Imaging Tab

Timely and Effective Care - O/P

	O/P Breast Screening - Rad	O/P CT Chest Combo Scan	O/P CT Scans Abd Combo
LACH	N/A(4)	N/A(4)	N/A(4)
SCH	N/A(4)	0.0%	2.8%
Nix	8.7%	2.2%	11.2%
RW	2.1%	0.3%	14.9%
OLF	24.5%	0.0%	7.1%
National Avg	8.9%	2.4%	9.4%
MGH	14.7%	0.0%	3.1%
RGH	12.3%	0.6%	4.6%

Key:
LAC - Los Angeles Community Hospital, and Norwalk Campus, CA
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NIX - Nix Health System, TX
RW - Roger Williams Medical Center, RI
OLF - Our Lady of Fatima, RI
MGH - Manchester General Hospital, CT
RGH - Rockville General Hospital, CT

RESPONSE TO DEFICIENCIES
EXHIBIT O Information Contained in Requested APA Schedules

Owned Real Property DRAFT

Last Updated: 10/16/2015

Owned Real Property Address	City	State	Zipcode	Property Description
17 Armory Street	Manchester	CT	06040	Residential
19 Armory Street	Manchester	CT	06040	Residential
319 Broad Street	Manchester	CT	06040	Thrift Shop/Commercial
460 Hartford Turnpike	Vernon	CT	06066	Commercial
18 Haynes Street	Manchester	CT	06040	Office Building/Commercial
26 Haynes Street	Manchester	CT	06040	Office Building/Commercial
36 Haynes Street	Manchester	CT	06040	Office Building/Commercial
44 Haynes Street	Manchester	CT	06040	Office Building/Commercial
56 Haynes Street	Manchester	CT	06040	Vacant lot
71-80 Haynes Street	Manchester	CT	06040	Hospital
37-97 Hemlock Street	Manchester	CT	06040	vacant land
314 Main Street	Manchester	CT	06040	Parking lot
320 Main Street	Manchester	CT	06040	Office Building/Commercial
353 Main Street	Manchester	CT	06040	Office Building/Commercial
945 Main Street	Manchester	CT	06040	Office Condominium
310-312 Main Street	Manchester	CT	06040	Mixed Use
190 Meadow Street	Lee	MA	01260	Time Share
150 North Main Street	Manchester	CT	06040	Office Building
72 Russell Street	Manchester	CT	06040	Residential
110 Russell Street	Manchester	CT	06040	Residential
26 Shenipsit Lake Road	Tolland	CT	06084	Elder Care/Commercial
62 So. Hawthorne Street	Manchester	CT	06040	vacant land
66 So. Hawthorne Street	Manchester	CT	06040	vacant land
11 South Alton Street	Manchester	CT	06040	Residential
77 South Alton Street	Manchester	CT	06040	vacant land
31 Union Street	Vernon	CT	06066	Hospital
35 Village Street	Vernon	CT	06066	vacant land
22-25-26 Village Street	Vernon	CT	06066	Vacant Building
8-11-12 Ward Street	Vernon	CT	06066	Vacant Land
70 West Middle Turnpike	Manchester	CT	06040	Residential
74 West Middle Turnpike	Manchester	CT	06040	Residential
88 West Main Street	Vernon	CT	06066	Parking lot
94 West Middle Turnpike	Manchester	CT	06040	Residential
98 West Middle Turnpike	Manchester	CT	06040	Residential
104 West Middle Turnpike	Manchester	CT	06040	Residential
108 West Middle Turnpike	Manchester	CT	06040	Residential
114 West Middle Turnpike	Manchester	CT	06040	Residential
28-34-40-46-50 West Middle Turnpike	Manchester	CT	06040	Parking lot

Leased Real Property

DRAFT

Last Updated: 10/16/2015

Leased Real Property Address	City	State	Zipcode	Property Description
1707 Boston Turnpike	Coventry	CT	06238	Commercial
47 Hartford Turnpike	Vernon	CT	06066	Commercial
57 Hartford Turnpike	Vernon	CT	06066	Commercial
130 Hartford Road	Manchester	CT	06040	Commercial
428 Hartford Turnpike	Vernon	CT	06066	Commercial
428 Hartford Turnpike	Vernon	CT	06066	Commercial
29 Haynes Street	Manchester	CT	06040	Commercial
100 Haynes Street	Manchester	CT	06040	Commercial
100 Haynes Street	Manchester	CT	06040	Commercial
100 Haynes Street	Manchester	CT	06040	Commercial
622 Hebron Avenue	Glastonbury	CT	06033	Commercial
622 Hebron Avenue	Glastonbury	CT	06033	Commercial
28 Main Street	East hartford	CT	06118	Commercial
146 Merrow Road	Tolland	CT	06084	Commercial
11 Pinney Street	Ellington	CT	06029	Commercial
95 Somers Road/Somers Crossing	Somers	CT	06071	Commercial
2400 Tamarack Avenue	South Windsor	CT	06074	Commercial
2400 Tamarack Avenue	South Windsor	CT	06074	Commercial
2400 Tamarack Avenue	South Windsor	CT	06074	Commercial
2600 Tamarack Avenue	South Windsor	CT	06074	Commercial
2600 Tamarack Avenue	South Windsor	CT	06074	Commercial
2600 Tamarack Avenue	South Windsor	CT	06074	Commercial
2800 Tamarack Avenue	South Windsor	CT	06074	Commercial
2800 Tamarack Avenue	South Windsor	CT	06074	Commercial
2800 Tamarack Avenue	South Windsor	CT	06074	Commercial
2800 Tamarack Avenue	South Windsor	CT	06074	Commercial
2800 Tamarack Avenue	South Windsor	CT	06074	Commercial
2800 Tamarack Avenue	South Windsor	CT	06074	Commercial
2800 Tamarack Avenue	South Windsor	CT	06074	Commercial
2800 Tamarack Avenue	South Windsor	CT	06074	Commercial
2800 Tamarack Avenue	South Windsor	CT	06074	Commercial
2800 Tamarack Avenue	South Windsor	CT	06074	Commercial
2800 Tamarack Avenue	South Windsor	CT	06074	Commercial
2800 Tamarack Avenue	South Windsor	CT	06074	Commercial
2800 Tamarack Avenue	South Windsor	CT	06074	Commercial
2800 Tamarack Avenue	South Windsor	CT	06074	Commercial
360 Tolland Turnpike, Suite 3E	Manchester	CT	06040	Commercial
145 Union Street	Vernon	CT	06066	Commercial
43 West Main Street	Vernon	CT	06066	Parking Lot
175 West Road	Ellington	CT	06029	Commercial
43 Woodland Street, Suite 280	Hartford	CT	06105	Commercial

Building Maintenance and Repairs

DRAFT

Last Updated: 11/6/2015

Property Address	City	State	Zipcode	Property Description	Property Description
22-25-26 Village Street	Vernon	CT	06066	Vacant Historical Building	Polish American Club Building Fire Damage, No Working Building systems or Utilities, Not in Working Order

Rent Roll

DRAFT

Last Updated: 10/16/2015

Lease Address (Street, City, Zip)	Current Month Rental Payment	Outstanding Concessions	Tenant Deposits	Lease Commencement Date	Space Lease Expiration Date	Square Footage of Space Leased	Renewal Options Available to Tenant
17 Armory Street, manchester, CT 06040	$875.00	None	$975.00 - Security Dep.	2/1/2012	1/31/2016	1,532	yearly
19 Armory Street, Manchester, CT 06040	$950.00	None	$1050.00 - Security Dep.	6/1/2015	5/31/2016	1,920	yearly
1707 Boston Tpke., Coventry, CT 06238	$1,829.50	None	0	2/1/2006	1/31/2018	1,280	yearly
460 Hartford Tpke., Vernon, CT 06066	$26,100.88	Before 8/31/2016 install new carpet	$20789.66 - Security Dep.	9/1/2006	8/31/2021	10,616	yearly
460 Hartford Tpke., Vernon, CT 06066	$7,267.00	None	$6828.77 - Security Dep.	11/1/2009	10/31/2015	3,785	yearly
460 Hartford Tpke., Vernon, CT 06066	$5,259.77	None	0	9/1/2007	8/31/2016	2,980	yearly
18 Haynes Street, Manchester, CT 06040	$5,400.50	None	0	12/1/2012	11/30/2017	3,066	5 years
18 Haynes Street, Manchester, CT 06040	$1,950.00	None	0	4/1/2015	3/31/2016	1,075	yearly
18 Haynes Street, Manchester, CT 06040	$310.00	None	0	10/1/2014	9/30/2016	session	yearly
26 Haynes Street, Manchester, CT 06040	$1,334.02	None	0	12/1/2010	11/30/2015	750	yearly
36 Haynes Street, Manchester, CT 06040	$6,698.33	None	0	4/11/2013	3/31/2018	3,719	5 years
44 Haynes Street, Manchester, CT 06040	$3,091.75	None	0	2/1/2007	1/31/2016	1,523	yearly
71 Haynes Street, Manchester, CT 06040	$453.57	None	0	7/1/2006	1/29/2017	190	yearly
622 Hebron Ave., Suite 104B, Glastonbury, CT 06033	$5,000.82	None	$2617.71 - Security Dep.	2/1/2012	1/31/2022	1,997	yearly
622 Hebron Ave., Suite 104C, Glastonbury, CT 06033	$546.36	None	$325.00 - Security Dep.	2/1/2012	1/31/2017	1,215	yearly
622 Hebron Ave., Suite 201, Glastonbury, CT 06033	$9,480.78	None	$3720.21 - Security Dep.	2/1/2012	1/31/2022	2,588	yearly
28 Main Street, East Hartford, CT 06118	$5,578.10	None	0	8/1/2008	7/31/2017	3,672	yearly
310 Main Street, Manchester, CT 06040	$900.00	None	850.00 - Security Dep.	1/4/2010	12/31/2015	1,018	yearly
312 Main Street, Manchester, CT 06040	$450.00	None	0	2/28/2005	month to month		yearly
353 Main Street, Manchester, CT 06040	$10,250.33	None	0	5/9/2014	4/30/2017	5,348	yearly
353 Main Street, Manchester, CT 06040	$300.00	None	0	12/1/2014	11/30/2015	session	yearly
353 Main Street, Manchester, CT 06040	$1,487.33	None	0	10/1/2015	9/30/2016	776	yearly
945 Main Street, Manchester, CT 06040	$3,776.26	None	0	7/1/2012	6/30/2016	2,330	yearly
146 Merrow Road, Tolland, CT 06084	$11,802.15	None	0	9/1/2008	6/30/2016	5,163	yearly
146 Merrow Road, Tolland, CT 06084	$8,102.43	None	$7719.75 - Security Dep.	10/1/2006	6/30/2016	3,431	5 years
146 Merrow Road, Tolland, CT 06084	$4,966.66	None	$4608.00 - Security Dep.	9/1/2006	6/30/2016	2,048	5 years
146 Merrow Road, Tolland, CT 06084	$2,275.00	None	$2600.00 - Security Dep.	4/30/2007	8/31/2016	1,340	5 years
150 North Main Street, Manchester, CT 06040	$6,947.46	None	$2925.00 - Security Dep.	6/1/2005	4/30/2016	4,672	yearly
72 Russell Street, Manchester, CT 06040	$800.00	None	0	12/1/2014	11/30/2016	1,150	yearly
110 Russell Street, Manchester, CT 06040	$1,500.00	None	$1500.00 - Security Dep.	2/1/2007	11/30/2015	1,976	yearly
11 South Alton Street, Manchester, CT 06040	$925.00	None	$1025.00 - Security Dep.	9/1/2003	8/31/2016	1,080	yearly
145 Union Street, Vernon, CT 06066	$4,109.38	None	0	3/15/2012	3/31/2016	1,968	yearly
145 Union Street, Vernon, CT 06066	$1,561.15	None	0	4/1/2009	3/31/2016	532	yearly
70 West Middle Tpke., Manchester, CT 06040	$900.00	None	$900.00 - Security Dep.	9/1/2002	10/31/2016	1,080	yearly
74 West Middle Tpke., Manchester, CT 06040	$900.00	None	$1000.00 - Security Dep.	1/15/2006	1/31/2016	1,320	yearly
94 West Middle Tpke., Manchester, CT 06040	$900.00	None	$1000.00 - Security Dep.	6/1/2010	5/31/2016	1,080	yearly
98 West Middle Tpke., Manchester, CT 06040	$975.00	None	$1075.00 - Security Dep.	8/1/2012	7/31/2016	1,270	yearly
104 West Middle Tpke., Manchester, CT 06040	$925.00	None	$1025.00 - Security Dep.	6/1/2012	6/30/2016	1,080	yearly
108 West Middle Tpke., Manchester, CT 06040	$925.00	None	$1025.00 - Security Dep.	6/1/2009	5/31/2016	1,200	yearly
175 West Road, Ellington, CT 06029	$579.25	None	0	4/12/2010	4/30/2016	252	yearly

Tenant Lease Encumbrances

DRAFT

Last Updated: 10/16/2015

None.

Environmental Claims DRAFT

Last Updated: 10/16/2015

On April 28, 2011 an Emergency Incident Report was made to the State of Connecticut, Department of Environmental Protection as to an in-ground tank failure resulting in the release of #6 Fuel Oil (Petroleum) at Manchester Memorial Hospital, 71 Haynes Street, Manchester, Connecticut. All corrective action items completed with the installation of four monitoring wells. Water samples will be regularly monitored. First report after installation had no issues.

On February 13, 2014 the Department of Energy and Environmental Protection (DEEP) was contacted as to a possible break in an oil line resulting in the release of hydraulic fuel oil at 36 Haynes Street, Manchester, CT. The area of concern was excavated and no break in the pipe was found. DEEP determined that the leak occurred under the building and was un-recoverable as digging under the foundation would jeopardize the building structure. The excavated area was restored. There are no follow-up action items.

Underground Storage Tanks and Waste Disposal

DRAFT

Last Updated: 10/22/2015

Underground Storage Tank Inventory							
Address	**City**	**State**	**Zipcode**	**Location**	**Tank #**	**Capacity (Gallons)**	**Contents**
71 Haynes Street	Manchester	CT	06040	MMH	D1R1	20,000	Heating Oil (#2)
71 Haynes Street	Manchester	CT	06041	MMH	C1R1	4,000	Diesel Fuel
71 Haynes Street	Manchester	CT	06042	MMH	B1R1	6,000	Diesel Fuel
31 Union Street	Vernon	CT	06066	RGH	O1R1	20,000	Fuel Oil
31 Union Street	Vernon	CT	06066	RGH	D1R1	5,000	Diesel Fuel

Waste Disposal Location					
Address	**City**	**State**	**Zipcode**	**Property Description**	**Prpperty Type**
1707 Boston Turnpike	Coventry	CT	06238	Commercial	Leased Real Property
130 Hartford Road	Manchester	CT	06040	Commercial	Leased Real Property
47 Hartford Turnpike	Vernon	CT	06066	Commercial	Leased Real Property
57 Hartford Turnpike	Vernon	CT	06066	Commercial	Leased Real Property
428 Hartford Turnpike	Vernon	CT	06066	Commercial	Leased Real Property
460 Hartford Turnpike	Vernon	CT	06066	Commercial	Owned Real Property
29 Haynes Street	Manchester	CT	06040	Commercial	Leased Real Property
100 Haynes Street	Manchester	CT	06040	Commercial	Leased Real Property
18 Haynes Street	Manchester	CT	06040	Office Building/Commercial	Owned Real Property
36 Haynes Street	Manchester	CT	06040	Office Building/Commercial	Owned Real Property
71-80 Haynes Street	Manchester	CT	06040	Hospital	Owned Real Property
622 Hebron Avenue	Glastonbury	CT	06033	Commercial	Leased Real Property
28 Main Street	East hartford	CT	06118	Commercial	Leased Real Property
353 Main Street	Manchester	CT	06040	Office Building/Commerical	Owned Real Property
945 Main Street	Manchester	CT	06040	Office Condominium	Owned Real Property
146 Merrow Road	Tolland	CT	06084	Commercial	Leased Real Property
150 North Main Street	Manchester	CT	06040	Office Building	Owned Real Property
25 Oakland Road	South Windsor	CT	06074	Commercial	Leased Real Property
11 Pinney Street	Ellington	CT	06029	Commercial	Leased Real Property
26 Shenipsit Lake Road	Tolland	CT	06084	Elder Care/Commercial	Owned Real Property
95 Somers Road/Somers Crossing	Somers	CT	06071	Commercial	Leased Real Property
2400 Tamarack Avenue	South Windsor	CT	06074	Commercial	Leased Real Property
2600 Tamarack Avenue	South Windsor	CT	06074	Commercial	Leased Real Property
2800 Tamarack Avenue	South Windsor	CT	06074	Commercial	Leased Real Property
360 Tolland Turnpike, Suite 3E	Manchester	CT	06040	Commercial	Leased Real Property
145 Union Street	Vernon	CT	06066	Commercial	Leased Real Property
31 Union Street	Vernon	CT	06066	Hospital	Owned Real Property
175 West Road	Ellington	CT	06029	Commercial	Leased Real Property
43 Woodland Street, Suite 280	Hartford	CT	06105	Commercial	Leased Real Property

RESPONSE TO DEFICIENCIES
EXHIBIT P CMS Statements of Deficiency

RESPONSE TO DEFICIENCIES
EXHIBIT P CMS Statements of Deficiency

Los Angeles Community Hospital

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	CA930000085	A. BUILDING: _____ B. WING _____	C 07/09/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOS ANGELES COMMUNITY HOSPITAL	4081 E OLYMPIC BLVD LOS ANGELES, CA 90023

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
E 292	Continued From page 1 Findings: 1. Patient 1 was admitted to the facility on 4/29/15 with diagnoses that included high blood sugar levels, anemia (low concentration of red blood cells), and acute respiratory failure. Patient 2 was admitted to the facility on 6/15/15 with diagnoses that included seizure disorder. During an interview with the Director of Quality Management on 7/8/15 at 10:35 AM, she stated Patient 2 had been physically assaultive to two staff nurses when Patient 2 pulled the two nurse's hair on 6/20/15 while they were inside Patient 2's room, and also had tried to kick the social worker on 6/20/15. During this interview with the Director of Quality Management, she further stated that on 6/21/15, Patient 2 hit Patient 1 in the face and Patient 1 sustained a jaw fracture. During an interview with the Lead Social Worker on 7/8/15 at 10:40 AM, she stated on 6/20/15, she was working with Patient 2 in Patient 2's room, when the patient became agitated and upset, and kicked out at her. She stated Patient 2's foot grazed her breast area and stomach. During this interview, the social worker further stated that Patient 2 had a "sitter" for one-to-one supervision that day because of the patient's risk of leaving the facility against physician order. During an interview with RN 1 (Registered Nurse) on 7/8/15 at 10:55 AM, she stated on 6/20/15 around lunchtime, she took over one-to-one supervision of Patients 1 and 2. She stated she and another nurse were looking down at paperwork and Patient 2 grabbed both of their	E 292	***Monitoring*** Nursing Supervisors will monitor nursing units daily for appropriate ratio of sitters to patients as ordered by physicians. Any non-conformity will immediately be corrected and reported to the CNO. ***Responsible Persons*** Chief Nursing Officer	7/21/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	CA930000085	A. BUILDING: _____ B. WING _____	C 07/09/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOS ANGELES COMMUNITY HOSPITAL	4081 E OLYMPIC BLVD LOS ANGELES, CA 90023

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
E2145	Continued From page 6 safety or health of patients, personnel or visitors would be reported as soon as reasonably practical, whether by telephone or by telegraph, to the CDPH (California Department of Public Health). The policy indicated the reporting timeframe would be no later than five days after the adverse event had been detected. The P&P further indicated the facility's Quality Management Department would e-mail the regulatory supervisor at the CDPH as well as e-mailing the sender to validate the delivery. In addition, the hospital Quality Management Department would fax the report to CDPH and secure the fax confirmation sheet to be kept on file for validation purposes.	E2145		
E2243	T22 DIV5 CH1 ART7-70751(g) Medical Record Availability (g) Medical records shall be completed promptly and authenticated or signed by a physician, dentist or podiatrist within two weeks following the patient's discharge. Medical records may be authenticated by a signature stamp or computer key, in lieu of a physician's signature, only when that physician has placed a signed statement in the hospital administrative offices to the effect that he is the only person who: This Statute is not met as evidenced by: Based on interview and record review, the facility failed to ensure Patient 2's EHR (electronic health record) was complete and contained a discharge summary within two weeks after Patient 2 was discharged. Findings:	E2243	E2243 Medical Record Availability ***Corrective Action*** The discharge summary for Patient 2 was completed on 07/08/15 and added to the patient's record immediately. To assure other patients' discharge summaries are completed within two weeks following discharge, the Director of Health Information Management is tracking completion of discharge summaries on a daily basis and notifying physicians when they have not been completed timely. ***Monitoring*** Rates of completion of discharge summaries within 2 weeks is monitored and reported at monthly Quality Council meetings. ***Responsible Persons*** Director of Health Information Management	7/31/15

Alta Los Angeles Hospitals, Inc.

Los Angeles Community Hospital
4081 East Olympic Blvd.
Los Angeles, CA 90023
(323) 267-0477
(323) 881-2611 Fax

Los Angeles Community Hospital
at Norwalk
13222 Bloomfield Avenue
Norwalk, CA 90650
(562) 863-4763
(562) 207-9721 Fax

Los Angeles Community Hospital
at Bellflower
9542 Artesia Blvd.
Bellflower, CA 90706
(562) 273-1800
(562) 273-1818 Fax

July 29, 2015

Ms. Renee Buell, Health Facilities Evaluator Nurse
State of California Department of Public Health
Licensing and Certification Program
State Facilities Section
625 E. Carnegie Dr., Suite 280
San Bernardino, CA 92408

Dear Ms. Buell:

Attached you will find our Plan of Correction related to your visit of July 9, 2015, during which you investigated an incident involving a patient who assaulted another patient.

We feel we have adequately addressed your findings in this Plan of Correction. However, please feel free to contact us if further information is needed.

Sincerely,

Barbara Studer, RN, MAOM, CPHQ
Corporate Director of Quality & Risk Management

ENC: Plan of Correction (2567)

California Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	CA930000085	A. BUILDING: _____ B. WING _____	C 07/09/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOS ANGELES COMMUNITY HOSPITAL	4081 E OLYMPIC BLVD LOS ANGELES, CA 90023

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E 000	Initial Comments The following reflects the findings of the California Department of Public Health during the investigation of an entity reported incident. Entity Reported Incident: CA00449364 Representing the Department: 2091, HFEN The investigation is limited to the specific entity reported incident investigated and does not represent the findings of a full inspection of the facility. Three deficiencies were written for entity reported incident CA00449364	E 000		
E 292	T22 DIV5 CH1 ART3-70215(a)(2) Planning and Implementing Patient Care (a) A registered nurse shall directly provide: (2) The planning, supervision, implementation, and evaluation of the nursing care provided to each patient. The implementation of nursing care may be delegated by the registered nurse responsible for the patient to other licensed nursing staff, or may be assigned to unlicensed staff, subject to any limitations of their licensure, certification, level of validated competency, and/or regulation. This Statute is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide one-to-one supervision as ordered by the physician for three of three sampled patients (Patient 1, Patient 2, and Patient 3). This failure resulted in Patient 1 sustaining a jaw fracture after being hit in the face by Patient 2.	E 292	E 292 Planning & Implementing Patient Care – One-to-One Supervision ***Corrective Action*** Patient 1 was immediately placed in a room separate from Patient 2 after being hit by Patient 2. Patient 2's discharge to a mental health unit was expedited. Regarding one-to-one observation of Patient 3, the ordering physician was contacted to clarify whether 1:2 or 1:3 observation would be acceptable. The physician indicated that 1:3 observation would be acceptable. Computerized order entry now offers a "SITTER" option, where prior to this, "1:1 Observation" was the only available choice when a physician ordered observation of a patient. This became effective 7/21/15. To assure other patients are appropriately observed when sitters are ordered, the policy, "Sitter Usage, Assessment and implementation," was revised to include criteria for observation by sitters, to include 1:1, 1:2, 1:3, and 1:4 sitter-to-patient ratios. Nursing Supervisors were in-serviced on the revised policy on 7/21/15.	

Licensing and Certification Division

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: COO (X6) DATE: 7-29-15

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E 292	Continued From page 1 Findings: 1. Patient 1 was admitted to the facility on 4/29/15 with diagnoses that included high blood sugar levels, anemia (low concentration of red blood cells), and acute respiratory failure. Patient 2 was admitted to the facility on 6/15/15 with diagnoses that included seizure disorder. During an interview with the Director of Quality Management on 7/8/15 at 10:35 AM, she stated Patient 2 had been physically assaultive to two staff nurses when Patient 2 pulled the two nurse's hair on 6/20/15 while they were inside Patient 2's room, and also had tried to kick the social worker on 6/20/15. During this interview with the Director of Quality Management, she further stated that on 6/21/15, Patient 2 hit Patient 1 in the face and Patient 1 sustained a jaw fracture. During an interview with the Lead Social Worker on 7/8/15 at 10:40 AM, she stated on 6/20/15, she was working with Patient 2 in Patient 2's room, when the patient became agitated and upset, and kicked out at her. She stated Patient 2's foot grazed her breast area and stomach. During this interview, the social worker further stated that Patient 2 had a "sitter" for one-to-one supervision that day because of the patient's risk of leaving the facility against physician order. During an interview with RN 1 (Registered Nurse) on 7/8/15 at 10:55 AM, she stated on 6/20/15 around lunchtime, she took over one-to-one supervision of Patients 1 and 2. She stated she and another nurse were looking down at paperwork and Patient 2 grabbed both of their	E 292	***Monitoring*** Nursing Supervisors will monitor nursing units daily for appropriate ratio of sitters to patients as ordered by physicians. Any non-conformity will immediately be corrected and reported to the CNO. ***Responsible Persons*** Chief Nursing Officer	

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E 292	Continued From page 2 hair. RN 1 stated Patient 2 had a one-to-one "sitter" for high risk of leaving the facility without physician order, and because the patient "gets aggressive." During this interview, RN 1 stated, "The next day was the fight between the patients. ... (Patient 2) hit ... (Patient 1) in the face." During an interview with CNA 1 (Certified Nurse Assistant) on 7/8/15 at 11:25 AM, stated that on 6/21/15, she was assigned to "sitter" duties for Patient 1 and Patient 2 who shared the same room. CNA 1 stated Patient 1 was coming out of the restroom inside the patient room when Patient 2 "went and hit ... (Patient 1)." During this interview, CNA 1 stated that she was aware of Patient 2 pulling the nurses hair the day before and was afraid of Patient 2, so she sat in a chair by the doorway to supervise Patients 1 and 2. During a review of the EHR (electronic health record) for Patient 1, Physician Orders dated 6/20/15 at 6:53 AM, indicated an order for "1:1 Observation". During a review of the EHR for Patient 1, Physician Orders dated 6/21/15 at 7:38 AM, indicated an order for "1:1 Observation". During a review of the EHR for Patient 1, Assessment and Care Note dated 6/21/15 at 1:45 PM, indicated Patient 1 "was found with blood and several cuts on lips due to trauma caused by patient next to her." During a review of the EHR for Patient 1, an X-ray result dated 6/21/15, indicated Patient 1 had a fracture of the left lower jaw. During a review of the EHR for Patient 2, Physician Orders dated 6/19/15 at 7:05 PM, and	E 292		

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E 292	Continued From page 3 6/20/15 at 3:41 PM, indicated order for "1:1 Observation". During a review of Patient 2's EHR, Assessment and Cares documentation by nursing staff, dated 6/20/15 at 10:14 AM, indicated Patient 2 had a "1:1 sitter." During a review of Patient 2's EHR, Assessment and Cares documentation by nursing staff, dated 6/20/15 at 4:00 PM, indicated "received pt (Patient 2) very aggressive Ativan given pt with 1:1 sitter monitoring pt." During a review of Patient 2's EHR, Assessment and Cares documentation by nursing staff, dated 6/21/15 at 3:20 PM, indicated "pt with 1:1 sitter became very aggressive starting punching another pt in the face, separated pts...working on transferring pt to a psych facility. Pt place on 5150 (a 72 hour hold for danger to others or danger to self)." 2. Patient 3 was admitted to the facility on 6/23/15 with diagnoses that included unsteady gait. During a random observation of unit 3, room 207, a medical/surgical unit, on 7/9/15 at 9:05 AM, a four-patient room was occupied by four male patients. A staff member was located inside the room and identified himself as a hospital "sitter. During an interview with this hospital "sitter" on 7/9/15 at 9:05 AM, he stated he was assigned to watch three of the four patients inside the room for the duration of his shift on 7/9/15. He stated he "occasionally is assigned one-to-one observation, but not today." He further stated he sits on a chair by the doorway unless one of the patients needs help. During this interview, the	E 292		

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E 292	Continued From page 4 "sitter" stated Patient 3 is being observed because of an unsteady gait and has a history of falling. During an interview with a RN supervisor on 7/9/15 at 9:25 AM, he reviewed Patient 3's EHR and located a physician order dated 7/9/15 for "1:1 Observation." During this interview, the RN supervisor stated the "sitter" for this date was assigned to Patient 3 and two other patients in the same room. He further stated that a 1:1 supervision order means one staff supervises one patient, but further stated implementation depends on the patient mobility in bed, and the staff member assigned to watch the patient may also be assigned more than one patient to observe. During a review of Patient 3's EHR, physician order dated 7/9/15 indicated, "1:1 Supervision" for history of falls and unsteady gait.	E 292		
E2145	T22 DIV5 CH1 ART7-70737(a) Reporting (a) Reportable Disease or Unusual Occurrences. All cases of reportable diseases shall be reported to the local health officer in accordance with Section 2500, Article 1, Subchapter 4, Chapter 4, Title 17, California Administrative Code. Any occurrence such as epidemic outbreak, poisoning, fire, major accident, disaster, other catastrophe or unusual occurrence which threatens the welfare, safety or health of patients, personnel or visitors shall be reported as soon as reasonably practical, either by telephone or by telegraph, to the local health officer and to the Department. The hospital shall furnish such other pertinent information related to such occurrences as the local health officer or the Department may	E2145	E 2145 Reporting ***Corrective Action*** At a staff meeting on 7/22/15, all Quality Management Department staff reviewed CDPH reporting requirements and the hospital's policy on unusual occurrence reporting, emphasizing the importance of immediately faxing a report and not relying on the U. S. mail to deliver a report within the 5-day reporting period. ***Monitoring*** Quality Management will report a minimum of quarterly to the Quality Council regarding the length of time from recognition of an unusual occurrence to the reporting to CDPH of an unusual occurrence. ***Responsible Persons*** Director of Quality & Risk Management	7/22/15

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E2145	Continued From page 5 require. This Statute is not met as evidenced by: Based on interview and record review, the facility failed to report an unusual occurrence of a patient to patient altercation within 5 days to the California Department of Public Health according to the facility Policy and Procedure titled, "Reporting Unusual Occurrences to the California Department of Public Health." This failure had the potential to compromise and threaten the welfare, safety or health of patients. Findings: During an interview with the Director of Quality Management on 7/8/15 at 1:45 PM, she stated unusual incidents should be reported to CDPH (California Department of Public Health) within 5 days. During an interview with the Director of Quality Management on 7/9/15 9:00 AM, she stated the incident was not telephoned in or faxed to CDPH, but was only mailed to CDPH via United States Postal Service on 6/23/15 and "thought it would get to CDPH on time." During this interview, she reviewed the stamped date and time of July 2, 2015 at 3:20 PM that indicated when the facility report of unusual occurrence was received by CDPH. The facility P&P (Policy and Procedure) titled "Reporting Unusual Occurrences to the California Department of Public Health" dated August, 2007, indicated it was the policy of the facility to report unusual occurrences which threaten the welfare,	E2145		

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E2145	Continued From page 6 safety or health of patients, personnel or visitors would be reported as soon as reasonably practical, whether by telephone or by telegraph, to the CDPH (California Department of Public Health). The policy indicated the reporting timeframe would be no later than five days after the adverse event had been detected. The P&P further indicated the facility's Quality Management Department would e-mail the regulatory supervisor at the CDPH as well as e-mailing the sender to validate the delivery. In addition, the hospital Quality Management Department would fax the report to CDPH and secure the fax confirmation sheet to be kept on file for validation purposes.	E2145		
E2243	T22 DIV5 CH1 ART7-70751(g) Medical Record Availability (g) Medical records shall be completed promptly and authenticated or signed by a physician, dentist or podiatrist within two weeks following the patient's discharge. Medical records may be authenticated by a signature stamp or computer key, in lieu of a physician's signature, only when that physician has placed a signed statement in the hospital administrative offices to the effect that he is the only person who: This Statute is not met as evidenced by: Based on interview and record review, the facility failed to ensure Patient 2's EHR (electronic health record) was complete and contained a discharge summary within two weeks after Patient 2 was discharged. Findings:	E2243	E2243 Medical Record Availability ***Corrective Action*** The discharge summary for Patient 2 was completed on 07/08/15 and added to the patient's record immediately. To assure other patients' discharge summaries are completed within two weeks following discharge, the Director of Health Information Management is tracking completion of discharge summaries on a daily basis and notifying physicians when they have not been completed timely. ***Monitoring*** Rates of completion of discharge summaries within 2 weeks is monitored and reported at monthly Quality Council meetings. ***Responsible Persons*** Director of Health Information Management	

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E2243	Continued From page 7 During a review of Patient 2's EHR on 7/8/15, the face sheet indicated Patient 2 was discharged from the facility on 6/21/15. During an interview with the Director of Health Information Management on 7/8/15 at 2:00 PM, 17 days after Patient 2 was discharged, he reviewed the EHR for Patient 2 and was unable to locate a discharge summary. He stated the discharge summary had not been dictated by the physician yet. He stated the summary should have been dictated and in the patient's EHR by this date. He further stated that staffing had been low for the department that handles the dictations. During an interview with the Director of Health Information Management on 7/8/15 at 2:55 PM, he stated he was aware the clinical record for Patient 2 was "delinquent and had been flagged." He stated the discharge summary for Patient 2 was being typed at the time of this interview. The facility policy and procedure titled "Discharge and Death Summaries" dated April, 2008, indicated the physician must dictate a concise discharge summary which recapitulated the significant findings and events of the patient's hospitalization and condition on discharge. The policy indicated it was the responsibility of the Health Information Services department to monitor medical records to ensure the proper documentation was present.	E2243		

DEPARTMENTOF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555638	A. BUILDING 01 – **MAIN BUILDING 01** B. WING_____	01/12/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOS ANGELES COMM HOSPITAL	**4081 EAST OLYMPIC BLVD. LOS ANGELES, CA 90023**

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K 000	INITIAL COMMENTS This facility was surveyed under the Life Safety Code NFPA 101, 2000 Edition, Chapter 19, Existing Health Care Occupancies, and other applicable codes. The following represents the findings of the California Department of Public Health during a Life Safety Code Survey. Representing the California Department of Public Health: Evaluator 14041, REHS, HFE I	K 000		
K 050 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: NFPA 72, 1999 Edition, 208.2.1 Manual fire alarm boxes shall be located throughout the protected area so that they are unobstructed and accessible. Based on observation and interview, the facility failed to ensure that the only manual pull fire alarm device located in the hospital's licensed area was immediately available and visible at all times.	K 050	**Corrective Action** 1. Fire drill conducted in SubAcute. (See Attachment C-1 through C-9.) 2. Inservice was given during the drill in regards to the location of the pull stations in the nurse's area free of any obstacles. (See Attachment C-1 through C-9.) 3. Signage was placed above the nurse station pull device for activating fire alarm. (See Attachments A&B). **Date of Implementation** Fire Drill & Education conducted 1/31/14. **Monitoring Process** All fire drills are reviewed in the EOC/Safety Committee that meets 4 times a year. **Responsible Person** Director of Facilities	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 2/17/14

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K 050	Continued From page 1 Finding: On January 11, 2014, at 1:20 p.m., the evaluator conducted an inspection and observation of the life safety code system fire alarm devices. The evaluator held an interview with Staff 2 regarding the Life Safety Code System. The evaluator asked Staff 2 how she would activate the fire alarm. She stated that there were no manual pull fire alarms in the area and the closest fire alarm box was located near the exit doors outside the licensed area of the hospital. The evaluator held an interview with the building supervisor and he stated, "There is a manual pull alarm located in the nurse station." The evaluator had previously inspected the nurse station and she did not see a manual pull fire alarm. The building supervisor directed the evaluator to a section of nurse station used for the patient monitors and the communication system. A licensed nurse relocated one of the monitors and the evaluator saw a manual pull fire alarm. The computer monitor hid the manual pull fire alarm from view or access and there was no signage or information that manual pull alarm was available in the licensed area of the hospital in case of fire emergency. A review of the fire drills revealed that no one had activated the manual pull alarm at any time. NFPA 101 LIFE SAFETY CODE STANDARD	K 050	**Corrective Action** 1. Fire drill conducted in SubAcute. (See Attachment C-1 through C-9.) 2. Inservice was given during the drill in regards to the location of the pull stations in the nurse's area free of any obstacles. (See Attachment C-1 through C-9.) 3. Signage was placed above the nurse station pull device for activating fire alarm. (See Attachments A&B). **Date of Implementation** Fire Drill & Education conducted 1/31/14. **Monitoring Process** All fire drills are reviewed in the EOC/Safety Committee that meets 4 times a year. **Responsible Person** Director of Facilities	
K 051 SS=D	A fire alarm system with approved components,	K 051		

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LOS ANGELES COMM HOSPITAL	4081 EAST OLYMPIC BLVD. LOS ANGELES, CA 90023

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K 051	Continued From page 2 devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4, 9.6 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure that all activated smoke detector locations were correctly identified on the main fire alarm panel, in case of a fire emergency. Finding: On January 11, 2014, at 11:11 a.m., the evaluator conducted an inspection and observed a test of the fire alarm system devices. The Building Supervisor activated the patients'	K 051	**Corrective Action** 1. Vendor was called for service. 2. Vendor found a smoke detector that was faulty and replaced. System was tested and all signals were good. (See Attachment D). **Date of Implementation** 1/24/14 **Monitoring Process** Fire alarm systems are tested periodically with reporting to the EOC/Safety Committee that meets 4 times/year. **Responsible Person** Director of Facilities	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555638	A. BUILDING 01 - **MAIN BUILDING 01** B. WING_____	01/12/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOS ANGELES COMM HOSPITAL	4081 EAST OLYMPIC BLVD. LOS ANGELES, CA 90023

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY SHOULD BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERRED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 051	Continued From page 3 sleeping room smoke detectors. The smoke detector located in room 102 activated and the alarm sounded. The evaluator checked the fire alarm panel and the panel incorrectly identified sleeping room 107 vs. room 102. The evaluator held an interview with the Building Supervisor and he stated that he would have the fire alarm panel serviced as soon as possible. NFPA 101 LIFE SAFETY CODE STANDARD	K 051		
K 061 SS=D	Required automatic sprinkler systems have valves supervised so that at least a local alarm will sound when the valves are closed. NFPA 72, 9.7.2.1 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure the fire sprinkler alarm system was monitored and maintained. Finding: On January 11, 2014, at 11:45 a.m., the evaluator conducted an inspection of the fire sprinkler supervised system. An interview was held with the facility building employee and he stated that the fire sprinkler alarm only sounds when a fire sprinkler is activated or if the fire sprinkler system is drained. The evaluator requested and observed a test of the fire sprinkler system tamper switch. The employee turned off the system control valve that	K 061	**Corrective Action** 1. Vendor was called for service. 2. Vendor replaced tamper switch. Later tested and all signals were good. (See Attachment E-1.) **Date of Implementation** 2/10/14 **Monitoring Process** The sprinkler system is periodically tested and reports of such are shared with the EOC/Safety Committee that meets 4 times/year. **Responsible Person** Director of Facilities	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555638	A. BUILDING 01 - **MAIN BUILDING 01** B. WING_____	01/12/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOS ANGELES COMM HOSPITAL	4081 EAST OLYMPIC BLVD. LOS ANGELES, CA 90023

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY SHOULD BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERRED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 061	Continued From page 4 is connected to the tamper switch, and no local alarm sounded. The fire sprinkler system tamper switch is designed to alert the facility staff when the fire sprinkler system water is shut off for repairs, inadvertently, or maliciously. The fire sprinkler system shall be electronically supervised to locally alert the facility staff regarding a fire sprinkler flow, tamper, or trouble at all times. An interview was held with the Building Supervisor and he stated that he would have the tamper switch serviced as soon as possible. NFPA 101 MISCELLANEOUS	K 061		
K 130 SS=D	OTHER LSC DEFICIENCY NOT ON 2786 This STANDARD is not met as evidenced by: NFPA 72, 1999 Edition, 2-8.2.1 Manual fire alarm boxes shall be located throughout the protected area so that they are unobstructed and accessible. Based on observation and interview, the facility fail to ensure that the only manual pull fire alarm device located in the hospital's licensed area was immediately available at all times. Finding: The evaluator conducted an inspection of the facility's licensed area with one central nurse	K 130		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555638	A. BUILDING 01 - **MAIN BUILDING 01** B. WING_____	01/12/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOS ANGELES COMM HOSPITAL	4081 EAST OLYMPIC BLVD. LOS ANGELES, CA 90023

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY SHOULD BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERRED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 130	Continued From page 5 station, three smoke compartments, and one manual pull alarm. An interview was held with Staff 2 and she stated that there was no manual pull alarm located in the licensed area and she guided the evaluator outside the smoke compartments to the nearest exit door. The door lead directly outside and the evaluator observed a manual pull fire alarm device located adjacent to the floor. An interview was held with the building engineer and he stated that there was a manual pull fire alarm within the licensed area located in the nurse station. The building engineer led the evaluator to the nurse station and pointed to a patient monitor on a counter top. A licensed nurse sitting nearby pushed aside the monitor to reveal a manual pull alarm that was hidden from view. The evaluator did not observe any signage or indication that a manual pull fire alarm was available in the nurse station in case of a fire emergency.	K 130	**Corrective Action** 1. Fire drill conducted in SubAcute. (See Attachment C-1 through C-9.) 2. Inservice was given during the drill in regards to the location of the pull stations in the nurse's area free of any obstacles. (See Attachment C-1 through C-9.) 3. Signage was placed above the nurse station pull device for activating fire alarm. (See Attachments A&B). **Date of Implementation** Fire Drill & Education conducted 1/31/14. **Monitoring Process** All fire drills are reviewed in the EOC/Safety Committee that meets 4 times a year. **Responsible Person** Director of Facilities	
K 144 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.	K 144		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555638	A. BUILDING 01 - **MAIN BUILDING 01** B. WING_____	01/12/2014

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LOS ANGELES COMM HOSPITAL	4081 EAST OLYMPIC BLVD. LOS ANGELES, CA 90023

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K 144	Continued From page 6 This STANDARD is not met as evidenced by: NFPA 110 Standard for Emergency and Standby Power Systems 1999 Edition 6-4.1 Level 1 and Level 2 EPSSs, including all appurtenant components, shall be inspected weekly and shall be exercised under load at least monthly. 6-4.1 Generator sets in Level 1 and Level 2 service shall be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods: (a) under operating temperature conditions or at not less than 30 percent of the EPS nameplate rating (b) Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer. The date and time of day for required testing shall be decided by the owner, based on facility operations. NFPA 110 Standard for Emergency and Standby Power Systems 99 Ed 6-2.1, At least two sets of instruction manuals for all major generator components of the EPSS shall be supplied by the manufacturer(s) of the EPSS and shall contain the following: (a) A detailed explanation of the operation of the system (b) Instructions for routine maintenance (c) Detailed repair instructions for the EPS and other major components of the EPSS (d) An illustrated parts list and part numbers (e) Illustrated and schematic drawings of electrical wiring systems, including operating and safety devices, control panels, instrumentation and annunciators NFPA 99, Chapter 3, Electrical System, 3-4.4.1.1, Maintenance and Testing of Alternate Power Source and Transfer Switches (b) 3 Test	K 144	**Corrective Action** Inservice was performed to all plant operations staff in regards to understanding proper testing of the emergency generator and proper documentation. (See Attachments E-2 and E-3.) **Date of Implementation** 2/11/14 **Monitoring Process** Generator testing is reported to the EOC/Safety Committee that meets 4 times/year. **Responsible Person** Director of Facilities	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 144	Continued From page 7 Personnel. The scheduled tests shall be conducted by competent personnel. The tests are need to keep the machines ready to function and, in addition, serve to detect causes of malfunction and to train personnel in operating procedures….. The Occupational Safety and Health Administration (OSHA) mandates training in such areas as electrical safety, personal protective equipment, and hazard communication. Relevance to emergency generators should be determined. Based on observation, interview, and record review, the facility failed to ensure that the back up source of power, the generator, was tested and maintained in accordance with the operator manual and by a staff that was trained. The facility failed to ensure that the monthly generator test documentation was fully documented with all the pertinent information regarding the status of the generator. Finding: On January 11, 2014, at 10:30, the evaluator conducted an inspection of the facility's Life Safety Code System. A review of the emergency generator monthly test and maintenance records revealed no information regarding the condition or status of the generator other than check marks, and there was no generator operating manual available at the time of the survey. An interview was held with the Building Supervisor and he stated that there was no documentation regarding the training of the staff in charge of the generator monthly test available	K 144		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 144	Continued From page 8 at the time of the survey. In case of a loss of normal power, the emergency back up generator shall be tested and maintained based on the manufacturer's recommendation, all information shall be documented on the generator's monthly test record, and the staff in charge of the monthly test shall be trained and competent.	K 144		

Attachment A

Attachment B

Attachment C-1

ALTA Healthcare

Los Angeles Community Hospital

4081 East Olympic Blvd., Los Angeles Ca 90023

EDUCATION
Training Records

DEPARTMENT: DATE:

TOPIC: Fire Drill / Practice Pull station Activation

SHIFT: LOCATION:

Reason For Class / In Service:

- [x] Mandatory
- [x] Hospital Wide
- [x] Department
- [x] Staff Needs / Request
- [x] Safety
- [x] Risk Management
- [ ] New Product / Procedure
- [ ] Patient Population /
- [ ] Infection Control
- [x] Performanace Improvement
- [x] Annual Update
- [x] Competency
- [ ] Equipment
- [ ] **Other:**

Teaching Methods:

- [ ] Video
- [ ] Slide Presentation
- [x] Lectures
- [ ] Demonstration
- [ ] **Other:**

Instructor: (i.e., Sales Rep., Person with Expertise On Subject):

Jose A. Barahona

Objective (By the Completion of the Class/In-Service the learner will be able to):

EMPLOYEES WILL KNOW LOCATION, AND HOW TO ALARM PULL STATION PREVENT FIRE FROM SPREADING

TRAINING OUTLINE: INFORMED STAFF ABOUT LOCATION OF OXYGEN SHUT OFF VALVE / LOCATION OF NEAREST FIRE

RESPOND TO REAL FIRE & / EVACUATION ROUTE / LOCATION OF AIR CONDITIONING THERMOSTAT / TYPES OF

FIRE EXTINGUISHERS / HOW TO REPORT FIRE / HOW TO USE FIRE EXTINGUISHER / HOW TO EVACUATE

Class Outline: (May attach outline if there is one available): *SCHEDULE AND TRAINING ADJUSTED TO COMPLY WITH CDPH FINDING REQUEST***

SEE ATTACHED: PAGE 3 TO 5

Evaluation:

- [ ] Quiz
- [ ] Written Evaluation
- [ ] Return Demonstration
- [x] Discussion
- [ ] **Other:**

INSTRUCTOR: Jose A. Barahona.

SIGNATURE: Jose A. Barahona. TIME 2:45 DATE: 1.31.14

ALTA Healthcare

Los Angeles Community Hospital
4081 East Olympic Blvd., Los Angeles Ca 90023

EDUCATION
Training Records

FIRE / LIFE SAFETY

The mission of Fire and Life Safety management is to support the hospital in maintaining a safe environment for our patient, Visitors, and employees.
In the entire field of fire life safety, nothing is more important than prevention!

Prepare For The Fire:

- Keep fire alarm pull boxes, fire extinguishers, sprinkler heads, and smoke detectors free from obstruction.
- Keep corridors, passageways and exits clear at all times.
- Know the locations of the nearest fire alarm pull boxes and fire extinguishers in your area.
- Know the location of the closest exits, evacuation routes and what to do in response to the fire alarm
- Keep work areas and storage rooms free from combustible clutter and debris.
- Report defective electrical equipment, blocked exits, stairways, and fire doors to your Supervisor.
- DO NOT BLOCK EXITS.

Possible causes of fires include:

- Electrical equipment and small appliances;
- combustible materials-such as paper, cardboard boxes, dirty linen – pile up;
- Carelessness with oxygen;
- Arson.
- Keep an eye out for all these problems, and report them as appropriate.

Types of Fire:

CLASS "A"
fires occur in combustible solids, like paper, linen, and clothing. Can be extinguish by water.

CLASS "B"
Fires involving flammable liquids, such as gasoline, oil, alcohol, benzine, etc., which are best extinguished by smothering. (This includes food on the stove fires.)

CLASS "C"
Fires involving electrical equipment, appliances and wiring in which the use of non-conductive extinguishing agent prevents injury.

THE MAJORITY OF LACH & NCH FIRE EXTINGUISHERS ARE: ABC TYPE

The Fire Response Plan – RACE

- RESCUE / **The highest priority are saving people's Lives**, the first step is to get everyone out of the room or area where the fire is. We are especially concerned about patients who can't take care of themselves. Employees and visitors with disabilities will also need special attention.
  When leaving the room be sure to shut the doors behind you. They should latch, but not lock, so the fire fighters can get in when they arrive.

- ALARM / **Activate alarm.** (Know Location of Nearest Pull Station) Activating alarm ensures that the building occupants are alerted to the emergency and fire department is notified. call the PBX operator to report the fire. Be sure to take this step immediately after rescuing, so that the appropriate emergency response personnel are notified and can start to the scene of the fire.

  In addition to the alarm, call the emergency number- 911

  DIRECT OPERATOR HOTLINE:
  LACH Ext. 555 NCH Ext. 77

- CONTAIN / The third step is to keep the fire – and smoke – from spreading. Close each door and window in the area.
  If fire threatens your area, initiate the following procedures:

  a. Turn off all fans, air-conditioning, exhaust fans, etc.
  b. Turn off all electrically operated equipment, however leave the lights on.
  c. In case of an electrical fire, power is to be turned off at the main switch.
  d. Keep telephone lines clear.
  e. Close all doors and windows.
  f. Use the fire extinguisher to suppress the fire only if you have been trained and it is safe to do so.
  g. Notify the Control Center when you are in readiness for evacuation.
  h. Standby for orders.

  If the fire is not in your area, be alert, be guided by the instructions of your area supervisor, or Director of Plant Operations.

  a. Area supervisors will direct activities of staff members within their units by:
     - Assigning personnel to take fire extinguishers and reporting to the scene of the fire.
     - Turning off all fans, air-conditioning, exhaust fans.
     - Turning off utilities as required.
     - Turning off oxygen shut-off valves as required.
     - Closing all doors and windows.
     - Standing by for further orders.

- EXTINGUISH / When you reach the fourth step, it is time to attempt to extinguish the fire, by using a fire extinguisher.

The steps to Putting Out a Fire – PASS

- PULL the pin. / Break the plastic tie by turning the pin like a key in a lock, and then pull the pin out. Don't squeeze the handle while doing this.

- AIM the hose, horn at the base of the fire. Water extinguisher will shoot 30-40 feet when fully charged. The other kinds require you to get up to 8-10 feet away, or even closer.

- SQUEEZE the handle.

- SWEEP the stream from side to side, covering the material that is burning.

Evacuation

It is important for each employee to know their department's specific evacuation procedures. If evacuation is required, give special attention to children and person with disabilities. Go to your appropriate relocation point and verify that everyone from your area is accounted for. If someone is missing, notify fire department personnel on scene.

C-4

Los Angeles Community Hospital

SHIFT:	DAY	✓
	SWING	
	NIGHT	

FIRE OBSERVATION REPORT

DATE: 1.31.14

OBSERVERS LOCATION: Sub Acute

☑ Simulated Situation ☐ Fire ☐ Smoke ☐ Other _____

CAUSE & SOURCE OF FIRE:

☐ Bed ☑ Wastebasket ☐ Electrical ☐ Laundry ☐ Medical Gas
☐ Explosion ☐ Paper ☐ Wood ☐ Other _____

EXTENT OF FIRE:

☐ Large ☑ Small

INSTRUCTIONS:
Place "yes" in the blank space if conditions are satisfactory and "no" in space if unsatisfactory.

SAFETY OF LIFE

Yes ☐ No ☑ Occupant removed from the room. Simulated
Yes ☑ No ☐ closed to fire room.

NOTIFICATION / COMMUNICATION

Yes ☑ No ☐ Did Staff sound the alarm when the fire was recognized?
Yes ☑ No ☐ Did Staff sound the alarm by pulling down on the alarm box?
Yes ☑ No ☐ Notification from fire area to the PBX
Yes ☐ No ☑ Was the Fire department called? By who? Simulated
Yes ☑ No ☐ Administrator Paged? By who? PBX
Yes ☑ No ☐ Was fire alarm audible?
Yes ☑ No ☐ Was the page audible? Was the location clear?
Yes ☑ No ☐ "All Clear" sounded to all departments?

ORDERS

Yes ☑ No ☐ Was on duty personnel reported to assigned area and remained for orders?
Yes ☑ No ☐ Was personnel stationed at the telephone for further orders?
Yes ☐ No ☑ Was personnel sent to meet and direct the Fire Department? Sim
Yes ☐ No ☑ Were elevators brought down and held on the main floor? Sim.

RETURN/REPORT TO FIRE LOCATION

Yes ☑ No ☐ Were all doors closed?
Yes ☑ No ☐ Were Fire Extinguishers taken to the to the fire area?
Yes ☑ No ☐ Did Staff simulate fire extinguishment?
Yes ☑ No ☐ Did Staff know their specific fire response duties?

EVACUATION

C.5

_____ Horizontal (at least one set of fire doors)
_____ Vertical
_____ Total
Yes ☑ No ☐ Was Staff prepared to evacuate the building?

PATIENT AND VISITOR SAFETY

Yes ☑ No ☐ Were all exits and passageways leading to exits kept clear?
Yes ☑ No ☐ Were Patients and visitors escorted to a safe area?
Yes ☑ No ☐ Did personnel assisted in calming Patients and visitors?

EQUIPMENT AND APPLIANCES

Yes ☐ No ☑ Were gas appliances turned off
Yes ☐ No ☑ Were electrical equipment shut down? (Not lights) Simulated
Yes ☐ No ☑ was it necessary to shut off oxygen?
Yes ☐ No ☑ Were HVAC systems shut off

PROTECTION OF HOSPITAL SUPPLIES AND RECORDS

Yes ☑ No ☐ Were the narcotics cabinets locked?
Yes ☐ No ☐ Were all cash, books, ledgers, charts & files prepared for removal?

INTERIM LIFE SAFETY MEASURES (ILSMS) (Los Angeles Community Hospital)

Before actual fire or Fire Drill:

Yes ☐ No ☑ Did Engineering, Security, or Housekeeping personnel SHUT OFF the air conditioning unit switches in the corridor adjacent to room 105 and 106. Sim

After actual fire or Fire Drill:

Yes ☐ No ☑ Did Engineering, Security, or Housekeeping personnel TURNED the air conditioning unit switches in the corridor adjacent to room 105 and 106. Sim.

REMARKS AND RECOMMENDATIONS

Note: Reports to be made out immediately after each drill by the unit/department supervisor
Reports shall be sent to the Director of Plant Operations

Comments: No issues to Report.

1.31.14 / 2:45
Date / Time

Jose A. Barahona / Engineer. / Jose A. Barahona
Name / Position /Title / Signature

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ALTA Healthcare

Los Angeles Community Hospital

4081 East Olympic Blvd., Los Angeles Ca 90023

Fire Drill Critique

Date: 1-31-14		Shift: day	
Location	Sub Acute	Fire Dept. Notified	☐ YES ☑ NO
Coordinator	Mohammad Davani	Drill Started	2:15 pm
Engineer	Jose Barahona	Drill Ended	2:45 pm
Safety Officer	Jim Ruiz		

✓	TYPE of Fire	✓	In-service Training
X	A- Wood, Paper, Rubbish	X	Verbal Critique
	B- Flammable, Oil, Gas	√	HandOut Training Memos
	C- Electrical		
	D-		

✓	Initiator Response	✓	Department Response
	Called Fire Department (911) NO	√	Administration
√	Called Operator (Ex. ~~555~~) ~~777~~	√	Admitting
	Called Emergency (911) NO	√	Security
√	Pulled Fire Alarm Pull Station	√	Engineering / Safety Officer

✓	PBX Operator Response	✓	Equipment Response
√	Time Before Announcement	√	First Bells Sounded
√	3 Time "Code Red (Location)"	√	Door Closed and Latched
√	Notified Appropriate Personnel		Oxygen was Shut Off Simulated
√	3 Time "Code Red All Clear"	√	Alarm System Was Reset

GENERAL RESPONSE			
✓	PBX Operator Response	✓	Equipment Response
	Excellent		Slow
√	Good	√	Calm
	Fair		Exited
	Poor		Panic

OBSERVATION MADE FROM : Unit 3

SIGNATURE: Brian Mulvey TIME 2:45 DATE: 1-31-14

C-7

ALTA Healthcare

Los Angeles Community Hospital

4081 East Olympic Blvd., Los Angeles Ca 90023

EDUCATION

Training Records

ATTENDANCE RECORD:

Date: 1.31.14

No.	NAME (PLEASE PRINT)	TITLE / DEPARTMENT	SIGNATURE
1	SILVIA ARBOLEDA	HIS	[signature]
2	Remy Miranda	HIS	[signature]
3	Martha Marquez	S/A	Martha Marquez
4	M. Gonzalez	ICU	M Gonzalez
5	Hector Castillo	CNA / S/A	[signature]
6	[illegible]	S/A	[signature]
7	Ana Capristo	CNA	[signature]
8	W. GINETE	RN / Unit IV	[signature]
9	Richard [illegible]	LAB	[signature]
10	Christine Joh	Pharmacy	[signature]
11	Claudia Rivera	CNA	[signature]
12	OCTAVIO LUNA	C.S.	O. Luna
13	[illegible]	[illegible]	[signature]
14	Nelson Tobon	LVN / S/A	[signature]
15	MEALY MIN	S/A	[signature]
16	[illegible]	LVN	[signature]
17	[illegible]	RN	ER
18	Victor Paz	RT	[signature]
19	PINKY LITUANIA	PT	[signature]
20	Cesar Lopez	S/A	[signature]
21	[illegible]	PT- WC	[signature]
22	Brian Gutierrez	ENG	Brian Gutierrez
23			

C-8

Los Angeles Community Hospital

4081 East Olympic Blvd., Los Angeles Ca 90023

SHIFT:	DAY	✓
	SWING	
	NIGHT	

Fire Drill Attendance Sign Sheet

Date: 1.31.14	Time: 2:15	Location: Sub Acute.

No.	Name:	Department:	Fire Ext.
1	[illegible]	LAB	
2	Christine Joh	Pharmacy	
3	[illegible]	M-4	
4	[illegible]	M/S	
5	Antonio Salazar	Resp.	
6	Claudia Rivera	M/S.	
7	OCTAVIO LUNA	e.l.s.	
8	[illegible]	Ley	
9	NELSON TOLA-	S/A	
10	[illegible]	CVN	
11	MERLY MIN	SA	
12	SHEHAN MERZA	SA	
13	Melissa Acero	SA	
14	ANNA PASTORES	SA	
15	DANIELLE JAMES	SA	
16	PINKY LIVANAG	PT	
17	[illegible]	ACC-SB	
18	[illegible]	PT-WC	

FIRE DRILL TOPIC:

C-9

Los Angeles Community Hospital

4081 East Olympic Blvd., Los Angeles Ca 90023

SHIFT:		
	DAY	✓
	SWING	
	NIGHT	

Fire Drill Attendance Sign Sheet

Date: 1.31.14	Time: 2:15	Location: Sub Acute.

No.	Name:	Department:	Fire Ext.
1	BOCFERIA	PEDS	
2	Isabel Virdel	S/A	
3	[illegible]	[illegible]	
4	[illegible]	S/A	
5	FLORENCIO CRUZ.	S/A	yes
6	SILVIA ARBOLEDA	HIS	
7	Remy Miranda	HIS.	yes
8	M. Gonzalez	ICU	yes
9	Martha Marquez	S/A	yes
10	Ana Capristo	S/A	
11	Hector Castillo	S/A	
12	W. GINETE	OB UNIT IV	[illegible]
13	[illegible]	S/A	[illegible]
14	MARIANO [illegible]	[illegible]	
15	Eric Abarca	E.R.	
16	[illegible] SRN	Tele	
17	[illegible]	ER	
18	[illegible]	[illegible]	

FIRE DRILL TOPIC:

Attachment D

MID VALLEY AUTOMATIC FIRE PROTECTION SYSTEMS, INC.

347 Paseo Sonrisa
Walnut, CA 91789
(909) 594-4060 FAX: No. (909) 595-9828
www.midvalleyfire.com

WORK ORDER

№ A14102

DATE: 1/24/14

CUSTOMER NAME: Los Angeles Community Hospital

ADDRESS: _____

CITY: Los Angeles STATE: Ca ZIP: _____

JOB LOCATION: _____

WORK DONE BY: Mary + Jon

PO#: _____

Smoke detector trouble

QUANTITY	ITEM	DESCRIPTION	PRICE	TOTAL
		Need to replace smoke detector on 1st fl. Patient Rm. #5.		
		Replaced smoke detector and fire alarm is now Normal, System Normal,		
		Mary		
		Trouble shoot 2 HRS.		190.00
		Replace w/ new 2 HR. minimum		190.00
				380.00

SUMMARY OF INSPECTION: _____

X Josh A. Berkhoven
CUSTOMERS SIGNATURE

Attachment E-1

MID VALLEY AUTOMATIC FIRE PROTECTION SYSTEMS, INC.

347 Paseo Sonrisa
Walnut, CA 91789
(909) 594-4060 FAX: No. (909) 595-9828
www.midvalleyfire.com

WORK ORDER

№

MID AVF MID-VALLEY AUTOMATIC FIRE SYSTEMS, INC

Alta Hospitals

DATE: 2/10/14

CUSTOMER NAME: East Los Angeles Community Hospital

ADDRESS: 4081 Olympic Bl.

CITY: Los Angeles STATE: Ca ZIP: 90023

Acct # WK50131

JOB LOCATION:

WORK DONE BY: Harry

PO#:

* Check Tamper *

QUANTITY	ITEM	DESCRIPTION	PRICE	TOTAL
		*Checked existing tamper and it was not operational. I showed George Martinez and he agreed that existing tamper was not operational. I replaced with a new potter OS+Y tamper and tested Zone 7. operational and normal.		
1	OS+Y	(New Tamper) →		
		*I was also instructed that system was not monitored anymore by Simplex so I got acct. Info from John Martinez at our office and I reprogrammed Silent Knight dialer to our central station and tested. System Normal		
		Acct # is WK50131		
		Harry		

SUMMARY OF INSPECTION:

[signature]

CUSTOMERS SIGNATURE

E-2

ALTA Healthcare

Los Angeles Community Hospital
4081 East Olympic Blvd., Los Angeles Ca 90023

EDUCATION
Training Records

DEPARTMENT: **Engineering** DATE: **2-11-14**

TOPIC: Testing and documenting of Emergency Generator

SHIFT: **1st Shift (Day)** LOCATION: **Generator Area**

Reason For Class / In Service:

- [x] Mandatory
- [x] Hospital Wide
- [ ] Department
- [ ] Staff Needs / Request
- [ ] Safety
- [ ] Risk Management
- [ ] New Product / Procedure
- [ ] Patient Population /
- [ ] Infection Control
- [ ] Performanace Improvement
- [ ] Annual Update
- [ ] Competency
- [x] Equipment
- [ ] **Other:**

Teaching Methods:

- [ ] Video
- [ ] Slide Presentation
- [ ] Lectures
- [ ] Demonstration
- [ ] **Other:**

Instructor: (notified Engineering staff of location of Manuals):
A COPY OF GENERATOR MANUAL IS LOCATED AT THE ENGINEERING OFFICE AND INSIDE THE GENERATOR ENCLOSURE.

Objective (By the Completion of the Class/In-Service the learner will be able to):
1.UNDERSTANDING THE EMERGENCY GENERATOR TESTING PROCESS AND THE PROPER DOCUMENTATION OF THE RESULTS. WE MUST INDICATE PROPER LEVELS AND OR RESPONSES NOT ONLY CHECK MARKS.

Class Outline: (May attach outline if there is one available):
*******THIS IS TRAINING IS TO COMPLY WITH CDPH FINDING *******

Evaluation:

- [ ] Quiz
- [ ] Written Evaluation
- [ ] Return Demonstration
- [x] Discussion
- [ ] **Other:**

INSTRUCTOR: MARTIN RODRIGUEZ / JIM RUIZ /GEORGE MARTINEZ

E-3

ALTA Healthcare

Los Angeles Community Hospital

4081 East Olympic Blvd., Los Angeles Ca 90023

EDUCATION
Training Records

ATTENDANCE RECORD:

Date: February 11 2014

No.	NAME (PLEASE PRINT)	TITLE / DEPARTMENT	SIGNATURE
1	BENNY ANAYA	HVAC MECHANIC/ENG.	
2	Brian Gutierrez	ENG	Brian Gutierrez
3	HIPOLITO. ORTEGA	ENG	Hipolito Ortega
4	Jose A. Barchona	Eng.	Jose A Barchona
5	Jose Romero	Eng. Dept.	
6			
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RESPONSE TO DEFICIENCIES
EXHIBIT P CMS Statements of Deficiency

Newport Specialty Hospital
(Now called Foothill Regional Medical Center)

CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555730	A. BUILDING _____ B. WING _____	04/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEWPORT SPECIALTY HOSPITAL D/P SNF	14662 Newport Ave, Tustin, CA 92780-6064 ORANGE COUNTY

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
	The following reflects the findings of the Department of Public Health during a Comp'aint Investigation visit: CLASS B CITATION – PATIENT CARE 06-2207-0011387-F Complaint(s): CA00434111 Representing the Department of Public Heal:h: Surveyor ID # 27007, HFEN The inspection was limited to the specific facility event investigated and does not represent the find ngs of a full inspection of the facility. Accidents and Supervision F323 G. The facility must ensure that the resident environment remains as free of acc dent hazards as is possible, and each resident receives adequate supervision and assistance devices to prevent accidents The facility failed to ensure Resident 1 was as free from accident hazards as possib'e Resident 1 was nonverbal, had contractures to her arms and hands, and was unable to move her extremities On 1/18/15, while attempting to dry Resident 1's hair, LVN 1 left a hairdryer on and placed in close proximity to Resident 1's left hand A few hours later, a staff member noticed Resident 1 had sustained blisters from a second degree burn to her left hand and left shoulder. Rev'ew of an article titled Hair Dryer Burns in Children published in 1990, by the Official Journal of the American Academy of Ped:atrics showed	F323 G	Corrective actions for the affected resident: . Upon discovery of Resident's skin impairment, the physician was called, orders obtained and treatment was immediately initiated. . Consults obtained from wound care nurse and Infectious Disease physic:an. . Facility conducted a thorough investigation, including interviews with all staff. . Family was immediately notified upon discovery, and kept apprised of the resident's condition, plan of care, and told of the facilities plans to conduct a formal investigation. . Hairdryer was immediately removed from pat'ent room. Hairdryers to be kept at nurses' station and checked out for use with patients, January 2015. . Safety check of hairdryer was done by engineering, January 2015. . Treatment was successful, and no longer required as of 3/12/2015. Wound healed completely, and without any scaring. The Director of Nurses was responsible to ensure the above mentioned actions were taken.	1/18/2015 1/24/2015 2/3/2015 1/18/2015 1/19/2015 1/24/15 3/12/2015

Event ID 5OLP11 4/14/2015 9 01 57AM

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

CSO 4/14/15

By signing this document, I am acknowledging receipt of the entire citation packet. Page(s) 1 thru 7

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correct'g providing it is determined that other safeguards provide sufficient protection to the patients Except for nurs.ng homes the findings above are disclosab'e 90 days following the date of survey whether or not a plan of correction is provided For nursing homes the above findings and p ans of correct.on are d.sclosable 14 days following the date these documents are made available to the fac.'ty If deficiencies are cited an approved plan of correction is requisite to continued program participation

State-2567

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555730	A. BUILDING _____ B. WING _____	04/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEWPORT SPECIALTY HOSPITAL D/P SNF	14662 Newport Ave, Tustin, CA 92780-6064 ORANGE COUNTY

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
	testing of home hairdryers was done to determine their heat output. At the highest heat settings, the hairdryers rapidly generated temperatures in excess of 110°C (230 degrees F). After the hairdryers were turned off, the protective grills maintained sufficient temperatures to cause full-thickness burns for up to 2 minutes. These cases and the results of testing demonstrate that hairdryers must be added to the list of known causes of accidental and non-accidental burns in children. www.medicinenet.com showed a first degree burn is superficial and causes local inflammation of the skin. Sunburns often are categorized as first degree burns. The inflammation is characterized by pain, redness, and a mild amount of swelling. The skin may be very tender to touch. A second degree burn is deeper than a first degree burn and in addition to the pain, redness and inflammation, there is also blistering of the skin. Clinical record review for Resident 1 was initiated on 3/16/15. Resident 1, a pediatric, was admitted to the facility on 11/29/08, with diagnoses including severe encephalopathy, quadriplegia, and near vegetative state. Review of the computerized note (untitled) dated 1/18/15, showed Resident 1 was identified to have blisters to her left hand. The "primary nurse and CNA are unaware of how it may have happened." Review of the Nursing Progress/Summary Notes dated 1/18/15 at 1500 hours, identified Resident 1	F323 G	How the facility will identify other residents having the potential to be affected by the same deficit practice and what corrective action will be taken: ▪ Routine daily skin assessments of all residents are performed by the primary nurse each shift. ▪ Weekly comprehensive skin assessments will be performed by charge nurse and monitored daily for any identified skin issue. ▪ Ongoing spot checks of Hair Dryer usage to ensure that proper usage techniques are followed. The Director of Nurses is ultimately responsible to ensure the above actions are taken. All resident skin assessments completed. No other residents affected.	1/18/2015 1/18/2015 4/22/15 LM ~~4/15/15~~ Ongoing 1/18/15 LM

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555730	A BUILDING _____ B WING _____	04/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS CITY STATE ZIP CODE
NEWPORT SPECIALTY HOSPITAL D/P SNF	14662 Newport Ave, Tustin, CA 92780-6064 ORANGE COUNTY

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	had blisters to her left hand. At 2000 hours staff documented there were multiple open weeping fluid blisters to her left hand On 1/19/15 at 1030 hours, staff documented Resident 1 also had a small blister to her left shoulder Review of Resident 1's physician's order dated 1/20/15 at 1015 hours showed to administer Motrin and Tylenol (alternate) every four hours for 48 hours for pain prophylaxis On 1/22/15 at 1315 hours a physician's order was received to administer Motrin 220 mg via GT every eight hours for four days for pain Review of Resident 1's Comprehensive Skin Assessments showed the following * On 1/18/15 at 1600 hours, showed blisters and redness to the dorsal aspect (back) of Resident 1's left hand. The photograph showed multiple raised fluid filled blisters. Staff documented if the blister was to open to apply Bacitracin (antibiotic) ointment four times a day for 10 days. * On 1/20/15 at 1100 hours, Resident 1's left hand blisters opened and draining serous fluid. The affected area measured 6 cm (length) x 4 cm (width) Staff documented Bacitracin ointment was to be started after the C&S of the left hand blister drainage was obtained. The photograph showed some of the blisters had popped and others remained filled with fluid. * On 1/23/15 at 0900 hours, the left hand blisters and redness were present and continued to be	F323G	What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur: • New Equipment Usage policy, effective January 2015. Emphasized using all unit equipment only for the manufacturer's intended purpose, and included mandatory education of patient families wishing to use facility equipment to participate in the care of their family member. • New Treatment of Hypothermia policy, effective January 2015. Outlines appropriate use of Bair Hugger for patient warming, appropriate heat settings, and guidelines for monitoring patient while Bair Hugger is in use. • Hairdryers were immediately removed from patient rooms. • New lower wattage, short shaft hairdryers were ordered for the unit, 4/15/2015. • Hair dryer competency to be completed by all nursing staff, applicable to their patient care role. (DSD) • All staff educated by DON and Quality & Risk Director about the use of equipment, treating hypothermia, as well as informed about hairdryer usage and the need to monitor families use of such equipment. Staff also encouraged to actively participate in ongoing investigation and unit improvement activities The Director of Nurses will be ultimately responsible to ensure the above written action plan is followed.	1/27/2015 1/27/2015 1/18/2015 4/22/15 MM ~~4/15/2015~~ 4/22/15 MM ~~4/16/2015~~ 2/3/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555730	A. BUILDING _____ B. WING _____	04/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEWPORT SPECIALTY HOSPITAL D/P SNF	14662 Newport Ave, Tustin, CA 92780-6064 ORANGE COUNTY

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	treated with Bacitracin ointment. * On 1/26/15 at 1800 hours, Resident 1's left hand blisters were assessed to be a second degree burn * On 1/29/15 at 2000 hours, staff documented all of Resident 1's blisters had popped. The treatment was changed to Silvadene cream (medication used to treat burns) daily and to cover with a non-stick dressing for seven days. On 3/10/15 at 1000 hours, staff documented Resident 1's left hand wound had completely healed Review of Resident 1's Doctors' Progress Note dated 1/24/15, showed an evaluation was completed by an Infectious Disease Consultant. The doctor documented Resident 1 had a recent appearance of blisters over the left dorsal hand and fingers, and to treat the blisters as a "second degree burn" injury. Review of a (untitled) document dated 3/11/15 at 1616 hours, showed on 2/5/15, the left hand (blisters) healing well and appeared to be in much less pain. Review of the Restorative Administration Record for January 2015, showed Resident 1 was to have PROM to her upper extremities and the application of bilateral elbow extensor splints for 12 hours a day five days per week. However, the RNA documented on the reverse side of the sheet from 1/20/15 to 1/30/15, the PROM and left hand splint were not provided due to the resident's left hand	F323G	How the facility plans to monitor its performance to make sure that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for effectiveness: • Daily routine daily skin assessments will be performed by the primary nurse and documented in the resident's medical record. • Weekly comprehensive skin assessments will be performed by charge nurse and monitored daily for any identified skin issue. • Quarterly reports of the results of skin assessment and reassessments will be submitted to Peds Committee, Quality Patient Safety Committee, Medical Executive Committee, and Governing Board. To continue through 2015 and evaluated during annual evaluation. • Hair dryer competency to be completed by all new hires, and annually. This will be performed by the DSD. A competency report of findings will be submitted to the Pediatric Medical Staff Committee, Medical Executive Committee, and Governing Board. • Weekly spot checks of hairdryer usage to be done by charge nurses and data collected for at least 6 months with reevaluation to determine the need to continue. Results to be reported to DON and Director of Quality/Risk Management on a monthly basis. The Director of Nurses will be ultimately responsible to ensure the above written action plan is followed.	Ongoing since 9/2014 Ongoing since 9/2014 4/22/15 LM ~~4/16/15~~ 4/22/15 LM ~~4/16/15~~ 4/22/15 LM ~~4/16/15~~

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555730	A. BUILDING _____ B. WING _____	04/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEWPORT SPECIALTY HOSPITAL D/P SNF	14662 Newport Ave, Tustin, CA 92780-6064 ORANGE COUNTY

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wound.

On 3/16/15 at 1405 hours, Resident 1 was observed sitting in her wheelchair next to her bed. She was unable to respond to verbal commands. Her arms and hands were contracted and the top of her left hand had multiple skin (pigment) discolorations as a result of the burn.

On 3/16/15 at 1455 hours, Resident 1's attending physician was interviewed. The physician stated Resident 1 had limited movement in her extremities and required total assistance from the staff for all ADL care. When asked how Resident 1 sustained the burn to her left hand, the physician stated he could not think of anything "hot enough" to cause a burn, but the item would have to be very close (to the left hand).

An interview with RN 1 was conducted on 3/16/15 at 1540 hours. RN 1 stated Resident 1 was showered every day on the day shift. She stated the resident's hair was washed during the showers.

On 3/16/15 at 1550 hours, an interview was conducted with CNA 1. CNA 1 stated before the burn to the resident's left hand, the resident's family and staff used a hairdryer to dry the resident's hair. CNA 1 stated the hairdryer was stored in Resident 1's room but had been removed after the 1/18/15 incident.

On 3/16/15 at 1605 hours, an interview was conducted with LVN 1. LVN 1 stated she was assigned to work as a caregiver for Resident 1 on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555730	A. BUILDING _____ B. WING _____	04/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEWPORT SPECIALTY HOSPITAL D/P SNF	14662 Newport Ave, Tustin, CA 92780-6064 ORANGE COUNTY

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREF X TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
	1/18/15. LVN 1 stated on the morning of 1/18/15, she gave Resident 1 a shower and washed her hair. She stated while Resident 1 was still lying on the shower gurney, she took the hairdryer from Resident 1's bedside to dry the resident's hair. LVN 1 stated when she was going to dry the back of her hair, she took the hairdryer from her left hand and placed it down near the top of the gurney, on the left side, so she could raise Resident 1's head. She stated the hairdryer was remained on while she was repositioning the resident's head. LVN 1 stated Resident 1's arms/hands were contracted (when lying down the resident's hands were up by her head) and the heat from of the hairdryer was blowing in the direction toward the resident's left hand. When LVN 1 was asked if she thought the burn could have been caused by the hairdryer being left on and placed at the head of the shower gurney, she stated the hairdryer was "the only thing it could have been." When LVN 1 was asked if the burn to Resident 1's hand could have been prevented, she stated "yea." She stated she could have placed Resident 1 in a wheelchair before she dried her hair, like she had seen other CNAs do. When LVN 1 was asked if she was aware of Resident 1's left shoulder blister that was observed on 1/19/15, she stated "no." During an interview on 3/16/15 at 1635 hours, the DON stated Resident 1 required total care from the staff for all her ADL care. When asked how Resident 1 sustained the burn to her left hand, the DON stated she was unable to determine the cause. The DON stated since the incident to Resident 1's left hand, all hairdryers had been			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1 PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555730	A. BUILDING _____ B. WING _____	04/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEWPORT SPECIALTY HOSPITAL D/P SNF	14662 Newport Ave, Tustin, CA 92780-6064 ORANGE COUNTY

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

removed from all residents' rooms and were to have a safety check by the Maintenance Director

The facility's failure had a direct or immediate relationship to the health safety or security of long-term health care facility residents

State of California--Health and Human Services Agency
Department of Public Health

KAREN L. SMITH, MD, MPH
Director and State Health Officer

EDMUND G. BROWN JR.
Governor

April 8, 2015

Barbara Schneider, Administrator
Newport Specialty Hospital
14662 Newport Avenue
Tustin, CA 92780

Dear Ms. Schneider:

FACILITY: Newport Specialty Hospital
ENTITY REPORTED INCIDENT NUMBER'S: CA00325828 and CA00329252

The purpose of this letter is to inform you of the results of our entity reported incident investigation's completed on March 24, 2015.

Attached you will find a Statement of Deficiencies and Plan of Correction (CMS 2567), indicating that no deficiencies were found during this investigation. Please sign and date this document and return it to the department. Please make a copy for your facility.

Sincerely,

Hang Nguyen

Hang Nguyen, RN, MSN
District Manager
Orange County District Office

HN/sd

Enclosure *(CMS 2567)*

Licensing and Certification Program, 681 S. Parker Street, Suite 200, Orange, CA 92868
Telephone: (714) 567-2906 / Fax: (714) 567-2815
Internet Address: www.cdph.ca.gov

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	CA06000013	A. BUILDING: _____ B. WING _____	C 03/24/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEWPORT SPECIALTY HOSPITAL	14662 NEWPORT AVENUE TUSTIN, CA 92780

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments The following reflects the findings of the California Department of Public Health during the investigation of Entity Reported Incident No. CA00325828 and CA00329252. Inspection was limited to the specific Entity Reported Incident(s) investigated and does not represent the findings of a full inspection of the facility. Representing the California Department of Public Health: Surveyor 2097, HFES. THE DEPARTMENT SUBSTANTIATED THE ENTITY REPORTED INCIDENTS THAT DID NOT CONSTITUTE A VIOLATION OF THE REGULATIONS.	A 000		
A 001	Informed Adverse Event Notification Health and Safety Code Section 1279.1 (c), "The facility shall inform the patient or the party responsible for the patient of the adverse event by the time the report is made." The CDPH verified that the facility informed the patient or the party responsible for the patient of the adverse event by the time the report was made.	A 001		
A 010	1279.1(b) HSC Section 1279 (b) For purposes of this section, "adverse event" includes any of the following: This Statute is not met as evidenced by:	A 010		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	CA06000013	A. BUILDING: _____ B. WING _____	C 03/24/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEWPORT SPECIALTY HOSPITAL	14662 NEWPORT AVENUE TUSTIN, CA 92780

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 010	Continued From page 1	A 010		
A 031	1279.1(b)(4)(F) Stage 3 or 4 ulcer acquired after admission (b) For purposes of this section, "adverse event" includes any of the following: (4) Care management events, including the following: (F) A Stage 3 or 4 ulcer, acquired after admission to a health facility, excluding progression from Stage 2 to Stage 3 if Stage 2 was recognized upon admission. This Statute is not met as evidenced by:	A 031		

State of California-Health and Human Services Agency
California Department of Public Health

Ron Chapman, MD, MPH
Director & State Health Officer

EDMUND G. BROWN JR.
Governor

January 26, 2015

Letter 1

IMPORTANT NOTICE – PLEASE READ CAREFULLY

Lawrence Bottorff, Administrator
Newport Specialty Hospital
14662 Newport Avenue
Tustin, CA 92780

Dear Mr. Bottorff:

On January 15, 2015, an abbreviated survey for complaint no. 426078 was conducted at your facility by the California Department of Public Health, Licensing and Certification Program (State Agency), to determine if your facility was in compliance with federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs.

The enclosed Centers for Medicare and Medicaid Services (CMS) form, entitled "Statement of Deficiencies and Plan of Correction" (CMS-2567), documents that no deficiencies of participation requirements were identified during this visit. Please sign, date, and return this form to our office (see address below) by February 6, 2015.

If you have questions concerning the instructions contained in this letter, please contact Kathleen Davidson, District Administrator at 714-567-2906.

Sincerely,

Hang Nguyen

Hang Nguyen, RN
Orange County District Office

Enclosure: CMS-2567

HN/ap

Licensing and Certification, 681 S. Parker Street, Suite 200, Orange, CA 92868
Telephone: (714) 567-2906 / Fax: (714) 567-2815
Internet Address: www.cdph.ca.gov

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555730	A. BUILDING _____ B. WING _____	C 01/15/2015

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NEWPORT SPECIALTY HOSPITAL	14662 NEWPORT AVENUE TUSTIN, CA 92780

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F 000	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health during an ABBREVIATED SURVEY for investigation of COMPLAINT No: CA00426078. Inspection was limited to the specific complaints investigated and does not represent the findings of a full inspection of the facility. Representing the California Department of Public Health: Surveyor 27007, HFEN. THE DEPARTMENT WAS ABLE TO PARTIALLY SUBSTANTIATE THE COMPLAINT ALLEGATION(S) AND FOUND NO VIOLATION OF THE REGULATIONS.	F 000		

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

Barbara Sell | CEO | 1/21/15

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

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000	INITIAL COMMENTS	F 000		

The following reflects the findings of the California Department of Public Health during a RECERTIFICATION survey.

This Plan of Correction constitutes my written credible allegation of compliance to the deficiencies noted.

Representing the California Department of Public Health: Surveyor 28950, HFEN; Surveyor 29767, HFEN, and Surveyor 34325, HFEN.

The surveyors entered the facility on 9/3/14 at 0730 hours. The census was 21.

GLOSSARY OF ABBREVIATIONS:
BM - bowel movement
CDC - Centers for Disease Control and Prevention
C-diff - Clostridium difficile
cm - centimeter(s)
CNA - Certified Nurses Aide
CNO - Chief Nursing Officer
CPR - cardiopulmonary resuscitation
DSS - Dietary Service Supervisor
ESBL - Extended Spectrum Beta Lactamase
EMT - Emergency Medical Technician
GT - gastrostomy tube
H2O - water
H&P - History and Physical
IDT - Interdisciplinary Team
kg - kilogram(s)
LVN - Licensed Vocational Nurse
MAR - Medication Administration Record
mg - milligram(s)
MLT - Minimal Leak Test
MRSA - Methicillin Resistant Staphlycoccus Aureus
P&P - Policy and Procedure
PEEP - Positive End Expiratory Pressure
PIP - Peak Inpiratory Pressure (the pressure

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ATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: CEO — (X6) DATE: 10/6/14

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POC Accepted 10-20-14

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F 000	Continued From page 1 needed to provide each breath from the ventilator) RD - Registered Dietician RN - Registered Nurse RT - Respiratory Therapist/Respiratory Therapy UTI - Urinary Tract Infection VRE - Vancomycin Resistant Enterococcus	F 000	Resident 7 → Crib Resident E → Crib Resident H → Lo Boy	
F 221 SS=E	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review, interview, review of the facility's P&P, and review of the manufacturer's specifications, the facility failed to ensure one of 10 sampled residents (Resident 7) and two non-sampled residents (Residents E and H) were free from a physical restraint. The facility failed to obtain the informed consents from the responsible parties regarding the risks and benefits of the Posey bed (an A-framed canopy system enclosure which when attached to a hospital bed, restricts the resident from exiting the bed. The sides of the canopy have zippered panels which can only be accessed from the outside). Failure to provide the information regarding the risks and benefits of the Posey bed restraint as well as any other alternative interventions posed the risk of the residents' responsible parties not having the necessary	F 221	**482.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS** **F221** Corrective Actions Taken for Affected Residents: *All residents in the Posey bed not meeting the manufactures height and weight recommendations were immediately removed from the Posey beds. 9/20/14 *Appropriate alternative measures have been deployed and others are being explored for residents not meeting the requirements for the Posey bed, including low boy beds, cribs, hospital beds and alternative enclosed beds. 9/4/14 – Ongoing *All physician orders for specialty beds have been reviewed with the Medical Director and revised as appropriate. 10/3/14	

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F 221	Continued From page 2 ~~information to make an informed decision~~ regarding the use of the Posey bed. The facility failed to follow the manufacturer's specifications for the use of the Posey bed. According to the manufacturer, the Posey bed is a restraint and improper use of the Posey bed could lead to serious injury or death. The Posey bed is "not intended for use with patients who weigh less than 46 pounds, or are shorter than 46 inches." Resident 7, E, and H did not meet the manufacturer's minimum height and weight requirements for the use of the Posey bed. This posed the risk of serious injury to the residents. The facility failed to attempt alternative measures prior to the implementation of the Posey bed restraint. This placed the residents at risk for an unnecessary restraint. The facility failed to develop a comprehensive plan of care to address the use of the Posey bed, including restraint free periods, therapeutic interventions to minimize decline in function, and a process for restraint reduction. This posed the risk for not receiving the appropriate care. The facility failed to ensure documentation in the weekly progress notes addressing the alternatives attempted other than the use of a Posey bed restraint as described in their P&P. This had the potential for unnecessary restraint for the residents. The facility failed to follow the physician's order regarding observing the restraint every 15 minutes. This had the potential for a serious injury not to be detected in a timely manner	F 221	* The remaining resident in a Posey bed had a signed inform consent in their record. for the use of the enclosed bed. 8/6/13 *The care plan for the remaining resident in a Posey Beds was updated and appears in the resident record. including discussion of restraint free periods and monthly assessment of ROM. by physical therapy. 10/5/14 *Monthly reviews in IDT will be done to re-evaluate the appropriateness of enclosed beds and less restrictive options will be explored for each resident. 10/16/14 *A new enclosed bed policy has been drafted and approved to address the specific handling and documentation of enclosed bed usage specific to the pediatric population. Evaluation of patient need for bed monthly and IDT review of less restrictive options. 10/14/14 *Pediatric staff was re-educated on the use of enclosed beds and the special charting requirements. (10/16/14) licensed nursing staff 10/16/14	

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F 221	Continued From page 3 Findings:	F 221	Corrective Actions for Other Residents:	

According to the facility's P&P titled Restraints - Physical dated 5/2014, a physical restraint is any device attached or adjacent to the resident's body which restricts the resident's freedom of movement. A physician's order must be obtained prior to the use of a restraint. Possible alternative measures other than the use of the restraint should be discussed with the resident or responsible party. If a restraint is needed, the nurse should contact the physician and initiate verification of informed consent. The care plan should be updated to reflect the needs of the resident. The weekly progress note shall address the need for the restraint, any alternatives to the restraint, any least restrictive measures other than the restraint, address the possibility of a restraint reduction and address how the resident can maintain his highest functional level.

1. On 9/3/14 at 1500 hours, Resident E was observed sitting up in bed. The resident's bed was enclosed with a mesh covering on top of the bed and around all sides. The mesh covering had a zippered area to allow the staff to provide the resident's care as needed while the resident was in the bed. The zipper was closed.

Clinical record review for Resident E was initiated on 9/10/14. Resident E was admitted to the facility on 11/5/13.

On 9/4/14, Resident E's height was 113.5 cm (44.7 inches) and weight was 21.3 kg (44.86 pounds).

Review of the physician's orders showed an order dated 5/16/14, for the use of a Posey bed to

*Residents will be reviewed monthly during the Interdisciplinary Team meeting. Discussion will include the appropriateness of beds, and to explore less restrictive bedding options. as long as Posey bed is in use. 10/16/14

*The records of all residents using enclosed beds will be audited monthly to ensure proper documentation is being followed. 10/10/14

*Quarterly fall risk assessment will be reviewed at the Interdisciplinary Team monthly meeting. 10/16/14

*All new orders for enclosed beds will be audited to ensure that all required elements are in place, including MD order, trial of less restrictive measures, signed consent and parent request for enclosed bed when appropriate. while Posey bed is in use. 10/5/14

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F 221	Continued From page 5	F 221	*Findings will be included in quarterly PI reports and reported to Organization-Wide Quality Council for further actions as needed. Person(s) Responsible: Pediatric Director of Nursing (DON), Quality and Compliance Coordinator and DSD	

Review of the clinical record failed to show documentation an informed consent was obtained from Resident E's responsible party regarding the risks and benefits of the use of the Posey bed.

Documentation in the clinical record failed to show Resident E was thoroughly assessed for the need of the restraint and which alternative therapies had been implemented prior to the use of the Posey bed.

An interview and concurrent clinical record review with RN 1 was initiated on 9/10/14 at 1500 hours. When asked why Resident E was using the Posey bed, RN 1 stated Resident E could stand up and was in danger of falling out of bed. When asked if the resident had ever fallen out of bed since his admission to the facility, RN 1 stated no, but he was at risk of falling. When asked for documentation to show the informed consent was obtained to address the use of Resident E's Posey bed, RN 1 stated she would check the overflow files to find the consent. However, no documentation to show the informed consent was obtained was provided. RN 1 was unable to provide documentation showing alternative interventions had been attempted prior to the implementation of the Posey bed. RN 1 was unable to provide documentation to show Resident E was thoroughly assessed regarding the need for the Posey bed.

2. Clinical record review for Resident 7 was initiated on 9/3/14. Resident 7 was admitted to the facility on 3/28/14.

On 9/4/14, Resident 7's height was 106.5 cm (41.93 inches) and weight was 17.6 kg (38.72

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F 221	Continued From page 4 ~~replace the crib for safety purposes.~~ Further review of the clinical record showed a "Physician Order: Pediatric Sub-Acute Restraints" form dated 9/4/14. The documentation on the form showed the use of the Posey bed as a restraint for up to seven days. The form showed the definition of behavioral modification restraints included: "the use of physical or mechanical devices to involuntarily retain movement of the whole or a portion of the patient's body as a means for controlling his/her physical activity in order to protect him/her or others from injury. Patient restraints will be observed every 15 minutes." The area to document the status of the resident showed "fall risk." The area to document the reason for the implementation of the restraint order showed a check mark in the box indicating to "prevent the patient from climbing out of the bed/chair and injuring himself" and a check mark in the box indicating to "protect the patient from self-harm." Review of the care plan showed a care plan problem to address Resident E's need for a restraint. An entry dated 5/16/14, showed to replace the crib with a Posey bed for safety. The interventions included to monitor for ongoing need of environmental restraints and discontinue as change of condition warranted and as ordered, monitor the resident on the restraint, assess every two hours, and document on the restraint flow sheet. However, the plan of care failed to show the approaches to include observing the resident every 15 minutes for the use of the restraint as ordered, specific measures to address Resident E's climbing out of bed, and prior interventions to be attempted prior to the implementation of the Posey bed.	F 221	Measures/Systemic Changes: ~~*Re-education was provided to the~~ licensed nursing staff about the use of restraints and informed consent. 10/25/14 *Charge nurses and RNs have been re-educated on the charting requirements for Posey beds, including restraint documentation, signed consents, MD progress notes, care plans, and the re-evaluation of resident condition and options for less restrictive measures. 10/25/14 Monitoring: *Monthly audits are being conducted by the Quality and Compliance Coordinator of nursing documentation and includes charting requirements for Posey beds, including restraint documentation, signed consents MD progress notes, care plans, and the re-evaluation of resident condition and options for less restrictive measures *Audit results to be presented in monthly Interdisciplinary Team meetings.	

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pounds).

Review of the September 2014 recapitulated physician's orders failed to show an order for the use of the Posey bed. Further review of the clinical record showed a "Physician Order: Pediatric Sub-Acute Restraints" form dated 7/21/14. The type of restraint was documented as a Posey bed. The area to document the status of Resident 7 showed "over actively moves bilateral lower extremities out of the bed, kicking rails and constantly moves in bed." The instructions on the form showed restraints "will be observed every 15 minutes." Further review showed a "Physician Order : Pediatric Sub-Acute Restraints" form dated 9/4/14, showing the use of the Posey bed with the status of the Resident 7 documented as a "Fall Risk"

Review of the Doctors Progress Notes dated 7/21/14, showed an IDT conference was held and Resident 7 was doing well with no major issues over the month. The documentation failed to show the need for the Posey bed.

Review of the care plan failed to show a care plan problem to address the use of the Posey bed or a care plan problem to address Resident 7's behavior of "over actively moving of his lower extremities out of the bed, kicking the side rails, constantly moving in bed" or his risk for a fall.

Review of the Weekly Nursing Summary reports dated 8/25 and 8/18/14, failed to address any alternatives or least restrictive measures to be attempted prior to using the Posey bed for Resident 7.

On 9/4/14 at 0750, a Posey bed was observed in

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Room B which was designated for Resident 7. Resident 7 was out of the facility at the time.

An interview and concurrent clinical record review was conducted with RN 1 on 9/4/14 at 0800 hours. RN 1 verified the Posey bed was considered a restraint. RN 1 was unable to find an informed consent regarding the use of Resident 7's Posey bed. Furthermore, RN 1 was unable to find documentation showing Resident 7's responsible party had been informed of the risks and benefits of using a Posey bed as a restraint and had been provided information regarding alternative therapies.

A telephone interview was conducted with RN 1 on 9/9/14 at 1100 hours. When asked if ongoing assessments to address Resident 7's need for the Posey bed had been completed, RN 1 stated she was unable to find an assessment to address Resident 7's need for the Posey bed restraint. RN 1 stated the physician rewrote the order every 7 days and documented the status of the resident on the form. RN 1 further verified the Weekly Nursing Summary reports dated 8/25 and 8/18/14, failed to address the use of any alternative interventions or least restrictive measures to be attempted prior to using the Posey bed for Resident 7. RN 1 verified the physician's order form showed restraints to be observed every 15 minutes and stated the facility did not check the resident every 15 minutes when a restraint was ordered. The facility's P&P is to check the resident every two hours and document on the Restraint Flow sheet.

3. On 9/10/14 at 1430 hours, Resident H was observed in a Posey bed restraint with all the mesh covering zippered closed. Resident H was

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resting quietly with arms moving.

On 9/10/14, clinical record review was initiated for Resident H. Resident H was admitted to the facility on 5/6/14.

On 9/4/14, Resident H's height was 89 cm (35.04 inches) and weight was 13.5 kg (29.7 pounds).

A care plan problem to address the use of the Posey bed was not found in the clinical record.

Review of the Physician Order: Pediatric Sub -Acute Restraints form dated 9/4/14, showed the Posey Crib as the type of the restraint for "Spastic Movements".

An interview and concurrent clinical record review was conducted with RN 1 on 9/10/14 at 1445 hours. RN 1 verified Resident H's use of the Posey bed as a restraint. RN 1 was unable to find an informed consent to address the use of Resident H's Posey bed. Furthermore, RN 1 was unable to find documentation showing Resident H's responsible party had been informed of the risks and benefits of using a Posey bed as a restraint. RN 1 was unable to find a care plan problem to address the approaches including the staff needed to take when caring for Resident H while using the Posey bed restraint. RN 1 was also unable to find documentation an assessment to address Resident H's need for the Posey bed restraint had been completed. RN 1 stated there was no documentation found in the IDT notes dated 8/14/14, or in the Weekly Nursing Summary dated 8/28/14.

An interview by phone was conducted with the

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Medical Director on 9/10/14 at 1700 hours. The Medical Director stated he did not obtain the informed consent or speak to the family regarding the risks and benefits of the Posey bed restraints. The Medical Director state the nursing staff obtained the informed consent for restraints, psychoactive medications, and pain medications from the residents' responsible parties. He further stated he would talk to the family if they were in the facility or if the nurse informed him the family would like to speak to him.

On 9/30/14 at 0905 hours, an interview and concurrent clinical record review was conducted with the CNO. The CNO verified the facility utilized the Posey bed model number 8070 as means of restraint for Residents 7, E, and H. The CNO verified Resident 7, E, and H's heights and weights were last obtained on 9/4/14. When the manufacturer's specifications regarding the minimum height and weight requirements for the use of the Posey bed was discussed, the CNO verified Residents 7, E, and H did not meet the manufacturer's specifications. When asked how the facility verified the use of the Posey beds was appropriate for these residents, the CNO stated the facility had been using the Posey beds for some time, and he was not aware of the manufacturer's specifications. When asked if the facility had attempted any other interventions such as a low bed and floor mats as an intervention prior to the implementation of the Posey beds, the CNO stated he needed to research other alternatives than the Posey beds.

F 279 SS=D 483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS — F 279

A facility must use the results of the assessment

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F 279	Continued From page 10 to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on interview and clinical record review, the facility failed to update the plan of care to reflect the resident's current care needs for one of 10 sampled residents (Resident 6). Resident 6 had bilateral myringotomy tympanostomy tubes (tubes inserted into the eardrums to prevent accumulation of fluid in the middle ear) inserted on 8/26/14. Seven days later Resident 6 was started on antibiotics due to an ear infection. The facility failed to update the plan of care for Resident 6 to address the placement of the ear tubes and the current ear infection. This had the potential of Resident 6 not to receive the appropriate care he required to minimize or prevent complications.	F 279	**483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS** **F279** Resident 6 - Care plan was immediately revised. Corrective Actions Taken for Affected Residents: 10/10/14 Care plans for all Pediatric Sub-Acute residents have been reviewed and updated as appropriate to include all new MD orders and changes in resident conditions. (10/10/2014) Corrective Actions for Other Residents: 10/10/14 RN staff were assigned monthly auditing responsibility to ensure that care plans reflect services that are to be furnished to attain or maintain the resident's highest attainable physical, mental and psychosocial well-being, to reflect any changes in resident condition, and to immediately update any care plan found to be incomplete. Findings will be reported at the monthly RN/Charge Nurse meeting. 10/21/14	

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F 279	Continued From page 11 Findings: Clinical record review for Resident 6 was initiated on 9/3/14. Resident 6 was admitted to the facility on 1/22/10 and readmitted to the facility on 5/6/14. Review of the physician's order dated 8/20/14, showed the bilateral myringotomy typmpanostomy tubes were to be surgically inserted on 8/26/14. Further review of the clinical record showed an order dated 9/3/14, to administer an antibiotic for a right ear infection for seven days. The order also showed specific instructions regarding use of the Otwick ear sponge (sponge is used to administer antibiotic drops deep into the ear canal) Review of the care plan problem dated 10/11/12, to address Resident 6's bilateral ear cerumen (ear wax) failed to include the insertion of the ear tubes or the current ear infection and approaches needed to provide the appropriate care. An interview and concurrent clinical record review with RN 1 was conducted on 9/4/14 at 0810 hours. RN 1 was unable to find a care plan problem addressing Resident 6's ear tubes or current ear infection. RN 1 verified the finding and stated the plan of care needed to address these issues.	F 279	Measures/Systemic Changes: Patient load has been equally distributed to RNs for *Quarterly audits of care plans will be performed by the charge nurses and presented at the monthly IDT meetings. 10/16/14 *All RN staff received re-education of care plan policies and procedures and nursing responsibilities. 9/25/14 *Re-education of care plan policies and procedures and nursing responsibilities was done with all RN staff. 9/25/14 Monitoring: *Quarterly reports of monthly audit findings will be reported to the Organization-Wide Quality Council. Person(s) Responsible: Pediatric DON, Quality and Compliance Coordinator and DSD	
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in	F 309		

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Review of the physician's order order dated 11/26/10, showed Resident 6 "may only OOF (out of facility) if two people with completed educational packet and valid CPR cards" were present. A physician's order dated 12/31/11, showed Resident 6 might go out of facility for six hours up to two times per week.

Review of the care plan showed a care plan problem to address Resident 6's family dynamics dated 1/22/10; however, it failed to address the physician's order regarding the need for two persons with completed educational packets and valid CPR cards to accompany Resident 6 for out of the facility passes.

Further review of the clinical record showed two American Heart Association Healthcare Provider CPR cards for Resident 6's family members issued on 10/2010, which had expired on 10/2012. No further documentation of current CPR card verification was found in the clinical record.

Review of the facility's form titled Out of Facility Release showed the facility and the physician were free from all responsibility in regards to the resident's condition during the resident's absence from the facility. Review of Resident 6's Out of Facility Release form dated 9/7/14, showed Resident 6's family member signed him out at 1400 hours, and returned Resident 6 to the facility at 2000 hours. Resident 6's family member also signed him out on 8/3, 8/10, 8/17, 8/24, and 9/1/14, for a period of approximately six hours each time. Further review of the Out of Facility Release form failed to show documentation of a second person being present during Resident 6's

requirements continue to be met, including current family education. CPR cards and other requirements per the MD order.

Measures/Systemic Changes:

*All parents requesting OOF privileges will be required to complete all education and other requirements before being granted OOF pass. 9/5/14

*Monthly audits of all residents that are eligible for OOF passes to ensure that all eligibility requirements have been met, including CPR card, other requirements per MD order. Facility will offer assistance to family members in finding locations and times to obtain required certifications. 10/1/14

*Parents will receive monthly reminder notices about impending expiration dates of CPR cards. 10/1/14

Monitoring:

*Monthly audits of all eligibility requirements, including current 10/1/14

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F 309	Continued From page 12	F 309	**483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING**	

accordance with the comprehensive assessment and plan of care.

This REQUIREMENT is not met as evidenced by:
Based on interview and clinical record review, the facility failed to follow the physician's order regarding the necessary medical training and supervision needed to ensure one of 10 sampled residents (Resident 6) was safe when taken out of the facility by the family. Resident 6 has a tracheostomy (a tube going from the front of the neck to the trachea to provide an air passage to help with breathing when the usual route for breathing is obstructed or impaired) due to a history of respiratory distress (not enough oxygen passes from the lungs into blood) A physician's order showed two people with valid CPR cards were needed to take Resident 6 out of the facility. The facility failed to follow the physician's order to ensure two people with valid CPR cards were present when taking Resident 6 out of the facility. This posed the risk of compromising Resident 6's health and safety during out of the facility passes.

Findings:

Clinical record review initiated on 9/3/14, showed Resident 6 was admitted to the facility on 1/22/10 and readmitted to the facility on 5/6/14. Resident 6 had a tracheostomy tube and GT (a tube placed through a surgical opening in the abdomen to the stomach for the purpose of feeding and medication administration) Resident 6 had diagnoses including anoxic encephalopathy (brain damage due to lack of oxygen) and respiratory failure.

F309

Corrective Actions Taken for Affected Residents:

*The affected resident family has been notified that their Out of Facility (OOF) pass are suspended until evidence of current CPR cards is presented. 9/3/14

*New Out of Facility Policy has been drafted and approved by the Medical Director to include guidelines about OOF passes and family requirements. 10/14/14

Corrective Actions for Other Residents:

*Immediate audit of all resident records was done. No others were found to be deficient. 9/4/14

*Monthly audits will be done of all residents that are eligible for OOF passes to ensure that all eligibility throughout the year The need to continue audits will be determined at the annual evaluation. 10/1/14

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release from the facility as specified in the physician's order.

An interview with RN 1 was conducted on 9/4/14 at 0930 hours. RN 1 verified due to family dynamics, two people with valid CPR cards were necessary to accompany Resident 6 when he left the facility. RN 1 was unable to find documentation showing proof of current CPR cards of Resident 6's family members who had been taking Resident 6 out of the facility. Furthermore, she was unable to find a care plan problem to address Resident 6's needs when leaving the facility.

F 322 SS=D 483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS

Based on the comprehensive assessment of a resident, the facility must ensure that --

(1) A resident who has been able to eat enough alone or with assistance is not fed by naso gastric tube unless the resident ' s clinical condition demonstrates that use of a naso gastric tube was unavoidable; and

(2) A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills.

F 309

CPR cards and other requirements per the MD order, certification expiration and review of OOF requests will be done.

*Parents will receive monthly reminder notices about impending expiration dates of CPR cards.

*Findings will be included in quarterly PI reports, and reported to Organization-Wide Quality Council. and re evaluated at the end of the year for the need to continue reporting.

F 322

Person(s) Responsible:

Pediatric DON, DSD, Quality and Compliance Director

483.25(G)(2) NG TREATMENT/ SERVICES – RESTORE EATING SKILLS

F322

Resident 5: immediate re evaluation by medical director. New treatment is started.

Corrective Actions Taken for Affected Residents:

*All residents were re-assessed for skin integrity. Skin monitoring sheets have been started for residents showing any alteration in skin integrity. 9/5/14

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This REQUIREMENT is not met as evidenced by:
Based on observation, interview, clinical record review, and review of the facility's P&P, the facility failed to accurately assess the GT (tube surgically inserted through the abdominal wall into the stomach to deliver nutrition and medication) site for one of 10 sampled residents (Resident 5). Resident 5 was receiving treatments for redness at the GT site. The nurses failed to assess the GT site daily as specified in their P&P. The wound area continued to deteriorate. The nurses failed to notify the physician and provide ongoing assessments of the wound condition. This posed the risk of Resident 5 not receiving the appropriate care and treatment

Findings

Review of the facility's P&P titled Assessment of Skin Breakdown dated May 2014, showed the skin and/or wounds will be reassessed daily. Assessment will include centimeter measurements, characteristics of the wound bed, surrounding skin and exudates, and presence of pain associated with the wound.

Clinical record review for Resident 5 was initiated on 9/3/14. Resident 5 was admitted to the facility on 3/13/07 and readmitted on 6/17/14. Resident 5 had a G/JT tube (a combination gastric and jejeunostomy tube. Tubes surgically inserted through the abdominal wall into the stomach and intestine to deliver nutrition and medication) which was leaking and became dislodged on 9/3/14, and replaced with a temporary catheter.

Review of the physician's order dated 8/13/14,

Corrective Actions for Other Residents:

*Skin integrity is assessed daily - Incidents of skin breakdown will be documented in the resident record and comprehensive skin assessment tool and shift reassessment tool initiated and MD notified. 9/5/14

*Initial assessment will be completed, including photo and measurements of skin breakdown or redness and will be documented on the comprehensive skin assessment sheet. Re-assessment will occur every shift until the issue has resolved. 10/14/14
Initial / weekly assessment - charge nurse.
Daily monitoring - primary licensed nurse.

*New wound measurement tools, and upgraded camera and photo printer have been ordered to help in charting and monitoring the progress of identified skin problems. 10/14/14

Measures/Systemic Changes:

New skin monitoring tool is in place to directly address and facilitate the special skin assessment needs of the pediatric population. 10/14/14

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F 322	Continued From page 17 and 0400 hours, the GT was leaking. Documentation describing the skin redness or condition was not found. There was no documentation the physician had been notified of the change in the condition regarding the GT leaking. On 9/3/14 at 2000 hours, the LVN documented the GT site was very red and excoriated down the left side of the abdomen but failed to show the size of the excoriation, the condition of the surrounding skin, or the presence of any signs of pain. There was no documentation showing the physician had been notified of the change in the condition of the resident's skin. On 9/4/14 at 1145 hours, an interview was conducted with RN 1. She stated she was not aware of the open area surrounding Resident 5's GT site, LVN 1 had just reported the redness to her. RN 1 stated it was LVN 1's responsibility to perform daily treatments and monitor the GT site. She further stated the nurses did not have a form to document their findings. When asked how she would determine if the redness was getting worse, RN 1 stated there was no way to tell if the redness was getting larger or worse. On 9/4/14 at 1520 hours, an interview was conducted with LVN 1. He stated the open area surrounding Resident 5's GT was not reported to him at change of shift. He further stated the facility policy was to report any open areas on the resident's skin to the Charge Nurse. LVN 1 was unable to provide documentation showing centimeter measurements, characteristics of the wound bed, surrounding skin and exudates, and presence of pain associated with the wound were assessed daily. LVN 1 stated Resident 5's GT site had been reddened for a long time, and the	F 322	*New skin monitoring tools are in place to directly address the special needs of the pediatric population. 10/14/14 Person(s) Responsible: Pediatric DON/ DSD/Director of Quality and Compliance	

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F 322	Continued From page 16 showed an order to apply 1/2 Maalox (an antacid medication used topically to dry the area) mixed with 1/2 hydrophilic cream (topical skin cream) to GT site redness twice daily for 30 days. On 9/4/14 at 1115 hours, LVN 1 was observed performing treatment for Resident 5's GT. A red, excoriated (damage or superficial loss of the surface of the skin), open area was noted surrounding Resident 5's GT, measuring approximately 4 cm x 2 cm. An additional crescent shaped excoriated area was observed to the left of the GT site. There was a clear liquid leaking from the GT site, which dripped down Resident 5's left abdomen. Review of the care plan showed a care plan problem to address Resident 5's nutrition dated 6/17/14. The approaches included to provide GT site care every shift and as needed; however, there was no documentation to show the type of treatment to be provided for the GT site. Further review of the care plan for Resident 5's failed to show a specific care plan problem to address the resident's skin redness/excoriation around the GT and the indicated treatment to address the leaking of fluid from the GT site. The Nursing Progress/Summary Notes for 8/30/14 at 2000 hours, showed the GT site was still red with excoriation. Further review of the documentation failed to show measurements of the size and location of the excoriation or presence of signs of pain. There was no documentation the physician was notified of the change in the condition of the resident. The entry for 9/2/14, showed at 0800 hours, the GT was intact and patent, at 1200 hours and 1600 hours the GT site was clean and dry; and at 2400 hours	F 322	*Shift skin monitoring tool revised to reflect the unique needs of the pediatric population. 10/14/14 *Skin monitoring/pain assessment will be done on all residents every shift, and skin sheets started for all residents with redness, excoriation or any other skin issues. by primary licensed nurse. 10/15/14 Monitoring: Weekly audits of skin monitoring tool is being done by the licensed nursing staff. *Unit DON will review report and assign staff to follow up on findings. *Summary of findings will be reported to MD at weekly IDT meetings. *Findings will be included in quarterly PI reports, and reported to the Organization-Wide Quality Council.	

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only place to document this would be in the Nursing Progress/Summary Notes.

On 9/4/14 at 1530 hours, a follow-up interview and concurrent clinical record review was conducted with RN 1. When asked who was responsible for assessing the effectiveness of the skin treatments, RN 1 stated it was the RN's responsibility to assess and measure any open areas on the skin of the resident and document on the "skin sheet." She confirmed there was no "skin sheet" for Resident 5's treatments of the redness surrounding his GT. RN 1 further stated the RNs did not monitor redness even if there was a treatment. The RNs only monitored open areas on the skin.

F 328 SS=E 483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS

The facility must ensure that residents receive proper treatment and care for the following special services:
Injections;
Parenteral and enteral fluids;
Colostomy, ureterostomy, or ileostomy care;
Tracheostomy care;
Tracheal suctioning;
Respiratory care;
Foot care; and
Prostheses.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and clinical record review, the facility failed to provide proper treatment and care for the residents requiring ventilator (a machine used to provide assisted

F 322

Resident 2, 3, 4 & 5: Were immediately re assessed with involvement of Medical director. Settings were adjusted according to policy.

483.25(K) TREATMENT/CARE FOR SPECIAL NEEDS

F328

F 328

Corrective Actions Taken for Affected Residents:

*All resident records were reviewed with the Medical Director and MD orders were updated to comply with Policy & Procedures in regards to vent settings and cuff pressures. 9/4/14

*All Cardio-Pulmonary staff were re-educated on Ventilator Alarm Policy CPS 340. as well as proper documentation of tracheostomy cuff pressures where appropriate. 9/4/14

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F 328	Continued From page 19 breathing when they can not breathe effectively on their own) support. *Ventilator alarm settings for four of 10 sampled residents (Residents 2, 3, 4, and 5) and six nonsampled residents (Residents B, C, D, E, F, and G) were set too high. Alarm settings alert the staff to potential problems between the ventilator and the residents. When the alarm setting is too high, early detection and troubleshooting of ventilator problems does not occur. * Physician's orders to check the tracheostomy [a surgically created opening through the front of the neck into the airway (trachea) which provides an air passage when the usual route for breathing is obstructed or impaired or when long term use of a ventilator is required] cuff (a balloon at the end of the tracheostomy tube) pressure every shift were not followed for two of 10 sampled residents (Residents 3 and 5). The tracheostomy cuff seals the lower airway to prevent excessive air leakage and ensure the ventilator delivers the correct volume of air to the lungs. If the cuff pressure is too high, damage to the surrounding tissue may occur. These had the potential for serious complications to go undetected and resolved timely. Findings 1. Residents 2, 3, 4, 5, B, C, D, E, F, and G had medical conditions requiring ventilator support. During the initial tour on 9/3/14 at 0750 hours, RT 4 stated the RT set the normal ventilator high pressure alarm at 10 to 15 cm H2O above the residents' PIPs.	F 328	*Orders for all residents receiving ventilator support have been reviewed by Cardio Pulmonary leads, and limits updated to reflect current vent settings and trach cuff pressures. 9/10/14 Corrective Actions for Other Residents: *All residents receiving mechanical ventilation were audited for ventilator alarm settings to insure that all are set according to policy CPS 340 (10cm-15cm above/or below set pressure). 9/9/14 Measures/Systemic Changes: *Audits of MD orders and Cardio Pulmonary charts will be conducted daily and deficiencies will be addressed immediately. Audit overall results will be included in the Performance Improvement reports will be reported quarterly to the Organization-Wide Quality Council. for ~~at-lea~~ one year, then re evaluated for need to continue. 10/16/14 *Alarm settings will be reviewed by the interdisciplinary team at the 10/16/14	

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Review of the physician's orders for Residents 2, 4, 5, B, C, D, E, F, and G showed the orders for the ventilator settings to include:

* Mode (refers to the method of inspiratory or breathing support from the ventilator).

* Tidal volume (the volume of gas exchanged during each breathe from the ventilator).

* Rate (the number of times per minute the ventilator pushes air into the lungs).

* PEEP (this ventilator pressure is applied at the end of expiration to hold the lungs open and thereby increase oxygenation in the lungs).

* Amount of oxygen (room air contains 21% oxygen. The physician may order more oxygen depending on the resident's condition).

* Pressure control (provides a set pressure during inspiration).

* Pressure support (a spontaneous mode of ventilation when the resident initiates every breathe and the ventilator delivers a preset pressure).

The physician's orders did not contain the orders for the high pressure alarm settings (a ventilator alarm is triggered when there is something wrong with the ventilator pressure, volume, or the rate of air being delivered. The high pressure alarm occurs if two consecutive breaths are limited because they reach the high pressure setting. Triggering of high pressure alarm is usually caused by coughing but may indicate the airway

monthly scheduled IDT meeting and modifications to orders will be made by the MD based on recommendations as appropriate.

Monitoring:

Alarm

*Audits will be conducted daily and deficiencies will be addressed immediately. Audit overall results will be included in the Performance Improvement reports for the department.

*Audit findings will be reviewed with Cardio Pulmonary staff in monthly staff meetings and/or posted for all to review.

Person(s) Responsible:

Respiratory Leads and Chief of Ancillary Services.

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is blocked. The high pressure alarm will continue to be triggered if pressures do not decrease below the high pressure setting. If the high pressure alarm is set too high, a potentially serious complication may not be detected timely because the ventilator alarm will be delayed.

For Resident 3, the physician's order included the mode, rate, pressure control, pressure support, PEEP, amount of oxygen, and setting for a high pressure alarm at 45 cm H2O.

Review of the 24 Hour Continuous Mechanical Ventilator Records for Residents 2, 3, 4, B, C, D, E, F, and G for August and early September 2014, showed the high pressure alarms were continuously set at 45 cm H2O. The 24 Hour Continuous Mechanical Ventilator Records for Resident 5 for August and early September 2014 showed the high pressure alarm was continuously set at 50 cm H2O.

Further review of the 24 Hour Continuous Mechanical Ventilator Records for August and early September 2014, showed the following:

* The PIP for Resident 2 ranged from 15 to 25 cm H2O (20-30 cm H2O below the high pressure alarm setting). On 8/28/14 at 1530 hours, the PIP for Resident 2 was recorded at 31 cm H2O (14 cm H2O below the high pressure alarm setting).

* The PIP for Resident 3 ranged from 15 to 25 cm H2O (20-30 cm H2O below the high pressure alarm setting).

*The PIP for Resident 4 ranged from 20 to 25 cm H2O (15-20 cm H2O below the high pressure alarm setting).

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* The PIP for Resident 5 ranged from 24 to 48 cm H2O (2-26 cm below the high pressure alarm setting of 50 cm H20).

* The PIP for Resident B ranged from 14 to 20 cm H2O (25-31 cm H20 below the high pressure alarm setting).

* The PIP for Resident C ranged from 8 to 25 cm H2O (20-37 cm below the high pressure alarm setting).

* The PIP for Resident D ranged from 16 to 20 cm H2O (25-29 cm H2O below the high pressure alarm setting) . On 8/24, 8/27, and 8/29/14, the PIP for Resident D was recorded at 30 and 31 cm H2O (14-15 cm H2O below the high pressure alarms setting).

* The PIP for Resident E ranged from 14 to 27 cm H2O (18-31 cm below the high pressure alarm setting).

* The PIP for Resident F ranged from 18 to 26 cm H2O (19-27 cm H2O below the high pressure alarm setting). On 8/31/14 at 1900 hours, the PIP for Resident F was recorded at 32 cm H2O (13 cm H2O below the high pressure alarm setting).

* The PIP for Resident G ranged from 16 to 24 cm H2O (21-29 cm H2O below the high pressure alarm setting).

Review of the facility's P&P titled Mechanical Ventilator Set-Up dated May 2014, showed recommended setting for the ventilator high pressure alarm is 45 cm H2O.

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During an interview with the Medical Director on 9/8/14 at 1330 hours, when asked if he approved the facility's P&P, the Medical Director stated he had reviewed and approved the facility's clinical P&P. When the facility's P&P for Mechanical Ventilator Set-up dated May 2014, showing a recommended setting for the high pressure alarm at 45 cm H2O was discussed, the Medical Director stated this P&P needed to be reviewed.

When the Medical Director was informed the RT staff had stated during the initial tour, the high pressure alarms should be set at 10 to 15 cm H2O above the residents' PIPs, the Medical Director stated in most cases, this would be the correct setting.

After the Medical Director was informed of the 24 Hour Continuous Mechanical Ventilator Records for three sampled and six nonsampled residents showed all of the ventilator high pressure alarms were set at 45 cc H2O despite the residents' varying PIPs, the Medical Director agreed the high pressure alarm was set to high

During an interview with RT 1 and the Director for Ancillary Services on 9/8/14 at 1530 hours, the findings from the 24 Hour Continuous Mechanical Ventilator Records for three sampled and six nonsampled residents were reviewed and showed all of the ventilator high pressure alarms were set at 45 cm H2O even though the residents' PIPs varied from 8 to 32 cm H2O. RT 1 and the Director for Ancillary Services agreed the high pressure alarms should have been set at 10 to 15 cm H20 above the residents' PIPs.

Review of the facility's P&P for the Ventilator Flow Sheet showed the department/team's approval

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dated May 2014, and the approval by the Medical Executive Committee and the Board of Directors dated June 2014. The policy showed "...pressure alarms will be set by the RT at 10 cm - 15 cm above and/or below pressures ...unless specified by MD (medical doctor)."

During an interview and review of the Ventilator Flow Sheet P&P with RT 1 and RT 2 on 9/10/14 at 1610 hours, the two RTs were asked why the Ventilator Flow Sheet P&P differed from the Mechanical Ventilator Set-Up P&P regarding the settings for the high pressure alarm. Neither RTs were able to answer.

During a telephone interview with the Corporate RT on 9/10/14 at 1115 hours, the Corporate RT stated he was unaware of any P&P showing the recommended settings for the ventilator high pressure alarm at 45 cm H2O. When asked if the RT should be adjusting the high pressure alarm based on the resident's condition, the Corporate RT stated unless the physician had ordered the high pressure alarm to be set at a specific setting, the RT should be adjusting the high pressure alarm to be 10-20 cm H2O above the residents' PIPs.

2. According to Respiratory Board Review, tracheal tube cuffs seal off the lower airway which facilitates ventilator support without excessive gas leaks and minimizes aspiration into the lungs. The pressure used to inflate the cuff can cause damage to the surrounding tissues. If the cuff pressure is high enough to block off capillary blood flow it can cause ischemia, tissue ulceration, and necrosis. Capillary perfusion pressures range between 20-30 cm H2O. The goal is to keep the cuff pressure below these

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levels.

According to the Respiratory Board Review, a MLT is used to measure cuff pressure and minimize the air leak around the tracheostomy cuff. The procedure outlined the technique to be used and recommended recording of the measured cuff pressure.

Review of the physician's orders for Resident 3 showed an order dated 1/22/14, to check the tracheostomy tube (cuff) pressure every shift and as needed and maintain the pressure at 18-20 cm H2O.

Review of the physician's orders for Resident 5 showed an order dated 6/17/14, to check the tracheostomy tube (cuff) pressure every shift and as needed and maintain the pressure at 18-20 cm H2O.

The Medical Director was the primary care physician for both Residents 3 and 5.

During an interview, concurrent clinical record review, and review of the facility's P&P with RT 1 and RT 2 on 9/10/14 at 1610 hours, the physician's orders and the 24 hour Mechanical Ventilator Record for Residents 3 and 5 were reviewed. The physician's orders showed to check the tracheostomy tube pressure every shift and as needed and maintain the pressure at 18-20 cm H2O. The designated area to document the cuff pressure on the 24 hour Mechanical Ventilator Record showed the MLT, however, the documentation failed to show the amount of pressure determined. RT 1 stated she had already spoken to the Medical Director about the order to check Residents 3's and 5's

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tracheostomy tube cuff pressures. RT 1 stated the Medical Director indicated the order needed to be clarified because the facility used the MLT to ensure the tracheostomy cuff was not overly inflated. RT 1 stated the RT was to record just "MLT" on the 24 hour Mechanical Ventilator Record, not the actual tracheostomy cuff pressure. Review of the facility's P&P titled Ventilator Flow Sheet dated May 2014, showed the various procedures for completing the data on the 24 hour Mechanical Ventilator Record. The section to document the cuff pressure showed "observed amount of pressure (cm of H2O/MLT/MOV minimal occluding volume) in ..tracheostomy tube cuff." RT 1 verified the RT's document of "MLT" under cuff pressure not the actual cuff pressure.

When the physician's order for checking the tracheostomy cuff pressure for Residents 3 and 5 were reviewed with RT 1, RT 1 agreed the order required documentation of the actual cuff pressure, not the "MLT."

RT 1 also agreed if the physician's orders needed to be clarified, the clarification should have been done at the time the order was written, not months later.

F 371 SS=E 483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY

The facility must -
(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities, and
(2) Store, prepare, distribute and serve food under sanitary conditions

F 328 **483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY**

F371

Corrective Actions Taken for Affected Residents:

*Immediate replacement of dented, discolored, pitted, bowed cookware was accomplished. 9/14/14

*Repair of the wall board, removal of the silver-colored tape and repair of the torn cove base was done. 10/16/14

("Cove base is a type of trim that is installed along the base of an interior wall where the wall meets the floor. It is primarily made of vinyl or rubber and is used to protect the base of a wall from damage and to provide a finished and more aesthetically pleasing look where it is installed.")

F 371

Corrective Actions for Other Residents:

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This REQUIREMENT is not met as evidenced by:
Based on observation and interview, the facility failed to complete preventive maintenance in the kitchen to decrease the likelihood of harborage sites for pest infestations. Additionally, multiple cooking pots had bowed bottoms and pitting on the inside of the pots. Bowed bottoms of the cooking pots had the potential for the pots to rock on the stove and spill hot contents onto the staff using them. Pots with pitting were more apt to leach aluminum into foods and gave food an off taste.

Findings:

During a tour of the kitchen on 9/8/14 at 1200 hours, with the RD and the DSS, the wall beneath the sinks near the puree station was tapped using a yardstick. The wall board was spongy and moveable when pressed with the yardstick. The moveable section was approximately four feet wide. Additionally, silver colored tape was observed on the linoleum coving next to the walk-in refrigerator. The RD and DSS agreed with these findings.

An observation was made of a pot on a stove burner which appeared to be leaning to one side. The pot contained approximately two inches of warm water. When the pot was touched it rocked from side to side. The bottom of the pot was bowed outward. The RD agreed with this finding.

During an inspection of all of the cooking

This deficiency has no direct impact on the Pediatric Sub Acute resident population; as the resident involved is the only one currently in residence that is able to take food PO (by mouth). All other residents of the Pediatric Sub Acute unit are NPO (nothing by mouth) and are fed exclusively by gastrostomy (GT) tube.

Measures/Systemic Changes:

*Nutrition Services will conduct daily inspections of the kitchen to identify problems, including cookware needing to be replaced, and to identify potential repairs needed for walls, coves, etc.. 9/5/14

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Monitoring:

*Monthly Environment of Care rounds will be completed in the kitchen and include cookware needing to be replaced, and to identify potential repairs needed for walls, coves, etc..

*Kitchen checklist was revised to include cookware. 10/9/14

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equipment, eight large pots and three medium pots were observed having bowed bottoms. Two medium pots and one large pot were observed to have pitting in the bottom and sides. One large colander was dented and showed black discoloration on the outside bottom.

The RD agreed with these findings.

F 428 SS=D 483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON

The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.

The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.

This REQUIREMENT is not met as evidenced by:
Based on interview and clinical record review, the facility failed to ensure the drug regimen review was completed and irregularities were reported for one of 10 sampled residents (Resident 8). Failure to review a medication ordered an excessive dose and make recommendations had the potential for this resident to have an adverse reaction or an overdose.

Findings:

Clinical record review for Resident 8 was initiated

F 371

Person(s) Responsible:

Director of Dietary and Director of Engineering

F 428

483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON

F428

Corrective Actions Taken for Affected Residents:

Resident 8:

*Physician's PRN (as needed) order for Ativan was changed to include a maximum 24 hours dose not to exceed 10 mg. 9/4/14

Corrective Actions for Other Residents:

*Review was completed of all residents with PRN Ativan orders, as well as other PRN orders, to ensure that maximum dose limits are included where needed. 9/5/14

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on 9/4/14. Resident 8 was admitted to the facility on _____with diagnoses including tuberous sclerosis [a rare genetic incurable disease that causes noncancerous (benign) lesions to grow in many parts of the body. It may effect the brain, lungs, and kidneys. Lesions in the brain can be associated with seizures, intellectual disability, learning disabilities or developmental delays] and seizures.

Review of the physician's orders showed an order dated 8/14/13, to administer lorazepam (anti-anxiety medication) 2 mg every four hours as needed for agitation (a total 24 hour dose equaling 12 mg). Review of the MAR for July and August 2014, showed no as needed doses of lorazepam had been given.

Review of Lexi-comp, an online drug reference for healthcare professionals showed the total oral dose of lorazepam ordered for anxiety disorders is 1 mg to 10 mg daily in divided doses; the usual dose is 2-6 mg daily in divided doses.

During a telephone interview with the pharmacist on 9/4/14 at 1600, the pharmacist stated she did the drug regimen review for the facility in July and August 2014. When asked if she had made any recommendations for the lorazepam 2 mg every four hours as needed ordered for Resident 8, the pharmacist stated she did not make any recommendations because Resident 8 had not received any doses of lorazepam in July 2014 or August 2014. When asked if the 2 mg dose was of concern, the pharmacist stated she was not concerned because Resident 8 had not received any doses in July 2014 or August 2014. When asked what would happen if a nurse gave the lorazepam as ordered and Resident 8 received

Measures/Systemic Changes:

*Review of findings with Omnicare (contracted pharmacy) for educational purposes was done to insure that pharmacist is able to identify order issues specific to PRN daily dosing limits in the future. 10/16/14

*Monthly review of the appropriateness of anti-psychotic medication dosing will be done at monthly IDT meetings. 10/16/14

*Monthly pharmacist review of each resident's medication regiment is being done. The monthly review report is forwarded to the Pediatric Sub-Acute DON and CNO. All recommendations requiring modification will be followed up by DON or designee with the MD for modification or clarification as needed 10/16/14

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Monitoring:

Monthly drug review is completed by pharmacy and reviewed at IDT meetings 9/28/14

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12 mg of lorazepam in 24 hours, the pharmacist responded that would be a change of condition and the nurse would have called the physician before giving all 12 mg in 24 hours. When reminded the physician's order for lorazepam did not contain any specific instructions to call the physician after a certain number of doses, the pharmacist agreed. When asked if the nurse followed the physician's order as written and did not question the dosing of lorazepam, then Resident 8 could receive 12 mg of lorazepam in a 24 hour period. The pharmacist agreed and stated she would do a recommendation in September 2014, to discontinue the lorazepam if no doses had been given.

During an interview with the Medical Director on 9/8/14 at 1330 hours, the order for lorazepam 2 mg every four hours as needed for agitation for Resident 8 and the findings in Lexi-comp for a total daily dose of lorazepam was 1 to 10 mg was reviewed. The Medical Director agreed with the potential for Resident 8 to receive 12 mg in 24 hours seemed to be an excessive dose and needed to be reviewed.

F 441 SS=F 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS

The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.

(a) Infection Control Program
The facility must establish an Infection Control Program under which it -
(1) Investigates, controls, and prevents infections

F 428

Unit DON will review report and assign staff to follow up on findings. 10/9/14

Summary of findings will be reported to MD at weekly IDT meetings. 10/11/14

Findings will be included in quarterly PI reports, and reported to the Organization-Wide Quality Council.

Person(s) Responsible:

DON/pharmacist

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483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS

F441

Corrective Actions Taken for Affected Residents:

*At the time of the survey the CNO/CIC (Certification in Infection Control) was the acting infection

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F 441	Continued From page 31 in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on interview, observation, and clinical record review, the facility failed to maintain an infection control program designed to provide a safe and sanitary environment and help prevent the development and transmission of infections * The monthly infection control surveillance data was not complete for 10 of 10 months reviewed. This had the potential to not recognize infection trends.	F 441	control nurse while the position was being filled. A qualified infection control nurse was subsequently recruited and hired. Columns were added to the infection control log to indicate which McGeers Criteria were met including the clinical signs and symptoms. A column for antibiotic usage and rationale was also added. *All resident isolation status was reviewed and it was decided, in collaboration with the Medical Director and unit leadership, to initiate enhanced standard precautions on all residents pursuant to AFL 10-27. The new policy and procedure includes procedures for identification of and isolation of actual or potential C. diff infections. *Infection Control refresher and procedures for enhanced precautions were reviewed with the teacher from the school district.	10/10/14 10/8/14 10/16/14 10/15/14

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* The facility failed to use the infection control surveillance data to monitor the use of unnecessary antibiotics for conditions not meeting McGeer's Criteria (a symptom based criteria to identify true infections in long-term nursing facilities). In addition, the facility did not document the symptoms associated with infections, which was an important part of the McGeer's criteria. This had the potential for unnecessary use of antibiotics, which could contribute to the development of antibiotic resistant bacteria and could cause a secondary infection such as C-diff (a bacterium causing severe diarrhea).

* The facility failed to document any infection control surveillance for the months of January and February 2014. This had the potential for an infection outbreak to go unrecognized.

* Resident 5 had signs and symptoms of a C-diff infection. However, the facility did not implement isolation precautions while waiting for Resident 5's culture (a laboratory test taking approximately 72 hours to determine if infectious bacteria is present) was being processed. This had the potential for other residents to be exposed to infection.

* Teacher 1 did not follow proper infection control practices to minimize the risk of spread of infections in the facility.

Findings:

According to the CDC, each year in the United States at least 2 million people become infected with bacteria that are resistant to antibiotics and

*All residents are being reviewed daily and new potential infections and/or antibiotic usage is entered into the infection control log for further investigation. 9/8/14

*Enhanced standard precautions were initiated for all residents. A new policy and procedure was introduced and contained procedures for identification and isolation of actual and/or suspected C diff infections. All staff who enters resident rooms received in-service education regarding the new enhanced procedures. All EMT and other unscheduled non-staff individuals who enter resident rooms receive instruction upon arrival, prior to their interaction with the resident. 10/15/14

*Any new teachers and other scheduled non-staff individuals who enter resident rooms receive infection control instruction upon arrival, prior to their interaction with the resident. 10/15/14

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEWPORT SPECIALTY HOSPITAL	14662 NEWPORT AVENUE TUSTIN, CA 92780

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F 441	Continued From page 34 facility did not have an infection control nurse on staff. Review of the Subacute Infection Control Logs which included the facility's infection control surveillance showed the log had columns for staff to document resident name, room number, presumptive diagnosis such as a UTI, infectious organism, if the resident was placed in isolation, any pertinent laboratory results, the treatment given and the dates the infection started and resolved. However, the log did not have a column or an area for staff to identify the resident's signs or symptoms of the infection (i.e. fever, cough or changes in the color of sputum or urine) as specified in McGeer's criteria. In addition, there was no area to document if the infection met McGeer's criteria and considered a true infection, which would help identify unnecessary antibiotic usage. a. Review of the Subacute Infection Control Log for November 2013, showed a total of three infections documented for the month. Two of the infections were UTIs and one infection was pneumonia. Both UTI were identified to have cultures done. A culture is a test to determine the amount and type of bacteria present in the specimen, in this case urine. According to McGeer's criteria, the amount of bacteria present must be greater than 100,000 to be considered a true infection. Further review of the Subacute Infection Control Logs showed incomplete documentation. For example: * The column entitled "Pertinent Lab (laboratory) or X-ray Findings" showed no documentation	F 441	Monitoring: *The infection control practitioner will prepare monthly summaries of the infection control log including antibiotic usage, infections using McGeer's criteria, isolation, trends, etc. The report will be reviewed by the unit Medical Director and CNO for completeness. The report along with a summary of other infection control monitors will be reported to the Organization-Wide Infection Control Committee and Quality Council on a quarterly basis unless there are significant opportunities for improvement noted in the interim. *Results of monitoring adherence to enhanced standard precautions are presented monthly to the Pediatric Unit Medical Director and other leadership. The results are reported to the Organization-Wide Quality Council on a quarterly basis unless there are significant opportunities for improvement noted in the interim. *Results of monitoring adherence to infection control standards are	

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related to the results of the lab or x-ray done. Staff only documented a culture or x-ray had been done.

b. Review of the Subacute Infection Control Logs for December 2013, March, April, May, June, July and August 2014, showed the following:

* Under the area for pertinent laboratory findings, staff documented all the infections had either a culture or x-rays done. However, no results were identified to show if the bacteria counts were positive for a true infection, or an x-ray revealed a positive findings such as pneumonia.

* All of the seven months of log failed to have documentation of each of the resident's signs or symptoms which would help determine if the resident had a true infection, or if it was treated with antibiotics unnecessarily.

* The treatment column for these logs failed to consistently identify what medication was used to treat the infections. Of the 16 entries, only four were identified. In the treatment column staff had been documenting the route the medication was given (i.e. by mouth or intravenously), not the actual medication.

c. Review of the Subacute Infection Control Logs for January and February 2014, showed the logs were blank. The CNO confirmed the logs were blank. He stated he did not fill out the logs for these two months.

On 9/4/14 at 1400 hours, an interview was conducted with the CNO. The CNO was asked about the Subacute Infection Control Logs. The CNO stated he entered the data based on the

presented monthly to the Pediatric Unit Medical Director and other leadership. The results are reported to the organization-wide quality council on a quarterly basis unless there are significant opportunities for improvement noted in the interim.

Person(s) Responsible:

Infection Control Practitioner and Pediatric Sub-Acute DON.

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culture reports he received from the nursing staff. He was asked based on the information provided on the Subacute Infection Control Logs, whether he could determine if the residents had a true infection or were being treated with unnecessary antibiotics. He stated based on the Subacute Infection Control Logs he could not determine this information. The CNO was asked if the facility was monitoring for the use of unnecessary antibiotics. The CNO stated, "No not yet." He also stated he had just hired an infection control nurse. The CNO was asked about the missing information, such as the culture results, resident specific signs and symptoms of the infection, and the medication used to treat the infection. The CNO verified he had not been documenting this information on the logs. He stated he was not aware this information was needed. He stated the infection control committee had last met in April 2014, and he had reported the infection control rates at that time. He stated he was not aware the unnecessary antibiotic usage should be part of the surveillance.

2.a. On 9/3/14 at 0745 hours, Resident 5 was observed in bed. A sign posted on the wall outside the room showed Resident 5 was on contact isolation precautions (isolation requiring staff to wear gown, gloves, and mask if they may come in contact with any body secretions or fluids).

Clinical record review for Resident 5 was initiated on 9/3/14. Resident 5 was readmitted to the facility on 6/17/14, with diagnoses including history of partial small bowel obstruction and history of recurrent intermittent ileus (disruption of the muscle contractions of the intestines stopping

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the movement of food and fluid through the digestive system). Resident 5 was ventilator dependent.

Review of the H&P dated 6/23/14, showed Resident 5 was to be placed on isolation.

Review of a care plan problem dated 6/17/14, addressed the Resident 5's infections of VRE, MRSA, and ESBL (multi-drug resistant organisms where the bacteria is resistant to many antibiotics) and contact isolation precautions.

Review of the physician's orders for Resident 5 failed to find an order for contact isolation.

Review of the facility P&P titled Infection Control dated 11/2010, showed the physician had to write an order on what extra precautions were necessary.

On 9/4/14 at 1100 hours, an interview with LVN 4 was conducted. LVN 4 was unable to find an order for contact isolation for Resident 5.

b. Further review of the physician's orders for Resident 5 showed an order dated 7/6/14, for stool culture for C-diff.

Review of the nursing progress summary notes dated 7/4/14, showed Resident 5 had a total of 9 BMs for that day. On 7/5/14, the resident had a total of 6 BMs for that day. On 7/6/14 at 1130 hours, staff documented Resident 5 has loose yellow stool, with a total of 6 BMs for that day.

On 9/8/14 at 1010 hours, an interview with RN 2 was conducted regarding Resident 5. RN 2 stated the resident's C-diff culture was obtained

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due to the resident experiencing more than normal BMs. She stated if a resident had C-diff due to the symptoms of more than normal loose BMs, they would have placed the resident in a private room. When asked if Resident 5 was transferred to a private room when the symptoms were observed. RN 2 stated, "No, he remained in the same room with his current roommate." RN 2 stated the roommate did not have any symptoms of C-diff.

c. On 9/8/14 at 0840 hours, two EMTs entered Resident 5's room with a gurney. EMT 1 was wearing gloves and a mask and EMT 2 was only wearing gloves. Neither EMTs were wearing a gown. The EMTs were accompanied by an RT from the EMT company. This RT was wearing a mask and gloves. In addition, the facility's RT 5 was in Resident 5's room and was observed to be wearing a gown, a mask, and gloves.

The RT from the EMT company stood at Resident 5's bedside on the nonventilator side of the bed. He turned on the portable ventilator located on the gurney, checked the ventilator settings, and then removed Resident 5 from the facility's ventilator and attached the resident to the portable ventilator.

EMT 1 was observed to lift Resident 5 off of the bed and placed her onto the gurney. Neither EMTs removed or changed their gloves or attempted to sanitize or wash their hands before they exited the resident's room.

The RT from the EMT company removed the gloves and a mask while inside the resident's room and used a sanitizing hand gel on his hands as he exited the room.

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During this observation, RT 5 did not provide any directions to either EMT company staff regarding the contact isolation precautions for Resident 5.

3. On 9/4/14 at 1030 hours, an observation was made of a teacher (Teacher 1) walking down the hallway holding a tray containing small cut pieces of purple tissue paper and a bottle of tacky glue. As the teacher was walking down the hallway, three small pieces of the tissue paper flew off of the tray and landed on the floor. Teacher 1 bent down, retrieved the pieces of tissue paper, and replaced the pieces back onto the tray. Teacher 1 continued down the hallway to Room A, placed the tray down on the isolation cart, and opened one drawer to retrieve an isolation gown.

However, before Teacher 1 retrieved a gown she was asked about the above observation. The teacher agreed this was the sequence of events. When asked what procedure she should have followed when the papers fell off of the tray. The teacher stated she should have discarded the pieces of tissue and washed her hands before proceeding on to a resident's room.

F 518 SS=E 483.75(m)(2) TRAIN ALL STAFF-EMERGENCY PROCEDURES/DRILLS

The facility must train all employees in emergency procedures when they begin to work in the facility, periodically review the procedures with existing staff, and carry out unannounced staff drills using those procedures.

This REQUIREMENT is not met as evidenced by:

F 441

483.75(M)(2) TRAIN ALL STAFF-EMERGENCY PROCEDURE/DRILLS

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F518

Corrective Actions Taken for Affected Residents:

This issue does not directly address resident life.

*All staff were re-educated about the Environment of Care (EOC), including emergency food/water, location of emergency equipment, location of emergency shut off valves, etc. 9/5/14

F 518

Corrective Actions for Other Residents:
This issue does not directly address resident life.

*All staff were re-educated about the Environment of Care (EOC), including emergency food/water, 10/16/14

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at least 23,000 people die each year as a direct result of these infections. Many more people die from other conditions that were complicated by an antibiotic-resistant infection. Studies indicate that 30-50% of antibiotics prescribed in hospitals are unnecessary or inappropriate. "There is no doubt that overprescribing and misprescribing is contributing to the growing challenges posed by C-diff and antibiotic-resistant bacteria." Most deaths related to antibiotic resistance happen in healthcare settings, such as hospitals and nursing homes. Studies demonstrate that improving prescribing practices in hospitals can not only help reduce rates of C-diff infection and antibiotic resistance but can also improve individual patient outcomes, all while reducing healthcare costs. A CDC analysis of data regarding antibiotics prescribed in hospitalized patients, showed a 30% reduction in use of broad-spectrum antibiotics would result in a 26% reduction in C-diff infections. In addition, improvement of physician antibiotic prescribing habits from overuse and incorrect use would also help to reduce antibiotic resistance.

According to Medscape.com, C-diff colitis results from a disturbance of the normal bacterial flora of the colon and the release of toxins that cause mucosal inflammation and damage. Antibiotic therapy is the key factor that alters the colonic flora causing C-diff infections.

1 An interview and concurrent clinical record review of the Subacute Infection Control Logs was initiated with the CNO on 9/4/14 at 1345 hours. The CNO stated the facility was using McGeer's criteria to determine the facility's infection rates. The CNO stated he was completing the logs monthly. He stated the

Measures/Systemic Changes:

*A dedicated/qualified infection control practitioner has been recruited and hired to oversee the infection control process. The infection control log has been modified to include the necessary information needed to properly monitor infections on the unit and detect trends in infections and/or antibiotic usage. 10/10/14 9/8/14

*Direct observation of adherence to enhanced standard precautions is being accomplished. A monitoring tool has been developed and will be used to perform direct observation of compliance to the precautions. 10/15/14 Monthly for 6 months and then quarterly thereafter with annual evaluation for need to continue.

*Direct Observation of adherence to infection control practices is being accomplished. A monitoring tool has been developed and will be used to perform direct observation of compliance. 10/15/14

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F 518	Continued From page 41 emergency fire alarm pull was located. She pointed to an oxygen/gas turn off valve located on the wall near the conference/activity room. However, the fire alarm pull was located near the entrance to the nursing unit. 4. On 9/8/14 at 1130 hours, an interview was conducted with RT 3 regarding emergency preparedness. He was able to identify the main gas supply and stated the red lever was the emergency gas shut off valve. However, when asked what the wrench hanging by the main gas supply was for, he stated it could be used to turn off the gas if the red lever broke. 5. During an interview with CNA 2 on 9/4/14 at 0710 hours, CNA 2 was able to locate the facility's main gas supply. When asked how the gas would be shut off in the event of a disaster, CNA 2 stated she would use the large wrench attached with a chain to the main gas supply. When asked where she would place the wrench, CNA 2 stated she was not sure since there were two bolts that could be turned. The Maintenance Director happened to pass by and was asked how to turn off the main gas supply. The Maintenance Director pointed to the bolt located near the ground and stated that was the correct bolt to turn to shut off the gas.	F 518	at all times with identification badge. Person(s) Responsible: Pediatric DSD. DON	

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F 518	Continued From page 40 Based on observation and interview, the facility failed to ensure five of six staff were knowledgeable about the facility's emergency procedures. This had the potential to place residents, staff, and visitors in danger in the event of an emergency. Findings: 1. On 9/8/14 at 1015 hours, an interview was conducted with the Activities Coordinator regarding emergency preparedness. When asked where the facility's emergency food and water supply were located. She stated she did not know. When asked where the emergency water shut off valve was located. The Activities Coordinator stated in the basement. She pointed to a green lever as the shut off valve. However, the emergency water shut off valve was located in an adjacent room and on a pipe near the ceiling. She was able to identify the main emergency gas shut off valve. However, when asked what the wrench hanging by the main gas supply was for, she stated she did not know. The wrench was needed to turn off the gas valve. 2. On 9/8/14 at 1030 hours, an interview was conducted with RN 2 regarding emergency preparedness. She was able to point out the main gas supply and stated the red lever was the emergency gas shut off valve. When asked what the wrench hanging by the main gas supply was for, she stated she did not know. 3. On 9/8/14 at 1100 hours, an interview was conducted with CNA 1 regarding emergency preparedness. When asked where the facility's emergency food supply was located. CNA 1 stated she did not know. When asked where the	F 518	location of emergency equipment, location of emergency shut off valves, etc. Measures/Systemic Changes: *Re-education of all staff on EOC, including facility tours. *Signage was placed on the wall near the main gas shut off valve to instruct in conducting emergency shut off procedure. *Staff provided with reference material outlining emergency procedures (badge buddies) to wear at all times with identification badge. Monitoring: *Staff re-education of emergency procedure. *Monthly assessment of staff knowledge is done during EOC rounds and drills. evaluated by direct questions to and return answers by the staff. *Staff were provided with reference material outlining emergency procedures (badge buddies) to wear	10/16/14 10/16/14 10/16/14 9/15/14 – ongoing 10/14/15

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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K 000	INITIAL COMMENTS K3 BUILDING: 02 WING K6 PLAN APPROVAL 1998 K7 SURVEY UNDER 2000 EXISTING STRUCTURE TYPE: ONE STORY, CONSTRUCTION TYPE (V) (111), FULLY SPRINKLERED The following reflects the find ngs of the California Department of Public Health, during an annual Life Safety Code recertification survey. The findings are in accordance with 42 CFR (Code of Federal Regulations) 483.70 (a) and NFPA (National Fire Protection Association) 101, Life Safety Code 2000 edition, Existing codes Representing the California Department of Public Health 26387 The facility is not in substantial compliance with 42 CFR 483.70 (a) for Long Term Care Facilities. Census = 22	K 000	**This Plan of Correction constitutes my written credible allegation of compliance to the deficiencies noted.**	
K 018 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of res sting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping	K 018	**NFP 101 Life Safety code Standard** **K018** Immediate Actions Taken: 9/9/2014 All brown rubber wedges were removed and discarded to allow proper un-impeded closure of the doors noted. All areas were reviewed and no other door hold open devices were found. Education was immediately provided to all staff present focusing on the need to maintain proper closure of all doors and the exclusion of hold open devices	

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

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

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K 018	Continued From page 1 the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities This STANDARD is not met as evidenced by. Based on observation and interview, the facility failed to maintain their corridor doors. This was evidenced by corridor doors that were impeded from closing. This could result in delay to contain smoke or fire to a room in the event of a fire. This affected 2 of 3 smoke compartments. NFPA 101, Life Safety Code, 2000 Edition 19.3.6.3.1* Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4-in. (4.4-cm) thick, solid-bonded core wood or of construction that resists fire for not less than 20 minutes and shall be constructed to resist the passage of smoke. Compliance with NFPA 80, Standard for Fire Doors and Fire Windows, shall not be required. Clearance between the bottom of the door and the floor covering not exceeding 1 in. (2.5 cm) shall be permitted for corridor doors. Exception No. 1: Doors to toilet rooms, bathrooms, shower rooms, sink closets, and similar auxiliary spaces that do not contain flammable or combustible materials	K 018	Systemic Changes: Education was provided to all staff 9/27/14 during a staff meeting to reinforce the proper function and of all doors in the hospital and that any hold open device that impedes the door from proper closure is forbidden. This will also be reinforced in the orientation of any new staff. Absence of hold open devices is included on the environment of care inspection tool and Charge nurse rounding tool. Monitoring: Absence of hold open devices is being monitored during monthly Safety Rounds as well as daily during charge nurse rounds. Results of the monitoring will be reported through the quality assurance reports at the Leadership Team meetings and the hospital Quality Assurance meeting at least quarterly in order to evaluate the POCs effectiveness. . Any deficiencies noted in the interim will be immediately corrected.	

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K 018	Continued From page 2 Exception No. 2: In smoke compartments protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.2, the door construction requirements of 19.3.6.3.1 shall not be mandatory, but the doors shall be constructed to resist the passage of smoke. NFPA 80, Standard for Fire Doors and Fire Windows, 1999 Edition 2-4.1.4. All closing mechanisms shall be adjusted to overcome the resistance of the latch mechanism so that positive latching is achieved on each door operation. 19.3.6.3.3* Hold-open devices that release when the door is pushed or pulled shall be permitted A.19.3.6.3.3 Doors should not be blocked open by furniture, door stops, chocks, tie backs, drop down or plunger type devices, or other devices that necessitate manual unlatching or releasing action to close. Examples of hold-open devices that release when the door is pushed or pulled are friction catches or magnetic catches. Findings: During a tour of the facility with the Director of Plant Operations, and the Chief of Ancillary Services on 9/9/14, the doors in the facility were observed, and a staff person was interviewed 1. At 9:40 a.m., the self-closing corridor door to the Staff Break Room, was impeded from closing with a brown rubber wedge under the door. 2. At 10:59 a.m., the self-closing corridor door to Physical Therapy/Rehab, was impeded from	K 018		

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	555730	A. BUILDING 01 B. WING	09/09/2014

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K 018	Continued From page 3 closing with a brown rubber wedge under the door 3. At 11:00 a.m., the Director of Plant Operations said during an interview that he checked all of the doors yesterday and they were not wedged open	K 018		
K 025 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 This STANDARD is not met as evidenced by Based on observation, the facility failed to maintain the integrity of the fire resistance rated construction of its smoke barrier walls. This was evidenced by an unsealed penetration. This could result in the reduction in staff ability to protect in place due to smoke and fire. This affected 2 of 3 smoke compartments NFPA 101, Life Safety Code, 2000 Edition 19.3.7.3 Any required smoke barrier shall be constructed in accordance with Section 8.3 and shall have a fire resistance rating of not less than 1/2 hour	K 025	**NFP 101 Life Safety code Standard** **K025** Immediate Actions Taken: The noted unsealed pipe penetration was sealed with the proper fire caulking. All other smoke barriers were inspected and no other unsealed penetrations were found. 9/9/14 Systemic Changes: 9/24/14 All work done above the ceiling by contractors and/or in-house personnel will be required to obtain an "above the ceiling work permit" that includes a final inspection of any work done to insure that any penetrations are properly sealed. Monitoring: All above the ceiling work will be monitored through the work permit process. Monthly life safety inspections will include observation of smoke barrier walls. Work permits and inspections will be reported through the quality assurance reports at the Leadership Team meetings and the	

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K 025	Continued From page 4 Exception No 1 Where an atrium is used, smoke barriers shall be permitted to terminate at an atrium wall constructed in accordance with Exception No 2 to 8 2.5 6(1) Not less than two separate smoke compartments shall be provided on each floor. Exception No 2 * Dampers shall not be required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems where an approved, supervised automatic sprinkler system in accordance with 19 3 5 3 has been provided for smoke compartments adjacent to the smoke barrier 8 3.6 1 Pipes, conduits, ducts, cables, wires, air ducts, pneumatic tube and ducts and similar building services equipment that pass through floors and smoke barriers shall be protected as follows: (1) The space between the penetrating item and the smoke barrier shall meet one of the following conditions a. It shall be filled with a material that is capable of maintaining the smoke resistance of the smoke barrier b It shall be protected by an approved device that is designed of the specific purpose (2) Where the penetrating item uses a sleeve to penetrate the smoke barrier, the sleeve shall be solidly set in the smoke barrier, and the space between the item and the sleeve shall meet one of the following conditions a. It shall be filled with a material that is capable of maintaining the smoke resistance of the smoke barrier. b. It shall be protected by an approved device that is designed for the specific purpose. (3) Where designs take transmission of vibration into consideration, any vibration isolation shall	K 025	hospital Quality Assurance meeting at least quarterly in order to evaluate the POCs effectiveness. Any deficiencies noted in the interim will be immediately corrected.	

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K 025	Continued From page 5 meet one of the following a. It shall be made on either side of the smoke barrier. b. It shall be made by an approved device that is designed for the specific purpose. Findings. During a tour of the facility with the Director of Plant Operations, and the Chief of Ancillary Services on 9/9/14, the smoke barrier walls were observed. At 12:49 p.m., there was an approximately 1/2 inch unsealed conduit pipe in the smoke barrier wall near Room 309. The Director of Plant Operations acknowledged the finding	K 025		
K 027 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7 This STANDARD is not met as evidenced by Based on observation and interview, the facility failed to maintain the smoke barrier doors. This was evidenced by a smoke barrier door that failed to latch. This could fail to contain smoke during a	K 027	**NFP 101 Life Safety code Standard** **K027** Immediate Actions Taken: 9/9/14 The door near room 307 was adjusted to insure proper latching. All other doors were checked and no others were found to be deficient. Systemic Changes: 9/23/14 All fire doors will be checked for proper latching with each fire drill (monthly) and each safety inspection (monthly). Any deficiencies will immediately be corrected.	

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K 027	Continued From page 6 fire. This affected 2 of 3 smoke compartments. NFPA 101, Life Safety Code, 2000 Edition 19.2.2.2.6* Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier, or hazardous area enclosure shall be permitted to be held open only by an automatic release device that complies with 7.2.1.8.2. The automatic sprinkler system, if provided, and the fire alarm system, and the systems required by 7.2.1.8.2 shall be arranged to initiate the closing action of all such doors throughout the smoke compartment or throughout the entire facility. 7.2.1.8.2 In any building of low or ordinary hazard contents, as defined in 6.2.2.2 and 6.2.2.3, or where approved by the authority having jurisdiction, doors shall be permitted to be automatic-closing, provided that the following criteria are met. (1) Upon release of the hold-open mechanism, the door becomes self-closing. (2) The release device is designed so that the door instantly releases manually and upon release becomes self-closing, or the door can be readily closed. (3) The automatic releasing mechanism or medium is activated by the operation of approved smoke detectors installed in accordance with the requirements for smoke detectors for door release service in NFPA 72, National Fire Alarm Code®. (4) Upon loss of power to the hold-open device, the hold-open mechanism is released and the door becomes self-closing. (5) The release by means of smoke detection of one door in a stair enclosure results in closing all doors serving that stair.	K 027	Monitoring: Results of the inspection and drills will be reported through the quality assurance reports at the Leadership Team meetings and the hospital Quality Assurance meeting at least quarterly in order to evaluate the POCs effectiveness.	

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K 027	Continued From page 7 Findings: During a tour of the facility with the Director of Plant Operations, and the Chief of Ancillary Services on 9/9/14, the facility smoke barrier doors were observed, and a staff person was interviewed 1. At 11:07 a.m., the north smoke barrier door near Room 307 was not latching when tested. Two attempts were made without the door latching. 2. At 11:08 a.m., the Director of Plant Operations said during an interview that he checked all of the doors yesterday and they all worked.	K 027	**NFP 101 Life Safety code Standard** **K050** Immediate Actions Taken: 9/9/14 Remedial instruction was immediately provided to the staff members on the unit including the two that could not properly answer the questions. All other staff members present were given instruction as well. Systemic Changes: 9/15/14 Remedial instruction was given for all staff members. RACE, PASS, Code Red and unlocking of the bathroom doors is included in the annual competency assessment with return demonstration. Devices to open the bathroom doors are maintained in each Fire Extinguisher cabinet to facilitate.	
K 050 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: Based on interview, the facility failed to prepare staff members to respond to emergency situations. This was evidenced by staff members that failed to know how to open a locked bathroom door and by not being aware of the facility protocols. This could result in facility staff	K 050		

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K 050	Continued From page 8 not being prepared to respond to emergency evacuation with a person locked in a bathroom. This affected 3 of 3 smoke compartments. NFPA 101, Life Safety Code, 2000 Edition 19.7.1.3 Employees of health care occupancies shall be instructed in life safety procedures and devices. 19.7.2 Procedure in Case of Fire 19.7.2.1* For health care occupancies, the proper protection of patients shall require the prompt and effective response of health care personnel. The basic response required of staff shall include the removal of all occupants directly involved with the fire emergency, transmission of an appropriate fire alarm signal to warn other building occupants and summon staff, confinement of the effects of the fire by closing doors to isolate the fire area, and the relocation of patients as detailed in the health care occupancy's fire safety plan. 19.7.2.2 A written health care occupancy fire safety plan shall provide for the following (1) Use of alarms (2) Transmission of alarm to fire department (3) Response to alarms (4) Isolation of fire (5) Evacuation of immediate area (6) Evacuation of smoke compartment (7) Preparation of floors and building for evacuation (8) Extinguishment of fire 19.7.2.3 All health care occupancy personnel shall be instructed in the use of and response to fire alarms. In addition, they shall be instructed in the use of the code phrase to ensure transmission of an alarm under the following conditions (1) When the individual who discovers a fire must immediately go to the aid of an endangered	K 050	<u>Monitoring:</u> Staff knowledge of RACE, PASS, Code Red and unlocking of the bathroom doors is being monitored during monthly Safety Rounds and fire drills as well as periodically during leadership rounds. Results of the monitoring will be reported through the quality assurance reports at the Leadership Team meetings and the hospital Quality Assurance meeting at least quarterly in order to evaluate the POCs effectiveness. Any deficiencies noted in the interim will be immediately corrected.	

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K 050	Continued From page 9 person (2) During a malfunction of the building fire alarm system Personnel hearing the code announced shall first activate the building fire alarm using the nearest manual fire alarm box and then shall execute immediately their duties as outlined in the fire safety plan. Findings During a tour of the facility with the Director of Plant Operations, and the Chief of Ancillary Services on 9/9/14, staff members were interviewed. At 12:55 p.m., staff member 1 and staff member 2 were interviewed and were asked to open a locked bathroom door to evacuate a person out of the room during a trash can fire. Two of two staff could not open the locked door and were unable to describe the facilities protocols RACE (Rescue, Alarm Confine, Extinguish), PASS (Pull Aim, Squeeze, and Sweep), code word (Code RED). The door could be unlocked with a small key or a coin.	K 050		
K 062 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by Based on document review and interview, the facility failed to maintain the fire sprinkler system.	K 062	**NFP 101 Life Safety code Standard** **K062** Immediate Actions Taken: 9/23/14 The fire sprinkler repairs listed were scheduled and completed on 9/23/2014	

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K 062	Continued From page 10 This was evidenced by documented failures of the sprinkler system during an inspection by a licensed vendor and by the failure to conduct 1 of 4 quarterly test of the Inspector's Test Valve. This could result in the failure of the fire sprinkler system in the event of a fire. This affected 3 of 3 smoke compartments. NFPA 101, Life Safety Code, 2000 Edition 9.7.5 Maintenance and Testing. All automatic sprinkler and standpipe systems required by this Code shall be inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems 4.6.12.1 Whenever or wherever any device, equipment, system, condition, arrangement, level of protection, or any other feature is required for compliance with the provisions of this Code, such device, equipment, system, condition, arrangement, level of protection, or other feature shall thereafter be continuously maintained in accordance with applicable NFPA requirements or as directed by the authority having jurisdiction. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 1998 Edition 1-11.3 Corrective maintenance includes, but is not limited to, replacing loaded, corroded, or painted sprinklers; replacing missing or loose pipe hangers, cleaning clogged fire pump impellers, replacing valve seats and gaskets, restoring heat in areas subject to freezing temperatures where water-filled piping is installed, and replacing worn or missing fire hose or nozzles. 9-5.1.1 All valves shall be inspected quarterly.	K 062	Systemic Changes: Annual fire sprinkler inspection and quarterly valve testing are scheduled on an ongoing basis by the Director of Plant Operations. A vendor was selected who will also calendar the required inspections and testing in their PM system.. Any corrective actions required as a result of the scheduled testing are performed as soon as possible following the testing. The testing schedule, results of the testing and any corrective actions required and performed are reported to and reviewed by hospital leadership and the Environment of Care Team by the Director of Plant Operations. Monitoring: The Annual fire sprinkler inspection and quarterly valve testing schedule, results of the testing and any corrective actions required and performed are monitored and reported through Leadership Team meetings and the hospital Quality Assurance and Environment of Care Team meetings at least quarterly in order to evaluate the POCs effectiveness. . Any deficiencies noted in the interim will be immediately corrected.	9/23/14

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K 062	Continued From page 11 The inspection shall verify that the valves are in the following condition: (a) In the open position (b) Not leaking (c) Maintaining downstream pressures in accordance with the design criteria (d) In good condition, with handwheels installed and unbroken 1-8.1 Records shall indicate the procedure performed (e.g., inspection, test, or maintenance), the organization that performed the work, the results, and the date. 2-2.1.1 Sprinklers shall be inspected from the floor level annually. Sprinklers shall be free of corrosion, foreign materials, paint and physical damage and shall be installed in the proper orientation (e.g., upright, pendent, or sidewall). Any sprinkler shall be replaced that is painted, corroded, damaged, or in the improper orientation. Exception No. 1: Sprinklers installed in concealed spaces such as above suspended ceilings shall not require inspection. Exception No. 2: Sprinklers installed in areas that are inaccessible for safety considerations due to process operations shall be inspected during each scheduled shutdown. 2-2.6 Alarm Devices. Alarm devices shall be inspected quarterly to verify that they are free of physical damage. Findings: During document review with the Director of Plant Operations and the Chief of Ancillary Services on 9/9/14, the sprinkler maintenance documents	K 062		

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K 062	Continued From page 12 were reviewed, repair documents were requested, and a staff member was interviewed. 1. At 9:57 a.m., there was no documented evidence of an Inspector's Test Valve test for the month of March 2014. The testing records provided the dates 6/17/14 and 1/13/14. 2. At 9:59 a.m., there was documented evidence that 29 sprinklers failed during an annual inspection on 6/6/14 by a licensed vendor. There was no evidence of repairs. The following items were identified as failed: a. 15 corroded sprinkler heads at the main entrance. b. 3 corroded sprinkler heads in the kitchen. c. 1 corroded sprinkler head in the basement. d. 2 corroded sprinkler heads at the south exit. e. 4 corroded sprinkler heads located at the west over hang. f. 2 corroded sprinkler heads at south exit (165 ssp 8 ft ceiling). g. 2 corroded sprinkler heads at west exit (165 ssp 8 ft ceiling). 3. At 10:02 a.m., the Director of Plant Operations said during an interview, that he has schedu'ed to have the sprinklers repaired tomorrow.	K 062		
K 064 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6. NFPA 10	K 064	**NFP 101 Life Safety code Standard** **K064** Immediate Actions Taken: 9/9/14 The dresser was removed and remedial instruction was immediately provided to all staff members on the unit in the proper clearance required to maintain access to all fire extinguishers.	

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K 064	Continued From page 13	K 064		

This STANDARD is not met as evidenced by:
Based on observation and interview, the facility failed to maintain its portable fire extinguishers. This was evidenced by a portable fire extinguisher that was obstructed from access. This could result in a delay of access to the fire extinguisher in the event of a fire. This affected 1 of 3 smoke compartments.

NFPA 101, Life Safety Code, 2000 Edition
9.7.4 Manual Extinguishing Equipment.
9.7.4.1* Where required by the provisions of another section of this Code, portable fire extinguishers shall be installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers.

NFPA 10, Standard for Portable Fire Extinguishers, 1998 Edition
1-6.3 Fire extinguishers shall be conspicuously located where they will be readily accessible and immediately available in the event of fire. Preferably they shall be located along normal paths of travel, including exits from areas.

Findings:

During a tour of the facility with the Director of Plant Operations, and the Chief of Ancillary Services on 9/9/14, the portable fire extinguishers were observed, and staff was interviewed.

1. At 9:51 a.m. there was a fire extinguisher near the soiled utility Room/Bio-Hazard Room near shower B, that was impeded from access with a three drawer dresser in front of the device.

Systemic Changes:

9/25/14

Remedial instruction was given for all staff members in the proper clearance required to maintain access to all fire extinguishers. In addition, signage was placed on each fire extinguisher cabinet as a reminder.

Monitoring:

Proper clearance for all fire extinguishers is being monitored during monthly Safety Rounds as well as daily during charge nurse rounds. Results of the monitoring will be reported through the quality assurance reports at the Leadership Team meetings and the hospital Quality Assurance meeting at least quarterly in order to evaluate the POCs effectiveness. . Any deficiencies noted in the interim will be immediately corrected.

PRINTED 09/22/2014
FORM APPROVED
OMB NO 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555730	A BUILDING 01 B WING	09/09/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS CITY, STATE ZIP CODE
NEWPORT SPECIALTY HOSPITAL	14662 NEWPORT AVENUE TUSTIN, CA 92780

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 064	Continued From page 14 2. At 9:52 a.m., the Director of Plant Operations said during an interview that the dresser should not be in front of the fire extinguisher. The Director of Plant Operations stated that it not there yesterday when he toured.	K 064		
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9 1.2 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain their electrical equipment and utilities. This was evidenced by a multi-plug power strip that was plugged into another multi-plug power strip, and by unidentified circuit breakers. This could result in an electrical fire and cause delay in locating a circuit breaker. This affected 1 of 3 smoke compartments. NFPA 101, Life Safety Code, 2000 Edition SECTION 9.1 UTILITIES 9.1.2 Electric. Electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code, unless existing installations, which shall be permitted to be continued in service, subject to approval by the authority having jurisdiction. NFPA 70, National Electrical Code, 1999 Edition 240-4 Flexible cord, including tinsel cord and extension cords, and fixture wires shall be protected against overcurrent by either (a) or (b) (a) Ampacities. Flexible cord shall be protected by an overcurrent device in accordance with its ampacity as specified in Tables 400-5(A) and (B)	K 147	**NFP 101 Life Safety code Standard** **K147** Immediate Actions Taken: 9/10/14 The improperly deployed multi-plug power strips were removed and all plugs and cords were re-done to insure that they were orderly and proper. Re Remedial instruction was immediately provided to the staff members on the unit. An Electrical contractor was hired to begin to work to trace electrical circuits 2, 5, 25 26, and 28 to label appropriately. Systemic Changes: 9/25/14 Remedial instruction was given for all staff members in the proper use when required of extension cords/multi-plug power strips. Whenever an extension cord or multi-plug power strip is needed, the plant operations department will inspect to insure proper usage. The electrical contractor will verify the hospital single line drawing and review each circuit to insure that they are all labeled correctly.	

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NEWPORT SPECIALTY HOSPITAL	14862 NEWPORT AVENUE TUSTIN, CA 92780

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K 147	Continued From page 15 Fixture wire shall be protected against overcurrent in accordance with its ampacity as specified in Table 402-5. Supplementary overcurrent protection, as in Section 240-10, shall be permitted to be an acceptable means for providing this protection. 400-8 Unless specifically permitted in Section 400-7, flexible cord and cables shall not be used for the following. (1) As a substitute for the fixed wiring of a structure (2) Where run through holes in walls, structural ceilings, suspended ceilings, dropped ceilings, or floors (3) Where run through doorways, windows, or similar openings (4) Where attached to building surfaces (5) Where concealed behind building walls, structural ceilings, suspended ceilings, dropped ceilings, or floors (6) Where installed in raceways, except as otherwise permitted in this Code 384-13. General. All panelboards shall have a rating not less than the minimum feeder capacity required for the load computed in accordance with Article 220. Panelboards shall be durably marked by the manufacturer with the voltage and the current rating and the number of phases for which they are designed and with the manufacturer's name or trademark in such a manner so as to be visible after installation, without disturbing the interior parts or wiring. All panelboard circuits and circuit modifications shall be legibly identified as to purpose or use on a circuit directory located on the face or board Findings:	K 147	Monitoring: The absence of improper usage of Multi-plug power strips and extension cords and the proper labeling of electrical circuits is being monitored during monthly Safety Rounds. Results of the monitoring will be reported through the quality assurance reports at the Leadership Team meetings and the hospital Quality Assurance meeting at least quarterly in order to evaluate the POCs effectiveness. . Any deficiencies noted in the interim will be immediately corrected.	

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K 147	Continued From page 16 During a tour of the facility with the Director of Plant Operations, and the Chief of Ancillary Services on 9/9/14, the electrical equipment and wiring were observed, and a staff person was interviewed. 1. At 9:47 a.m., there was a multi-plug power strip that was plugged into another multi-plug power strip under the desk of the nursing station 2. At 9:49 a.m., there were 6 of 42 circuit breakers that were not identified to their purpose Circuits 2, 5, 6, 25, 26, and 28 were not labeled. 3. At 9:50 a.m., the Director of Plant Operations said during an interview, that he was working with Office of Statewide Health Planning and Development to correct the unmarked circuit breakers	K 147		

California Department of Public Health

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	CA060001166	A. BUILDING _____ B. WING _____	C 08/18/2014

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A 000	Initial Comments The following reflects the findings of the California Department of Public Health during the investigation of COMPLAINT NUMBER: CA00408741. Inspection was limited to the specific complaint(s) investigated and does not represent the findings of a full Inspection of the facility. Representing the California Department of Public Health: Surveyor 1835, HFEN. Findings for Complaint Number: CA00408741. The complaint allegation(s) were substantiated and regulatory violations written at A001 and A017.	A 000	**This Plan of Correction constitutes my written credible allegation of compliance to the deficiency noted.**	
A 001	Informed Medical Breach Health and Safety Code Section 1280.15 (b)(2), " A clinic, health facility, agency, or hospice shall also report any unlawful or unauthorized access to, or use or disclosure of, a patient's medical information to the affected patient or the patient's representative at the last known address, no later than five business days after the unlawful or unauthorized access, use, or disclosure has been detected by the clinic, health facility, agency, or hospice." The CDPH verified that the facility informed the affected patient(s) or the patient's representative(s) of the unlawful or unauthorized access, use or disclosure of the patient's medical information.	A 001	**Health and Safety Code Section 1280.15(b)(2),** **A001** Immediate Actions Taken: As soon as the potential breach was identified, the Activity Coordinator (AC) was interviewed and placed on administrative suspension until the investigation was complete. The AC was asked if she had posted PHI on any social media for any patient at any time other than this one incident. The AC stated that there were no other	8/4/2014

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

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A 017	Continued From page 1	A 017	postings. Additionally the Facebook page was reviewed at the time and this was confirmed. The posting with the photo was removed from the AC's Facebook account at this time. The hospital Compliance Officer was notified who then informed the patient's representatives of the disclosure.	8/7/14
A 017	1280.15(a) Health & Safety Code 1280 (a) A clinic, health facility, home health agency, or hospice licensed pursuant to Section 1204, 1250, 1725, or 1745 shall prevent unlawful or unauthorized access to, and use or disclosure of, patients' medical information, as defined in subdivision (g) of Section 56.05 of the Civil Code and consistent with Section 130203. The department, after investigation, may assess an administrative penalty for a violation of this section of up to twenty-five thousand dollars ($25,000) per patient whose medical information was unlawfully or without authorization accessed, used, or disclosed, and up to seventeen thousand five hundred dollars ($17,500) per subsequent occurrence of unlawful or unauthorized access, use, or disclosure of that patients' medical information. For purposes of the investigation, the department shall consider the clinic's, health facility's, agency's, or hospice's history of compliance with this section and other related state and federal statutes and regulations, the extent to which the facility detected violations and took preventative action to immediately correct and prevent past violations from recurring, and factors outside its control that restricted the facility's ability to comply with this section. The department shall have full discretion to consider all factors when determining the amount of an administrative penalty pursuant to this section. This Statute is not met as evidenced by: Findings: Review of hospital documentation showed a breach involving Patient A, an incapacitated	A 017	Systemic Changes: HIPAA in-services were performed by the Compliance Officer for all staff. The Compliance Officer met with the AC for a one on one session. The use of social media and its potential for privacy violations was emphasized. A pamphlet titled "A Nurse's Guide to the Use of Social Media" was ordered from the National Council of State Boards of Nursing and shared with all patient care staff. The content of the Compliance Officer's in-services as well as the pamphlet is included in new employee orientation for all new employees. Monitoring: The staff has been requested to notify the leadership/supervisory team about any potential social media (or other) HIPAA violations immediately, either ones they committed or other staff may have committed. The leadership and supervisory teams will be reminded by the CNO/COO during monthly management meetings to reinforce this reporting requirement with their staff and query the staff during unit staff	9/2/14 9/2/14 9/2/14 ongoing

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A 017	Continued From page 2 minor, occurred on 8/2/14. On 8/4/14, the hospital's investigation showed a photo of Patient A was posted onto the Activity Coordinator's (AC) Facebook (a social network) account. The Facebook post of Patient A's photo showed it had been viewed by unauthorized "friends" of the AC. There were also comments posted between the parents of Patient A and the AC. Further review of the hospital's investigation showed an interview with the AC occurred on 8/4/14. The AC stated, when asked, she was aware taking the picture and posting it on Facebook violated privacy laws as well as hospital policy, but did it anyway for the parents. Patient A's disclosed PHI included a full face and torso picture which showed the tracheostomy dressing at his neck and the use of stabilization cushions. The picture portrays Patient A as a patient of the hospital as evidenced by the electrical socket in the wall behind the patient and the privacy curtains at each side. On 8/18/14 at 1132 hours, an informal telephone conference with the Chief Compliance Officer confirmed the breach occurred as documented. Additionally, it was confirmed there was no documentation found permitting the AC to photograph the patient for posting on a social network.	A 017	meetings. Any reports about potential violations are reported to the Compliance Officer and investigated in accordance with the usual compliance investigations procedure. Results are reported by the Compliance Officer to the Compliance Committee on a quarterly basis. Periodically the process will be assessed by the Compliance Committee to determine whether additional or different measures might be considered.	

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F 000	INITIAL COMMENTS The following represents the findings of the California Department of Public Health during an ABBREVIATED survey for complaint No: CA00405575. The investigation was limited to the specific complaint investigated and does not represent the findings of a full investigation of the facility. Representing the California Department of Public Health: Pharmacist Consultant II, 32097 and Pharmacist Consultant II, 13095 The Pharmacist Consultants entered the facility on 7/22/14 at 1340 hours and reviewed three clinical records. THE DEPARTMENT WAS ABLE TO SUBSTANTIATE THE COMPLAINT ALLEGATIONS. Glossary: P&P: Policy and Procedure RPh: Facility Pharmacist RN: Registered Nurse MAR: Medication Administration Record	F 000	**This Plan of Correction constitutes my written credible allegation of compliance to the deficiencies noted.** **483.60(1)(b) PHARMACEUTICAL SVC-ACCURATE PROCEDURES, RPH** **F425** Immediate Actions Taken:	
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.	F 425	1. Cephalexin was immediately administered to Resident 1 upon return from the outside appointment. Charge nurses will immediate notify the pharmacy upon receipt of any new medication order The charge nurse will call the pharmacy for any new order for anti-infectives, and drugs used for nausea, agitation, diarrhea or other	8/8/2014

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	CEO	8/22/14

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

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F 425	Continued From page 1 A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility document review, the facility failed to implement their P&Ps to ensure resident safety as evidenced by: 1. Cephalexin (antibiotic used to treat infections) was not administered within four hours of the ordered time for Resident 1. This failure has the potential to result in a delay of treatment. 2. The pharmacy dispensed pediatric glycerin (laxative) suppositories instead of a dulcolax (laxative) suppository for Resident 2. This failure has the potential to result in a medication error. 3. A physician's medication order was not accurately transcribed for Resident 3. This failure has the potential to result in a medication error. 4. There was no accountability of the medications in the oral emergency kit (E-Kit) when it was left unlocked and there was no documentation of the	F 425	severe discomfort if not received within 2 hours to insure timely delivery. The medication will be administered immediately upon receipt. 2. All medications were reviewed to insure that there were no other errors in dispensing. All medications are verified with the MAR before administration. 3. The Transcription error was corrected before any incorrect doses were administered. All other new orders and recaps were reviewed to insure accurate transcription. No other errors were found. 4. The e-kit withdrawal form was immediately completed and the kit was locked with the appropriate lock and pharmacy notified for replacement. Systemic Changes: 1. E-kit contents were reviewed to insure that common anti-infectives, and drugs used for nausea, agitation, diarrhea or other severe discomfort are present and stocked. A meeting was held with the pharmacy to insure that any new stat or anti-infectives, and drugs used for nausea, agitation, diarrhea or other severe discomfort that are not present in the e-kit will be delivered by the pharmacy in a timely manner so that the medication can be administered	8/6/2014 8/8/2014 8/8/2014 8/29/2014

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F 425	Continued From page 2 medication removed from the kit found on the emergency medication log. This failure has a potential to result in a medication diversion or loss. Findings: 1. Review of the facility's P&P titled "Administration of Medication: General - Sub-Acute" dated 3/11, showed on page 4: anti-infectives and drugs used to treat severe pain, nausea, agitation, diarrhea, or other severe discomfort shall be available and administered within four hours of the time ordered. Clinical record review for Resident 1 was initiated on 8/4/14. Review of Resident 1's physician's orders showed cephalexin 250 mg was ordered on 8/2/14 at 1015 hours, for a possible infected ingrown hair on the left labia. Review of the facility's faxed confirmation showed the order was faxed to the pharmacy on 8/2/14 at 1025 hours, per the charge RN. Review of the Out of Facility Release form showed the resident was out of the facility on 8/2/14 between the 1500 and 2100 hours. Review of Resident 1's MAR showed cephalexin was administered at 2200 hours on 8/2/14, 11 hours and 45 minutes after the ordered time. During an interview on 8/4/14 at 1415 hours, RPh 1 stated the Pharmacy's documentation showed the order was received at 1115 hours. Cephalexin was delivered at 1800 hours. During an interview on 8/4/14 at 1220 hours, Charge RN 1 confirmed the cephalexin for Resident 1 was delivered from the pharmacy at	F 425	within the 4 hour time window. In-service education was conducted with the Charge Nurses. 2. It was noted that the two drugs in question were packaged very similarly. Glycerin suppositories and dulcolax suppositories were added to the look alike/sound alike alert list. A different brand of drug is being requested so that there is a greater contrast between the two packaging. 3. A new computer system is being deployed to reduce manual transcription of medication recaps and renewals. The 24 hour chart check policy and procedure was written and reviewed with the licensed nursing staff during a mandatory in-service education session. 4. In-service education was completed for all licensed nurses on the proper use of the e-kit. The e-kit review was added to the charge nurse checklist to insure that the proper procedures are being followed. <u>Monitoring:</u> 1. All orders for new stat or anti-infectives, and drugs used for nausea, agitation, diarrhea or other severe discomfort will be monitored for timely administration. The number of drugs administered within the 4 hour time frame divided by the number ordered will be	8/29/2014 8/29/2014 8/29/2014 8/29/2014

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F 425	Continued From page 3 1800 hours on 8/2/14 and administered at 2200 hours. 2. Inspection of medication cart 1 was initiated on 8/4/14 at 1205 hours. A clear medication bag labeled as containing a dulcolax suppository for Resident 2 was found in the medication cart. However, the content of the medication bag was identified as two pediatric glycerin suppositories. RN 1, RPh 1 and RPh 2 examined the bag labeled as dulcolax suppository for Resident 2 and acknowledged the bag contained pediatric glycerin suppositories. 3. Review of the facility's Administration P&P titled ADM-334 Transcription of Physician's Orders" dated 11/10, read: "Goal: To assure accuracy in transcription as well as coordination and implementation of therapeutic orders ....L. The physician must be notified of the inability to carry out an order if appropriate. A 24 hour chart check must be completed during the Night Shift to verify the accuracy and follow through of all orders written that day." Review of the facility's Nursing Services P&P titled NUR-232 Medication Administration, General Guidelines dated 11/10, read: "A. All medication orders must be ordered for a specific patient and include the name of drug, exact dosage ..." Review of the facility's Pharmacy P&P titled RX-173 Orders: Drugs dated 11/10, read: "All orders for drugs shall be written ....All orders for medications, procedures and devices shall be reviewed by a pharmacist." The clinical record for Resident 3 was reviewed	F 425	reported through the quality assurance reports at the Leadership Team meetings in order to evaluate the POCs effectiveness. Further changes will be implemented if necessary based on this evaluation. 2. All medications are verified by the licensed nurse to insure the proper medication is administered. Any discrepancies are immediately reported to the charge nurse and pharmacy. Each incidence will be reported through the quality assurance reports at the Leadership Team meetings in order to evaluate the POCs effectiveness. Further changes will be implemented if necessary based on this evaluation. 3. All Transcription errors found during the 24 hour chart check and/or pharmacist review will be immediately verified and corrected. Each incidence will be reported through the quality assurance reports at the Leadership Team meetings in order to evaluate the POCs effectiveness. Further changes will be implemented if necessary based on this evaluation. 4. Each entry into the e-kit will be monitored by the charge nurse. Each entry divided by the number of correctly processed entries will be reported through the quality assurance reports at the Leadership Team meetings in order	8/29/2014 8/29/2014 8/29/2014

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F 425	Continued From page 4 on 8/4/14 at 1500 hours. A hand-written physician's medication order for Baclofen (a muscle relaxant) dated on 8/3/14, showed an order for "Baclofen 10 milligram (mg) tab via gastrostomy tube (GT) every 6 hours for spasticity." Review of Resident 3's MAR on 8/4/14 at 1505 hours, showed the resident received a different amount of Baclofen than was ordered on 8/3/14. The medication order transcribed on Resident 3's MAR read: "Baclofen 10 mg tab take 2.5 tabs (25 mg) via G-Tube every 6 hours for spasticity." During an interview with Charge Nurse 2 on 8/4/14 at 1545 hours, Charge Nurse 2 confirmed the above order for Baclofen on Resident 3's MAR. In a concurrent interview with RN 1, the RN stated she transcribed the physician's medication order for the Baclofen in Resident 3's clinical record on 8/3/14. During the interview, RN 1 stated: "I gave this resident 25 mg of Baclofen this morning, but I must have been writing too fast when I wrote this order and I made this mistake." RN 1 further stated a second licensed nurse on the night shift of 8/3/14, reviewed the physician's medication order for Baclofen transcribed by RN 1. The second licensed nurse, who was responsible for reviewing all medication orders written during the day shift, did not catch the transcription error made by RN 1 earlier on 8/3/14, regarding Resident 3's Baclofen order. During an interview with Charge Nurse 2 and PIC on 8/4/14 at 1550 hours, they stated the physician's order, written by RN 1 for Resident 3's Baclofen, was not reviewed by the RPh. 4. Review of the facility's Pharmacy P&P titled	F 425	to evaluate the POCs effectiveness. Further changes will be implemented if necessary based on this evaluation.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555730	A. BUILDING _____ B. WING _____	C 08/08/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEWPORT SPECIALTY HOSPITAL	14662 NEWPORT AVENUE TUSTIN, CA 92780

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 425	Continued From page 5 Emergency Medication Supplies dated 01/01/13, showed the facility should complete the emergency box withdrawal form for documenting the resident and the medication used for the resident. On 8/7/14 at 1410 hours, the E-Kits were inspected in the medication room with the Charge Nurse, RPh 2 and the Nurse Manager. The oral E-kit was unlocked. Review of the Emergency Medication log inside the E-kit showed it was not completed. The Charge Nurse, RPh 2 and the Nurse Manager acknowledged the unlocked E-kit and that there was no documentation as to when the E-kit was opened, by whom and what medication was removed from the E-kit. The Charge Nurse stated the E-kit was opened during the night, and the night Charge Nurse notified the pharmacy that the E-Kit was opened per the change of shift report.	F 425		

RESPONSE TO DEFICIENCIES
EXHIBIT P CMS Statements of Deficiency

Southern California Hospital at Culver City

COUNTY OF LOS ANGELES
HEALTH FACILITIES DIVISION
3400 Aerojet Avenue, Suite 323
El Monte, CA 91731

FACSIMILE TRANSMISSION

ADDRESSEE:	ORIGINATOR:
NAME: Pamela Loo, RN Director of Quality **Attention:**	FROM: Rosario Grospe, RN, Senior HFEN Assistant Supervisor, Acute and Ancillary Unit
ORGANIZATION: Southern California Hosp at Culver City SNF DP	**Phone:** (626) 312-1129
CITY, STATE, & ZIP Culver City	FAX: (626) 927-9293
Telephone 310-836-7000 ext 1046	DATE 714/15
FAX #: 310-840-5426	PAGES INCLUDING COVER PAGE = 11

NOTES TO ADDRESSEE:

Attached is the ameded CMS 2567, Statement of Deficiencies and Plan of Correction for the Recertification Survey (LSC) completed 6/22/15, The hard copy will be mailed today. Please sign the Signature Requirement Notice and fax it back to our office as soon as possible.

Please submit the plan of correction on or before 7/24/15.

If you have any questions, please don't hesitate to call us.

Thank you, Rosario Grospe, Senior HFEN

State of California—Health and Human Services Agency Department of Health Services

SIGNATURE REQUIREMENT NOTICE
(For Plan of Correction)

Notice to Licensee/Designee

The surveying state agency is required to obtain a signed plan of correction for deficiencies noted on the Statement of Deficiencies and Plan of Correction (Code of Federal Regulations, Title 42, Section 489.13; State Operations Manual, Section 2612; and California Health and Safety Code, Section 1280). By signing a plan of correction, a licensee or designee does not necessarily admit guilt of any alleged violation nor does this interfere with the right to contest or appeal any alleged violations on which the plan of correction is based or the same period for correction. It does acknowledge responsibility for compliance with licensing requirements, with appropriate requirements of the Medicare and Medi-Cal programs, that an exit conference was held during which the items listed were discussed, and that a copy of the deficiency/report and plan of correction was received.

Name of facility	City
Southern California Hosp at Culver City SNF/DP	Culver City

Copy of this notice received:

Licensee or designee signature	Date
[signature]	7/20/15

Copy of this notice presented to licensee or designee:

Licensing Evaluator signature	Date
Rosario Groye for Sin Lin Cheng	7/13/15

Complaint Notice

If there should be disagreement between the Licensee or Designee and the Evaluator of the Survey Team on an interpretation of the regulations or a field decision, the Licensee of Designee may wish to call and discuss this with the District Licensing Supervisor.

Name of Licensing Supervisor	Telephone
Eric Stone, Program Manager	626-312-1142

Instructions

This notice is to be used with Plans of Correction for Skilled Nursing Facilities, Intermediate Care Facilities, Intermediate Care Facilities/Developmentally Disabled, Intermediate Care Facilities/Developmentally Disabled-Habilitative, Intermediate Care Facilities/Developmentally Disabled-Nursing, Congregate Living Health Facilities, Pediatric Day Health and Respite Care Facilities, and Hospitals with Distinct Part Skilled Nursing Facilities or Intermediate Care Facilities. It is to be signed by the licensee/designee and the licensing evaluator. A copy is left with the licensee/designee and the original is kept in the district office licensing file.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/13/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555874	A. BUILDING _____ B. WING _____	06/20/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN CALIFORNIA HOSP AT CULVER CITY D/P SNF	3828 DELMAS TERRACE CULVER CITY, CA 90230

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following reflects the findings of the Department of Public Health during a re-certification survey. Representing the Department of Public Health: Surveyor 17030, RN, HFEN Surveyor 25524, RN, HFEN Surveyor 16281, REHS, HFE Total Resident Population 17 Total Resident Sample Size: 8 Highest Scope/Severity: E	F 000		
F 154 SS=E	483.10(b)(3), 483.10(d)(2) INFORMED OF HEALTH STATUS, CARE, & TREATMENTS The resident has the right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition. The resident has the right to be fully informed in advance about care and treatment and of any changes in that care or treatment that may affect the resident's well-being. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure the resident or the resident's representative had the right to be fully informed in advance of the risks and benefits of anti-antipsychotic and physical restraints to be administered to six (6) of eight (8) sampled residents (1, 2, 3, 4, 6, and 7). The facility failed	F 154	1. How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice Corrective Action will be accomplished by the re-education of staff on the Restraints Policy and Procedure Application and monitoring SAA.049 and Consents PAT.037, completed on 7/19/2015. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken The SubAcute Unit at Southern California Hospital at Culver City (SCHCC) will identify other residents having the same potential for deficient practice by discussing restraint plan of care in interdisciplinary weekly rounds, and 100% monitoring of restraint documentation and informed consents, and will monitor them beginning August 1,2015 as process improvements and report it quarterly to quality council, medical executive committee and governing board.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Ronald [illegible] | TITLE: CEO | (X6) DATE: 7/20/15

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555874	A. BUILDING 01 - BROTMAN MEDICAL CENTER DP SNF B. WING _____	06/22/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN CALIFORNIA HOSP AT CULVER CITY D/P SNF	3828 DELMAS TERRACE CULVER CITY, CA 90230

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS This facility was surveyed under 42 CFR Part 483.70(a), Life Safety Code NFPA 101, 2000 Edition, Chapter 19, Existing Health Care Occupancies, and other applicable codes. Amended 7/14/15 Representing the Department of Public Health: Evaluator ID#16281 The following represents the findings of the Department of Public Health during a Life Safety Code Survey.	K 000		
K 050 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: Based on record review, and interview, the facility failed to provide supporting documentation that the subacute staff participated in fire drills at least quarterly on each shift. The deficiency had the potential for staff to not be familiar with the facility's fire emergency plan, and not be prepared to put it in effect in the event of a	K 050	*Fire Drill reports* • **No residents were affected by the deficient practice.** • **The Facility performs audits of all Fire Life Safety requirements on a monthly basis to ensure compliance.** • **An additional form has been added to the Fire Drill Critique package to document participation/attendance for all employees. The facilities Environment of Care committee meets regularly and fire drills are monitored and reviewed at these meetings. The hospital has also assigned the Vice President of Facilities to ensure that all Life safety & Environmental requirements are met.** • **Fire Drills are reported to the EOC Committee and any deficiencies will be corrected immediately. EOC reports quarterly to the Quality Council, Medical Executive Committee and the Governing Board.** • **Changes completed on 6/30/15**	6/30/15

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

CEO | 7/20/15

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

State of California—Health and Human Services Agency

Department of Health Services

SIGNATURE REQUIREMENT NOTICE
(For Plan of Correction)

Notice to Licensee/Designee

The surveying state agency is required to obtain a signed plan of correction for deficiencies noted on the Statement of Deficiencies and Plan of Correction (Code of Federal Regulations, Title 42, Section 489.13; State Operations Manual, Section 2612; and California Health and Safety Code, Section 1280). By signing a plan of correction, a licensee or designee does not necessarily admit guilt of any alleged violation nor does this interfere with the right to contest or appeal any alleged violations on which the plan of correction is based or the same period for correction. It does acknowledge responsibility for compliance with licensing requirements, with appropriate requirements of the Medicare and Medi-Cal programs, that an exit conference was held during which the items listed were discussed, and that a copy of the deficiency/report and plan of correction was received.

Name of facility	City
Southern California Hosp at Culver City SNF/DP	Culver City

Copy of this notice received:

Licensee or designee signature	Date

Copy of this notice presented to licensee or designee:

Licensing Evaluator signature	Date
Rosario Groye for Sin Lin Chung	7/13/15

Complaint Notice

If there should be disagreement between the Licensee or Designee and the Evaluator of the Survey Team on an interpretation of the regulations or a field decision, the Licensee of Designee may wish to call and discuss this with the District Licensing Supervisor.

Name of Licensing Supervisor	Telephone
Eric Stone, Program Manager	626-312-1142

Instructions

This notice is to be used with Plans of Correction for Skilled Nursing Facilities, Intermediate Care Facilities, Intermediate Care Facilities/Developmentally Disabled, Intermediate Care Facilities/Developmentally Disabled-Habilitative, Intermediate Care Facilities/Developmentally Disabled-Nursing, Congregate Living Health Facilities, Pediatric Day Health and Respite Care Facilities, and Hospitals with Distinct Part Skilled Nursing Facilities or Intermediate Care Facilities. It is to be signed by the licensee/designee and the licensing evaluator. A copy is left with the licensee/designee and the original is kept in the district office licensing file.

COUNTY OF LOS ANGELES
Public Health

CYNTHIA A. HARDING, M.P.H.
Interim Director

JEFFREY D. GUNZENHAUSER, M.D., M.P.H.
Interim Health Officer

ANGELO J. BELLOMO, REHS, QEP
Director of Environmental Health

TERRI S. WILLIAMS, REHS
Assistant Director of Environmental Health

5050 Commerce Drive
Baldwin Park, California 91706
TEL (626) 430-5100 · FAX (626) 813-3000

www.publichealth.lacounty.gov

Letter 4

IMPORTANT NOTICE - PLEASE READ CAREFULLY

July 13, 2015

Darrin Buckner, RN
Director of Subacute
Southern California Hosp At Culver City D/p Snf
3828 Delmas Terrace
Culver City, CA 90230

Dear Administrator:

On June 22, 2015, a standard annual Health and Life Safety Code survey was conducted at your facility by the California Department of Public Health, Licensing and Certification Program (Los Angeles Acute - South), to determine if your facility was in compliance with federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiency(ies) to be:

[ ] Isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy, as evidenced by the enclosed "Statement of Deficiencies and Plan of Correction" form, whereby corrections are required (D).

[x] A pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy, as evidenced by the enclosed "Statement of Deficiencies and Plan of Correction" form, whereby corrections are required (E).

The enclosed Centers for Medicare and Medicaid Services (CMS) form, entitled "Statement of Deficiencies and Plan of Correction" (CMS–2567), documents the deficiencies of participation requirements identified during this visit. All references to regulatory requirements contained in this letter are found in Title 42, Code of Federal Regulations (CFR).

Plan of Correction (POC)

A POC for the deficiencies must be submitted within **ten (10) days from receipt of the CMS- 2567.** Failure to submit an acceptable POC by the due date will result in remedies being recommended for imposition by the CMS and/or the State Medicaid Agency effective as soon as notice requirements are met.

Your POC must be submitted on the enclosed CMS-2567 form and must contain the following:

- How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;
- What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur;
- How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system; and
- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State Agency.

Remedies will be recommended for imposition by the CMS Regional Office and/or the State Medicaid Agency if your facility has failed to achieve substantial compliance by .

Recommended Remedies

The remedies, which will be recommended if substantial compliance has not been achieved by July 23, 2015 , include the following:

[x] Civil money penalty of $ 150.00 , effective June 22, 2015 (§488.430).

We are also recommending to the CMS Regional Office and/or the State Medicaid Agency that your provider agreement be terminated on if substantial compliance is not achieved by that time.

Denial of Payment for New Admissions (DPNA)

Based on deficiencies cited during this survey and as authorized by CMS San Francisco Regional Office, we are giving formal notice of imposition of statutory DPNA effective September 22, 2015. This remedy will be effectuated on the stated date unless you demonstrate substantial compliance with an acceptable POC and subsequent revisit. This notice in no way limits the prerogative of CMS to impose discretionary DPNA at any appropriate time.

CMS Regional Office will notify your intermediary and the Medicaid Agency. If effectuated, denial of payment will continue until your facility achieves substantial Compliance or your provider agreement is terminated. Facilities are prohibited from billing those Medicare/Medicaid residents or their responsible parties during the denial period for services normally billed to Medicare or Medicaid.

Appeal Rights

If you disagree with **the determination of noncompliance (and/or substandard quality of care, if applicable)**, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board. Procedures governing this process are set out in 42 CFR §498.40, et. seq. You may appeal the finding of noncompliance that led to an enforcement action, but not the enforcement action or remedy itself. A written request for hearing must be filed no later than 60 days from the date of receipt of this letter.

Such written request should be made directly to:

Attention: Ms. Karen Robinson
Departmental Appeals Board
Civil Remedies Division
Cohen Building, Room G-644
330 Independence Avenue S.W.
Washington, D.C. 20201

A request for hearing should identify specific issues, and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You may be represented at a hearing by counsel at your own expense.

Be sure to include a copy of this letter with your request to the Departmental Appeals Board. In addition, please forward a **copy of your request** to:

Attention: Paula Perse, Manager
Long Term Care Branch
Division of Survey and Certification
Centers for Medicare & Medicaid Services
90 7th Street, Suite 5-300 (5W)
San Francisco, CA 94103-6707

Alternatively, you can file your appeal electronically at the Departmental Appeals Board Electronic Filing System Web site (DAB E-File) at https://dab.efile.hhs.gov.

To file a new appeal using DAB E-File, you first need to register a new account by: (1) clicking **Register** on the DAB E-File home page; (2) entering the information requested on the "Register New Account" form; and (3) clicking **Register Account** at the bottom of the form. If you have more than one representative, each representative must register separately to use DAB E-File on your behalf.

The e-mail address and password provided during registration must be entered on the login screen at https://dab.efile.hhs.gov/user_sessions/new to access DAB E-File. A registered user's access to DAB E-File is restricted to the appeals for which he or she is a party or authorized representative. Once registered, you may file your appeal by:

-Clicking the **File New Appeal** link on the Manage Existing Appeals screen, then clicking Civil Remedies Division on the File New Appeal screen.
And,
-Entering and uploading the requested information and documents on the "File New Appeal-Civil Remedies Division" form.

At minimum, the Civil Remedies Division (CRD) requires a party to file a signed request for hearing and the underlying notice letter from CMS that sets forth the action taken and the party's appeal rights. All documents must be submitted in Portable Document Format ("PDF"). Any document, including a request for hearing, will be deemed to have been filed on a given day, if it is uploaded to DAB E-File on or before 11:59 p.m. ET of that day. A party that files a request for hearing via DAB E-File will be deemed to have consented to accept electronic service of appeal-related documents that CMS files, or CRD issues on behalf of the Administrative Law Judge, via DAB E-File. Correspondingly, CMS will also be deemed to have consented to electronic service. More detailed instructions on DAB E-File for CRD cases can be found by clicking the CRD E-File Procedures link on the File New Appeal Screen for CRD appeals.

If you choose to file your appeal electronically, please also send a copy of the hearing request to:

Attention: Paula Perse, Manager
Long Term Care Branch
Division of survey and Certification
Centers for Medicare & Medicaid Services
90 7th Street, Suite 5-300 (5W)
San Francisco, CA 94103-6707

Allegation of Compliance

If you believe these deficiencies have been corrected, you may submit your POC as your allegation of compliance to Eric Stone, Program Manager, California Department of Public Health, Licensing and Certification Program, Los Angeles Acute and Ancillary Unit - South, 3400 Aerojet Suite 323 El Monte, CA 91731. We may accept your POC as your allegation of compliance and presume compliance until substantiated by a revisit or other means. In such a case, neither the CMS Regional Office nor the State Medicaid Agency will impose the previously recommended remedy(ies) at that time.

If, upon a subsequent revisit or by other means it is determined your facility has not achieved substantial compliance, we will recommend the remedies previously mentioned in this letter be imposed by the CMS Regional Office beginning on June 22, 2105 and continue until substantial compliance is achieved. Additionally, the CMS Regional Office may impose a revised remedy(ies), based upon changes in the seriousness of the noncompliance at the time of the revisit, if appropriate.

Informal Dispute Resolution

In accordance with §488.331, you have one (1) opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request, along with the specific deficiencies being disputed, and relevant information (evidence) as to why you are disputing those deficiencies to Suzette Leverett - Clark, RN Assistant Chief, California Department of Public Health, Licensing and Certification Division at 12440 East Imperial Highway Room 522, Norwalk, CA 90650.

This request must be sent during the same ten (10) days you have for submitting a POC for the cited deficiencies. An informal dispute resolution for the cited deficiencies will not delay the imposition of the recommended enforcement actions. A change in the seriousness of the noncompliance may result in a change in the remedy selected. When this occurs, you will be advised of any change in remedy.

Should CMS determine that termination or any other remedy is warranted, they will provide you with a separate formal notification of that determination.

If you have questions concerning the instructions contained in this letter, please contact, Eric Stone, Program Manager, at (626) 312-1142.

Sincerely,

Nwamaka Oranusi, Acting Chief
Health Facilities Inspection Division

Rosario Quispe RN, Sr. HFEW for

Eric Stone, Program Manager
Acute and Ancillary Unit- South
3400 Aerojet Avenue Suite 323
Tel. (626) 312-1142 - Fax (626) 927-9293

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555874	A. BUILDING 01 - BROTMAN MEDICAL CENTER DP SNF B. WING _____	06/22/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN CALIFORNIA HOSP AT CULVER CITY D/P SNF	3828 DELMAS TERRACE CULVER CITY, CA 90230

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 147	Continued From page 9 (2) Where run through holes in walls, structural ceilings, suspended ceilings, dropped ceilings, or floors (5) Where concealed behind building walls, structural ceilings, suspended ceilings, dropped ceilings, or floors. These Codes were not met as evidenced by: Based on observation and interview, the facility failed to ensure electrical wiring was in accordance with NFPA 70 National Electrical Code by having electrical cord run through a wall. The deficiency had the potential of not adhering to the provisions of NFPA 70 necessary for safety, and the practical safeguarding of persons, and property from hazards arising from the use of electricity. Findings: On 6/19/15 at 9:20 a.m., there was an electrical cord coming out of and entering a wall in the kitchen, above the dietary office room door. During an interview at the same time as the observation, the Dietician/Director of food & Nutrition stated that the electrical cord was connected to a video camera, but did not know why the wire was pulled out of, and back into the wall.	K 147	*Electrical Wiring* • No residents or staffs were affected by the said deficient practice. • The facility performs environmental rounds regularly and identifies deficiencies and reports the deficiencies to the Facilities Operations Center for repair. Environmental/Safety deficiencies are top priority and repairs are scheduled first. • The cable observed by the surveyor was identified as being video cable and is not high voltage and poses no electrical shock risk. The walls that the cable penetrates are not fire walls. • The facilities Environment of Care committee meets regularly and EOC audits are monitored and reviewed at these meetings. The hospital has also assigned the Vice President of Facilities to ensure that all Life safety & Environmental requirements are met. • Completed 6/24/2015	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555874	A. BUILDING 01 - BROTMAN MEDICAL CENTER DP SNF B. WING _____	06/22/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN CALIFORNIA HOSP AT CULVER CITY D/P SNF	3828 DELMAS TERRACE CULVER CITY, CA 90230

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K 140	Continued From page 8 log that included monitoring of the main and reserve liquid oxygen vessels' level and pressure readings. Earlier that morning at 9:10 a.m., the gauges at the main vessel had readings of 180 inches of water and 140 psi., and the gauges at the reserve vessel had readings of 108 inches of water and 135 psi. Both vessels were within their marked limits. Nine (9) of seventeen (17) residents were on nasal cannula or trach aerosol.	K 140		
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: NFPA 70 National Electrical Code 1999 Edition 110-12. Mechanical Execution of Work. Electrical equipment shall be installed in a neat and workmanlike manner. 305-4.(h) Protection from Accidental Damage. Flexible cords and cables shall be protected from accidental damage. Sharp corners and projections shall be avoided. Where passing through doorways or other pinch points, protection shall be provided to avoid damage. 400-8. Uses not permitted. Unless specifically permitted in Section 400-7, flexible cords and cables shall not be used for the following:	K 147	*Electrical Wiring* • No residents or staffs were affected by the said deficient practice. • The facility performs environmental rounds regularly and identifies deficiencies and reports the deficiencies to the Facilities Operations Center for repair. Environmental/Safety deficiencies are top priority and repairs are scheduled first. • The cable observed by the surveyor was identified as being video cable and is not high voltage and poses no electrical shock risk. The walls that the cable penetrates are not fire walls. • The facilities Environment of Care committee meets regularly and EOC audits are monitored and reviewed at these meetings. The hospital has also assigned the Vice President of Facilities to ensure that all Life safety & Environmental requirements are met. • Completed 6/24/2015	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555874	A. BUILDING 01 - BROTMAN MEDICAL CENTER DP SNF B. WING _____	06/22/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN CALIFORNIA HOSP AT CULVER CITY D/P SNF	3828 DELMAS TERRACE CULVER CITY, CA 90230

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 140	Continued From page 7 Findings: 1. On 6/22/15 at 10:10 a.m., during document review, the Bulk Oxygen Source Evaluation Report Annual Inspection equipment checklist dated 12/30/14, indicated the following: The bulk primary system did not have a pressure switch for "Emergency Reserve in use". The signals were not wired to the master alarm panel(s). The source valve was not labeled. Source equipment was not free of leaks. The report also indicated a physical deficiency that reserve wires were cut at the pressure switch above the liquid gauge, and that the location of leakage was at the source valve. During an interview at the same time as the record review, the Director of Facilities stated that the physical deficiency listed on the report were wires that were cut because they use to be connected to the former fire alarm control panel (FACP), where it would activate an alarm if the oxygen was low at the bulk liquid oxygen vessels. That the new FACP does not activate an alarm when the oxygen is low at the vessels. That the there has never been an alarm system at the facility to monitor the operation and condition of the bulk oxygen source of supply and reserve. That the oxygen vessels did not send a signal to the liquid oxygen supplier/vendor when the vessels were low. That in lieu of the alarm, engineering staff conducted three rounds per day to monitor the oxygen tank and pressure levels at the gauges of the liquid oxygen vessels. Further document review revealed an engineering	K 140	*Source Valve labeled* • No residents were affected by the deficient practice. • The facility performs an annual medical gas deficiency audit annually and review by the Facilities Management staff. Any deficiencies found during the audit are prioritized and repaired in a timely manner. • The oxygen annual test is part of the quarterly EOC report and is reported to the EOC Committee, Quality Council, Medical Executive Committee and the Governing Board on a quarterly basis. • Completed 7/23/15 *Source equipment free of leaks* • No residents were affected by the deficient practice. • The facility performs an annual medical gas deficiency audit annually and review by the Facilities Management staff. Any deficiencies found during the audit are prioritized and repaired in a timely manner. • The oxygen annual test is part of the quarterly EOC report and is reported to the EOC Committee, Quality Council, Medical Executive Committee and the Governing Board on a quarterly basis. • The source leak was repaired 4/6/2015	

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	555874	A. BUILDING 01 - BROTMAN MEDICAL CENTER DP SNF B. WING _____	06/22/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN CALIFORNIA HOSP AT CULVER CITY D/P SNF	3828 DELMAS TERRACE CULVER CITY, CA 90230

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 140	Continued From page 6 for use only in an emergency. An actuating switch shall be connected to the master signal panels to indicate when, or just before, the reserve begins to supply the system. 4-3.1.2.2 Gas Warning Systems. (b) Master Alarms. 1. A master alarm system shall be provided to monitor the operation and condition of the source of supply, the reserve (if any), and the pressure of the main lines of all medical gas piping systems. 2. The master alarm system shall consist of two or more alarm panels located in two separate locations. One panel shall be located in the principal working area of the individual responsible for the maintenance of the medical gas piping systems and one or more panels shall be located to assure continuous surveillance during the working hours of the facility (e.g., the telephone switchboard, security office, or other continuously staffed location). This Standard was not met as evidenced by: Based on document review, interview, and observation, the facility staff failed to ensure the medical gas warning system was in accordance with NFPA 99 by not having medical gas master alarm panels with visible and audible alarms, and failed to ensure an emergency oxygen supply connection was present. The deficiency had the potential to not alarm the facility of a low oxygen tank level and pressure, and to not have a connection for emergency oxygen supply.	K 140	• No residents were affected by the deficient practice as the oxygen alarm is checked by the engineering staff three (3) per day and values are logged and reported to the Facilities Management staff. If oxygen levels are low, the oxygen supply company is called for service. • The facility performs environmental rounds regularly and identifies deficiencies and reports the deficiencies to the Facilities Operations Center for repair. Environmental/Safety deficiencies are top priority and repairs are scheduled first. • A master alarm system will be installed in two locations per NFPA 101 4.3.1.2.2. • The EOC committee meets at least (6) six times per year and environmental issues including oxygen systems and oxygen alarm systems are reported annually, which is then reported to the Quality Council, Medical Executive Committee and the Hospital Board. • The Master Alarm system will be an OSHPD project and require multiple disciplines for design. Estimated completion date 3/31/2016	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555874	A. BUILDING 01 - BROTMAN MEDICAL CENTER DP SNF B. WING _____	06/22/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN CALIFORNIA HOSP AT CULVER CITY D/P SNF	3828 DELMAS TERRACE CULVER CITY, CA 90230

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 130	Continued From page 5 Based on observation and interview, the facility failed to ensure a minimum of 6 spare sprinkler were maintained at the facility. The deficiency had the potential to not have spare sprinklers immediately available to help put the system back into service without delay, in the event a sprinkler was needed to be replaced because it has operated or has been damaged. Finding: On 6/22/15 at 3 p.m., there was one spare sprinkler in the spare sprinklers cabinet box in the sprinkler main riser room. At the time of the observation, during an interview, the Lead Man stated that the 5 missing spare sprinklers had been used during the installation of the sprinkler system.	K 130		
K 140 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Master alarm panels are in two separate locations and have audible and visible signals. There are high/low alarms for +/- 20% operating pressure. NFPA 99, 4.3.1.2.2 This STANDARD is not met as evidenced by: NFPA 99 Standard for Health Care Facilities 1999 Edition 4-3.1.1.7 Bulk Medical Gas Systems. (a) The bulk system shall consist of two sources of supply, one of which shall be a reserve supply	K 140	K 140 *Pressure Switch for "Emergency Reserve in Use"* • No residents were affected by the deficient practice. • The facility performs an annual medical gas deficiency audit annually and review by the Facilities Management staff. Any deficiencies found during the audit are prioritized and repaired in a timely manner. • The oxygen annual test is part of the quarterly EOC report and is reported to the EOC Committee, Quality Council, Medical Executive Committee and the Governing Board on a quarterly basis. • Installation of the emergency oxygen supply connection will be an OSHPD project and require design from a mechanical engineer for and OSHPD approval. Estimated completion date is 3/31/16.	3/31/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555874	A. BUILDING 01 - BROTMAN MEDICAL CENTER DP SNF B. WING _____	06/22/2015

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SOUTHERN CALIFORNIA HOSP AT CULVER CITY D/P SNF	3828 DELMAS TERRACE CULVER CITY, CA 90230

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 130	Continued From page 4 3-2.9.3 The stock of spare sprinklers shall include all types and ratings installed and shall be as follows: (1) For systems having less than 300 sprinklers - not fewer than 6 sprinklers (2) For systems with 300 to 1000 sprinklers - not fewer than 12 sprinklers (3) For systems with over 1000 sprinklers - not fewer than 24 sprinklers NFPA 25 Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems 1998 Edition 2-4.1.4 A supply of at least six spare sprinklers shall be stored in a cabinet on the premises for replacement purposes. The stock of spare sprinklers shall be proportionally representative of the types and temperature ratings of the system sprinklers. A minimum of two sprinklers of each type and temperature rating installed shall be provided. The cabinet shall be so located that it will not be exposed to moisture, dust, corrosion, or a temperature exceeding 100 degrees Fahrenheit (38 degrees Celsius). 2-4.1.5 The stock of spare sprinklers shall be as follows: (a) For protected facilities having under 300 sprinklers - no fewer than 6 sprinklers (b) For protected facilities having 300 to 1000 sprinklers - no fewer than 12 sprinklers (c) For protected facilities having over 1000 sprinklers - no fewer than 24 sprinklers These requirements were not met as evidenced by:	K 130	*Supply of spare sprinkler heads* • **No residents were affected by the deficient practice.** • **The facility performs environmental rounds regularly and identifies deficiencies and reports the deficiencies to the Facilities Operations Center for repair. Environmental/Safety deficiencies are top priority and repairs are scheduled first.** • **Fire sprinkler spare head check has been added to the "Environmental Rounds" list and will be checked during audit time. Based upon the finding fire sprinkler heads have been ordered. The facilities Environment of Care committee meets regularly and EOC audits are monitored and reviewed at these meetings. The hospital has also assigned the Vice President of Facilities to ensure that all Life safety & Environmental requirements are met.** • **EOC Audits are reported to the EOC Committee, Quality Council and the Governing Board on a quarterly basis.** • **Changes completed on 7/23/15**	7/23/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555874	A. BUILDING 01 - BROTMAN MEDICAL CENTER DP SNF B. WING _____	06/22/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN CALIFORNIA HOSP AT CULVER CITY D/P SNF	3828 DELMAS TERRACE CULVER CITY, CA 90230

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K 077	Continued From page 3 Finding: On 6/22/15 at 10:10 a.m., during document review, the Bulk Oxygen Source Evaluation Report Annual Inspection equipment checklist dated 12/30/14, indicated that an emergency oxygen supply connection was not present. During an interview at the same time as the record review, the VP of Corporate Facilities Operations, stated that he had not seen an emergency oxygen supply connection for the facility's oxygen system. Nine (9) of seventeen (17) residents were on nasal cannula or trach aerosol.	K 077		
K 130 SS=D	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 This STANDARD is not met as evidenced by: NFPA 13 Standard for the Installation of Sprinkler Systems 1999 Edition 3-2.9.1 A supply of spare sprinklers (never fewer than six) shall be maintained on the premises so that any sprinklers that have been operated or have been damaged in any way can be promptly replaced. These sprinklers shall correspond to the types of temperature ratings of the sprinklers in the property. The sprinklers shall be kept in a cabinet located where the temperature to which they are subjected will at no time exceed 100 degrees Fahrenheit (38 degrees Celsius).	K 130	*Supply of spare sprinkler heads* • No residents were affected by the deficient practice. • The facility performs environmental rounds regularly and identifies deficiencies and reports the deficiencies to the Facilities Operations Center for repair. Environmental/Safety deficiencies are top priority and repairs are scheduled first. • Fire sprinkler spare head check has been added to the "Environmental Rounds" list and will be checked during audit time. Based upon the finding fire sprinkler heads have been ordered. The facilities Environment of Care committee meets regularly and EOC audits are monitored and reviewed at these meetings. The hospital has also assigned the Vice President of Facilities to ensure that all Life safety & Environmental requirements are met. • EOC Audits are reported to the EOC Committee, Quality Council and the Governing Board on a quarterly basis. • Changes completed on 7/23/15	7/23/15

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	555874	A. BUILDING 01 - BROTMAN MEDICAL CENTER DP SNF B. WING	06/22/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN CALIFORNIA HOSP AT CULVER CITY D/P SNF	3828 DELMAS TERRACE CULVER CITY, CA 90230

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 077	Continued From page 2 This STANDARD is not met as evidenced by: NFPA 99 Standard for Health Care Facilities 1999 Edition 4-3.1.1.8 (h) Emergency Oxygen Supply Connection. Where the cryogenic oxygen supply is located outside of the building served, there shall be incorporated in the piping system and inlet for connecting a temporary auxiliary source of supply for emergency or maintenance situations. The inlet shall be located on the exterior of the building served and shall be physically protected to prevent tampering and unauthorized access. It shall be labeled "EMERGENCY LOW PRESSURE GASEOUS OXYGEN INLET." This connection shall be installed downstream of the shutoff valve on the main supply line [see 4-3.1.2.3(b)] and be suitably controlled with the necessary valves to allow emergency supply of oxygen and isolation of the piping to the normal source of supply. It shall have one check valve in the main line between the main line shutoff valve and the tee'd connection and one check valve between the tee'd connection and the emergency supply shutoff valve. [See Figure 4-3.1.1.8(h) and Figure 4-3.1.2.] This Standard was not met as evidenced by: Based on document review, and interview, the facility staff failed to ensure an emergency oxygen supply connection was present. The deficiency had the potential to not have a connection for emergency oxygen supply.	K 077	*Emergency oxygen supply connection* • No residents were affected by the deficient practice. • The facility performs an annual medical gas deficiency audit annually and review by the Facilities Management staff. Any deficiencies found during the audit are prioritized and repaired in a timely manner. • The oxygen annual test is part of the quarterly EOC report and is reported to the EOC Committee, Quality Council and the Governing Board on a quarterly basis. • Installation of the emergency oxygen supply connection will be an OSHPD project and require design from a mechanical engineer for and OSHPD approval. Estimated completion date is 3/31/16.	3/31/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555874	A. BUILDING 01 - BROTMAN MEDICAL CENTER DP SNF B. WING _____	06/22/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN CALIFORNIA HOSP AT CULVER CITY D/P SNF	3828 DELMAS TERRACE CULVER CITY, CA 90230

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K 050	Continued From page 1 fire emergency. Findings: On 6/22/15 at 10 a.m., during record review of the facility's fire drill reports for the period of April 2014 through June 2015, it revealed there were 3 fire drill reports missing, for the following shifts and quarters: Swing shift - 3rd quarter of 2014. Night shift - 2nd,and 4th quarter of 2014. Further review of the fire drill reports revealed there was no documented evidence, such as participant signatures in the fire observation report, identifying sub acute staff participation in 5 fire drills, for the following shifts and dates: Day shift - 7/12/14, 8/10/14, 11/8/14, 1/31/15. Swing shift - 5/28/15. During an interview at the same time as the observation, the Lead Man stated that the Fire Observation Report was the only document staff would sign as evidence of participation in a fire drill. During record review, and by the end of the survey, the facility failed to provide the missing fire drills reports or documentation to review that would show participation of the subacute staff in the 5 fire drills.	K 050	*Fire Drill reports* • No residents were affected by the deficient practice. • The Facility performs audits of all Fire Life Safety requirements on a monthly basis to ensure compliance. • An additional form has been added to the Fire Drill Critique package to document participation/attendance for all employees. The facilities Environment of Care committee meets regularly and fire drills are monitored and reviewed at these meetings. The hospital has also assigned the Vice President of Facilities to ensure that all Life safety & Environmental requirements are met. • Fire Drills are reported to the EOC Committee and any deficiencies will be corrected immediately. EOC reports quarterly to the Quality Council, Medical Executive Committee and the Governing Board. • Changes completed on 6/30/15	6/30/15
K 077 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Piped in medical gas systems comply with NFPA 99, Chapter 4.	K 077	*Emergency oxygen supply connection* • No residents were affected by the deficient practice. • The facility performs an annual medical gas deficiency audit annually and review by the Facilities Management staff. Any deficiencies found during the audit are prioritized and repaired in a timely manner.	3/31/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555874	A. BUILDING 01 - SROTMAN MEDICAL CENTER DP SNF B. WING _____	06/22/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN CALIFORNIA HOSP AT CULVER CITY D/P SNF	3828 DELMAS TERRACE CULVER CITY, CA 90230

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K 000	INITIAL COMMENTS This facility was surveyed under 42 CFR Part 483.70(a), Life Safety Code NFPA 101, 2000 Edition, Chapter 19, Existing Health Care Occupancies, and other applicable codes. Amended 7/14/15 Representing the Department of Public Health: Evaluator ID#16281 The following represents the findings of the Department of Public Health during a Life Safety Code Survey.	K 000		
K 050 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: Based on record review, and interview, the facility failed to provide supporting documentation that the subacute staff participated in fire drills at least quarterly on each shift. The deficiency had the potential for staff to not be familiar with the facility's fire emergency plan, and not be prepared to put it in effect in the event of a	K 050	*Fire Drill reports* • No residents were affected by the deficient practice. • The Facility performs audits of all Fire Life Safety requirements on a monthly basis to ensure compliance. • An additional form has been added to the Fire Drill Critique package to document participation/attendance for all employees. The facilities Environment of Care committee meets regularly and fire drills are monitored and reviewed at these meetings. The hospital has also assigned the Vice President of Facilities to ensure that all Life safety & Environmental requirements are met. • Fire Drills are reported to the EOC Committee and any deficiencies will be corrected immediately. EOC reports quarterly to the Quality Council, Medical Executive Committee and the Governing Board. • Changes completed on 6/30/15	6/30/15

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

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

SOUTHERN CALIFORNIA HEALTHCARE SYSTEM, INC.

Southern California Hospital at Culver City
3828 Delmas Terrace
Culver City, CA 90232
(310) 836-7000(310) 202-4141 Fax

July 21, 2015 **Via Fax 62 pages including this page**

Attention Rosario Grospe, RN Senior HFEN Assistant Supervisor, Acute and Ancillary Unit
California Department of Public Health
County of Los Angeles Health Facilities Division
3400 Aerojet Avenue, Suite 323
El Monte, CA 91731

Phone: 626-312-1129 **Fax 626-927-9293**

Re: 55874

POC Response to the 2567 from the Annual Health and Life Safety Code survey conducted on 6/22/15.

Sincerely,

Pamela Loo, Director of Quality
310-486-8911
Contact info: 310 836 7000 ext. 1046 cell: **310-486-8911**

State of California—Health and Human Services Agency Department of Health Services

SIGNATURE REQUIREMENT NOTICE
(For Plan of Correction)

Notice to Licensee/Designee

The surveying state agency is required to obtain a signed plan of correction for deficiencies noted on the Statement of Deficiencies and Plan of Correction (Code of Federal Regulations, Title 42, Section 489.13; State Operations Manual, Section 2612; and California Health and Safety Code, Section 1280). By signing a plan of correction, a licensee or designee does not necessarily admit guilt of any alleged violation nor does this interfere with the right to contest or appeal any alleged violations on which the plan of correction is based or the same period for correction. It does acknowledge responsibility for compliance with licensing requirements, with appropriate requirements of the Medicare and Medi-Cal programs, that an exit conference was held during which the items listed were discussed, and that a copy of the deficiency/report and plan of correction was received.

Name of facility	City
Southern California Hosp at Culver City SNF/DP	Culver City

Copy of this notice received:

Licensee or designee signature	Date
[signature]	7/20/15

Copy of this notice presented to licensee or designee:

Licensing Evaluator signature	Date
Rosario Bosque for Sirlin Chang	7/13/15

Complaint Notice

If there should be disagreement between the Licensee or Designee and the Evaluator of the Survey Team on an interpretation of the regulations or a field decision, the Licensee of Designee may wish to call and discuss this with the District Licensing Supervisor.

Name of Licensing Supervisor	Telephone
Eric Stone, Program Manager	626-312-1142

Instructions

This notice is to be used with Plans of Correction for Skilled Nursing Facilities, Intermediate Care Facilities, Intermediate Care Facilities/Developmentally Disabled, Intermediate Care Facilities/Developmentally Disabled-Habilitative, Intermediate Care Facilities/Developmentally Disabled-Nursing, Congregate Living Health Facilities, Pediatric Day Health and Respite Care Facilities, and Hospitals with Distinct Part Skilled Nursing Facilities or Intermediate Care Facilities. It is to be signed by the licensee/designee and the licensing evaluator. A copy is left with the licensee/designee and the original is kept in the district office licensing file.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/13/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	556874	A. BUILDING _____ B. WING _____	06/20/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN CALIFORNIA HOSP AT CULVER CITY D/P SNF	3828 DELMAS TERRACE CULVER CITY, CA 90230

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F 000	INITIAL COMMENTS The following reflects the findings of the Department of Public Health during a re-certification survey. Representing the Department of Public Health: Surveyor 17030, RN, HFEN Surveyor 25624, RN, HFEN Surveyor 16281, REHS, HFE Total Resident Population 17 Total Resident Sample Size: 8 Highest Scope/Severity: E	F 000		
F 154 S3=E	483.10(b)(3), 483.10(d)(2) INFORMED OF HEALTH STATUS, CARE, & TREATMENTS The resident has the right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition. The resident has the right to be fully informed in advance about care and treatment and of any changes in that care or treatment that may affect the resident's well-being. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure the resident or the resident's representative had the right to be fully informed in advance of the risks and benefits of anti-antipsychotic and physical restraints to be administered to six (6) of eight (8) sampled residents (1, 2, 3, 4, 6, and 7). The facility failed	F 154	1. *How corrective action() will be accomplished for those residents found to have been affected by the deficient practice* Corrective Action will be accomplished by the re-education of staff on the Restraints Policy and Procedure Application and monitoring SAA.049 and Consents PAT.037, completed on 7/19/2015. 2. *How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken* The SubAcute Unit at Southern California Hospital at Culver City (SCHCC) will identify other residents having the same potential for deficient practice by discussing restraint plan of care in interdisciplinary weekly rounds, and 100% monitoring of restraint documentation and informed consents, and will monitor them beginning August 1,2015 as process improvements and report it quarterly to quality council, medical executive committee and governing board.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: CEO — (X6) DATE: 7/20/15

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555874	A. BUILDING 01 - BROTMAN MEDICAL CENTER DP SNF B. WING _____	06/22/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN CALIFORNIA HOSP AT CULVER CITY D/P SNF	3828 DELMAS TERRACE CULVER CITY, CA 90230

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS This facility was surveyed under 42 CFR Part 483.70(a), Life Safety Code NFPA 101, 2000 Edition, Chapter 19, Existing Health Care Occupancies, and other applicable codes. Amended 7/14/15 Representing the Department of Public Health: Evaluator ID#16281 The following represents the findings of the Department of Public Health during a Life Safety Code Survey.	K 000		
K 050 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: Based on record review, and interview, the facility failed to provide supporting documentation that the subacute staff participated in fire drills at least quarterly on each shift. The deficiency had the potential for staff to not be familiar with the facility's fire emergency plan, and not be prepared to put it in effect in the event of a	K 050	*Fire Drill reports* • **No residents were affected by the deficient practice.** • **The Facility performs audits of all Fire Life Safety requirements on a monthly basis to ensure compliance.** • **An additional form has been added to the Fire Drill Critique package to document participation/attendance for all employees. The facilities Environment of Care committee meets regularly and fire drills are monitored and reviewed at these meetings. The hospital has also assigned the Vice President of Facilities to ensure that all Life safety & Environmental requirements are met.** • **Fire Drills are reported to the EOC Committee and any deficiencies will be corrected immediately. EOC reports quarterly to the Quality Council, Medical Executive Committee and the Governing Board.** • **Changes completed on 6/30/15**	6/30/15

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

CEO 7/20/15

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

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K 050	Continued From page 1 fire emergency. Findings: On 6/22/15 at 10 a.m., during record review of the facility's fire drill reports for the period of April 2014 through June 2015, it revealed there were 3 fire drill reports missing, for the following shifts and quarters: Swing shift - 3rd quarter of 2014. Night shift - 2nd,and 4th quarter of 2014. Further review of the fire drill reports revealed there was no documented evidence, such as participant signatures in the fire observation report, identifying sub acute staff participation in 5 fire drills, for the following shifts and dates: Day shift - 7/12/14, 8/10/14, 11/8/14, 1/31/15. Swing shift - 5/28/15. During an interview at the same time as the observation, the Lead Man stated that the Fire Observation Report was the only document staff would sign as evidence of participation in a fire drill. During record review, and by the end of the survey, the facility failed to provide the missing fire drills reports or documentation to review that would show participation of the subacute staff in the 5 fire drills.	K 050	*Fire Drill reports* • No residents were affected by the deficient practice. • The Facility performs audits of all Fire Life Safety requirements on a monthly basis to ensure compliance. • An additional form has been added to the Fire Drill Critique package to document participation/attendance for all employees. The facilities Environment of Care committee meets regularly and fire drills are monitored and reviewed at these meetings. The hospital has also assigned the Vice President of Facilities to ensure that all Life safety & Environmental requirements are met. • Fire Drills are reported to the EOC Committee and any deficiencies will be corrected immediately. EOC reports quarterly to the Quality Council, Medical Executive Committee and the Governing Board. • Changes completed on 6/30/15	6/30/15
K 077 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Piped in medical gas systems comply with NFPA 99, Chapter 4.	K 077	*Emergency oxygen supply connection* • No residents were affected by the deficient practice. • The facility performs an annual medical gas deficiency audit annually and review by the Facilities Management staff. Any deficiencies found during the audit are prioritized and repaired in a timely manner.	3/31/16

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K 077	Continued From page 2 This STANDARD is not met as evidenced by: NFPA 99 Standard for Health Care Facilities 1999 Edition 4-3.1.1.8 (h) Emergency Oxygen Supply Connection. Where the cryogenic oxygen supply is located outside of the building served, there shall be incorporated in the piping system and inlet for connecting a temporary auxiliary source of supply for emergency or maintenance situations. The inlet shall be located on the exterior of the building served and shall be physically protected to prevent tampering and unauthorized access. It shall be labeled "EMERGENCY LOW PRESSURE GASEOUS OXYGEN INLET." This connection shall be installed downstream of the shutoff valve on the main supply line [see 4-3.1.2.3(b)] and be suitably controlled with the necessary valves to allow emergency supply of oxygen and isolation of the piping to the normal source of supply. It shall have one check valve in the main line between the main line shutoff valve and the tee'd connection and one check valve between the tee'd connection and the emergency supply shutoff valve. [See Figure 4-3.1.1.8(h) and Figure 4-3.1.2.] This Standard was not met as evidenced by: Based on document review, and interview, the facility staff failed to ensure an emergency oxygen supply connection was present. The deficiency had the potential to not have a connection for emergency oxygen supply.	K 077	*Emergency oxygen supply connection* • No residents were affected by the deficient practice. • The facility performs an annual medical gas deficiency audit annually and review by the Facilities Management staff. Any deficiencies found during the audit are prioritized and repaired in a timely manner. • The oxygen annual test is part of the quarterly EOC report and is reported to the EOC Committee, Quality Council and the Governing Board on a quarterly basis. • Installation of the emergency oxygen supply connection will be an OSHPD project and require design from a mechanical engineer for and OSHPD approval. Estimated completion date is 3/31/16.	3/31/16

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K 077	Continued From page 3 Finding: On 6/22/15 at 10:10 a.m., during document review, the Bulk Oxygen Source Evaluation Report Annual Inspection equipment checklist dated 12/30/14, indicated that an emergency oxygen supply connection was not present. During an interview at the same time as the record review, the VP of Corporate Facilities Operations, stated that he had not seen an emergency oxygen supply connection for the facility's oxygen system. Nine (9) of seventeen (17) residents were on nasal cannula or trach aerosol.	K 077		
K 130 SS=D	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 This STANDARD is not met as evidenced by: NFPA 13 Standard for the Installation of Sprinkler Systems 1999 Edition 3-2.9.1 A supply of spare sprinklers (never fewer than six) shall be maintained on the premises so that any sprinklers that have been operated or have been damaged in any way can be promptly replaced. These sprinklers shall correspond to the types of temperature ratings of the sprinklers in the property. The sprinklers shall be kept in a cabinet located where the temperature to which they are subjected will at no time exceed 100 degrees Fahrenheit (38 degrees Celsius).	K 130	*Supply of spare sprinkler heads* • **No residents were affected by the deficient practice.** • **The facility performs environmental rounds regularly and identifies deficiencies and reports the deficiencies to the Facilities Operations Center for repair. Environmental/Safety deficiencies are top priority and repairs are scheduled first.** • **Fire sprinkler spare head check has been added to the "Environmental Rounds" list and will be checked during audit time. Based upon the finding fire sprinkler heads have been ordered. The facilities Environment of Care committee meets regularly and EOC audits are monitored and reviewed at these meetings. The hospital has also assigned the Vice President of Facilities to ensure that all Life safety & Environmental requirements are met.** • **EOC Audits are reported to the EOC Committee, Quality Council and the Governing Board on a quarterly basis.** • **Changes completed on 7/23/15**	7/23/15

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K 130	Continued From page 4 3-2.9.3 The stock of spare sprinklers shall include all types and ratings installed and shall be as follows: (1) For systems having less than 300 sprinklers - not fewer than 6 sprinklers (2) For systems with 300 to 1000 sprinklers - not fewer than 12 sprinklers (3) For systems with over 1000 sprinklers - not fewer than 24 sprinklers NFPA 25 Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems 1998 Edition 2-4.1.4 A supply of at least six spare sprinklers shall be stored in a cabinet on the premises for replacement purposes. The stock of spare sprinklers shall be proportionally representative of the types and temperature ratings of the system sprinklers. A minimum of two sprinklers of each type and temperature rating installed shall be provided. The cabinet shall be so located that it will not be exposed to moisture, dust, corrosion, or a temperature exceeding 100 degrees Fahrenheit (38 degrees Celsius). 2-4.1.5 The stock of spare sprinklers shall be as follows: (a) For protected facilities having under 300 sprinklers - no fewer than 6 sprinklers (b) For protected facilities having 300 to 1000 sprinklers - no fewer than 12 sprinklers (c) For protected facilities having over 1000 sprinklers - no fewer than 24 sprinklers These requirements were not met as evidenced by:	K 130	*Supply of spare sprinkler heads* • **No residents were affected by the deficient practice.** • **The facility performs environmental rounds regularly and identifies deficiencies and reports the deficiencies to the Facilities Operations Center for repair. Environmental/Safety deficiencies are top priority and repairs are scheduled first.** • **Fire sprinkler spare head check has been added to the "Environmental Rounds" list and will be checked during audit time. Based upon the finding fire sprinkler heads have been ordered. The facilities Environment of Care committee meets regularly and EOC audits are monitored and reviewed at these meetings. The hospital has also assigned the Vice President of Facilities to ensure that all Life safety & Environmental requirements are met.** • **EOC Audits are reported to the EOC Committee, Quality Council and the Governing Board on a quarterly basis.** • **Changes completed on 7/23/15**	7/23/15

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K 130	Continued From page 5 Based on observation and interview, the facility failed to ensure a minimum of 6 spare sprinkler were maintained at the facility. The deficiency had the potential to not have spare sprinklers immediately available to help put the system back into service without delay, in the event a sprinkler was needed to be replaced because it has operated or has been damaged. Finding: On 6/22/15 at 3 p.m., there was one spare sprinkler in the spare sprinklers cabinet box in the sprinkler main riser room. At the time of the observation, during an interview, the Lead Man stated that the 5 missing spare sprinklers had been used during the installation of the sprinkler system.	K 130		
K 140 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Master alarm panels are in two separate locations and have audible and visible signals. There are high/low alarms for +/- 20% operating pressure. NFPA 99, 4.3.1.2.2 This STANDARD is not met as evidenced by: NFPA 99 Standard for Health Care Facilities 1999 Edition 4-3.1.1.7 Bulk Medical Gas Systems. (a) The bulk system shall consist of two sources of supply, one of which shall be a reserve supply	K 140	K 140 *Pressure Switch for "Emergency Reserve in Use"* • No residents were affected by the deficient practice. • The facility performs an annual medical gas deficiency audit annually and review by the Facilities Management staff. Any deficiencies found during the audit are prioritized and repaired in a timely manner. • The oxygen annual test is part of the quarterly EOC report and is reported to the EOC Committee, Quality Council, Medical Executive Committee and the Governing Board on a quarterly basis. • Installation of the emergency oxygen supply connection will be an OSHPD project and require design from a mechanical engineer for and OSHPD approval. Estimated completion date is 3/31/16.	3/31/16

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K 140	Continued From page 6 for use only in an emergency. An actuating switch shall be connected to the master signal panels to indicate when, or just before, the reserve begins to supply the system. 4-3.1.2.2 Gas Warning Systems. (b) Master Alarms. 1. A master alarm system shall be provided to monitor the operation and condition of the source of supply, the reserve (if any), and the pressure of the main lines of all medical gas piping systems. 2. The master alarm system shall consist of two or more alarm panels located in two separate locations. One panel shall be located in the principal working area of the individual responsible for the maintenance of the medical gas piping systems and one or more panels shall be located to assure continuous surveillance during the working hours of the facility (e.g., the telephone switchboard, security office, or other continuously staffed location). This Standard was not met as evidenced by: Based on document review, interview, and observation, the facility staff failed to ensure the medical gas warning system was in accordance with NFPA 99 by not having medical gas master alarm panels with visible and audible alarms, and failed to ensure an emergency oxygen supply connection was present. The deficiency had the potential to not alarm the facility of a low oxygen tank level and pressure, and to not have a connection for emergency oxygen supply.	K 140	• No residents were affected by the deficient practice as the oxygen alarm is checked by the engineering staff three (3) per day and values are logged and reported to the Facilities Management staff. If oxygen levels are low, the oxygen supply company is called for service. • The facility performs environmental rounds regularly and identifies deficiencies and reports the deficiencies to the Facilities Operations Center for repair. Environmental/Safety deficiencies are top priority and repairs are scheduled first. • A master alarm system will be installed in two locations per NFPA 101 4.3.1.2.2. • The EOC committee meets at least (6) six times per year and environmental issues including oxygen systems and oxygen alarm systems are reported annually, which is then reported to the Quality Council, Medical Executive Committee and the Hospital Board. • The Master Alarm system will be an OSHPD project and require multiple disciplines for design. Estimated completion date 3/31/2016	

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K 140	Continued From page 7 Findings: 1. On 6/22/15 at 10:10 a.m., during document review, the Bulk Oxygen Source Evaluation Report Annual Inspection equipment checklist dated 12/30/14, indicated the following: The bulk primary system did not have a pressure switch for "Emergency Reserve in use". The signals were not wired to the master alarm panel(s). The source valve was not labeled. Source equipment was not free of leaks. The report also indicated a physical deficiency that reserve wires were cut at the pressure switch above the liquid gauge, and that the location of leakage was at the source valve. During an interview at the same time as the record review, the Director of Facilities stated that the physical deficiency listed on the report were wires that were cut because they use to be connected to the former fire alarm control panel (FACP), where it would activate an alarm if the oxygen was low at the bulk liquid oxygen vessels. That the new FACP does not activate an alarm when the oxygen is low at the vessels. That the there has never been an alarm system at the facility to monitor the operation and condition of the bulk oxygen source of supply and reserve. That the oxygen vessels did not send a signal to the liquid oxygen supplier/vendor when the vessels were low. That in lieu of the alarm, engineering staff conducted three rounds per day to monitor the oxygen tank and pressure levels at the gauges of the liquid oxygen vessels. Further document review revealed an engineering	K 140	*Source Valve labeled* • No residents were affected by the deficient practice. • The facility performs an annual medical gas deficiency audit annually and review by the Facilities Management staff. Any deficiencies found during the audit are prioritized and repaired in a timely manner. • The oxygen annual test is part of the quarterly EOC report and is reported to the EOC Committee, Quality Council, Medical Executive Committee and the Governing Board on a quarterly basis. • Completed 7/23/15 *Source equipment free of leaks* • No residents were affected by the deficient practice. • The facility performs an annual medical gas deficiency audit annually and review by the Facilities Management staff. Any deficiencies found during the audit are prioritized and repaired in a timely manner. • The oxygen annual test is part of the quarterly EOC report and is reported to the EOC Committee, Quality Council, Medical Executive Committee and the Governing Board on a quarterly basis. • The source leak was repaired 4/6/2015	

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K 140	Continued From page 8 log that included monitoring of the main and reserve liquid oxygen vessels' level and pressure readings. Earlier that morning at 9:10 a.m., the gauges at the main vessel had readings of 180 inches of water and 140 psi., and the gauges at the reserve vessel had readings of 108 inches of water and 135 psi. Both vessels were within their marked limits. Nine (9) of seventeen (17) residents were on nasal cannula or trach aerosol.	K 140		
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: NFPA 70 National Electrical Code 1999 Edition 110-12. Mechanical Execution of Work. Electrical equipment shall be installed in a neat and workmanlike manner. 305-4.(h) Protection from Accidental Damage. Flexible cords and cables shall be protected from accidental damage. Sharp corners and projections shall be avoided. Where passing through doorways or other pinch points, protection shall be provided to avoid damage. 400-8. Uses not permitted. Unless specifically permitted in Section 400-7, flexible cords and cables shall not be used for the following:	K 147	*Electrical Wiring* • No residents or staffs were affected by the said deficient practice. • The facility performs environmental rounds regularly and identifies deficiencies and reports the deficiencies to the Facilities Operations Center for repair. Environmental/Safety deficiencies are top priority and repairs are scheduled first. • The cable observed by the surveyor was identified as being video cable and is not high voltage and poses no electrical shock risk. The walls that the cable penetrates are not fire walls. • The facilities Environment of Care committee meets regularly and EOC audits are monitored and reviewed at these meetings. The hospital has also assigned the Vice President of Facilities to ensure that all Life safety & Environmental requirements are met. • Completed 6/24/2015	

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K 147	Continued From page 9 (2) Where run through holes in walls, structural ceilings, suspended ceilings, dropped ceilings, or floors (5) Where concealed behind building walls, structural ceilings, suspended ceilings, dropped ceilings, or floors. These Codes were not met as evidenced by: Based on observation and interview, the facility failed to ensure electrical wiring was in accordance with NFPA 70 National Electrical Code by having electrical cord run through a wall. The deficiency had the potential of not adhering to the provisions of NFPA 70 necessary for safety, and the practical safeguarding of persons, and property from hazards arising from the use of electricity. Findings: On 6/19/15 at 9:20 a.m., there was an electrical cord coming out of and entering a wall in the kitchen, above the dietary office room door. During an interview at the same time as the observation, the Dietician/Director of food & Nutrition stated that the electrical cord was connected to a video camera, but did not know why the wire was pulled out of, and back into the wall.	K 147	*Electrical Wiring* • No residents or staffs were affected by the said deficient practice. • The facility performs environmental rounds regularly and identifies deficiencies and reports the deficiencies to the Facilities Operations Center for repair. Environmental/Safety deficiencies are top priority and repairs are scheduled first. • The cable observed by the surveyor was identified as being video cable and is not high voltage and poses no electrical shock risk. The walls that the cable penetrates are not fire walls. • The facilities Environment of Care committee meets regularly and EOC audits are monitored and reviewed at these meetings. The hospital has also assigned the Vice President of Facilities to ensure that all Life safety & Environmental requirements are met. • Completed 6/24/2015	

COUNTY OF LOS ANGELES
Public Health

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Interim Director

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Interim Health Officer

ANGELO J. BELLOMO, REHS, QEP
Director of Environmental Health

TERRI S. WILLIAMS, REHS
Assistant Director of Environmental Health

5050 Commerce Drive
Baldwin Park, California 91706
TEL (626) 430-5100 - FAX (626) 813-3000

www.publichealth.lacounty.gov

Letter 4

IMPORTANT NOTICE - PLEASE READ CAREFULLY

July 13, 2015

Darrin Buckner, RN
Director of Subacute
Southern California Hosp At Culver City D/p Snf
3828 Delmas Terrace
Culver City, CA 90230

Dear Administrator:

On June 22, 2015, a standard annual Health and Life Safety Code survey was conducted at your facility by the California Department of Public Health, Licensing and Certification Program (Los Angeles Acute - South), to determine if your facility was in compliance with federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiency(ies) to be:

[ ] Isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy, as evidenced by the enclosed "Statement of Deficiencies and Plan of Correction" form, whereby corrections are required (D).

[x] A pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy, as evidenced by the enclosed "Statement of Deficiencies and Plan of Correction" form, whereby corrections are required (E).

The enclosed Centers for Medicare and Medicaid Services (CMS) form, entitled "Statement of Deficiencies and Plan of Correction" (CMS–2567), documents the deficiencies of participation requirements identified during this visit. All references to regulatory requirements contained in this letter are found in Title 42, Code of Federal Regulations (CFR).

Plan of Correction (POC)

A POC for the deficiencies must be submitted within **ten (10) days from receipt of the CMS- 2567.** Failure to submit an acceptable POC by the due date will result in remedies being recommended for imposition by the CMS and/or the State Medicaid Agency effective as soon as notice requirements are met.

Your POC must be submitted on the enclosed CMS-2567 form and must contain the following:

- How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;
- What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur;
- How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system; and
- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State Agency.

Remedies will be recommended for imposition by the CMS Regional Office and/or the State Medicaid Agency if your facility has failed to achieve substantial compliance by .

Recommended Remedies

The remedies, which will be recommended if substantial compliance has not been achieved by July 23, 2015 , include the following:

[x] Civil money penalty of $ 150.00 , effective June 22, 2015 (§488.430).

We are also recommending to the CMS Regional Office and/or the State Medicaid Agency that your provider agreement be terminated on if substantial compliance is not achieved by that time.

Denial of Payment for New Admissions (DPNA)

Based on deficiencies cited during this survey and as authorized by CMS San Francisco Regional Office, we are giving formal notice of imposition of statutory DPNA effective September 22, 2015. This remedy will be effectuated on the stated date unless you demonstrate substantial compliance with an acceptable POC and subsequent revisit. This notice in no way limits the prerogative of CMS to impose discretionary DPNA at any appropriate time.

CMS Regional Office will notify your intermediary and the Medicaid Agency. If effectuated, denial of payment will continue until your facility achieves substantial Compliance or your provider agreement is terminated. Facilities are prohibited from billing those Medicare/Medicaid residents or their responsible parties during the denial period for services normally billed to Medicare or Medicaid.

Appeal Rights

If you disagree with **the determination of noncompliance (and/or substandard quality of care, if applicable)**, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board. Procedures governing this process are set out in 42 CFR §498.40, et. seq. You may appeal the finding of noncompliance that led to an enforcement action, but not the enforcement action or remedy itself. A written request for hearing must be filed no later than 60 days from the date of receipt of this letter.

Such written request should be made **directly** to:

Attention: Ms. Karen Robinson
Departmental Appeals Board
Civil Remedies Division
Cohen Building, Room G-644
330 Independence Avenue S.W.
Washington, D.C. 20201

A request for hearing should identify specific issues, and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You may be represented at a hearing by counsel at your own expense.

Be sure to include a copy of this letter with your request to the Departmental Appeals Board. In addition, please forward a **copy of your request** to:

Attention: Paula Perse, Manager
Long Term Care Branch
Division of Survey and Certification
Centers for Medicare & Medicaid Services
90 7th Street, Suite 5-300 (5W)
San Francisco, CA 94103-6707

Alternatively, you can file your appeal electronically at the Departmental Appeals Board Electronic Filing System Web site (DAB E-File) at https://dab.efile.hhs.gov.

To file a new appeal using DAB E-File, you first need to register a new account by: (1) clicking **Register** on the DAB E-File home page; (2) entering the information requested on the "Register New Account" form; and (3) clicking **Register Account** at the bottom of the form. If you have more than one representative, each representative must register separately to use DAB E-File on your behalf.

The e-mail address and password provided during registration must be entered on the login screen at https://dab.efile.hhs.gov/user_sessions/new to access DAB E-File. A registered user's access to DAB E-File is restricted to the appeals for which he or she is a party or authorized representative. Once registered, you may file your appeal by:

-Clicking the **File New Appeal** link on the Manage Existing Appeals screen, then clicking Civil Remedies Division on the File New Appeal screen.
And,
-Entering and uploading the requested information and documents on the "File New Appeal-Civil Remedies Division" form.

At minimum, the Civil Remedies Division (CRD) requires a party to file a signed request for hearing and the underlying notice letter from CMS that sets forth the action taken and the party's appeal rights. All documents must be submitted in Portable Document Format ("PDF"). Any document, including a request for hearing, will be deemed to have been filed on a given day, if it is uploaded to DAB E-File on or before 11:59 p.m. ET of that day. A party that files a request for hearing via DAB E-File will be deemed to have consented to accept electronic service of appeal-related documents that CMS files, or CRD issues on behalf of the Administrative Law Judge, via DAB E-File. Correspondingly, CMS will also be deemed to have consented to electronic service. More detailed instructions on DAB E-File for CRD cases can be found by clicking the CRD E-File Procedures link on the File New Appeal Screen for CRD appeals.

If you choose to file your appeal electronically, please also send a copy of the hearing request to:

Attention: Paula Perse, Manager
Long Term Care Branch
Division of survey and Certification
Centers for Medicare & Medicaid Services
90 7th Street, Suite 5-300 (5W)
San Francisco, CA 94103-6707

Allegation of Compliance

If you believe these deficiencies have been corrected, you may submit your POC as your allegation of compliance to Eric Stone, Program Manager, California Department of Public Health, Licensing and Certification Program, Los Angeles Acute and Ancillary Unit - South, 3400 Aerojet Suite 323 El Monte, CA 91731. We may accept your POC as your allegation of compliance and presume compliance until substantiated by a revisit or other means. In such a case, neither the CMS Regional Office nor the State Medicaid Agency will impose the previously recommended remedy(ies) at that time.

If, upon a subsequent revisit or by other means it is determined your facility has not achieved substantial compliance, we will recommend the remedies previously mentioned in this letter be imposed by the CMS Regional Office beginning on June 22, 2105 and continue until substantial compliance is achieved. Additionally, the CMS Regional Office may impose a revised remedy(ies), based upon changes in the seriousness of the noncompliance at the time of the revisit, if appropriate.

Informal Dispute Resolution

In accordance with §488.331, you have one (1) opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request, along with the specific deficiencies being disputed, and relevant information (evidence) as to why you are disputing those deficiencies to Suzette Leverett - Clark, RN Assistant Chief, California Department of Public Health, Licensing and Certification Division at 12440 East Imperial Highway Room 522, Norwalk, CA 90650.

This request must be sent during the same ten (10) days you have for submitting a POC for the cited deficiencies. An informal dispute resolution for the cited deficiencies will not delay the imposition of the recommended enforcement actions. A change in the seriousness of the noncompliance may result in a change in the remedy selected. When this occurs, you will be advised of any change in remedy.

Should CMS determine that termination or any other remedy is warranted, they will provide you with a separate formal notification of that determination.

If you have questions concerning the instructions contained in this letter, please contact, Eric Stone, Program Manager, at (626) 312-1142.

Sincerely,

Nwamaka Oranusi, Acting Chief
Health Facilities Inspection Division

Rosario Gaspe RN, Sr. HFEA for

Eric Stone, Program Manager
Acute and Ancillary Unit- South
3400 Aerojet Avenue Suite 323
Tel. (626) 312-1142 - Fax (626) 927-9293

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/13/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555874	A. BUILDING _____ B. WING _____	06/20/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN CALIFORNIA HOSP AT CULVER CITY D/P SNF	3828 DELMAS TERRACE CULVER CITY, CA 90230

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F 000	INITIAL COMMENTS The following reflects the findings of the Department of Public Health during a re-certification survey. Representing the Department of Public Health: Surveyor 17030, RN, HFEN Surveyor 25624, RN, HFEN Surveyor 16281, REHS, HFE Total Resident Population 17 Total Resident Sample Size: 8 Highest Scope/Severity: E	F 000		
F 154 SS=E	483.10(b)(3), 483.10(d)(2) INFORMED OF HEALTH STATUS, CARE, & TREATMENTS The resident has the right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition. The resident has the right to be fully informed in advance about care and treatment and of any changes in that care or treatment that may affect the resident's well-being. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure the resident or the resident's representative had the right to be fully informed in advance of the risks and benefits of anti-antipsychotic and physical restraints to be administered to six (6) of eight (8) sampled residents (1, 2, 3, 4, 6, and 7). The facility failed	F 154	1. How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice Corrective Action will be accomplished by the re-education of staff on the Restraints Policy and Procedure Application and monitoring SAA.049 and Consents PAT.037, completed on 7/19/2015. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken The SubAcute Unit at Southern California Hospital at Culver City (SCHCC) will identify other residents having the same potential for deficient practice by discussing restraint plan of care in interdisciplinary weekly rounds, and 100% monitoring of restraint documentation and informed consents, and will monitor them beginning August 1, 2015 as process improvements and report it quarterly to quality council, medical executive committee and governing board.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: CEO — (X6) DATE: 7/20/15

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

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F 154	Continued From page 1 to develop a written policy and procedure for informing the resident or the resident's representative the risks and benefits of the physical restraints. For Resident 1 and 6, the physician failed to obtain an informed consent from the authorized representative for the use of anti-antipsychotic and anti-depressant medications. For Resident 1, 2 and 7, the physician failed to obtain an informed consent from the resident or resident's representative for the physical restraints. This deficient practice had the potential for violating the resident's right to be fully informed in advance about the care. For Resident 3's blood transfusion, the physician failed to obtain an informed consent from the resident or resident's representative. For Residents 4's Peripherally Inserted Central Line, (PICC) line insertion, the physician failed to obtain an informed consent from the resident or resident's representative. For Resident 6's PICC line insertion and psychotropic medication, the physician failed to obtain an informed consent from the resident or resident's representative. This deficient practice had the potential for violating the resident's right to be fully informed in advance about the care. Findings: 1. During the initial tour of the unit with Registered Nurse (RN) 1 on June 19, 2015 at 8:30 a.m., Resident 1 was observed lying in bed with a PEG	F 154	3. *What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur* 100% monitoring of restraint documentation and informed consents, and will monitor them beginning August 1, 2015 as process improvements and report it quarterly to Quality Council, Medical Executive Committee and Governing Board. 4. *How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system* Discussions of residents on restraints plan of care in interdisciplinary weekly rounds, and 100% monitoring of restraint documentation and informed consents, and will monitor them beginning August 1,2015 as process improvements and report it quarterly to quality council, medical executive committee and governing board.	7/19/15

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F 154	Continued From page 2 (Percutaneous endoscopic gastrostomy) tube (a tube passed into a patient's stomach through the abdominal wall, most commonly to provide a means of feeding when oral intake is not adequate) and tracheostomy tube (a tube to be inserted allows a person to breathe without the use of his or her nose or mouth). Resident 1 was observed with soft wrist restraints applied on his wrists. According to RN 1, the resident was confused and was on soft wrist restraints to prevent the resident from pulling out the tracheostomy tube and PEG tube. a. A review of clinical record indicated Resident 1 was admitted to the facility on April 20, 2015 with diagnosis of intracranial hemorrhage (bleeding within the skull). The Minimum Data Set (MDS- assessment tool) dated April 27, 2015, indicated the resident was on persistent vegetative state (A disorder of consciousness in which patients with severe brain damage are in a state of partial arousal rather than true awareness). A review of the safety restraint order indicated the physician had ordered bilateral soft wrist restraints on April 20, 2015. A review of the entire clinical record indicated there was no documentation the resident's surrogate had been informed of the risks and benefits for the use of physical restraints. b. A review of the medication administration record indicated the physician had prescribed haldol (antipsychotic medication) since May 2, 2015 for Resident 1. The "Consent to Receive psychotropic	F 154	1. *How corrective action() will be accomplished for those residents found to have been affected by the deficient practice* Corrective Action will be accomplished by the re-education of staff on the Restraints Policy and Procedure Application and monitoring SAA.049 and Consents PAT.037, completed on 7/19/2015. 2. *How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken* The SubAcute Unit at Southern California Hospital at Culver City (SCHCC) will identify other residents having the same potential for deficient practice by discussing restraint plan of care in interdisciplinary weekly rounds, and 100% monitoring of restraint documentation and informed consents, and will monitor them beginning August 1,2015 as process improvements and report it quarterly to quality council, medical executive committee and governing board. 3. *What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur* 100% monitoring of restraint documentation and informed consents, and will monitor them beginning August 1, 2015 as process improvements and report it quarterly to Quality Council, Medical Executive Committee and Governing Board. 4. *How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system* Discussions of residents on restraints plan of care in interdisciplinary weekly rounds, and 100% monitoring of restraint documentation and informed consents, and will monitor them beginning August 1,2015 as process improvements and report it quarterly to quality council, medical executive committee and governing board.	7/19/15

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F 154	Continued From page 3 Medications" dated May 2, 2015 was reviewed and indicated the physician and the nurse signed but there was no documented evidence that the physician had informed the surrogate the risks and benefits of the medication. During an interview on June 20, 2015 at 4 p.m., RN 1 stated the physician had not informed the surrogate of the risks and benefits of the medication. 2. During the initial tour of the unit with RN 1 on June 19, 2015 at 8:37 a.m., Resident 2 was observed lying in bed with a PEG tube and tracheostomy tube. According to RN 1, the resident was confused and was on soft wrist restraints to prevent the resident from pulling out the tracheostomy tube and PEG tube. A review of clinical record indicated Resident 2 was admitted to the facility on June 17, 2015 with diagnosis of intracranial hemorrhage (bleeding within the skull). A review of the safety restraint order indicated the physician had ordered bilateral soft wrist restraints on June 19, 2015. A review of the entire clinical record indicated there was no documentation that the resident's surrogate was informed of the risks and benefits for the use of physical restraints. 3. During the initial tour of the unit with RN 1 on June 19, 2015 at 8:49 a.m., Resident 7 was observed lying in bed with a PEG tube and tracheostomy tube. According to RN 1, the resident was confused and was on soft wrist restraints to prevent the resident from pulling out the tracheostomy tube and PEG tube.	F 154	1. *How corrective action() will be accomplished for those residents found to have been affected by the deficient practice* Corrective Action will be accomplished by the re-education of staff on the Restraints Policy and Procedure Application and monitoring SAA.049 and Consents PAT.037, completed on 7/19/2015. 2. *How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken* The SubAcute Unit at Southern California Hospital at Culver City (SCHCC) will identify other residents having the same potential for deficient practice by discussing restraint plan of care in interdisciplinary weekly rounds, and 100% monitoring of restraint documentation and informed consents, and will monitor them beginning August 1,2015 as process improvements and report it quarterly to quality council, medical executive committee and governing board. 3. *What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur* 100% monitoring of restraint documentation and informed consents, and will monitor them beginning August 1, 2015 as process improvements and report it quarterly to Quality Council, Medical Executive Committee and Governing Board. 4. *How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system* Discussions of residents on restraints plan of care in interdisciplinary weekly rounds, and 100% monitoring of restraint documentation and informed consents, and will monitor them beginning August 1,2015 as process improvements and report it quarterly to quality council, medical executive committee and governing board.	7/19/15

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F 154	Continued From page 4 A review of clinical record indicated Resident 7 was admitted to the facility on April 2, 2015 with diagnosis of respiratory failure (a condition in which not enough oxygen passes from the lungs into the blood). A review of the safety restraint order indicated the physician had ordered bilateral soft wrist restraints on April 2, 2015. A review of the entire clinical record indicated there was no documentation that the resident's surrogate had been informed of the risks and benefits for the use of physical restraints. During an interview on June 19, 2015 at 4:45 p.m., Employee 2 stated the physician had not informed the surrogate the risks and benefits of physical restraints. According to Employee 2, there was no policy and procedure developed for informing the resident/surrogate the risks and benefits of the physical restraints. 4. A review of the Admission Face sheet indicated Resident 3 was admitted to the facility on March 27, 2015, with diagnoses that included respiratory failure (a condition which not enough oxygen passes from your lungs into your blood). The Blood Component Requisition and Transfusion Record was dated June 9, 2015. The Informed Consent to Blood Transfusion form was dated April 9, 2015, was done by telephone, Resident 3's family member gave a consent, and the witness signed. However, there was no physician signature, date and time. There was no	F 154	*1. How corrective action() will be accomplished for those residents found to have been affected by the deficient practice* Corrective Action will be accomplished by the re-education of staff on the Restraints Policy and Procedure Application and monitoring SAA.049 and Consents PAT.037, completed on 7/19/2015. *2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken* The Sub Acute Unit at Southern California Hospital at Culver City (SCHCC) will identify other residents having the same potential for deficient practice by discussing restraint plan of care in interdisciplinary weekly rounds, and 100% monitoring of restraint documentation and informed consents, and will monitor them beginning August 1,2015 as process improvements and report it quarterly to quality council, medical executive committee and governing board.	7/19/15

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F 154	Continued From page 6 other consent for the blood transfusion on April 2015. A review of two (2) facility's policies indicated the following: a. The policy titled, "Blood Component Administration Protocol" dated November 28, 2014, indicated verify the resident had signed the informed consent and the physician had explained the risks and benefits of blood transfusion, alternatives to transfusion, and the right of the resident to refuse transfusion. b. The policy titled, "Blood Transfusion Consent" dated November 2012 indicated all patients receiving blood or blood products must be informed of the risks of such transfusion and must sign the consent. The treating physician must provide information to the patient or the patient's surrogate decision marker. The physician is responsible for documenting that the conversation took place. 5. A review of the Admission Face Sheet indicated Resident 4 was admitted to the facility on March 3, 2015 with diagnoses that included respiratory failure. The Authorization and Informed Consent to Surgery or Special Diagnostic or Therapeutic Procedures (page 1 of 6) indicated Peripherally Inserted Central Line (PICC- line is a long, thin, hollow tube that a doctor or nurse puts into a vein above the bend of your elbow. It is used to give you chemotherapy and other medicines). The Signatures for Surgery or Procedure Informed Consent (page 3 of 6) dated June 5, 2015 indicated Resident 4's family member gave a	F 154	*3. What measures will be put into place* 100% monitoring of restraint documentation and informed consents, and will monitor them beginning August 1, 2015 as process improvements and report it quarterly to Quality Council, Medical Executive Committee and Governing Board. *4. How the facility plans to monitor* Discussions of residents on restraints plan of care in interdisciplinary weekly rounds, and 100% monitoring of restraint documentation and informed consents, and will monitor them beginning August 1,2015 as process improvements and report it quarterly to quality council, medical executive committee and governing board. *5. Include dates when corrective action will be completed.* 7/19/15	7/19/15

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F 154	Continued From page 6 telephone consent. However, there was no physician's verification of informed consent which included the signature to indicate the risks, benefits, and alternatives were discussed with the resident and/or family member. A review of a facility's policy titled, "Peripherally Inserted Central Catheter" dated November 20, 2012, indicated the resident has the right to receive information on all aspects of care. Explanation should include the benefits, potential risks, and expected outcomes. 6. A review of the Admission Face Sheet indicated Resident 6 was admitted to the facility on April 9, 2015, with diagnoses that included respiratory failure. Resident 6 was able to make her needs known. a. The Authorization and Informed Consent to Surgery or Special Diagnostic or Therapeutic Procedures (page 1 of 6) indicated Computed Tomography Scan of the Abdomen with/without Contrast (CT or CAT scan is a noninvasive diagnostic imaging procedure that uses a combination of X-rays and computer technology to produce horizontal, or axial, images (often called slices) of the body. A computerized tomography (CT scan combines a series of X-ray images taken from different angles and uses computer processing to create cross-sectional images, or shows detailed images of any part of the body, including the bones, muscles, fat, organs, and blood vessels). The Signatures for Surgery or Procedure Informed Consent page 3 of 6 dated June 6, 2015 indicated Resident 6 gave consent. However, there was no physician's verification of informed consent which included signature to indicate that the risks,	F 154	1. *How corrective action() will be accomplished for those residents found to have been affected by the deficient practice* Corrective Action will be accomplished by the re-education of staff on the Restraints Policy and Procedure Application and monitoring SAA.049 and Consents PAT.037, completed on 7/19/2015. 2. *How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken* The SubAcute Unit at Southern California Hospital at Culver City (SCHCC) will identify other residents having the same potential for deficient practice by discussing restraint plan of care in interdisciplinary weekly rounds, and 100% monitoring of restraint documentation and informed consents, and will monitor them beginning August 1,2015 as process improvements and report it quarterly to quality council, medical executive committee and governing board. 3. *What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur* 100% monitoring of restraint documentation and informed consents, and will monitor them beginning August 1, 2015 as process improvements and report it quarterly to Quality Council, Medical Executive Committee and Governing Board. 4. *How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system* Discussions of residents on restraints plan of care in interdisciplinary weekly rounds, and 100% monitoring of restraint documentation and informed consents, and will monitor them beginning August 1,2015 as process improvements and report it quarterly to quality council, medical executive committee and governing board.	

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	558874	A. BUILDING _____ B. WING _____	06/20/2015

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F 154	Continued From page 7 benefits, and alternatives were discussed with the resident /or family member. b. The Consent to Receive Psychotropic Medications dated April 10, 2015 indicated Zoloft (antidepressant medication) 100 milligrams (mg) by mouth once a day and was signed by the resident and the licensed nurse. However, there was no physician signature on the consent.	F 154		
F 221 SS=E	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure that three (3) of eight (8) sampled residents (1, 4 and 7) had the right to be free from any physical restraints and not required to treat the resident's medical symptoms. For Resident 1 and 7, the physician failed to authenticate the order for soft wrist restraint within 24 hours after the initiation of restraint. For Resident 4 and 7, the facility failed to attempt the less restrictive measures prior to the use of restraint. These deficient practices had the potential to violate the resident's right to be free from injury and had the potential for decreased mobility. Findings:	F 221	1. *How corrective action() will be accomplished for those residents found to have been affected by the deficient practice* **Corrective Action for F221 will be accomplished by re-education of staff on policy SAA.049 Restraint Policy and Procedure and Monitoring on 7/19/2015. SCHCC will create a "Hard Stop in the EMR documentation" for nursing to document alternatives attempted before placing restraints, and use of least restrictive measures, by August 31, 2015. Medical Staff will receive re-education on Policy and Procedure regarding necessity of orders for restraint by a M.D. with date and time by 7/23/15.** 2. *How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken* **SCHCC will identify other residents having the potential to be affected by the same deficient practice after weekly Interdisciplinary Team (IDT) meetings. The Nursing Manager and MDS Coordinator will complete a 100% audit of "IDT" form for accuracy and completeness, starting July 21, 2015, and report any significant findings to Sub Acute Director.**	7/23/15

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F 221	Continued From page 8 1. During the initial tour of the unit with Registered Nurse (RN) 1 on June 19, 2015 at 8:30 a.m., Resident 1 was observed lying in bed with a PEG (Percutaneous endoscopic gastrostomy) tube (a tube passed into a patient's stomach through the abdominal wall, most commonly to provide a means of feeding when oral intake is not adequate) and tracheostomy tube (a tube to be inserted allows a person to breathe without the use of his or her nose or mouth). Resident 1 was observed with soft wrist restraints applied on his wrists. According to RN 1, the resident was confused and was on soft wrist restraints to prevent the resident from pulling out the tracheostomy tube and PEG tube. A review of clinical record indicated Resident 1 was admitted to the facility on April 20, 2015, with diagnosis of intracranial hemorrhage (bleeding within the skull). A review of the "Non-Behavioral restraint orders and flow sheet" dated April 20, 2015, indicated the physician had ordered bilateral soft wrist restraints to prevent the resident from pulling out tracheostomy tube and PEG tube. The order was countersigned by the physician. However, there was no documentation the physician had authenticated the order within 24 hours after the initiation of restraint for the following days: 5/29/15, 5/30/15, 6/3/15, 6/5/15, and 6/7/15 to 6/18/15. The less restrictive measures were attempted on 5/29/15 and 6/1/15. 2. During the initial tour of the unit with RN 1 on June 19, 2015 at 8:49 a.m., Resident 7 was observed lying in bed with a PEG tube and	F 221	*3. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur* **SCHCC will identify other residents having the potential to be affected by the same deficient practice after weekly Interdisciplinary Team (IDT) meetings. The Nursing Manager and MDS Coordinator will complete a 100% audit of "IDT" form for accuracy and completeness, starting July 21, 2015, and report any significant findings to Sub Acute Director.** *4. How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system* **The Nursing Manager and MDS Coordinator will complete a 100% audit of "IDT" form for accuracy and completeness, starting July 21, 2015, and report any significant findings to Sub Acute Director. Reports will be submitted quarterly to Quality Council, Medical Executive Committee and Governing Board.**	

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F 221	Continued From page 9 tracheostomy tube. According to RN 1, the resident was confused and was on soft wrist restraints to prevent the resident from pulling out the tracheostomy tube and PEG tube. A review of clinical record indicated Resident 7 was admitted to the facility on April 2, 2015, with diagnosis of respiratory failure (a condition in which not enough oxygen passes from the lungs into the blood). A review of the "Non-Behavioral restraint orders and flow sheet" dated April 20, 2015, indicated the physician had ordered bilateral soft wrist restraints to prevent the resident from pulling out tracheostomy tube and PEG tube. The order was countersigned by the physician. However, there was no documentation the physician had authenticated the order within 24 hours after the initiation of restraint from June 12, 2015 to June 16, 2015. According to the facility's policies and procedures dated May 2015, titled, "Non-Behavioral Restraints:" "PROCEDURES 4.7 Alternatives to Restraint use 4.7.1 Safe, effective and the least restrictive protective measures will be employed based on the patient's assessed needs and history of effective and ineffective. 4.7.2 Companionship/supervision 4.7.3 Continuous observation, i.e., sitter or family member; 4.7.4 Diversion/physical activities (music, television); 4.7.5 pain relief/comfort measures (warmth, noise	F 221	*1. How corrective action() will be accomplished for those residents found to have been affected by the deficient practice* Corrective Action for F 221 will be accomplished by re-education of staff on policy SAA.049 Restraint Policy and Procedure and Monitoring on 7/19/2015. SCHCC will create a "Hard Stop in the EMR documentation" for nursing to document alternatives attempted before placing restraints, and use of least restrictive measures, by August 31, 2015. Medical Staff will receive re-education on Policy and Procedure regarding necessity of orders for restraint by a M.D. with date and time by 7/23/15. *2. Identify Residents and Corrective action taken* SCHCC will identify other residents having the potential to be affected by the same deficient practice after weekly Interdisciplinary Team (IDT) meetings. The Nursing Manager and MDS Coordinator will complete a 100% audit of "IDT" form for accuracy and completeness, starting July 21, 2015, and report any significant findings to Sub Acute Director.	7/23/15

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F 221	Continued From page 10 level, etc.); 4.7.6 patient placement in room close to nurses' station; 4.7.7 Reality orientation/mental stimulation (music, television, reading materials); 4.7.8 Scheduled toileting, 4.7.9 Documentation in the patient's medical record will be reflect those times when less restrictive protective measures are attempted. 4.7.10 When less restrictive protective measures 4.8 Assessment and the Decision to Use restraints have been unsuccessful, or have been determined to be appropriate, restraints may be used. 4.8.3 Restraint will be employed only after less restrictive measure have been attempted and have failed to produce a desire outcome or have been found to be contraindicated. 4.10 Restraint Application without an Order 4.10.1 If an LIP (Licensed Independent Practitioner) is not available to issue a restraint order, a registered Nurse may initiate restraint use based on his/her appropriate assessment of the patient. The LIP is notified within 1-hour of the initiation of restraint, and a telephone order is obtained from the LIP and entered into the patient's record. The telephone order must be authenticated within 24-hours of the initial order." 3. During an initial tour on June 19, 2015, at 9:05 a.m., Resident 4 was lying in bed, his eyes closed, had a foley (indwelling) catheter, and soft wrist restraints were applied to both wrists. Licensed Vocational Nurse (LVN) 2 stated Resident 4 had bilateral soft restraints due to pulling out the tubes.	F 221	*3. Measures put into place.* SCHCC will identify other residents having the potential to be affected by the same deficient practice after weekly Interdisciplinary Team (IDT) meetings. The Nursing Manager and MDS Coordinator will complete a 100% audit of "IDT" form for accuracy and completeness, starting July 21, 2015, and report any significant findings to Sub Acute Director. *4. Monitoring performance to make sure that solutions are sustained.* The Nursing Manager and MDS Coordinator will complete a 100% audit of "IDT" form for accuracy and completeness, starting July 21, 2015, and report any significant findings to Sub Acute Director. Reports will be submitted quarterly to Quality Council, Medical Executive Committee and Governing Board. *5. Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State Agency.* 7/23/15	7/23/15

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F 221	Continued From page 11 a. A review of the Admission Face Sheet indicated Resident 4 was admitted to the facility on March 3, 2015, with diagnoses that included respiratory failure. The Minimum Data Set (MDS an assessment and care plan tool) dated March 10, 2015, indicated Resident 4 was totally dependent on the staff for activities of daily living such as dressing bed mobility, toileting, and bathing. The MDS Sections: Section G0400 indicated Resident 4 had impairment on both sides of his lower extremity. Section P-Restraints of the MDS assessment indicated Resident 4 had "limb restraints and were used daily." The Care Area Assessment (CAA) Worksheet dated March 10, 2015, indicated Resident 4 had episodes of confusion due to medical condition and diagnosis of dementia. A care plan for dementia will be developed. The CAA #3 "Limb Restraint Used in Bed" indicated Resident 4 was confused and at times had attempted to pull the tubing. The Care Area Assessment (CAA) Worksheet dated March 10, 2015, indicated to refer to the license nurses notes and documentation during the look back dated March 4, 2015 through March 10, 2015. There was no current documentation of Resident 4's behavior for the use of the soft wrist restraints. There were only the pre-printed Non-Behavioral Restraint Order and Flow Sheets which indicated checks. There was no documentation the RN had assessed the behavior that Resident 4 exhibited. During an electronic record review on June 20, 2015, at 11:40 a.m., RN 1 stated Resident 4's plan of care indicated the staff had been applying the wrist restraints on the resident since March	F 221	1. *How corrective action( ) will be accomplished for those residents found to have been affected by the deficient practice* **Corrective Action for F 221 will be accomplished by re-education of staff on policy SAA.049 Restraint Policy and Procedure and Monitoring on 7/19/2015. SCHCC will create a "Hard Stop in the EMR documentation" for nursing to document alternatives attempted before placing restraints, and use of least restrictive measures, by August 31, 2015. Medical Staff will receive re-education on Policy and Procedure regarding necessity of orders for restraint by a M.D. with date and time by 7/23/15.** 2. *How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken* **SCHCC will identify other residents having the potential to be affected by the same deficient practice after weekly Interdisciplinary Team (IDT) meetings. The Nursing Manager and MDS Coordinator will complete a 100% audit of "IDT" form for accuracy and completeness, starting July 21, 2015, and report any significant findings to Sub Acute Director.**	

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F 221	Continued From page 12 10, 2015. There was no documented evidence from the RN regarding other alternative measures used prior to the use of soft wrist restraints. A care plan titled, "Physical Restraint Limb secondary to varies at times to pull on cords and tubing, and fall risk." The staff approaches included refer to the IDT members for evaluation and recommendation of appropriate use of correct restraints. Attempt to use less restrictive devices on an ongoing basis. Quarterly assessment review and follow up by the IDT to ensure appropriateness of restraints. During an interview on June 20, 2105, at 10:45 a.m., RN 1 stated she had witnessed Resident 4 scratched himself when the bilateral soft restraints were removed. However, there was no documentation provided by the RN. A review of the Weekly IDT Notes dated May 26 through June 9, 2015, indicated no documented evidence the use of soft restraints was discussed in the IDT meeting. The Interdisciplinary Team (IDT) Conference Record Quarterly Review dated May 5, 2015, indicated the pre-printed box was checked off for bilateral soft restraints use to indicate the restraint was appropriate and necessary to manage Resident 4's safety needs. The IDT Conference Record had a section which indicated a discussion with the physician regarding the treatment plan without any changes made with	F 221	*3. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur* **SCHCC will identify other residents having the potential to be affected by the same deficient practice after weekly Interdisciplinary Team (IDT) meetings. The Nursing Manager and MDS Coordinator will complete a 100% audit of "IDT" form for accuracy and completeness, starting July 21, 2015, and report any significant findings to Sub Acute Director.** *4. How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system* **The Nursing Manager and MDS Coordinator will complete a 100% audit of "IDT" form for accuracy and completeness, starting July 21, 2015, and report any significant findings to Sub Acute Director. Reports will be submitted quarterly to Quality Council, Medical Executive Committee and Governing Board.**	

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F 221	Continued From page 13 the plan of care and/or discussed with physician regarding plan of care with new changes made. There was no documented evidence that Resident 4's physician was made aware of the continued use of the restraint. b. Review of the Non-Behavioral Restraint Order and Flow Sheet dated June 14, 2015 through June 19, 2015 indicated that on June 19, 2015 Resident 4 had been in restraints for 92 days. The Nursing- Clinical Assessment did not indicate the alternative/least restrictive measures attempted prior to the use of restraints.	F 221		
F 248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on a review of activity calendar and interview, the facility failed to provide an ongoing program of activities, designed to meet the interests and the physical, mental, and psychosocial well-being of the residents. There was no staff member conducting activities during the weekend as indicated by the facility's policy and procedure. This deficient practice had the potential for not meeting the residents' activity needs.	F 248	*1. How corrective action() will be accomplished for those residents found to have been affected by the deficient practice* ***Activity Coordinator Designee will be hired for weekend coverage to meet a seven day per week coverage.*** *2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken* **Staffing schedule will identify the potential and a designee Activities Coordinator will be assigned to cover the weekend.** *3. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur* ***Daily monitoring to ensure an Activity Coordinator or Designee is scheduled every day.*** *4. How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system* **Monitor staffing schedule daily. Outliers will be tracked and trended, then reported quarterly to Quality Council, Medical Executive Committee and Governing Board.**	

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F 248	Continued From page 14 Findings: A review of the Activity Calendar for May and June of 2015 indicated all variety of activities were scheduled seven days per week. During an interview with the Activity Coordinator on June 20, 2015 at 10:55 a.m., she stated there was no staff member who could coordinate the activities while she was off during the weekend. During an interview with Employee 2 on June 20, 2015 at 4 p.m., he stated the Activity Coordinator usually works 5 days per week (Monday to Friday) to coordinate and provide activities to the residents. Employee 2 stated there was no staff member conducting activities during the weekend. According to the facility's policy and procedure dated November 20, 2012, titled, "Activity Program-General Description": "4.2 Procedure 4.2.6 Activities are offered at hours convenient to the patient (i.e. morning, afternoon, some evenings and weekends) and involve the community when appropriate (in and out of he facility)."	F 248	*1. How corrective action() will be accomplished for those residents found to have been affected by the deficient practice* **MDS Coordinator had consulted the facilities MDS Software Company Point Click Care for information on how to add dates and location to the Summary of the Care Area Assessment. Adding Dates and location to the Care Area Assessment to begin by 7/22/2015 when next Care Area Assessment is due.**	
F 272 SS=C	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.	F 272	*2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken* **SCHCC will identify other residents having the potential to be affected by reviewing the Care Area Assessment at IDT meetings. Once identified, Care Area Assessment will be completed.**	

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F 272	Continued From page 15 A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility's licensed nurse failed to use the State specified RAI (Resident Assessment Instrument) in its entirety, when conducting an assessment of	F 272	3. *What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur* **MDS Coordinator had consulted the facilities MDS Software Company Point Click Care for information on how to add dates and location to the Summary of the Care Area Assessment. Adding Dates and location to the Care Area Assessment to begin by 7/22/2015 when next Care Area Assessment is due.** 4. *How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system* **This will be monitored weekly at the Interdisciplinary Team Meeting. Outliers will be tracked and trended, then reported quarterly to Quality Council, Medical Executive Committee and Governing Board.**	

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555874	A. BUILDING _____ B. WING _____	06/20/2015

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F 272	Continued From page 16 the needs of three (3) of eight (8)sampled residents (1, 7, and 8). The facility failed to conduct an MDS (Minimum Data Set, a standardized assessment and care planning tool) assessment with a CAA (Care Area Assessment) Summary Report that indicated the date of the CAA documentation (where information related to the CAA can be found) to help provide additional information for the development of an individualized care plan for Resident 1, 7, and 8. These deficient practices had the potential to result in not developing an individualized care plan to meet the resident's needs. Findings: 1. A review of clinical record indicated Resident 1 was admitted to the facility on April 20, 2015 with diagnosis of intracranial hemorrhage (bleeding within the skull). The MDS dated April 27, 2015 indicated the resident required total assistance in performing activities of daily living (ADLs), was incontinent of bowel and bladder, received nutrition and hydration via GT (gastrostomy tube, a tube that is placed directly into the stomach through an abdominal wall incision for administration of food, fluids, and medications), and was at risk for pressure sore development. A review of the CAA (Care Area Assessment) Summary dated April 30, 2015, indicated seven triggered care areas from the MDS findings that were problematic for the resident. These triggered care areas were urinary incontinence, falls, nutritional status, feeding tube, dehydration, pressure ulcer, and physical restraints. For the CAA Summary, the "Location and Date of CAA	F 272	1. *How corrective action() will be accomplished for those residents found to have been affected by the deficient practice* **MDS Coordinator had consulted the facilities MDS Software Company Point Click Care for information on how to add dates and location to the Summary of the Care Area Assessment. Adding Dates and location to the Care Area Assessment to begin by 7/22/2015 when next Care Area Assessment is due.** 2. *How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken* **SCHCC will identify other residents having the potential to be affected by reviewing the Care Area Assessment at IDT meetings. Once identified, Care Area Assessment will be completed.** 3. *What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur* **MDS Coordinator had consulted the facilities MDS Software Company Point Click Care for information on how to add dates and location to the Summary of the Care Area Assessment. Adding Dates and location to the Care Area Assessment to begin by 7/22/2015 when next Care Area Assessment is due.** 4. *How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system* **This will be monitored weekly at the Interdisciplinary Team Meeting. Outliers will be tracked and trended, then reported quarterly to Quality Council, Medical Executive Committee and Governing Board.**	

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F 272	Continued From page 17 Documentation" referred to CAA WS (Worksheet) dated April 15, 2015. However, the CAA WS did not provide documentation of the date and location where the assessment information could be found for the seven triggered areas. 2. A review of clinical record indicated Resident 7 was admitted to the facility on April 2, 2015 with diagnosis of respiratory failure (a condition in which not enough oxygen passes from the lungs into the blood). The MDS dated April 9, 2015 indicated the resident required total assistance in performing activities of daily living (ADLs), was incontinent of bowel, received nutrition and hydration via GT tube, and was at risk for pressure sore development. A review of the CAA (Care Area Assessment) Summary dated April 16, 2015, indicated nine triggered care areas from the MDS findings that were problematic for the resident. These triggered care areas were cognitive loss, communication, urinary incontinence, falls, nutritional status, feeding tube, dehydration, pressure ulcer, and physical restraints. For the CAA Summary, the "Location and Date of CAA Documentation" referred to CAA WS (Worksheet) dated April 15, 2015. However, the CAA WS did not provide documentation of the date and location where the assessment information could be found for the seven triggered areas. 3. A review of clinical record indicated Resident 8 was admitted to the facility on March 23, 2015 with diagnosis of respiratory failure. The resident expired on May 12, 2015.	F 272	1. *How corrective action() will be accomplished for those residents found to have been affected by the deficient practice* **MDS Coordinator had consulted the facilities MDS Software Company Point Click Care for information on how to add dates and location to the Summary of the Care Area Assessment. Adding Dates and location to the Care Area Assessment to begin by 7/22/2015 when next Care Area Assessment is due.** 2. *How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken* **SCHCC will identify other residents having the potential to be affected by reviewing the Care Area Assessment at IDT meetings. Once identified, Care Area Assessment will be completed.** 3. *What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur* **MDS Coordinator had consulted the facilities MDS Software Company Point Click Care for information on how to add dates and location to the Summary of the Care Area Assessment. Adding Dates and location to the Care Area Assessment to begin by 7/22/2015 when next Care Area Assessment is due.** 4. *How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system* **This will be monitored weekly at the Interdisciplinary Team Meeting. Outliers will be tracked and trended, then reported quarterly to Quality Council, Medical Executive Committee and Governing Board.**	

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F 272	Continued From page 18 The MDS dated March 30, 2015 indicated the resident required total assistance in performing activities of daily living (ADLs), was incontinent of bowel, received nutrition and hydration via GT (gastrostomy tube, a tube that is placed directly into the stomach through an abdominal wall incision for administration of food, fluids, and medications), and developed pressure sore. A review of the CAA (Care Area Assessment) Summary dated April 11, 2015, indicated five triggered care areas from the MDS findings that were problematic for the resident. These triggered care areas were urinary incontinence, nutritional status, feeding tube, dehydration, and pressure ulcer. For the CAA Summary, the "Location and Date of CAA Documentation" referred to CAA WS (Worksheet) dated April 10, 2015. However, the CAA WS did not provide documentation of the date and location where the assessment information could be found for the five triggered areas. On June 20, 2015 at 11:30 a.m., during an interview, MDS 1 stated the location of the date and assessment information for all triggered problem areas should have been documented.	F 272		
F 273 SS=D	483.20(b)(2)(i) COMPREHENSIVE ASSESSMENT 14 DAYS AFTER ADMIT A facility must conduct a comprehensive assessment of a resident within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or for therapeutic leave.)	F 273	1. *How corrective action() will be accomplished for those residents found to have been affected by the deficient practice* **Timely completion of the MDS Assessment within 14 days by the MDS Coordinator, the RN nursing manager will be certified in MDS 3.0 and Review MDS Comprehensive Assessment for completion in the correct time frame.**	

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F 273	Continued From page 19 This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to conduct a comprehensive assessment within 14 days of admission for one (1) of eight sample residents (8). This deficient practice had the potential for an untimely assessment of the resident's needs. Findings: A review of the medical record indicated Resident 8 was admitted to the facility on March 23, 2015, with diagnosis of respiratory failure (a condition in which not enough oxygen passes from the lungs into the blood). A review of the admission Minimum Data Set (MDS) for Resident 8 indicated the assessment was completed on April 11, 2015, which was 19 days of admission to the facility. In an interview with MDS 1 on June 20, 2015 at 11:30 a.m., she stated the admission MDS for Resident 8 was not completed within 14 days.	F 273	2. *How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken* **The certified RN nursing manager reviews the MDS Comprehensive Assessment for completion in the correct time frame.** 3. *What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur* 4. **The certified RN nursing manager reviews the MDS Comprehensive Assessment for completion in the correct time frame.**	
F 278 SS=E	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the	F 278	1. *How corrective action() will be accomplished for those residents found to have been affected by the deficient practice* **The facility RN nursing manager will become certified in MDS 3.0 and represent the MDS Coordinator.** 2. *How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken* **Identification of potential deficient practice will be made by reviewing MDS 3.0 certifications annually. HR will notify Director Sub Acute if Certification expires within 3 months.**	

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F 278	Continued From page 20 assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure a registered nurse coordinated each assessment with the appropriate participation of health professionals for three (3) of eight (8) sampled residents (1, 7, and 8). This deficient practice had a potential for not providing appropriate assessment and interventions for residents. Findings: 1. A review of the clinical record indicated Resident 1 was admitted to the facility on April 20, 2015 with diagnosis of intracranial hemorrhage	F 278	*3. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur* **The facility RN nursing manager will become certified in MDS 3.0 and represent the MDS Coordinator.** *4. How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system* **Outliers will be tracked and trended, then reported quarterly to Quality Council, Medical Executive Committee and Governing Board.**	

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F 278	Continued From page 21 (bleeding within the skull). A review of the CAA (Care Area Assessment) Summary dated April 30, 2015, indicated it was completed by Licensed Vocational Nurse (LVN) 1 and coordinated by MDS (Minimum Data Set) Coordinator. 2. A review of the clinical record indicated Resident 7 was admitted to the facility on April 2, 2015 with diagnosis of respiratory failure (a condition in which not enough oxygen passes from the lungs into the blood). A review of the CAA (Care Area Assessment) Summary dated April 16, 2015, indicated it was completed by LVN 1 and coordinated by MDS Coordinator. 3. A review of the clinical record indicated Resident 8 was admitted to the facility on March 23, 2015 with diagnosis of respiratory failure. The resident expired on May 12, 2015. A review of the CAA (Care Area Assessment) Summary dated April 11, 2015, indicated it was completed by LVN 1 and coordinated by MDS Coordinator. During an interview with Employee 2 on June 20, 2015 at 4:40 p.m., he stated the MDS Coordinator is the Director of the ICU (Intensive Care Unit), who signed under the "Signature of RN Assessment Coordinator Verifying Assessment Completion" for each MDS assessment. According to Employee 2, the MDS Coordinator had no formal training in MDS assessment.	F 278	1. *How corrective action() will be accomplished for those residents found to have been affected by the deficient practice* **The facility RN nursing manager will become certified in MDS 3.0 and represent the MDS Coordinator.** 2. *How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken* **Identification of potential deficient practice will be made by reviewing MDS 3.0 certifications annually. HR will notify Director Sub Acute if Certification expires within 3 months.** 3. *What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur* **The facility RN nursing manager will become certified in MDS 3.0 and represent the MDS Coordinator.** 4. *How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system* **Outliers will be tracked and trended, then reported quarterly to Quality Council, Medical Executive Committee and Governing Board.**	

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F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility's staff failed to develop comprehensive care plans for two (2) of eight (8) sampled residents (8 and 9). There was no care plan developed to address the care area for Resident 8's "urinary incontinence/indwelling catheter," as indicated in the Care Area Assessment (CAA). For Resident 9, there was no care plan developed for the isolation precautions for clostridium difficile (a fatal health care bacterium that can cause symptoms ranging from diarrhea to life-threatening inflammation of the colon).	F 279	1. *How corrective action() will be accomplished for those residents found to have been affected by the deficient practice* **Re-education of staff on review of Policy and Procedure at IDT meetings and necessity of review of all Comprehensive Care Plan items weekly during interdisciplinary team meeting.** 2. *How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken* **Residents will be identified through medical record reviews at IDT meetings.** 3. *What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur* **Comprehensive Care Plan items are reviewed weekly during IDT meetings.** 4. *How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system* **Monitoring at IDT meetings. Outliers will be tracked and trended, then reported quarterly to Quality Council, Medical Executive Committee and Governing Board.**	

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F 279	Continued From page 23 This deficient practice has the potential for not providing appropriate interventions when there was no comprehensive care plan developed for the resident. Findings: 1. A review of Resident 8's medical record indicated the resident was admitted to the facility on March 23, 2015 with diagnosis of respiratory failure (a condition in which not enough oxygen passes from the lungs into the blood). The resident expired on May 12, 2015. According to the Section V (Care Area Assessment) of the MDS, "urinary incontinence/indwelling catheter" was a triggered area and a care plan was necessary to address the problem. A review of the CAA Summary Report dated April 11, 2015, for Resident 8 indicated the care area for "urinary incontinence/indwelling catheter" was triggered. A review of the care plans indicated there was no documentation a care plan was developed for "urinary incontinence/indwelling catheter." During an interview with Licensed Vocational Nurse (LVN) 1 on June 20, 2015, at 11:30 a.m., she stated a care plan should have been developed for "urinary incontinence/indwelling catheter."	F 279	1. *How corrective action() will be accomplished for those residents found to have been affected by the deficient practice* **Re-education of staff on review of Policy and Procedure at IDT meetings and necessity of review of all Comprehensive Care Plan items weekly during interdisciplinary team meeting.** 2. *How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken* **Residents will be identified through medical record reviews at IDT meetings.** 3. *What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur* **Comprehensive Care Plan items are reviewed weekly during IDT meetings.** 4. *How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system* **Monitoring at IDT meetings. Outliers will be tracked and trended, then reported quarterly to Quality Council, Medical Executive Committee and Governing Board.**	

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F 279	Continued From page 24	F 279		
	2. Resident 9 was admitted to the facility on April 10, 2015, with diagnoses that included pulmonary embolism (Pulmonary embolism is the sudden blockage of a major blood vessel in the lung, usually by a blood clot). During an initial tour on June 19, 2015, at 8:30 a.m., LVN 2 stated that Resident 9 was on isolation precautions for clostridium difficile (C. diff) (a fatal health care bacterium that can cause symptoms ranging from diarrhea to life-threatening inflammation of the colon). A review of the medical record on June 19, 2015 , at 2:35 p.m., indicated there was a plan of care titled, "Contact Isolation" dated April 17, 2015, for Methicillin Resistant Staphylococcus Aureus, MRSA (a bacteria that resists antibiotics) of the nares and Vancomycin Resistant Enterococci (VRE -are a type of bacteria called enterococci that have developed resistance to many antibiotics especially vancomycin) in the urine. However, there was no documented evidence of a care plan for managing C-Diff. A review of a laboratory result for Resident 9 dated June 17, 2015, indicated C-Diff "positive. "			
F 283 SS=B	483.20(l)(1)&(2) ANTICIPATE DISCHARGE: RECAP STAY/FINAL STATUS When the facility anticipates discharge a resident must have a discharge summary that includes a recapitulation of the resident's stay; and a final summary of the resident's status to include items in paragraph (b)(2) of this section, at the time of the discharge that is available for release to	F 283	1. *How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice* **Will enforce the 14 day turn around for completion of discharge summaries. Completion of discharge summaries over 14 days Targeted date 60 days.**	

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SOUTHERN CALIFORNIA HOSP AT CULVER CITY D/P SNF	3828 DELMAS TERRACE CULVER CITY, CA 90230

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F 283	Continued From page 25 authorized persons and agencies, with the consent of the resident or legal representative. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to have a discharge summary that included a recapitulation of the resident's stay and a final summary of the resident's status, authenticated or signed and dated by the physician for completion within 14 days following discharge as indicated in the facility's policy and procedure for one of eight sampled residents (8). Findings: 1. A review of Resident 8's medical record indicated the resident was admitted to the facility on March 23, 2015. The resident expired on May 12, 2015. A review of the Discharge Summary indicated the discharge summary was dictated by the physician on June 20, 2015, which was 58 days after the resident expired. In addition, the Discharge Summary was not authenticated or signed by a physician. On June 20, 2015 at 11:50 a.m., during an interview with Employee 3, she stated the discharge summary was signed by the physician as of June 20, 2015. According to Employee 3, the discharge summary should be completed promptly and authenticated or signed by a physician within two (2) weeks following a patient's discharge. According to the facility's policy and procedure	F 283	2. *How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.* ***Discharge censuses are reviewed daily to identify deficiencies.*** **Will enforce the 14 day turn around for completion of discharge summaries. Completion of discharge summaries over 14 days Targeted date 60 days.** 3. *What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur* **Will enforce the 14 day turn around for completion of discharge summaries. Completion of discharge summaries over 14 days Targeted date 60 days.** 4. *How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system* **Outliers will be tracked and trended, then reported quarterly to Quality Council, Medical Executive Committee and Governing Board.**	

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F 283	Continued From page 26 dated 8/12, titled, "Completion Requirements for the Medical Record": "4.1 Policy 4.1.2 medical records shall be completed promptly and authenticated or signed by a physician, dentist or podiatrist within two (2) weeks following a patient's discharge."	F 283		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to assess and re-assess the rashes for one (1) of eight (8) sampled residents (3). Resident 3 was identified with rashes and was treated with Clotrimazole 1% cream (antifungal topical ointment) and Hydrocortisone 1% ointment (corticosteroid) for 30 days, then 20 days later treated with Elimite cream (a scabicide agent that kills the scabies mite). The facility did not assess and re-assess the effectiveness and/or ineffectiveness of the treatment and the resident's response to the treatment. This deficient practice had the potential to result in	F 309	1. *How corrective action() will be accomplished for those residents found to have been affected by the deficient practice* **Re-education of staff on review of Policy and Procedure SAA at IDT meetings and necessity of review of all Comprehensive Care Plan items weekly during interdisciplinary team meeting.** 2. *How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken* **Residents will be identified through medical record reviews at IDT meetings.** 3. *What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur* **Comprehensive Care Plan items are reviewed weekly during IDT meetings.** 4. *How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system* **Monitoring at IDT meetings. Outliers will be tracked and trended, then reported quarterly to quality council, medical executive committee and governing board.**	

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F 309	Continued From page 27 recurring skin problems. Findings: During an initial tour, on June 19, 2015, Licensed Vocational Nurse (LVN) 2 stated Resident 3 was positive for Scabies last month. A review of the Admission Face Sheet indicated Resident 3 was admitted to the facility on March 27, 2015 with diagnoses that included respiratory failure (a condition which not enough oxygen passes from your lungs into your blood). A review of a Consultation dated May 1, 2015, indicated Resident 3 had a 3 day history of a rash. The resident was transferred from a skilled nursing facility. Resident 3 had a rash that began on her upper chest and left shoulder and subsequently spread to the back. The Assessment and Plan indicated probable folliculitis (common skin condition in which hair follicles become inflamed) and candidiasis (fungal infection). Per the nurses, the resident has improved on Clindamycin (treatment of acne vulgaris) and clotrimazole (is an antifungal medication commonly used in the treatment of fungal infections) use. Recommendation to continue both medications be applied twice daily on affected skin. The follow-up Dermatology Consultation dated May 15, 2015, indicated scabietic infestation cannot be ruled out and a skin scrapping was done. During an interview and clinical record review on June 19, 2015, at 11:40 a.m., Registered Nurse (RN) 1 stated the documentation of skin rashes	F 309	1. *How corrective action() will be accomplished for those residents found to have been affected by the deficient practice* **Re-education of staff on review of Policy and Procedure SAA at IDT meetings and necessity of review of all Comprehensive Care Plan items weekly during interdisciplinary team meeting.** 2. *How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken* **Residents will be identified through medical record reviews at IDT meetings.** 3. *What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur* **Comprehensive Care Plan items are reviewed weekly during IDT meetings.** 4. *How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system* **Monitoring at IDT meetings. Outliers will be tracked and trended, then reported quarterly to quality council, medical executive committee and governing board.**	

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F 309	Continued From page 28 was on April 2, 2015. RN 1 stated the rash was not specific to location and was not descriptive. RN 1 stated from April 2 through June 19, 2015, there was a diagnosis of Scabies. RN 1 stated that on May 19, 2015, there was documentation of a rash but was not descriptive and location of the rash was not specified. When asked for the location and description, RN 1 replied, "Yes, there should be location and description." Resident 3 had rashes since April 2, 2015 with treatments. When asked for an assessment and reassessment, RN 1 stated, "Yes, there should be an assessment and reassesment of the resident." RN 1 stated there should be a weekly progress notes. A review of an order titled, "Miscellaneous Nursing Order" dated May 15, 2015, indicated "ask Id and Dermatologist consultants to see her about worsening of her rash." A review of the Pathology Consultation to Rule Out Scabies dated collected May 15, 2015, indicated Resident 3 was positive for Scabies and the plan was to recommend further treatment. A plan of care titled, "Resident had diagnoses of Scabies" indicated the staff approaches included to observe for effectiveness of medication. There was no description where the scabies were located on Resident 3's body. There was no assessment and re-assessment of the scabies and response to Elimite treatment. During an interview on June 19, 2015, at 11:30 a.m., Employee 4 stated the staff should monitor the resident's skin for any conditions.	F 309	1. *How corrective action() will be accomplished for those residents found to have been affected by the deficient practice* **Re-education of staff on review of Policy and Procedure SAA at IDT meetings and necessity of review of all Comprehensive Care Plan items weekly during interdisciplinary team meeting.** 2. *How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken* **Residents will be identified through medical record reviews at IDT meetings.** 3. *What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur* **Comprehensive Care Plan items are reviewed weekly during IDT meetings.** 4. *How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system* **Monitoring at IDT meetings. Outliers will be tracked and trended, then reported quarterly to quality council, medical executive committee and governing board.**	

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F 309	Continued From page 29 A review of the Weekly IDT Notes dated May 19, 2015 did not indicate documentation of scabies. The nursing section was not completed. According to the instructions, any progress, changes, additional information with current condition since review date should be documented. During a concurrent interview with Employee 1 and Employee 4 on June 20, 2015, between 9:55 a.m. and 10:20 a.m., Employee 1 reviewed the clinical record and stated there was a progress note dated May 1, 2015 which indicated Resident 3 had a 3 day rash and the dermatologist consultant came on May 15, 2015. Employee 4 stated Resident 4 had skin symptoms more than a few weeks ago. Employee 4 further stated Resident 3's physician did not feel Resident 3 had Scabies. A review of the Medication Administration Record indicated the following orders: 1. Clotriazole 1% Cream (Lotromin) dated April 7, 2015, to be applied twice a day, to the rash on back, chest, neck, ad arms. 2. Clindamycin Phosphate 1% lotion (Cleocin T) dated April 29, 2015, applied twice a day. There was no indication were to apply. A review of a facility's policy and procedure titled, "Comprehensive Care Plan" dated January 2014 indicated the care plan will be revised weekly as part of the Interdisciplinary Team process. It will be incorporated into team meeting or by having the nurse review the care plan during the team 's	F 309	1. *How corrective action() will be accomplished for those residents found to have been affected by the deficient practice* **Re-education of staff on review of Policy and Procedure SAA at IDT meetings and necessity of review of all Comprehensive Care Plan items weekly during interdisciplinary team meeting.** 2. *How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken* **Residents will be identified through medical record reviews at IDT meetings.** 3. *What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur* **Comprehensive Care Plan items are reviewed weekly during IDT meetings.** 4. *How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system* **Monitoring at IDT meetings. Outliers will be tracked and trended, then reported quarterly to quality council, medical executive committee and governing board.**	

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F 309	Continued From page 30 reports.	F 309		
F 315 6S=E	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure there was documented medical justification in the physician orders for the use of an indwelling urinary catheter (a flexible plastic tube inserted into the bladder used to drain urine) for three (3) of eight (8) sampled residents (2, 3 and 7). This deficient practice had the potential to result in urinary tract infection. Findings: 1. During the initial tour with Registered Nurse (RN) 1 on June 19, 2015 at 8:37 a.m., Resident 2 was observed resting in bed, and had an indwelling urinary catheter. RN 1 stated the resident was non-verbal. RN 1 further stated the resident's indwelling urinary catheter was due to the physician's request. According to RN 1, the	F 315	1. *How corrective action() will be accomplished for those residents found to have been affected by the deficient practice* **Change the CPOE order for Placement of Indwelling Catheters to include justification of Placement** 2. *How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken* **Residents will be identified through medical record reviews at IDT meetings.** 3. *What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur* **Change the CPOE order for Placement of Indwelling Catheters to include justification of Placement** 4. *How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system* **Review at IDT meetings. Outliers will be tracked and trended, then reported quarterly to Quality Council, Medical Executive Committee and Governing Board.**	

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F 315	Continued From page 31 resident had no urinary retention, neurogenic bladder, Stage III or VI pressure ulcers, or cancers. A review of clinical record indicated Resident 2 was admitted to the facility on June 17, 2015 with diagnosis of intracranial hemorrhage (bleeding within the skull). A review of the physician order indicated a Foley catheter had been prescribed for Resident 2 on 6/17/15. However, there was no medical justification in the physician order for the use of an indwelling catheter. During the interview with RN 1 on April 24, 2015 at 2:40 p.m., she stated there was no physician order for the indwelling catheter. 2. During the initial tour with RN 1 on June 19, 2015 at 8:49 a.m., Resident 7 was observed resting in bed, and had an indwelling urinary catheter. RN 1 stated the resident was confused. According to RN 1, the indwelling urinary catheter was used for Stage III ulcer on the sacral area. A review of clinical record indicated Resident 7 was admitted to the facility on April 2, 2015 with diagnosis of respiratory failure (a condition in which not enough oxygen passes from the lungs into the blood). A review of the physician order indicated a Foley catheter had been prescribed for Resident 7 on April 10, 2015. However, there was no medical justification in the physician order for the use of an indwelling catheter. There was no documentation the resident had been assessed	F 315	1. *How corrective action() will be accomplished for those residents found to have been affected by the deficient practice* **Change the CPOE order for Placement of Indwelling Catheters to include justification of Placement** 2. *How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken* **Residents will be identified through medical record reviews at IDT meetings.** 3. *What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur* **Change the CPOE order for Placement of Indwelling Catheters to include justification of Placement** 4. *How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system* **Review at IDT meetings. Outliers will be tracked and trended, then reported quarterly to Quality Council, Medical Executive Committee and Governing Board.**	

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F 315	Continued From page 32 as having urinary retention, neurogenic bladder, Stage III or VI pressure ulcers, or cancers. During an interview with RN 1 on June 20, 2015 at 9:35 a.m., she stated the Foley catheter was not medically indicated for Resident 7. During an interview with RN 2 on June 20, 2015 at 3:30 p.m., she stated the resident was assessed as having unstageable ulcer on the sacral area. A review of the urine specimen for urinalysis dated April 11, 2015 indicated the resident's urine had many bacteria. The urine specimen for culture dated April 14, 2015 indicated the resident's urine had more than 100,000 Proteus mirabilis (a Gram-negative facultative anaerobic, rod-shaped bacterium) CFU/ml (colony-forming unit per milliliter) (a measure of viable bacterial or fungal cells). According to the facility's policy and procedure dated March 2012, titled, "Urinary Tract Infection" " 3.0 Objectives 3.2 Criteria for urinary catherization include: 3.2.1 To relieve urinary tract obstruction 3.2.2 To permit bladder drainage in patients with neurogenic bladder dysfunction or retention 3.2.6 To maintain quality of life for terminally ill patients." 3. During an initial tour, on June 19, 2015, at 8:40	F 315	1. *How corrective action() will be accomplished for those residents found to have been affected by the deficient practice* **Change the CPOE order for Placement of Indwelling Catheters to include justification of Placement** 2. *How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken* **Residents will be identified through medical record reviews at IDT meetings.** 3. *What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur* **Change the CPOE order for Placement of Indwelling Catheters to include justification of Placement** 4. *How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system* **Review at IDT meetings. Outliers will be tracked and trended, then reported quarterly to Quality Council, Medical Executive Committee and Governing Board.**	

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F 315	Continued From page 33 a.m., Licensed Vocational Nurse (LVN) 2 stated Resident 3 was on strict intake and output and had an indwelling catheter. A review of the Admission Face Sheet indicated Resident 3 was admitted to the facility on March 27, 2015. A physician's order dated March 27, 2015, indicated strict intake and output. The laboratory culture dated May 15, 2015, was positive for bacteria and urine was cloudy. During an interview on June 20, 2015 at 11:40 a.m., RN 1 stated the initial order for Resident 3's indwelling catheter (a tube which is inserted into the bladder to drain urine from the bladder into a bag) was on March 27, 2015 for strict intake and output. RN 1 reviewed the laboratory results and stated Resident 3 was positive for bacteria in the urine and was cloudy. RN 1 further stated there was no indication why Resident 3 continued to have the indwelling catheter (Resident 3 had the indwelling catheter for 84 days).	F 315		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371	1. *How corrective action() will be accomplished for those residents found to have been affected by the deficient practice* **On the day of audit, once parts per million (PPM) was identified not at the correct PPM; the buckets were changed out immediately. In-service/re-education was provided to associates regarding proper PPM for sanitizer, when it should be checked, and by whom.** 2. *How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken* **Adherence to the policy and procedure related to sanitizer bucket will be monitored as part of Quality Control Program. Outliers will be tracked and trended, then reported quarterly to Quality Council, Medical Executive Committee and Governing Board.** 3. *What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur* **Adherence to the policy and procedure related to sanitizer bucket will be monitored as part of Quality Control Program. Outliers will be tracked and trended, then reported quarterly to Quality Council, Medical Executive Committee and Governing Board.**	

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F 371	Continued From page 34 This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to store and serve food under sanitary conditions by failing to ensure the presence of sanitizer in 2 sanitizer buckets, missing a light shield, and having ice build-up in a freezer. These deficiencies had the potential for contamination and adulteration of food. Findings: 1. On 6/19/15 at 9:34 a.m., there were two sanitizer buckets at the cafeteria service line. Each bucket contained liquid and a towel. The Dietician/Director of Food & Nutrition tested the liquid in the bucket by dipping orange color Hydrion Papers QT-40 into the liquid, the papers remained orange. During an interview, at the same time as the observation, the Dietician/Director of Food & Nutrition stated there should have been a 200 to 300 ppm sanitizer concentration in the sanitizer buckets, that the papers should have turned from orange to green in the presence of 200 to 300 ppm sanitizer concentration, and that he did not know why there was not a 200 to 300 ppm sanitizer concentration in the sanitizer bucket. 2. Between 9:34 a.m. and 10:30 a.m., the exterior walk in freezer was missing 1 of 2 light shields. During an interview, at the same time as the observation, the Dietician/Director of Food & Nutrition stated he was not aware of the missing light shield.	F 371	*4. How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system* **Adherence to the policy and procedure related to sanitizer bucket will be monitored as part of Quality Control Program. Outliers will be tracked and trended, then reported quarterly to Quality Council, Medical Executive Committee and Governing Board.** *1. How corrective action() will be accomplished for those residents found to have been affected by the deficient practice* **Light shield replace immediately upon discovery.** *2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken* **Potential deficiencies will be identified at EOC rounds.** *3. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur* **Regular and frequent monitoring during EOC rounds.**	

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555874	A. BUILDING _____ B. WING _____	06/20/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN CALIFORNIA HOSP AT CULVER CITY D/P SNF	3828 DELMAS TERRACE CULVER CITY, CA 90230

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F 371	Continued From page 35 3. Between 9:34 a.m. and 10:30 a.m., the exterior walk-in freezer had ice build-up at the ceiling, fan/blower, and floor. During an interview, at the same time as the observation, the Dietician/Director of Food & Nutrition stated that at one point water got into the freezer and expanded parts of the freezer and that could be why there is ice build-up.	F 371	*4. How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system* **Will monitor as part of our safety rounds and EOC rounds. Outliers will be tracked and trended, then reported quarterly to EOC, Quality Council, Medical Executive Committee and Governing Board.**	
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their	F 441	*1 How corrective action() will be accomplished for those residents found to have been affected by the deficient practice* **All cassettes with adhesive build up have been replaced. The new cassettes have label slots covered with clears. The patient labels with the backing will be inserted in the slots rather than affixed to the cassette. This process will prevent any use of adhesive.** *2 How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken* **Residents having the potential to be affected by the same deficient practice are identified when RN cleans the cassette before the next exchange. Cassettes with adhesive build up will be replaced. The new cassettes have label slots covered with clears. The patient labels with the backing will be inserted in the slots rather than affixed to the cassette.**	

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F 441	Continued From page 36 hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to implement its infection control policies and procedures. Two staff members were observed leaving the rooms with contact isolation residents with clostridium difficile (C. diff) (a bacterium that can cause symptoms ranging from diarrhea to life-threatening inflammation of the colon). The medication cassettes in the medication room were dirty with old adhesive markings of labels (old labels removed but the sticky part was not completely removed), brownish color dirt markings in/on the outside of the cassettes, and some names were faded. Resident 9, who was on isolation, had C-Diff. The registered nurse (RN) came out of the room without washing her hands with soap and water and used the key pad at the medication door and went in. Resident 3, who was on isolation, had C-Diff. The biomed technician went into the room with a cart and tool, to fix the television. Then as he was leaving the room used hand gel and he did not disinfect the equipment that he had brought into	F 441	*3 What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur* **Assessment has been made hospital wide. All old cassettes with adhesive buildup will be replaced with new cassettes. In addition, the cassettes are cleaned before the exchange take place daily.** *4 How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system* **The cleanliness of medication cassettes will be monitored as part of the monthly unit inspection conducted by a pharmacist. The result will be tracked and reported to the unit director and pharmacy director. Compliance reports will be submitted to Quality Council, Medical Executive Committee, and Governing Board.**	

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F 441	Continued From page 37 the room with proper disinfecting agents. This deficient practice had the potential to result in cross-contamination and spread of infection. Findings: During an initial tour, on June 19, 2015, at 8:35 a.m., Licensed Vocational Nurse (LVN) 2 stated that Resident 3 and 9 were on isolation precautions due to C-Diff. The following was observed: 1. Resident 9, was on isolation precautions for C-Diff. The RN was observed coming out of the room without washing her hands with soap and water. The RN 3 went to the keypad lock of the medication room, punch in the code, touched the door knob, and went into the medication room. The surveyor informed RN 3 that she did not wash her hands upon leaving Resident 9's room. RN 3 stated that she washed her hands in the medication room. 2. Resident 3, was on isolation precautions for C-Diff. The biomed technician went into the room with a cart and tool, to fix the television. Then as he was leaving the room, he used hand gel and he did not disinfect the equipment that he had brought into the room with proper disinfecting agents. The surveyor asked the biomed technician if he was informed to wash his hands with soap and water. He stated he was not informed he had to wash his hands with soap and water upon leaving the room. During an interview on, June 19, 2015, at 2:35 p.m., the Director of Laboratory and Patho stated	F 441	1 *How corrective action() will be accomplished for those residents found to have been affected by the deficient practice* **All cassettes with adhesive build up have been replaced. The new cassettes have label slots covered with clears. The patient labels with the backing will be inserted in the slots rather than affixed to the cassette. This process will prevent any use of adhesive.** 2 *How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken* **Residents having the potential to be affected by the same deficient practice are identified when RN cleans the cassette before the next exchange. Cassettes with adhesive build up will be replaced. The new cassettes have label slots covered with clears. The patient labels with the backing will be inserted in the slots rather than affixed to the cassette.** 3 *What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur* **Assessment has been made hospital wide. All old cassettes with adhesive buildup will be replaced with new cassettes. In addition, the cassettes are cleaned before the exchange take place daily.** 4 *How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system* **The cleanliness of medication cassettes will be monitored as part of the monthly unit inspection conducted by a pharmacist. The result will be tracked and reported to the unit director and pharmacy director. Compliance reports will be submitted to Quality Council, Medical Executive Committee, and Governing Board.**	

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F 441	Continued From page 38 Resident 3 and 9 were both positive for C-Diff. 3. During a medication room inspection, on June 20, 2015, at 9:15 a.m., with three (3) licensed nurses present they verified that the cassettes were dirty and had adhesive build up of bio-burden. The licensed nurses stated that everyday pharmacy comes to deliver new medications, the labels on the cassettes were removed by pharmacy when the resident was discharged, and replaced with a new label. The licensed nurses further stated that it was pharmacy's responsibility to clean the cassettes. According to the Centers for Disease Control and Prevention (CDC) website indicated C-Diff is shed in the feces. Any surface that becomes contaminated with feces may serve as a reservoir for C-Diff spores-Diff spores are transferred to patients mainly via hands of healthcare personnel who have touched a contaminated surface or item. The CDC recommends to prevent transmission in hospital and other healthcare settings "perform hand hygiene" use of soap and water is more effective than alcohol based hand rubs. According to the facility's policy titled, "Isolation Guidelines" dated May 2015 indicated the purpose was to provide a safe environment by preventing the spread/transmission of infectious diseases throughout the facility. 4.2.4 Contact Precautions included C-Diff the transmission can be hand or skin to skin contact, or indirect contact (touching) with environmental surfaces or patient care items in the patient's environment.	F 441	*1 How corrective action() will be accomplished for those residents found to have been affected by the deficient practice* **All cassettes with adhesive build up have been replaced. The new cassettes have label slots covered with clears. The patient labels with the backing will be inserted in the slots rather than affixed to the cassette. This process will prevent any use of adhesive.** *2 How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken* **Residents having the potential to be affected by the same deficient practice are identified when RN cleans the cassette before the next exchange. Cassettes with adhesive build up will be replaced. The new cassettes have label slots covered with clears. The patient labels with the backing will be inserted in the slots rather than affixed to the** *3 What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur* **Assessment has been made hospital wide. All old cassettes with adhesive buildup will be replaced with new cassettes. In addition, the cassettes are cleaned before the exchange take place daily.** *4 How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system* **The cleanliness of medication cassettes will be monitored as part of the monthly unit inspection conducted by a pharmacist. The result will be tracked and reported to the unit director and pharmacy director. Compliance reports will be submitted to Quality Council, Medical Executive Committee, and Governing Board.**	

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F 441	Continued From page 39 According to the facility's policy titled, "Dispensing of Medication" dated October 2010 indicated individual bins shall be labeled with the patient's name and/or room number. All bins will be checked by the pharmacist. Cassettes shall be exchanged daily. Furthermore, the policy did not mention who would be responsible to ensure the cassettes were cleaned daily and on a needed basis.	F 441		
F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to provide a safe, functional, and sanitary environment by not covering dumpsters, having stagnated water, closet doors not working, having peeling paint, broken cover plate, and not notifying the Office of Statewide Health Planning and Developing (OSHPD) of new equipment installation. OSHPD monitors the construction, renovation, and seismic safety of hospitals, and skilled nursing facilities. The OSPHD reviews and inspects health facility construction projects, and enforces building standards, per the California Building Standards Code, as they relate to health facilities construction. These deficiencies had the potential for vermin	F 465	1. *How corrective action() will be accomplished for those residents found to have been affected by the deficient practice* **Lid closed and replaced immediately upon discovery. Purchase new dumpster.** 2. *How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken* **Potential deficiencies will be identified at daily rounds.** 3. *What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur* **Regular and frequent monitoring during EOC rounds.** 4. *How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system* **Will monitor as part of our safety rounds and EOC rounds. Outliers will be tracked and trended, then reported quarterly to EOC, Quality Council, Medical Executive Committee and Governing Board.**	

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F 465	Continued From page 40 breeding and harborage, un-usable closets, non-easily cleanable surface, electrical hazard, and un-safe equipment installation. Findings: 1. On 6/19/15 at 10:05 a.m., 2 of 3 dumpsters located behind the dietary department had 3 of 4 lids fully open. There was also an accumulation of trash, debris, and stagnated yellow/white water at the trash bin area. 2. Between 3:15 p.m. and 3:50 p.m., 3 resident rooms (372, 373, 375), had closets with sliding doors that were impeded from opening and closing freely. During an interview, at the same time as the observation, the Facilities Director stated that the closets' sliding doors were off their tracks, impeding the doors from opening and closing freely. 3. There was peeling paint at the wall behind bed A of room 375. 4. There was a broken electrical receptacle cover at a wall in the Hydrotherapy room. 5. At 10 a.m., there were 3 new 3 door reach in coolers installed at the kitchen without notifying the Office of Statewide Health Planning and Developing (OSHPD). During an interview, at the same time as the observation, the Dietician/Director of Food & Nutrition stated the coolers were installed last August (2014).	F 465	*Resident rooms closet doors...* • No residents were affected by the deficient practice. • The facility performs environmental rounds regularly and identifies deficiencies and reports the deficiencies to the Facilities Operations Center for repair. Environmental/Safety deficiencies are top priority and repairs are scheduled first. • Door hardware will be adjusted to ensure this will not reoccur. • Environmental rounds are performed regularly and reported to the Environment of Care committee, Quality Council Committee and the Hospital Board. *Peeling paint behind bed...* • No residents were affected by the deficient practice. • The facility performs environmental rounds regularly and identifies deficiencies and reports the deficiencies to the Facilities Operations Center for repair. Environmental/Safety deficiencies are top priority and repairs are scheduled first. • Facility damage happens and there is no way to ensure it does not reoccur. Additionally Sub-Acute staff has been informed to call Facilities and request repairs when damage occurs. • Environmental rounds are performed regularly and reported to the Environment of Care committee, Quality Council Committee and the Hospital Board. • Repairs completed by 7/23/15	

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F 465	Continued From page 41 During an interview, at 1:50 p.m., the VP Corporate Facilities Operations stated that he was not aware that there were new coolers in the kitchen, and that the facility probably did not have any OSHPD paperwork on their installation. Review of the 2013 OSHPD FREER manual, indicated that the installation of new kitchen equipment required a field visit.	F 465	*Broken electrical receptacle cover broken...* • No residents were affected by the deficient practice. • The facility performs environmental rounds regularly and identifies deficiencies and reports the deficiencies to the Facilities Operations Center for repair. Environmental/Safety deficiencies are top priority and repairs are scheduled first. • Facility damage happens and there is no way to ensure it does not reoccur. Sub-Acute staff has been informed to call Facilities and request repairs when damage occurs. • Environmental rounds are performed regularly and reported to the Environment of Care committee, Quality Council Committee and the Hospital Board. *Reach-in coolers install without OSHPD approval...* • No residents were affected by the deficient practice. • The facility performs environmental rounds regularly and identifies deficiencies and reports the deficiencies to the Facilities Operations Center for repair. • The Facilities Operations Department will contact the OSHPD ACO prior to installation of equipment based off of the OSHPD FREER manual. • Environmental rounds are performed regularly and reported to the Environment of Care committee, Quality Council Committee and the Hospital Board. • This is an OSHPD item and plans for installation require a structural engineer design an approved anchorage system for submittal to OSHPD. An evaluation of electrical loads will be performed to ensure electrical loads are in compliance with OSHPD/NEC requirements; if necessary an electrical engineer will also be engaged to provide plans to OSHPD. Estimated completion date is 12/31/15.	

COUNTY OF LOS ANGELES
HEALTH FACILITIES DIVISION
3400 Aerojet Avenue, Suite 323
El Monte, CA 91731

FACSIMILE TRANSMISSION

ADDRESSEE:	ORIGINATOR:
NAME: Pamela Loo, RN Director of Quality **Attention:**	FROM: Rosario Grospe, RN, Senior HFEN Assistant Supervisor, Acute and Ancillary Unit
ORGANIZATION: Southern California Hosp at Culver City SNF DP	**Phone:** (626) 312-1129
CITY, STATE, & ZIP Culver City	FAX: (626) 927-9293
Telephone 310-836-7000 ext 1046	DATE 714/15
FAX #: 310-840-5426	PAGES INCLUDING COVER PAGE = 11

NOTES TO ADDRESSEE:

Attached is the ameded CMS 2567, Statement of Deficiencies and Plan of Correction for the Recertification Survey (LSC) completed 6/22/15, The hard copy will be mailed today. Please sign the Signature Requirement Notice and fax it back to our office as soon as possible.

Please submit the plan of correction on or before 7/24/15.

If you have any questions, please don't hesitate to call us.

Thank you, Rosario Grospe, Senior HFEN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 000	INITIAL COMMENTS The following reflects the finding of the Department of Public Health during a complaint investigation. Amended 10/22/14 Complaint Intake Number: CA00380633 Representing the Department of Public Health: Surveyor 16281, REHS, HFEI Surveyor 09452, RN, Sr. HFEN One Deficiency was issued for intake CA00380633.	F 000		
F 328 SSS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections: Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure that 1 of 3 sample residents (Resident 1) received proper treatment and care in intravenous antibiotics therapy. Medical record review revealed there was no	F 328		

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

M. [signature] | ADMINISTRATOR | 10/30/14

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

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F 328	Continued From page 1 documented evidence that the intravenous (IV) line was removed from Resident 1's arm at or before the resident was discharged from the facility. This deficient practice had the potential to result in bleeding and/or infection at the IV line site. Findings: On January 2, 2014 at 2:00 p.m., an investigation was conducted at the facility regarding allegation that the resident was discharged and left the hospital's transitional care unit with an IV still in the resident's arm. On January 3, 2014, between 8:00 a.m. and 1:30 p.m., a review of Resident 1's medical record revealed that there was no documented evidence the IV line was removed from the resident's arm before discharge from the facility. A review of a face/cover sheet disclosed Resident 1 was admitted to the facility on November 27, 2013, with diagnoses which included ankle wound and cellulitis. Cellulitis is a spreading bacterial infection just below the skin surface. A review of IV Site and Fluid Report dated November 28, 2013 at 8:40 p.m., indicated an IV Line was started on the resident's right arm. The IV site was discontinued on December 1, 2013 at 8:30 a.m. The Daily Focus Assessment Report dated December 3, 2013 at 6:15 p.m., indicated a PICC (peripherheral inserted central catheter-a from of intravenous access that can be used prolonged period of time), single lumen, was inserted on the resident's right upper arm and secured with "statlock."	F 328	Action: Education will be provided to TCU nursing staff on the following: a. The Policy and Procedure on discharging of patients to include the need for a nursing assessment to be performed the day of discharge. b. The procedure on the completion of the Patient Discharge Instructions form. Implementation Education will commence immediately with completion of all staff by November 21, 2014. Monitoring: 1. The provision of Education will be monitored by review of sign-in sheets to ensure 100% compliance of all staff, excluding those on MLOA. 2. The compliance of nursing assessment and the completion of discharge instructions will be monitored by a sample of 30 discharge charts or 100% if less than 30 per month; charts will be retrospectively reviewed for compliance with nursing assessment performed on day of discharge and completion of the Patient Discharge Instructions form. Monitoring will continue until 3 concurrent months of 100% compliance is achieved. Findings will be reported to the Quality Council on a quarterly basis. Responsible Person: ACNO and Director of Rehab Services	11/21//2014

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F 328	Continued From page 2 A review of the Medication Administration Record, and the Medication Administration History Report indicated the resident was administered Nafcillin antibiotics 1 gram and infused over 30 minutes every four hours by IV route with a start date of November 27, 2013 and a stop date of December 4, 2013 with a new stop date of December 7, 2013, and that the last dose of Nafcillin by route was administered on December 6, 2013. A review of a Physician Order dated December 6, 2013, indicated to discontinue Nafcillin after the last dose on the same day as the order. There was no order found for the discontinuation and removal of the IV line. A review of the Discharge Assessment/Summary report indicated the patient was discharged on December 9, 2013. The report had no indication if the IV line in the resident's are had been removed. A review of the Patient Discharge Instructions did not have a Discharge Summary and that there was no indication if the IV line had been removed. The Patient Discharge Instructions also did not have dated signatures of the caregiver, physician, patient/significant other and discharge coordinator at the signature/date area provided. A review of the medical record by the director of TCU (registered nurse) and the Director of Quality/Risk Management (registered nurse) revealed there was no documented evidence the IV line was removed from the resident's arm before being discharged from the facility.	F 328	Action: Education will be provided to TCU nursing staff on the following: A. Policy and Procedure on Intravenous Therapy and Peripherally Inserted Central Catheter Care and Maintenance. To include assurance that any appliances or tubes are removed per doctor's order. Implementation: Education will commence immediately with completion of all staff by November 21, 2014 Monitoring: 1. The provision of Education will be monitored by review of sign-in sheets to ensure 100% compliance of all staff, excluding those on MLOA. 2. Compliance will be monitored by a sample of 30 discharge charts or 100% if less than 30 per month; charts will be retrospectively reviewed for compliance with policy and procedure on Peripherally Inserted Central Catheter Care and Maintenance. Monitoring will continue until 3 concurrent months of 100% compliance is achieved. Findings will be reported to the Quality Council on a quarterly basis. Responsible Person(s): ACNO and Director of Rehab Services.	11/21/2014

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F 328	Continued From page 3 During an interview at the same time as the Record review, the Director of Quality/Risk Management stated that if there was a Discontinuation of the IV line and removal of the IV line, there should have been documentation in the medical record. The Director of Quality/Risk Management stated there was no documentation of a discontinuation or removal of the IV line in the record. Although there was a physician order for the discontinuation of the medication (Nafcillin), the Director of Quality/Risk Management stated she could not find a physician order for the discontinuation of the IV line and there should have been a physician order for the discontinuation of the IV line. The Director of Quality/Risk Management stated there was no reason why the IV line should not have been discontinued after the discontinuation of the antibiotic (Nafcillin) and that she could not find anything in the record of why the IV line should not have been removed. A review of the facility policy titled, "Intravenous Therapy-Initiation and Management of Peripheral Intravenous Lines" last reviewed November 20, 2012 indicated that a physician order was required for the discontinuing of IV therapy.	F 328		

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F 000	INITIAL COMMENTS The following reflects the findings of the Department of Public Health during a recertification survey. Representing the Department of Public Health: Surveyor 14042 RN, HFEN Surveyor 25487, RN, HFEN Surveyor 14041, REHS, HFE I Total Population: 11 Total Sample Size: 8	F 000		
F 253 SS=D	Highest Scope and Severity: E 483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain the premises in a sanitary manner at all times. This deficient practice did not promote a sanitary and comfortable interior for the residents and had the potential to result in the spread of disease-causing organisms. Findings: On March 7 and 8, 2014 at 8:55 a.m., an inspection was conducted on the premises and the following were observed:	F 253		

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

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F 253	Continued From page 1 a. missing vertical blind panels in residents' sleeping rooms, Room 371 (10 blind panels), 372 (seven blind panels), 373 (six blind panels), 374 (one blind panel), and Room 370 (eight blind panels); b. in the nurse station located on the 3rd floor, the restroom linoleum floor had a section replaced and glued to the existing linoleum with open blacken seams and a small trash receptacle was filled with fecal and urine soiled toilet paper that were clearly visible; c. the toilet base sealant was cracked with gaps and blacken in the resident room, Room 376; and d. two stained and blacken ceiling tiles located in the corridor and near resident room 374. On March 7, 2014, an inspection was conducted on the 3-floor kitchenette and a small double sink base cabinet storage compartment which was not locked was observed. The area was inspected and the following were also observed: a. mold throughout the base cabinet storage area; b. a badly rusted and dirty water filter with no installation date; c. one (1) of two (2) sink drain sealant was totally disintegrated and the water filter valve was leaking water; and d. the automatic icemaker with the water dispenser spout was encased with layers of unsanitary mineral deposit.	F 253		

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F 253	Continued From page 2 An interview was held with the Building Engineer and he stated he does not know when the water filter was installed and the lower cabinet is usually locked. On March 8, 2014 at 10:23 a.m., an interview was held with the Environmental Services and the staff in charge stated the staff could clean the base cabinet storage area because it was usually locked. The evaluator conducted an inspection of the dietary department and observed a two compartment sink used for food preparation. The evaluator inspected the waste water pipes and observed no air gap available at the time of survey. In case of sub-surface sewer system back-up, the sewage can back up into the sink and contaminate the food product held in the sink. On March 8, 20014, at the time of the exit, an interview was held with the staff in charge and he stated he will inform the building supervisor or housekeeping regarding the concerns as soon as possible.	F 253		
F 365 SS=D	483.35(d)(3) FOOD IN FORM TO MEET INDIVIDUAL NEEDS Each resident receives and the facility provides food prepared in a form designed to meet individual needs. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure that food was	F 365	**Dietary Reponse:** Re-trained Dietician Staff on proper assessment of dentition of patients and recommendation of altered texture diets, as well as record documentation. Method for Follow-Up: Audits and reporting on non-conformity to Quality Council. **Nursing Response:** • Review of oral and dietary assessment indicates that 100% of the residents who have dentures wear it daily in the duration of the admission in the TCU. • Review of the weight record of 100% of the residents revealed no significant weight loss of 3-5% in the duration of admission.	4/23/14 4/25/14 4/24/14

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F 365	Continued From page 3 prepared in a form designed to meet individual needs for one of eight sampled residents (4). Resident 4 was missing his dentures and was unable to bite/chew his food. Dietary and nursing services failed to identify/assess the resident's need for a mechanically altered diet. This deficient practice had the potential to result in weight loss and further medical complications for the resident. Findings: On March 7, 2014 at 6:30 p.m., during an observation, Resident 4 was awake and alert while lying in bed. The resident's dinner tray was still on his overbed table. The dinner tray contained a roast beef sandwich on a roll. One half of the sandwich appeared as if the resident had attempted to bite it, but had only broken the roll and did not go through the meat. During a concurrent interview, Resident 4 stated he did not have much of an appetite. The resident further stated he lost his dentures at the acute facility he was recently transferred from; therefore, he could not eat the sandwich. A review of the clinical record indicated Resident 4 was admitted to the facility on March 5, 2014 with diagnoses that included lung cancer and diabetes. The MDS (Minimum Data Set, a standardized assessment and care planning tool) was still in the process of being completed. A review of the physician's admission orders dated March 6, 2014 included a diet order for 1800 calories ADA (diet plan devised by the American Diabetes Association) and Boost (a nutritional supplement drink).	F 365	• The Director of Nursing re-educated the nursing staff on recognizing, evaluating, and addressing the needs of every resident including but not limited to, the resident at risk or already experiencing impaired nutrition. • The Dietician was re-educated on ensuring that resident's therapeutic diet takes into account the residents clinical condition, and preferences when there is nutritional indication. • The Director of Nursing re-educated the interdisciplinary committee (IDT) members about including the oral assessment/status and ensure that resident has the appropriate/therapeutic diet order in the IDT weekly meeting. • The Director of Nursing or Designee to monitor 100% compliance through the IDT notes. Any issues of non-compliance will be addressed to the appropriate staff who will be required to submit a plan of action	4/28/14 4/28/14 4/28/14 4/28/14 & Ongoing

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F 365	Continued From page 4	F 365		

According to the Daily Assessment Inquiry dated March 7, 2014, an initial dietary/nutritional assessment was conducted and the resident was assessed as having a diagnosis of lung cancer, a weight of 47.27 kg (kilograms), an ideal body weight of 70 kg, and being underweight. The initial assessment indicated the resident had a diet order 1800 calories ADA, Boost with meals and his nutritional intake was poor (less than 50%). The resident's nutritional related history indicated he had poor intake, no appetite, no food preferences at this time, only drinks Boost, and he was not appropriate for diet education due to poor po (mouth) intake. One of the nutritional interventions indicated that if the resident's intake did not meet 50% or greater, he may need more aggressive nutrition support. There was no documented evidence the assessment identified the resident's missing dentures.

On March 9, 2014 at 10:30 a.m., during an interview with the Registered Dietitian (RD), she stated information regarding missing dentures of a resident was usually provided by the resident during interviews with staff.

A review of the Intake/Output Reports indicated the resident's meal intake percentage on March 8 was 35% for lunch and 40% for dinner. On March 9, the resident ate 30% of his breakfast.

On March 9, 2014 at 11 p.m., during an interview, the Charge Nurse stated there were no other intake records available for the resident.

According to the facility's policy and procedure titled "Dietician Responsibilities," revised November 12, 2012, the primary responsibility of

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F 365	Continued From page 5 the dietician is the nutritional care of the patient/resident to include assessment, planning, application and monitoring of each patient's/resident's nutritional and hydration status. There was no documented evidence the RD assessed Resident 4's need for a mechanically altered diet due to his missing dentures to make the food easier to chew and safely swallow.	F 365		
F 371 SS=D	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure that food are prepared and held under optimal and safe condition at all times. This deficient practice had the potential to result in foodborne illnesses and outbreaks. Findings: On March 7, 2014 at 6:02 p.m., an inspection of the dietary department was conducted and 2 (two) Mobile Refrigerated Air Screen units were	F 371	Procedural changes were put into effect requiring the doors to the refrigerators to remain closed. Submitted a request for additional refrigeration for the department to replace inoperable refrigerators. Method for Follow-Up: Monitor at each meal period refrigerated cold food temperatures. Report non-conformity to Quality Council.	

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F 371	Continued From page 6 observed. The staff were setting up the residents' food trays for dinner and the two equipment doors were in an open locked position. A concurrent interview was held with the dietary supervisor and she stated the units were designed to remain open for an maximum of 90 minutes under acceptable refrigerator temperature. When asked how long were the refrigerators' doors held open and where was the time log, the dietary supervisor looked around the kitchen and could not produce any time log documentation at the time of the survey. Upon inspection of the units' thermometers, their temperatures were both 42 degrees Fahrenheit. On March 8, 2014 at 1:35 p.m., an additional inspection of the dietary department was conducted and the two refrigerator unit doors were again observed held open during the end of the tray line operation. Upon inspection of the refrigerators' thermometers, the temperature was observed as 66 degrees Fahrenheit. The digital temperature display flashed "open" and there was no alarm that made a sound or alerted the staff at the time of observation. A concurrent interview was held with the dietary supervisor and she stated she would check when the two units' doors were first locked in an open position. The log indicated the tray line started at 11:30 and the dietary supervisor stated the doors should have been closed at 1:00 p.m. The dietary supervisor stated the staff should have monitored the time and the temperature of the refrigerator units at all times. According to the Mobile Refrigerated Air Screen operating literature, undated, "when operating	F 371		

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F 371	Continued From page 7 with door open, the display will show 'OPEn' and an internal count down timer will start. This unit will allow open door operation for a maximum of 90 minutes. If the door is open longer than the allowed 90 minutes, an open door alarm will be activated. Display will flash 'OPEn' and beep three times every ten seconds". The refrigerator units were observed to hold small plates of cakes, Boost Plus, glucose control milk, juices, and small containers of 3-bean salads. The refrigerator units open door log, temperature, and alarm were not being monitored as often as necessary to maintain safe food storage temperature.	F 371		
F 425 SS=E	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.	F 425	**Nursing Response:** • The Director of Nursing verified with the Director of Environment Services and the Director of Pharmacy that appropriate biohazard containers are available and emptied daily and as needed. • The Director of Nursing or designee will conduct Department Audit Round that includes Medication Room Inspection to ensure appropriate biohazard container is available and emptied as appropriate: • The Director of Nursing or designee to monitor 100% compliance to Medication Room inspection from the Department Audit Report Form until July 30, 2014. Any issue of non-compliance will be reported to the appropriate staff who will be required to submit an action plan.	4/25/14 4/29/14 & Ongoing Ongoing

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F 425	Continued From page 8 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to properly dispose the leftover or unused medications in accordance with the facility's policy and procedure for two randomly selected residents (9, 10). The medication nurse divided into half by using a pill-splitter the Prednisone tablet (a hormone to treat severe illness) for Resident 9 and the Rivaroxaban tablet (a medication used to prevent blood clots from forming after surgery) for Resident 10. The medication nurse improperly disposed the unused half of the medications in the sink and residents' trash cans. This deficient practice had the potential to result in unauthorized access of prescription medications that could be lethal. Findings: 1. On March 8, 2014 at 9:12 a.m., during a medication pass observation, Registered Nurse (RN) 1 prepared routine medications to be administered to Resident 9. RN 1 opened the pill-splitter and found an unidentifiable pill which she discarded in the medication room sink. She then obtained a tablet of five (5) milligrams of Prednisone (a hormone to treat severe illnesses), divided the tablet into half using the pill-splitter, and then discarded half of the tablet, which was equivalent to 2.5 milligrams, in the resident's trash can. At 10 a.m., during an interview, RN 1 stated she was not familiar with the facility's policy on documenting and properly discarding the leftover	F 425	• The Director of Nursing re-educated the licensed nurses about the policy on Return, Handling, and Disposal of Medication Waste. • Director of Nursing or designee will conduct random observation to licensed nurses on correct medication waste to ensure 100%. The findings of the observation will be used to educate the staff and identify issues for competency and educational needs of all licensed nurses. Progressive issues of non-compliance will be addressed by progressive disciplinary action.	4/28/14 4/29/14 & Ongoing

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F 425	Continued From page 9 or unused medications. A review of Resident 9's clinical record indicated the resident was admitted to the facility on January 20, 2014 with diagnoses which included polyneuropathy (damage to multiple nerves). A review of the physician's order dated March 7, 2014 indicated to administer Prednisone tablet 7.5 mg (milligrams) twice a day with meals. A review of the facility's policy and procedure titled "Return, Handling, and Disposal of Medication Waste," dated July 31, 2010, indicated the purpose of the policy is to ensure safe disposition of the medications and any opened unit dose or loose items shall be placed in the regular pharmaceutical waste containers. 2. On March 8, 2014 at 9:35 a.m., during a medication pass observation, Registered Nurse (RN) 1 prepared routine medications to be administered to Resident 10 which included two tablets of 10 mg (milligrams) of Rivaroxaban. RN 1 divided one of the two tablets into half by using the pill-splitter in order to administer 15 milligrams of the medication to the resident. RN 1 then discarded half of the tablet, which was equivalent to five (5) milligrams, in the resident's trash can. At 10 a.m., during an interview, RN 1 stated she was not familiar with the facility's policy on documenting and properly discarding the leftover or unused medications in the regular pharmaceutical waste containers. A review of Resident 10's clinical record indicated the resident was admitted to the facility on March	F 425		

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	555874	A. BUILDING _____ B. WING _____	03/09/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN CALIFORNIA HOSP AT CULVER CITY D/P SNF	3828 DELMAS TERRACE CULVER CITY, CA 90230

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F 425	Continued From page 10 6, 2014 with diagnoses which included atrial fibrillation (abnormal heat beat) and deep vein thrombosis (DVT, a blood clot that forms in a vein deep in the body and when blood thickens it clumps together) requiring thromboprophylaxis (the prevention of blood clotting) medication. A review of the physician's order, dated March 8, 2014, indicated to administer Rivaroxaban 15 mg once a day as a thromboprophylaxis. A review of the facility's policy and procedure titled "Return, Handling, and Disposal of Medication Waste," dated July 31, 2010, indicated the purpose of the policy is to ensure safe disposition of the medications and any opened unit dose or loose items shall be placed in the regular pharmaceutical waste containers.	F 425		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection	F 441	**Nursing Response:** • Review of records of 100% of current residents revealed 0% nosocomial infection. • Review of the infection rate for the 1st quarter of 2014 revealed 0% nosocomial infection. • The Director of Nursing re-educated all staff about the policy on infection control through: Hand Hygiene Contact Precaution Use of Personal Protective Equipment	4/25/14 4/25/14 4/28/14

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F 441	Continued From page 11 (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to implement infection control practices for two of 10 sampled residents (1, 5). For Resident 1, the licenced nurse did not educate the family member to wash hands and wear personal protective equipment (PPE, protective items or garments worn to protect the body or clothing from hazards that can cause injury) before entering the contact precaution room, and to remove PPE and wash hands again before leaving the contact precaution room. For Resident 5, the licensed nurse did not wash hands after emptying a urinal filled with urine and before touching the resident's environment, such	F 441	• The Director of Nursing or designee will do 10 random observations to staff every month on the use of appropriate personal protective equipment to ensure 100% compliance. Any issues of non-compliance will be addressed to the individual staff and will be re-educated or given progressive disciplinary action • The Director of Nursing re-educated all licensed nurses about providing educational handout to patient and or family members and visitors on appropriate isolation precaution. • The Director of Nursing or designee to conduct chart review for the copy of the patient education handout until July 30, 2014 to ensure 100% compliance. Any issues of non-compliance will be addressed to the individual staff and will be re-educated or given progressive disciplinary action.	4/29/14 & Ongoing 4/28/14 4/28/14 & Ongoing

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F 441	Continued From page 12 as bedsheets and table. This failure increased the potential for spreading infections. Findings: 1. On March 7, 2014 at 5:15 p.m., during the initial tour of the facility in the presence of RN 2, a sign was observed posted outside Resident 1's room that indicated contact plus isolation (measures that are intended to prevent transmission of infectious agents which are spread by direct or indirect contact with the resident or resident's environment) and for visitors to see the nurse before entering the room. A family member was in the resident's room and was not wearing any PPE while touching the resident's bedding and table with his bare hands. During the course of the observation, RN 2 saw the family member leave the room, but she did not stop him to give an instruction to wash his hands and wear PPE the next time he visited. The family member went to the activity room after leaving the resident's room and sat on a chair to make phone calls. The family member was still not instructed to wash his hands. At 6 p.m., during an interview, the family member stated he knew the resident had an infection in her stomach but he did not know he had to wash his hands before entering the resident's room, wear PPE while inside the room touching the resident and/or the resident's environment, remove his PPE before leaving the room, and wash his hands again before he touched anything else.	F 441	**Infection Control Response:** Surveillance of isolated patients is conducted daily and review of laboratory results are done daily. Positive laboratory results of critical organisms are reported by phone call to Director of Infection Control and to patient's nurse. In-services are scheduled for each unit to re-educate staff on appropriate standard and isolation precautions and appropriate PPE use. Education will include topics such as C.difficile and methods of transmission. Will retrain staff on hand hygiene techniques and launch a hand hygiene campaign to increase compliance. Staff will be reminded to inform and educate visitors on PPE use and hand hygiene. Appropriate reporting of incidences will be reviewed and employees observed breaching policies will be counseled and incident reports recorded. All clinical staff and EVS staff will be retrained on the appropriate handling, storage, processing, and transport of all linens. Method for Follow-Up: Infection control rounds and review of incident reports. Non-conformity will be reported to the Infection Control Committee and Quality Council.	4/25/14

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F 441	Continued From page 13 A review of the clinical record indicated Resident 1 was admitted to the facility on March 6, 2014 with diagnoses which included urosepsis (urinary infection that travels to the blood stream), Clostridium difficile infection (C. diff, an infection of the colon which may be transferred to residents through the hands of health care personnel who had contact with contaminated residents, their feces or environment), and anemia (a condition in which the body does not have enough healthy red blood cells to provide oxygen to body tissues). The MDS assessment was still in the process of being completed. According to the facility's policy and procedure titled "Isolation Guidelines," dated November 2012, transmission-based precaution, such as contact plus precautions, was to be used in conjunction with Standard Precautions which are measures to be used in all patients regardless of diagnosis when there is potential for contact with any body fluid, non-intact skin or mucous membranes. Contact plus precaution was to be used for patients known or suspected to have a disease spread by direct contact, such as Clostridium difficile. A review of the Contact Plus Isolation signage indicated to clean hands and then wear a gown and gloves when entering (the room), discard gown and gloves and then wash hands when exiting (the room), and wash hands with soap and water only. 2. On March 8, 2014 at 9:12 a.m., during the medication pass observation, Registered Nurse (RN) 1 entered Resident 5's room in order to	F 441		

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F 441	Continued From page 14	F 441		

administer the routine medications. After RN 1 administered all the oral (through the mouth) medications, she put on a pair of gloves, emptied the resident's urinal in the toilet, and without removing her gloves to wash her hands, she moved the overbed table to the side and uncovered the resident by pulling the linen sheet in order to administer Vancomycin (an antibiotic) enema (a procedure of introducing liquids into the rectum and colon via the anus through a tube).

During a concurrent interview, RN 1 stated she should have washed her hands after she emptied the urinal and before she touched the resident's environment.

A review of Resident 5's clinical record indicated the resident was admitted to the facility on February 28, 2014 with diagnoses which included methicillin-resistant staphylococcus aureus (MRSA, a bacteria responsible for several difficult-to-treat infections in humans) of the nares (nose) and Clostridium difficile (C. diff). The MDS assessment was still in the process of being completed.

A review of the physician's order, dated March 4, 2014, indicated the antibiotic was changed to Vancomycin enema 500 milligrams (mg) twice a day for seven (7) days and to place the resident on contact isolation for C. diff in the stool.

According to the facility's policy and procedure titled "Isolation Guidelines," dated November 2012, transmission-based precaution, such as contact plus precautions, was to be used in conjunction with Standard Precautions which are measures to be used in all patients regardless of diagnosis when there is potential for contact with

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F 441	Continued From page 15 any body fluid, non-intact skin or mucous membranes. Contact plus precaution was to be used for patients known or suspected to have a disease spread by direct contact, such as Clostridium difficile. Wearing gloves does not replace the need hand antisepsis and hand hygiene must be practiced after removing the gloves.	F 441		

RESPONSE TO DEFICIENCIES
EXHIBIT P CMS Statements of Deficiency

Southern California Hospital at Hollywood

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	050135	A. BUILDING **01 – SOUTHERN CALIFORNIA HOSPITAL AT HOLLYWOOD** B. WING _____	**02/05/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN CALIFORNIA HOSPITAL AT HOLLYWOOD	**6245 DE LONGPRE AVE HOLLYWOOD, CA 90028**

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K 000	INITIAL COMMENTS This facility was surveyed under the Life Safety Code NFPA 101, 2000 Edition, Chapter 19, Existing Health Care Occupancies, and other applicable codes. The following represents the findings of the Department of Public Health during Life Safety Code Complaint Validation Survey at the Culver City Campus. Intake No: CA00429647 Representing the Department of Public Health: Surveyor 14041, REHS, CFI 1, HFE I Surveyor 16281, REHS, CFI 1, HFE I	K 000		
K 051	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4,9.6	K 051		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: INTERIM CEO — (X6) DATE: 5/29/15

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

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K 051	Continued From page 1 This STANDARD is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure that the 2 of 4 elevators Phase II firefighter operation were fully functional at all times. Finding: On February 3, 4, and 5, 2015, the evaluator conducted a complaint investigation into a fire / evacuation emergency. On February 5, 2015, the elevator requested the Pavilion elevator test and service documentation for all four elevators. The Building Engineer provided the service test documents and he explained that the State of California were slow in sending the current annual certificates. The evaluator reviewed the elevator documents and observed the following: North Elevator – the Phase II Operation failed from June 2014 through December 2014; the Staff Elevator – the Phase II Operation failed from August 2014 through December 2014; and the Service Elevator – the Phase II Operation failed from May 2, 2014 through July 16, 2014. The evaluator conducted a record review of the elevator's certificates posted and 2 of 2 elevators certificates were expired. One of the certificates expired on October 18, 2014 and the other	K 051	**Corrective Action:** Vendor, Liftech has corrected elevators to be. Phase II elevator testing has been inspected and permits have been renewed and obtained. **(Attachment #1 & #22)** **Date of Implementation:** 4/8/2015 **Monitoring Process:** Results of monitoring will be reported up to EOC and Quality Council on a quarterly basis. **Person Responsible:** Director of Facilities	04/08/2015

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K 051	Continued From page 2 expired on September 20, 2014. On February 13, 2014, at 11:30 a.m., the evaluator contacted the State of California, Department of Industrial Relations, Div of Occupational Safety & Health, and staff verified that the two elevators failed the Phase II annual test. The staff also stated that the facility was fined because the two elevators' Phase II were not repaired within the time period initially allowed, 5-weeks. The evaluator reviewed the fire incident report and it revealed that "Since the keys in the knox (security) box did not have the correct elevator recall key nor did security. Engineer T2 proceeded to recall elevators to the first floor and pull the "Emergency Stop" button in elevator panel." Under Phase I operation, elevators that are 25 feet or more above the main floor return either to a designated landing area or an alternate area. Phase I operation is activated either manually by a special key, or automatically by a fire alarm initiating device. The elevator Phase II operation is an override meant for firefighters after Phase I has been activated. Under the Phase II operation, firefighters can use a key-switch to operate the elevator, provided the hoistway is clear of smoke and the elevator has electricity.	K 051	**Corrective Action:** Upon review with the Culver City Fire Department Fire Inspector, Steve Poelstra, all necessary keys were in place inside knox box. Per request of the CCFD, an additional knox box has been ordered and approved; arrival pending **(Attachments #3 and #4).** **Date of Implementation:** April 7, 2015 **Monitoring Process:** Only CCFD has access to the knox boxes. Upon arrival of the additional knox box, CCFD will have to install and ensure all keys are in place. **Person Responsible:** Director of Facilities	4/27/2015
K 067	NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2	K 067		

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K 067	Continued From page 3 This STANDARD is not met as evidenced by: NFPA 90A, Standard for the Installation of Air Conditioning and Ventilating Systems. 2-3.11.1 Egress Corridors in health care, detention and correctional and residential occupancies shall not be used as a portion of a supply, return, or exhaust air system serving adjoining areas. An air transfer opening(s) shall not be permitted in walls or in doors separating egress corridors from adjoining areas. Exception No. 1: Toilet rooms, bathrooms, shower rooms, sink closets, and similar auxiliary spaces opening directly onto the egress corridor. Exception No. 2: Where door clearances do not exceed those specified for fire doors in NFPA 80, Standard for Fire Doors and Fire Windows, air transfer caused by pressure differentials shall be permitted. Exception No. 3: Use of egress corridors as part of the engineered smoke control system. Exception No. 4: In detention and correctional occupancies with corridor separations of open construction (e.g. grating doors or grating partitions). 4-3.1 Smoke dampers shall be controlled by an automatic alarm initiating device. Smoke dampers shall be permitted to be positioned manually from a command station.	K 067		

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K 067	Continued From page 4 4-4.1 All automatic shutdown devices shall be tested annually. 4-4.3 Smoke detectors provided as required by 4-4.2 shall automatically stop their respective fan(s) on detecting the presence of smoke. NFPA 101 Code for Safety to Life from Fire in Buildings and Structures 2000 Edition 9.2.1 Air Conditioning, Heating, Ventilating Ductwork, and Related Equipment. Air conditioning, heating, ventilating ductwork, and related equipment shall be in accordance with NFPA 90A, Standard for the Installation of Warm Heating and Air-Conditioning Systems, as applicable, unless existing installations, which shall be permitted to be continued in service, subject to approval by the authority having jurisdiction. 9.3.1* General. Smoke control systems, where required or permitted by Chapters 11 through 42, shall have an approved maintenance and testing program to ensure operational integrity. The purpose of such smoke control systems shall be to confine smoke to the general area of fire origin and maintain use of the means of egress system. 9.6.5.1 A fire alarm and control system, where required by another section of this Code, shall be arranged to actuate automatically the control functions necessary to make the protected premises safer for building occupants. 9.6.5.2 Where required by another section of this Code, the following functions shall be actuated by	K 067		

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K 067	Continued From page 5 the complete fire alarm system: (1) Release of hold-open devices for doors or other opening protectives (2) Stairwell or elevator shaft pressurization (3) Smoke management or smoke control systems (4) Emergency lighting control (5) Unlocking of doors 19.3.4.4 Emergency Control. Operation of any activating device in the required fire alarm system shall be arranged to accomplish automatically any control functions to be performed by that device. (See 9.6.5) 19.5.2.1 Heating, ventilating, and air conditioning shall comply with the provisions of Section 9.2 and shall be installed in accordance with the manufacturer's specifications. These codes and standards were not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure an air handler automatically shut down with the presence of smoke. The facility failed to ensure that all automatic shutdown devices were tested annually. The facility used corridors as plenums. The deficiencies permitted, and had the potential to permit accelerated spread of smoke and gases during a fire. Findings: 1. On 2/3/15, a review of an OSHPD Fire and Life Safety Field Visit Report dated 2/2/15, indicated that on 1/29/15 a fire appeared to have damaged	K 067		

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	050135	A. BUILDING **01 – SOUTHERN CALIFORNIA HOSPITAL AT HOLLYWOOD** B. WING _____	**02/05/2015**

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SOUTHERN CALIFORNIA HOSPITAL AT HOLLYWOOD	**6245 DE LONGPRE AVE HOLLYWOOD, CA 90028**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 067	Continued From page 6 the HVAC supply air-intake filter banks that apparently supply air to the 2nd, 4th, 5th, and 6th floor patient rooms. That the HVAC system did not automatically shut-down during the fire on 1/29/15 and the smoke from the fire was dispersed from the roof supply intake to other areas and floors of the building. On 2/3/15 at 12:05 p.m., during an interview the Project Manager stated that one of two air handlers (air handler 2) in the penthouse was affected by the fire, and that air handler 2 affected the 2nd, front 3rd SDU, 4th, 5th, and 6th floors that it served. At 2:10 p.m., Air handler 2 was observed to have fire, heat, and smoke damage. There was a duct detector located at the main supply duct coming form the air handler. The air handler was in the penthouse located at the 7th floor roof level. During an interview at the same time as the observation, the Project Manager and the Lead Man stated that the smoke from the fire should have activated the duct detectors to shut down both air handler 1 and 2. On 2/4/15 at at 11:05 a.m., during an interview, the Lead Man stated that every floor in the Pavilion had smoke dampers, and that there were two duct detectors in the main supply ducts located at the penthouse. That the way the system was suppose to function was that the duct detectors send a signal to the fire alarm control panel that activates the alarm and the panel sends a signal to the fire alarm air handler controls that shuts down the air handler motor. That on the day of the fire both air handler 1 and 2 had to be shut down manually at the air	K 067	**Corrective Action:** A new fire system is being installed **(Attachments #6 and #15)** which will immediately shut down air handlers, should the relays be pulled. Engineers have been instructed that relays are no longer to be pulled during fire alarm testing, as was common practice beforehand **(Attachment #7)**. New fire system is in final stages of testing. **Date of Implementation:** February 15, 2015 with an estimated completion date of May 30, 2015. **Monitoring Process:** Redesigned system will shut down air handlers should there be any attempt to pull or disable relays. **Person Responsible:** Vice President of Facilities Operations **Corrective Action** Air handler #1 is still in use, while air handler #2 has a temporary replacement. Air balancing for temporary unit not required per ACO Attachment #20 **(Attachment #8, 15, 16, 17, 18, 19, 20, 21, 23)**. **Date of Implementation:** Temporary air handler was installed on March 25, 2015. **Monitoring Process:** Testing will occur upon installation, with quarterly inspections thereafter. **(Attachment #2).** Results of monitoring will be reported up to EOC and Quality Council on a quarterly basis. **Person Responsible:** Director of Facilities **Corrective Action:** A new fire system is being installed **(Attachments #6 & #15)** which will immediately shut down air handlers, should the relays be pulled. Engineers have been instructed that relays are no longer to be pulled during fire alarm testing, as was common practice beforehand **(Attachment #7)**. New fire system is in final stages of testing. **Date of Implementation:** February 15, 2015 with an estimated completion date of June 15, 2015. **Monitoring Process:** Redesigned system will shut down air handlers should there be any attempt to pull or disable relays. **Person Responsible:** Vice President of Facilities	5/30/2015 3/25/2015 6/15/2015

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K 067	Continued From page 7 handlers, and that he did not know what part of the HVAC shut down system did not work. The Lead Man also stated that there were relays in the fire alarm air handlers control panel at the penthouse that could bi-pass the air handler shut down system so that the air handlers do no shut down when the fire alarm system was activated, and that only engineering knew about the relays. Between 11:05 a.m., and 12:40 p.m., the Corporate Vice President of Facilities Operations stated that the hospital engineers had not been asked about the relays. At 2:18 p.m., the Corporate Vice President of Facilities Operations stated that he had found out from the Engineer that the relays at the fire alarm air handlers control panel had been found pulled (unplugged). On 2/5/15 at 8:52 a.m., during an interview the Corporate Vice President of Facilities Operations stated that the 2nd shift Stationary Engineer had found the relays pulled. On 2/5/14 at 10:10 a.m., during an interview, the Lead Man stated that on the day of the fire (1/29/15) he heard a code red announced from the 3rd floor, that he went to the 3rd floor and saw smoke coming from the vents at the 3rd floor, that he went up to the penthouse and saw smoke coming from air handler 2, saw fire at the door of the air handler, and saw the air handler was still on, so he (manually) shut off the air handler. The Lead Man also stated that the engineers can pull the relays in the fire alarm air handlers control panel if a vendor is scheduled to conduct	K 067		

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K 067	Continued From page 8 a fire alarm test and then reconnect them after the test, that its was the practice when he came to the hospital, and its what they (engineering) have continued to do, that the relays have to be pulled otherwise air conditioning and heating is lost for the whole building and that there was no other reason to pull the relays. The Lead Man further stated that he asked the engineers to log whenever they pull and reconnect the relays, but did not know if the engineers log when they pull and reconnect the relays, that he did not know who the last person that pulled the relays was, that he asked the engineer who worked on the day of the fire, and the engineer told him he did not pull the relays. At 2:40 p.m., during an interview, the Lead Man stated that engineering was not logging when the relays in the fire alarm air handlers control panel were being pulled and reconnected. On 2/5/15, at 2:42 p.m., during an interview, the 2nd shift Stationary Engineer stated that on 1/29/15 he had arrived to the hospital at 1:30 p.m., after the fire, and discovered there had been a fire on the roof of the Pavilion. That around 5 p.m. the Lead Man asked him to go up to the penthouse to the fire alarm air handlers control panel to heck if the relays for air handlers 1 and 2 were installed in place. That upon opening the relay box he found both relays unplugged and laying at the bottom of the panel at which time he installed them in there place. The 2nd shift Stationary Engineer also sated he did not know who pulled the relays. 2. On 2/4/15 at 12:40 p.m., a review of fire alarm	K 067	**Corrective Action:** Engineering has been instructed that relays are never to be pulled, without exception. **(Attachment #7).** **Date of Implementation:** Staff meeting with education was held on February 5, 2015 **Monitoring Process:** The new fire system in place will automatically shut down air handlers should there be any attempt to pull or disable the relays. **Person Responsible:** Corporate VP of Facilities Operations	2/5/2015

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K 067	Continued From page 9 system inspection and test report dated 7/28/14, indicated there was no documented evidence that the duct detectors for air handlers 1 and 2 at the 7th floor penthouse were inspected and tested. During an interview, after reviewing the fire alarm system inspection and test report dated 7/28/14, the Corporate Vice President of Facilities Operations stated that he didn't see any evidence in the report that air handler one and two at the 7th floor penthouse were inspected and tested. During an interview, after reviewing the fire alarm system inspection and test reports dated 7/28/14, the Lead Man stated that the duct detectors on the air handlers were shut down devices that were tested annually, that per his review of the fire alarm inspection and test report dated 7/28/14, there was no evidence in the report that air handler 1 and 2 at the 7th floor penthouse were inspected and tested. The Lead Man also stated that when he received the fire alarm inspection and test report he review the deficiency sheet at the end of the report, but not review the rest of the report to check that all systems were tested, and that he should have reviewed the full report. A review of the facility's Fire Alarm and Inspection schedule for 2014 indicated that the smoke detection shut down devices for the HVAC system had an annual testing frequency and were supposed to be tested in July of 2014. On 2/5/15 at 1:15 p.m., review of the fire alarm system inspection and test report dated 4/24/13, indicated there was no documented evidence that the duct detectors for air handlers 1 and 2 at the 7th floor penthouse were inspected and tested.	K 067	**Corrective Action:** Vendor for testing is no longer being used; currently in the process of contracting a new vendor. Air handler #1 is still in use; air handler #2 has a temporary. Replacement. Air balancing for temporary unit not required per ACO Attachment #20 **(Attachment #8, 15, 16, 17, 18, 19, 20, 21, 23).** **Date of Implementation:** Implementation immediately upon installation of new fire system, an estimated date of June 15,2015 **Monitoring Process:** Testing will occur upon installation, with quarterly inspections thereafter **(Attachment #2).** Results of monitoring will be reported up to EOC and Quality Council on a quarterly basis. **Person Responsible:** Director of Facilities	6/15/2015

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K 067	Continued From page 10 During an interview, after reviewing the fire alarm system inspection and test report dated 4/24/13, the Lead Man stated that he he didn't see any evidence in the report that air handlers 1 and 2 at the 7th floor penthouse were inspected and tested. The last documented evidence of duct smoke detectors for air handler one and two being inspected was on 3/20/12. 3. On 2/5/15 between 10 a.m. and 12 a.m., the Lead Man stated that the tower building had plenums as part of the buildings air distribution system on some of the tower building floors , but that he would have to investigate to determine which floors had plenums. A review of the tower building's supply and exhaust conveyance document indicated that Tower floors 2, 4, 5, and 6 (T-2, T-4, T-5, and T-6) had plenums as part of the buildings air distribution system. On 2/17/15, between 2 p.m. and 4 p.m., the following condition existed in the Tower. At T-6, a Med-Detox unit, the air duct in the corridor was an open system with air blowing into the pen egress corridor space above the drop down suspended ceiling. There were no ducts branching out from the corridor air duct, and there were transfer openings in the egress corridor walls that separated patient rooms from the corridor. There were no ducts from the corridor duct to the patient rooms, and the egress corridor above the ceiling space was used as a portion of the supply air system serving the patient rooms.	K 067		

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K 067	Continued From page 11 During an interview at the same time as the observation, the Lead Man stated that there were no ducts between the corridor duct and the rooms. That the air duct in the corridor was an open system with air blowing into the open corridor space above the suspended ceiling, with that open space used as a plenum. That the air movement went from the open corridor duct, to the open space plenum above the corridor ceiling, to the transfer openings in the egress corridor walls, pulled through the transfer openings into the rooms by the direction of air flow of the the exhaust vents in the rooms taking the air out of the rooms. T-6 is a Med-Detox unit that had patients and staff at the time of the observation. At T-5, the corridor had hard lid ceilings. During an interview at the same time as the observation, the Lead Man stated that the air supply at T-5 had the same type of plenum system as T-6. During an interview at the same time as the observation, the Corporate Vice President of Facilities Operations stated that T-5 was used last week as turn around space to house patients while the cleaning was done at the Pavilion. At T-4, the corridor had hard lid ceilings. During an interview at the same time as the observation, the Lead Man stated that the air supply at T-4 had the same type of plenum system as T-6. At the same time as the observation, during an interview, the Risk Manager stated that T-4 is not on the facility's license and is not used for patients.	K 067		

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K 067	Continued From page 12 At T-2 the air duct in the corridor above the drop down suspended ceiling was a closed system with ducts branching from the corridor duct to the patient rooms. During an interview at the same time as the observation, the Lead Man stated that T-2 was completely ducted and did not have a plenum as part of the floors air distribution system. The egress (exit) corridors of T-4, T-5, and T-6 were the same corridors used as a portion of the air supply (plenums). T-2, T-4, T-5, and T-6 were not sprinklered. T-2, T-4, T-5, and T-6 had smoke detectors in the corridors including at the elevator lobby. T-2, -5, and T-6 had smoke detectors in the rooms. T-4 did not have smoke detectors in the rooms. Per an e-mail dated 2/9/15, from the Corporate Vice President of Facilities Operations, there was an automatic fan shut down for T-2, T-4, T-5, and T-6 upon detection of smoke and activation of the building fire alarm system. Per CMS S&C-06-18 letter dated 5/26/06, NFPA 90A, "Installation of Air Conditioning and Ventilating Systems" document, 1999 Edition prohibits egress (exit) corridors in health care occupancies from being used as a portion of the supply, return or exhaust air system serving adjoining areas (5-3.11.1, 1999 ed.). This prohibits the corridor from being used as a plenum.	K 067	**Corrective Action:** As per CMS S&C-06-18 criteria, a waiver has been requested, citing a review of the fire alarm system pertaining to the corridor protection. The existing system, as installed and tested, contains full corridor coverage, with smoke detectors, and is interconnected to the existing ventilation system. **(Attachments #8, #9, #10, #11, #12, #15 and #24)** **Date of Implementation:** Compliance confirmed May 4, 2015 **Monitoring Process:** Newly designed fire system will automatically shut down at any attempt to pull or disable relays. Anticipated completion of new fire alarm system 5/30/15 **Person Responsible:** Director of Facilities	5/4/2015

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K 147	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: NFPA 70 National Electrical Code 1999 edition 110-3. Examination, Identification, Installation, and Use of Equipment (a) Examination. In judging equipment, considerations such as the following shall be evaluated: (3) Wire-bending and connection space (4) Electrical insulation (8) Other factors that contribute to the practical safeguarding of persons using or likely to come in contact with the equipment 110-12(c) Internal parts of electrical equipment, including busbars, wiring terminals, insulators, and other surfaces, shall not be damaged or contaminated by foreign materials such as paint, plaster, cleaners, abrasives, or corrosive residues. There shall be no damaged parts that may adversely affect safe operation or mechanical strength of the equipment such as parts that are broken; bent; cut; or deteriorated by corrosion, chemical action, or overheating. 310-2. (a) Insulated. Conductors shall be insulated. These codes were not met as evidenced by: Based on observation and interview, the facility failed to ensure 2 electrical cords were not compromised.	K 147		

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K 147	Continued From page 14 The deficient practices bypassed the safe use and maintenance of electrical cords and their safeguards against fire and electric shock. Findings: On 2/3/15, between 4:20 p.m. and 4:55 p.m., there were two extension cords connected to air scrubbers on the 3rd and 5th floors of the pavilion. Closer observation revealed the extension cords had damaged that consisted of their electrical cord protective jacket being pulled away from the plug, thereby exposing the electrical wiring beneath. During an interview at the same time as the observations, the Corporate Vice President of Facilities Operations stated damaged extension cords would be removed.	K 147	**Corrective Action:** Third party vendor removed air scrubber, along with damaged electrical cord. **Date of Implementation:** Removed immediately on 2/3/15. **Monitoring Process:** No monitoring necessary. **Person Responsible:** Director of Facilities	2/3/2015

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K 067	Continued From page 12 At T-2 the air duct in the corridor above the drop down suspended ceiling was a closed system with ducts branching from the corridor duct to the patient rooms. During an interview at the same time as the observation, the Lead Man stated that T-2 was completely ducted and did not have a plenum as part of the floors air distribution system. The egress (exit) corridors of T-4, T-5, and T-6 were the same corridors used as a portion of the air supply (plenums). T-2, T-4, T-5, and T-6 were not sprinklered. T-2, T-4, T-5, and T-6 had smoke detectors in the corridors including at the elevator lobby. T-2, -5, and T-6 had smoke detectors in the rooms. T-4 did not have smoke detectors in the rooms. Per an e-mail dated 2/9/15, from the Corporate Vice President of Facilities Operations, there was an automatic fan shut down for T-2, T-4, T-5, and T-6 upon detection of smoke and activation of the building fire alarm system. Per CMS S&C-06-18 letter dated 5/26/06, NFPA 90A, "Installation of Air Conditioning and Ventilating Systems" document, 1999 Edition prohibits egress (exit) corridors in health care occupancies from being used as a portion of the supply, return or exhaust air system serving adjoining areas (5-3.11.1, 1999 ed.). This prohibits the corridor from being used as a plenum.	K 067	**Corrective Action:** As per CMS S&C-06-18 criteria, a waiver has been requested, citing a review of the fire alarm system pertaining to the corridor protection. The existing system, as installed and tested, contains full corridor coverage, with smoke detectors, and is interconnected to the existing ventilation system. **(Attachments #8, #9, #10, #11, #12, #15 and #24)** **Date of Implementation:** Compliance confirmed May 4, 2015 **Monitoring Process:** Newly designed fire system will automatically shut down at any attempt to pull or disable relays. Anticipated completion of new fire alarm system 5/30/15 **Person Responsible:** Director of Facilities	5/4/2015

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K 147	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: NFPA 70 National Electrical Code 1999 edition 110-3. Examination, Identification, Installation, and Use of Equipment (a) Examination. In judging equipment, considerations such as the following shall be evaluated: (3) Wire-bending and connection space (4) Electrical insulation (8) Other factors that contribute to the practical safeguarding of persons using or likely to come in contact with the equipment 110-12(c) Internal parts of electrical equipment, including busbars, wiring terminals, insulators, and other surfaces, shall not be damaged or contaminated by foreign materials such as paint, plaster, cleaners, abrasives, or corrosive residues. There shall be no damaged parts that may adversely affect safe operation or mechanical strength of the equipment such as parts that are broken; bent; cut; or deteriorated by corrosion, chemical action, or overheating. 310-2. (a) Insulated. Conductors shall be insulated. These codes were not met as evidenced by: Based on observation and interview, the facility failed to ensure 2 electrical cords were not compromised.	K 147		

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K 147	Continued From page 14 The deficient practices bypassed the safe use and maintenance of electrical cords and their safeguards against fire and electric shock. Findings: On 2/3/15, between 4:20 p.m. and 4:55 p.m., there were two extension cords connected to air scrubbers on the 3rd and 5th floors of the pavilion. Closer observation revealed the extension cords had damaged that consisted of their electrical cord protective jacket being pulled away from the plug, thereby exposing the electrical wiring beneath. During an interview at the same time as the observations, the Corporate Vice President of Facilities Operations stated damaged extension cords would be removed.	K 147	**Corrective Action:** Third party vendor removed air scrubber, along with damaged electrical cord. **Date of Implementation:** Removed immediately on 2/3/15. **Monitoring Process:** No monitoring necessary. **Person Responsible:** Director of Facilities	2/3/2015

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	050135	A. BUILDING _____ B. WING _____	02/05/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN CALIFORNIA HOSPITAL AT HOLLYWOOD	6245 DE LONGPRE AVE HOLLYWOOD, CA 90028

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 000	INITIAL COMMENTS The following represents the findings of the Department of Public Health during a Complaint Validation Survey at the Culver City Campus. Intake No.: CA00429647 Representing the Department of Public Health: Evaluator ID #14041, REHS, CFI 1, HFE I Evaluator ID #16281, REHS, CFI 1, HFE I	A 000	**A 700-1Corrective Action:** Hot work permit protocol has been revised **(Attachment # 1).** Project Manager no longer has authority to approve Hot Work permits. All permits must be approved by Facilities Director, or his designee. Contractor holds sole responsibility to notify IOR when presence is needed. Fire Watch has been conducted on 1/29/15, the day of the fire, albeit, incorrectly, by the contracting company MK Roofing. **(Attachment #2)** Contractor on site notice process has been implemented so that no contractor can have facility access without prior notification and approval by facilities director and project manager should IOR be required. Process includes description of work, area impacted with dates and times. See attachment 5 & 14. **Date of Implementation:** February 3, 2015 **Monitoring Process:** Fire Watch will be monitored and logged by SCHCC staff, rather than third party company. Fire Watch log sheet is attached to Hot Work policy and procedure. **Person Responsible:** Director of Facilities	2/3/2015
A 700	482.41 PHYSICAL ENVIRONMENT The hospital must be constructed, arranged, and maintained to ensure the safety of the patient, and to provide facilities for diagnosis and treatment and for special hospital services appropriate to the needs of the community. This CONDITION is not met as evidenced by: Based on observation, document review, and interview, the facility failed to meet the Condition of Participation in Physical Environment by failing to: 1. Maintain the physical plant in a manner that assured the safety and well-being of patients (Refer to A 701 and A 710). 2. Ensure the safety of patients and staff when the hospital failed to ensure the Inspector of Record was present during hot works construction (Refer to A 701). 3. Ensure the safety of patients and staff when the hospital failed to have an approved and effective Hot Work policy and procedure (Refer to A 701).	A 700	**A 710 Corrective Action:** A new fire system is being installed **(Attachment #6)** which will immediately shut down air handlers, should the relays be pulled. Engineers have been instructed that relays are no longer to be pulled during fire alarm testing, as was common practice beforehand **(Attachment #7)**. New fire system is in final stages of testing. **Date of Implementation:** February 15, 2015 with an estimated completion date of May 30, 2015. **Monitoring Process:** Redesigned system will shut down air handlers should there be any attempt to pull or disable relays. **Person Responsible:** Vice President of Facilities Operations **A 700-2 Corrective Action:** Hot work permit protocol has been revised **(Attachment # 1).** Project Manager no longer has authority to approve Hot Work permits. All permits must be approved by Facilities Director, or his designee. Contractor holds sole responsibility to notify IOR when presence is needed. Fire Watch has been conducted on 1/29/15, the day of the fire, albeit, incorrectly, by the contracting company MK Roofing. **(Attachment #2)** Contractor on site notice process has been implemented so that no contractor can have facility access without prior notification and approval by facilities director and project manager should IOR be required. Process includes description of work, area impacted with dates and times. See attachment 5 & 14. **Date of Implementation:** February 3, 2015 **Monitoring Process:** Fire Watch will be monitored and logged by SCHCC staff, rather than third party company. Fire Watch log sheet is attached to Hot Work policy and procedure. **Person Responsible:** Director of Facilities **A 700-3 Corrective Action:** Hot work permit protocol has been revised **(Attachment # 1).** Project Manager no longer has authority to approve Hot Work permits. All permits must be approved by Facilities Director, or his designee. Contractor holds sole responsibility to notify IOR when presence is needed. Fire Watch has been conducted on 1/29/15, the day of the fire, albeit, incorrectly, by the contracting company MK Roofing. **(Attachment #2)** Contractor on site notice process has been implemented so that no contractor can have facility access without prior notification and approval by facilities director and project manager should IOR be required. Process includes description of work, area impacted with dates and times. See attachment 5 & 14. **Date of Implementation:** February 3, 2015 **Monitoring Process:** Fire Watch will be monitored and logged by SCHCC staff, rather than third party company. Fire Watch log sheet is attached to Hot Work policy and procedure. **Person Responsible:** Director of Facilities	6/15/2015 2/3/2015 2/3/2015

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Interim CEO | (X6) DATE: 5/29/15

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

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A 700	Continued From page 1 4. Ensure the safety of patients and staff when the hospital failed to ensure relays at the fire alarm air handler shutoff control panel remained installed in place (Refer to A 701). 5. Ensure the safety of patients and staff when the hospital failed to ensure the air system operated continuously and provided balanced air-supply to patient rooms (Refer to A 701). 6. Ensure the safety of patients and staff when the hospital removed self-closing area separation fire doors from the fourth and fifth floors (Refer to A 701). 7. Ensure the safety of patients and staff when the hospital failed to ensure an air handler automatically shut down with the presence of smoke (Refer to A 710 and K 067). 8. Ensure the safety of patients and staff when the hospital failed to ensure that all automatic shutdown devices were tested annually (Refer to A 710 and K 067). 9. Ensure the safety of patients and staff when the hospital used egress corridors as plenums (Refer to A 710 and K 067). 10. Ensure the safety of patients and staff when the hospital failed to ensure electrical power cords were maintained intact (Refer to A 710 and K 147). 11. Ensure 2 of 4 elevators Phase II fire fighter operation were fully functional at all times (Refer to K 051).	A 700	**A 700-4 Corrective Action:** A new fire system is being installed **(Attachment #6 & 15)** which will immediately shut down air handlers, should the relays be pulled. Engineers have been instructed that relays are no longer to be pulled during fire alarm testing, as was common practice beforehand **(Attachment #7)**. New fire system is in final stages of testing. **Date of Implementation:** February 15, 2015 with an estimated completion date of June 15,, 2015. **Monitoring Process:** Redesigned system will shut down air handlers should there be any attempt to pull or disable relays. **Person Responsible:** Vice President of Facilities Operations **A700-5 Corrective Action:** A new fire system is being installed **(Attachment #6 & 15)** which will immediately shut down air handlers, should the relays be pulled. Engineers have been instructed that relays are no longer to be pulled during fire alarm testing, as was common practice beforehand **(Attachment #7)**. New fire system is in final stages of testing. **Date of Implementation:** February 15, 2015 with an estimated completion date of June 15,, 2015. **Monitoring Process:** Redesigned system will shut down air handlers should there be any attempt to pull or disable relays. **Person Responsible:** Vice President of Facilities Operations **A 700-6 Corrective Action:** Project for self-closing area separation fire doors has been opened with OSHPD and design has been approved **(Attachment #11).** Currently, the project is out for bids, with an anticipated award date of June 1, 2015 Anticipated completion date of July 15, 2015.. **Date of Implementation:** 1/30/2015 **Monitoring Process:** Fire Doors are inspected on a quarterly basis **(Attachment #12).** Results of monitoring will be reported up to EOC and Quality Council on a quarterly basis. **Person Responsible:** Corporate Vice President of Facilities Operations **A700-7 Corrective Action:** A new fire system is being installed **(Attachment #6 & 15)** which will immediately shut down air handlers, should the relays be pulled. Engineers have been instructed that relays are no longer to be pulled during fire alarm testing, as was common practice beforehand **(Attachment #7)**. New fire system is in final stages of testing. **Date of Implementation:** February 15, 2015 with an estimated completion date of June 15,, 2015. **Monitoring Process:** Redesigned system will shut down air handlers should there be any attempt to pull or disable relays. **Person Responsible:** Vice President of Facilities Operations **A700-8 Corrective Action:** A new fire system is being installed **(Attachment #6 & 15)** which will immediately shut down air handlers, should the relays be pulled. Engineers have been instructed that relays are no longer to be pulled during fire alarm testing, as was common practice beforehand **(Attachment #7)**. New fire system is in final stages of testing. **Date of Implementation:** February 15, 2015 with an estimated completion date of June 15,, 2015. **Monitoring Process:** Redesigned system will shut down air handlers should there be any attempt to pull or disable relays. **Person Responsible:** Vice President of Facilities Operations **A700-9 Corrective Action:** As per CMS S&C-06-18 criteria, a waiver has been requested, citing a review of the fire alarm system pertaining to the corridor protection. The existing system, as installed and tested, contains full corridor coverage, with smoke detectors, and is interconnected to the existing ventilation system. **(Attachments #9, #10, #11 and #12)** **Date of Implementation:** Compliance confirmed May 4, 2015 **Monitoring Process:** Newly designed fire system will automatically shut down at any attempt to pull or disable relays; receipt of waiver pending. **Person Responsible:** Director of Facilities	6/15/2015 6/15/2015 7/15/2015 6/15/2015 6/15/2015 5/4/2015

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A 700	Continued From page 2 The cumulative effect of the systemic issues resulted in the facility's inability to ensure and provide a safe patient care environment.	A 700	**A 700-10 Corrective Action:** Third party vendor removed air scrubber, along with damaged electrical cord. **Date of Implementation:** Removed immediately on 2/3/15. **Monitoring Process:** No monitoring necessary. **Person Responsible:** Director of Facilities **A 700-11Corrective Action:** Third party vendor removed air scrubber, along with damaged electrical cord. **Date of Implementation:** Removed immediately on 2/3/15. **Monitoring Process:** No monitoring necessary. **Person Responsible:** Director of Facilities	2/3/2015 4/8/2015
A 701	482.41(a) MAINTENANCE OF PHYSICAL PLANT The condition of the physical plant and the overall hospital environment must be developed and maintained such a manner that the safety and well-being of patients are assured. This STANDARD is not met as evidence by: Based on interview and document review, the hospital failed to assure a safe environment for the patients by not ensuring the IOR (Inspector of Record) was present during hot works construction done on the roof, failing to ensure two relays at the fire alarm air handler shutoff control panel remained installed in place, failing to have an approved and effective Hot Work policy and procedure, failure to provide an air system to operate continuously and provide balanced air-supply to patient rooms for the 2nd, front of 3rd (SDU), 4th, 5th, and 6th floors, removing self-closing area separation fire doors, and failing to ensure privacy curtains were in place. These deficient practices had the potential to have hot work construction being conducted in an unsafe manner, permitted the accelerated spread of smoke and gases during a fire, discontinued the provision of balanced air-supply to patient rooms on the 2nd, front of 4rd, 4th, 5th, and 6th floors, and affected the patients well-being, dignity and comfort while in the hospital. Findings:	A 701		

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A 701	Continued From page 3 1. On 2/3/15, a review of an OSHPD (Office of Statewide Health Planning & Development) Fire and Life Safety Field Visit Report dated 2/2/15, indicated that on 1/29/15 a fire occurred as a direct result of the scope of work for the "parapet" reconstruction project. That work being performed when the fire occurred was being performed without the knowledge or the presence of the Inspector of Record (IOR), as well as without an appropriate "Fire Watch." Review of the Inspector's Daily Report dated 3/4/14 from the IOR for the parapet roof repair project indicated that there was a kick off meeting with the roofing company, Corporate Project Manager, and the Special Instructor for preconstruction meeting. The report indicated that a minimum 48 hours notice was required for inspections. Review of the hot works permit dated 1/26/15, indicated there would be a parapet roof replacement at the roof of the pavilion. Review of the roofing company's fire watch log sheet dated 1/29/15, at 12 p.m., indicated the torch was started at "top of wing." Review of the Notice of Non-Conformance dated 1/29/15 (revised 1/30/15), from the IOR for the parapet roof repair project indicated that the contractor failed to notify the IOR that their intent was to perform hot work in order for the IOR to verify that a hot work permit had been obtained and posed in the direct area of work, confirm times allowed for hot work, verify that the interim life safety measures were in place, which included, fire extinguishers and required	A 701	**Corrective Action:** Hot work permit protocol has been revised **(Attachment # 1).** Project Manager no longer has authority to approve Hot Work permits. All permits must be approved by Facilities Director, or his designee. Contractor holds sole responsibility to notify IOR when presence is needed. Fire Watch has been conducted on 1/29/15, the day of the fire, albeit, incorrectly, by the contracting company MK Roofing. **(Attachment #2)** Contractor on site notice process has been implemented so that no contractor can have facility access without prior notification and approval by facilities director and project manager should IOR be required. Process includes description of work, area impacted with dates and times. **(See attachment 5 & 14).** **Date of Implementation:** February 3, 2015 **Monitoring Process:** Fire Watch will be monitored and logged by SCHCC staff, rather than third party company. Fire Watch log sheet is attached to Hot Work policy and procedure. **Person Responsible:** Director of Facilities	2/3/2015

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A 701	Continued From page 4 personnel available for fire watch for the entire duration of the work being performed. That without such notification, IOR was not scheduled to be onsite or aware of the work that needed to be observed. And that the contractor was in violation of CAC (California Administrative Code) Section 7-145. On 2/5/15 at 1:15 p.m., during an interview, the Director of Plant Operations stated the plant operations did not know the workers on the pavilion roof were going to use a torch. He further stated that when he knows there will be hot works he calls and ensures the IOR is present. Also, he would know if hot works are to be conducted because the vendors/contractors are suppose to notify him or the Lead Man before doing hot work, that usually the vendors/contractors notify the IOR first, and usually the IOR comes and stays the whole time the hot work is conducted. In addition, it was always the procedure for the vendors/contractors to notify plant operations before conducting hot work and that the vendors/contractors know they are suppose to report to plant operations first. 2. On 2/3/15, a review of an OSHPD Fire and Life Safety Field Visit Report dated 2/2/15, indicated that on 1/29/15 a fire appeared to have damaged the HVAC supply air-intake filter banks that apparently supply air to the 2nd , 4th, 5th , and 6th floor patient rooms. That the HVAC system did not automatically shut-down during the fire on 1/29/15 and the smoke from the fire was dispersed from the roof supply intake to other areas and floors of the building. On 2/4/15 at 11:05 a.m., during an interview, the	A 701	**Corrective Action:** All contractors must check in with Plant Engineering prior to starting any work, as well as signing out at the end of the work day. **(Attachment #3)**. A "Contractor on Site" notice must be sent out at least 24 hours in advance, preferably 48 hours when possible. **(Attachments #4 and #5).** **Date of Implementation:** February 3, 2015 **Monitoring Process:** Plant Engineering will establish and maintain a Contractor Sign IN/OUT Log for all contractors working on site. See Attachment #3. **Person Responsible:** Director of Facilities **Corrective Action:** A new fire system is being installed **(Attachment #6 & 15)** which will immediately shut down air handlers, should the relays be pulled. Engineers have been instructed that relays are no longer to be pulled during fire alarm testing, as was common practice beforehand **(Attachment #7)**. New fire system is in final stages of testing. **Date of Implementation:** February 15, 2015 with an estimated completion date of June 15, 2015. **Monitoring Process:** Redesigned system will shut down air handlers should there be any attempt to pull or disable relays. **Person Responsible:** Vice President of Facilities Operations	2/3/2015 6/15/2015

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A 701	Continued From page 5 Lead Man stated that the automatic shut down of the air handlers could be bi-passed by pulling (removing) the relays in the fire alarm air handler shutoff control panel. On 2/5/15 at 10:10 a.m., during an interview, the Lead Man stated that on the day of the fire (1/29/15), he heard a code red announced from the 3rd floor, that he went to the 3rd floor and saw smoke coming from vents at the 3rd floor, that he went up to the penthouse and saw smoke coming from air handler 2, and saw fire at the door of the air handler, and that he saw the air handler was still on, so he (manually) shut off the air handler. The Lead Man also stated that the engineers can pull the relays in the fire alarm air handlers control panel if a vendor is scheduled to conduct a fire alarm test and then reconnect them after the test, that it was the practice when he came to the hospital, and its what they (engineering) have continued to do, that the relays have to be pulled, otherwise air conditioning and heating is lost for the whole building and that there was no other reason to pull the relays. On 2/5/15 at 2:42 p.m., during an interview, the 2nd shift Stationary Engineer stated that on 1/29/15 he had arrived to the hospital at 1:30 p.m., after the fire, and discovered there had been a fire on the roof of the Pavilion. That around 5 p.m. the Lead Man asked asked him to go up to the penthouse to the fire alarm air handlers control panel to check if the relays for air handlers 1 and 2 were installed in place. That upon opening the relay box, he found both relays unplugged and laying at the bottom of the panel at which time he installed them in their place.	A 701	**Corrective Action:** A new fire system is being installed **(Attachment #6 & #15)** which will immediately shut down air handlers, should the relays be pulled. Engineers have been instructed that relays are no longer to be pulled during fire alarm testing, as was common practice beforehand **(Attachment #7)**. New fire system is in final stages of testing. **Date of Implementation:** February 15, 2015 with an estimated completion date of June 15, 2015. **Monitoring Process:** Redesigned system will shut down air handlers should there be any attempt to pull or disable relays. **Person Responsible:** Vice President of Facilities Operations	6/15/2015

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A 701	Continued From page 6 The 2nd shift Stationary Engineer, also stated he did not know who pulled the relays, and did not tell anyone that on Thursday (1/29/15) he had found the relays laying in the panel until the Lead Man asked him about it on Wednesday (2/4/15). On 2/5/15 at 2:45 p.m., during an interview, the Lead Man stated he did not know the relays were unplugged until Wednesday (2/4/15), when he asked the Stationary Engineer. That the last communication he had with the Stationary Engineer was on the day of the fire (1/29/15) and did not try to call the Stationary Engineer between that Thursday (1/29/15) and Wednesday (2/4/15). 3. On 2/3/15, a review of an OSHPD Fire and Life Safety Field Visit Report, dated 2/2/15, indicated that on 1/29/15 a fire occurred as a direct result of the scope of work for the parapet reconstruction project. That work being performed when the fire occurred was being performed without the knowledge or the presence of the IOR (Inspector of Record), as well as without an appropriate "Fire Watch". Review of the hot works construction permit dated 1/26/15 indicated there would be parapet roof replacement at the roof of the pavilion. Review of the roofing company's fire watch log sheet dated 1/29/15, at 12 p.m. indicated the torch was started at "top of wing." Review of the Notice of Non-Conformance dated 1/29/15 (revised 1/30/15) from the IOR for the parapet roof repair project indicated that the contractor failed to notify the Inspector of Record (IOR) that their intent was to perform hot work, in	A 701	**Corrective Action:** Hot work permit protocol has been revised **(Attachment # 1).** Project Manager no longer has authority to approve Hot Work permits. All permits must be approved by Facilities Director, or his designee. Contractor holds sole responsibility to notify IOR when presence is needed. Fire Watch has been conducted on 1/29/15, the day of the fire, albeit, incorrectly, by the contracting company MK Roofing. **(Attachment #2)** **Date of Implementation:** February 3, 2015 **Monitoring Process:** Fire Watch will be monitored and logged by SCHCC staff, rather than third party company. Fire Watch log sheet is attached to Hot Work policy and procedure. Results of monitoring will be reported up to EOC and Quality Council on a quarterly basis. **Person Responsible:** Director of Facilities	2/3/2015

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A 701	Continued From page 7 order for the IOR to verify that a hot work permit had been obtained and posted in the direct area of work, confirm times allowed for hot work, verify that the interim life safety measures were in place, which included, fire extinguishers and required personnel available for fire watch for the entire duration of the work being performed. On 2/5/15 at 1:15 p.m., during an interview, the Corporate Vice President of Plant Operations stated that plant operations did not know the workers on the pavilion roof were using a torch to put down roofing material. Also, the vendor/contractor did not contact plant operations or the IOR. On 2/5/15 at 1:15 p.m., during an interview, the Director of Plant Operations stated that plant operations did not know the workers on the pavilion roof were going to use a torch. The he would know if hot works are to be conducted because the vendor/contractor are suppose to notify him or the Lead Man before doing hotworks. That it was always the procedure for the vendors to notify plant operations before conducting hot works and that the vendors/contractors know they are suppose to report to plant operations first. Review of a document provided by the facility as a policy titled Hot Works, indicated there was no date of submittal to the governing body of the document and there was no effective date of the document. The document indicated that the purpose of the document was to maintain current policies and guidelines for Hot Work. The document did not indicate the procedure notifying the IOR when hot work would be performed, and did not indicate the procedure to ensure the	A 701	**Corrective Action:** Hot work permit protocol has been revised **(Attachment # 1).** Project Manager no longer has authority to approve Hot Work permits. All permits must be approved by Facilities Director, or his designee. Contractor holds sole responsibility to notify IOR when presence is needed. Fire Watch has been conducted on 1/29/15, the day of the fire, albeit, incorrectly, by the contracting company MK Roofing. **(Attachment #2)** **Date of Implementation:** February 3, 2015 **Monitoring Process:** Fire Watch will be monitored and logged by SCHCC staff, rather than third party company. Fire Watch log sheet is attached to Hot Work policy and procedure. Results of monitoring will be reported up to EOC and Quality Council on a quarterly basis. **Person Responsible:** Director of Facilities	2/3/2015

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SOUTHERN CALIFORNIA HOSPITAL AT HOLLYWOOD	6245 DE LONGPRE AVE HOLLYWOOD, CA 90028

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A 701	Continued From page 8 facility was aware of hot work being performed. 4. On 2/3/15, a review of an OSHPD Fire and Life Safety Field Visit Report dated 2/2/15, indicated that on 1/29/15 a fire appeared to have damaged the HVAC supply air-intake filter banks that apparently supply air to the 2nd, 4th, 5th, and 6th floor patient rooms. That the HVAC system serving these rooms had been shut down pending repairs to the damaged system. On 2/3/15 at 12:05 p.m., during an interview, the Project Manager stated that one of two air handlers (air handler 2) in the penthouse was affected by the fire, and that air handler 2 affected patient rooms of the 2nd , front 3rd SDU, 4th, 5th, and 6th floors that it served. On 2/3/15 at 12:35 p.m., the Corporate Vice President of Facilities Operations stated that patient room temperatures were not being monitored and there was no plan if there was a change in temperature due to inclement weather. At 1:10 p.m., the Corporate Vice President of Facilities Operations stated that plant operations would begin monitoring patient room temperatures immediately. At 2:10 p.m., the Project Manager stated that scrubbers were placed in the corridors of the affected floors to clean and circulate the air. Between 4:15 p.m. and 5:20 p.m., HEPA (High Efficiency Particulate Air) filtration systems (air scrubbers) were observed at the 2nd, 3rd, 4th, 5th, and 6th floors.	A 701	**Corrective Action:** Vendor for testing is no longer being used; currently in the process of contracting a new vendor. Air handler #1 is still in use, while air handler #2 has a temporary replacement. Air balancing for temporary unit not required per ACO Attachment #20 **(Attachment # 8, 15, 16, 17, 18, 19, 20 & 21).** **Date of Implementation:** Implementation immediately upon installation of new fire system, an estimated date of May 30, 2015. **Monitoring Process:** Testing will occur upon installation, with quarterly inspections thereafter. **(Attachment # 9).** Results of monitoring will be reported up to EOC and Quality Council on a quarterly basis. **Person Responsible:** Director of Facilities **Corrective Action:** Temperature monitoring was immediately implemented for all patient rooms impacted by the fire-damaged air hander. **Date of Implementation:** February 3, 2015 **Monitoring Process:** Temperatures were gauged for ranges between 73°-77°, every 4 hours. Temperatures were monitored until air handler #2 temporary replacement was installed on March 25, 2015. **(Attachment # 10)** **Person Responsible:** Director of Facilities	6/15/2015 3/26/2015

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A 701	Continued From page 9 A letter from the hospital dated 2/3/15 indicated that due to to the fire on 1/29/15, air handler #2 that provides supply air to patient rooms on P2, P3 SDU, P4, P6 and P6 was off line. That air scrubbers were installed on each of the floors to clean and circulate the air. That all patient rooms on the affected floors would be monitored for temperature every four hours, twenty four hours a day to insure ambient temperatures were between the range of 73 and 77 degrees Fahrenheit, and that because there was no temperature control, windows would be open for fresh air ensuring screens were in place and additional blankets were deployed to each affected floor should temperatures cool. 5. On 2/5/15 at 8:52 a.m., in response to a request of the incident report from the local fire department, the Corporate Vice President of Facilities Operations stated that the local fire department would not have the report until two weeks after the date of the incident. Review of the local fire department report undated Fire Investigation Report regarding the fire incident at the hospital on 1/29/15, indicated in its summary that it was noted at the time of the fire, that self-closing area separation fire doors had been removed from the fourth and fifth floors, and that an OTC (Order to Comply) for replacement of the doors had been issued. 6. On 2/3/15 at 5:07 p.m., 9 patient rooms (210, 211, 212, 214, 216 A, 217 B, 219 B, 220 A, and 221 A) in 2nd floor Telemetry, were observed to be without privacy curtains. There were patients in the beds of the 9 rooms at the time of the observation.	A 701	**Corrective Action:** Project for self-closing area separation fire doors has been opened with OSHPD and design has been approved **(Attachment #11).** Currently, the project is out for bids, with an anticipated award date of June 1, 2015 Anticipated completion date of July 15, 2015. **Date of Implementation:** 1/30/2015 **Monitoring Process:** Fire Doors are inspected on a quarterly basis **(Attachment #12).** Results of monitoring will be reported up to EOC and Quality Council on a quarterly basis. **Person Responsible:** Corporate Vice President of Facilities Operations	7/15/2015

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A 701	Continued From page 10 Between 5:07 p.m. and 5:10 p.m., the Director of Environmental Services (EVS) stated that the curtains had been taken down to be sent away to be washed. That the curtains had arrived at 4 p.m., that EVS had been downstairs checking that the replacement curtains were not stained, and that the curtains were being hung now. On 2/5/15 at 10:35 a.m., the Director of EVS stated that on Tuesday (2/3/15), the privacy curtains were taken down because the patients were complaining that the curtains were stained. That she had the Lead EVS take the curtains down and had EVS staff gather the replacement curtains.	A 701	**Corrective Action:** Privacy curtains have been installed in rooms 210, 211, 212, 214, 216 A, 217 B, 219 B, 220 A, and 221 A on the 2nd floor, Pavilion Building. Curtains are not to be removed, unless replacement curtains are readily available and are able to be hung immediately afterwards. A policy titled "Privacy Curtain Cleaning" has been drafted and is pending review by the EOC, Quality Council and Medical Executive Committees, as well as the Governing Board **(Attachment #13).** **Date of Implementation:** February 3, 2015 **Monitoring Process:** EVS will monitor during daily rounds. Results of monitoring will be reported up to EOC and Quality Council on a quarterly basis. **Person Responsible:** Director of EVS	2/3/2015
A 710	482.41 (b)(1)(2)(3) LIFE SAFETY FROM FIRE (1) Except as otherwise provided in this section – (i) The hospital must meet the applicable provisions of the Life Safety Code of the National Fire Protection Association. The Director of the Office of the Federal Register has approved the NFPA 101 2000 edition of the Life Safety Code, issued January 14, 2000, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR Part 51. A copy of the Code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html Copies may be obtained from the National Fire Protection Association, 1 Battermarch Park, Quincy, MA 02269. If any changes in this edition	A 710		

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A 710	Continued From page 11 of the Code are incorporated by reference, CMS will publish notice in the Feral Register to announce the changes. (ii) Chapter 19.3.6.3.2, exception number 2 of the adopted edition of the LSC does not apply to hospitals. (2) After consideration of State survey agency findings, CMS may waive specific provisions of the Life Safety Code which, if rigidly applied, would result in unreasonable hardship upon the facility, but only if the waiver does not adversely affect the health and safety of the patients. (3) The provisions of the Life Safety Code do not apply in a State where CMS finds that a fire and safety code imposed by State law adequately protects patients in hospitals. This STANDARD is not met as evidenced by: Based on observation, interview, and document review, the facility failed to meet the applicable provisions of the Life Safety Code of the National Fire Protection Association (NFPA) including NFPA 70 National Electrical Code 1999 edition, NPA 90A, Standard for the Installation of Air Condition and Ventilating Systems, and NFPA 101 Code for Safety to Life from Fire in Buildings and Structures 2000 Edition, as indicated in tags K067 and K 147 of the Statement of Deficiencies. These codes and standards were not met as evidenced by: Based on observation, interview and document review, the hospital failed to ensure an air handler automatically shut down with the presence of smoke. The hospital failed to ensure that all	A 710		

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A 710	Continued From page 12 automatic shutdown devices were tested annually. The hospital used corridors as plenums. The hospital failed to ensure electrical power cords were maintained in tact. The deficiencies permitted, and had the potential to permit accelerated spread of smoke and gases during a fire, and bypassed the safe use and maintenance of electrical power cords and their safeguards against fire and electric shock.	A 710	**Corrective Action:** A new fire system is being installed **(Attachment #6 & #15)** which will immediately shut down air handlers, should the relays be pulled. Engineers have been instructed that relays are no longer to be pulled during fire alarm testing, as was common practice beforehand **(Attachment #7)**. New fire system is in final stages of testing. **Date of Implementation:** February 15, 2015 with an estimated completion date of June 15, 2015. **Monitoring Process:** Redesigned system will shut down air handlers should there be any attempt to pull or disable relays. **Person Responsible:** Vice President of Facilities Operations	6/15/2015

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{A 000}	INITIAL COMMENTS The following reflects the findings of the Department of Public Health during the Follow-Up Visit to a Sampled Validation Survey completed on April 1, 2014. Representing the Department of Public Health: Surveyor 17030, RN, HFEN Surveyor 16281, REHS, HFE I Surveyor 10933, Nutritional Consultant Surveyor 17065, Nutritional Consultant Surveyor 25049, MD, Medical Consultant Surveyor 29775, MD, Medical Consultant Surveyor 28851, Pharm D, Pharmacy Consultant Surveyor 29643, RN, Nurse Consultant, L & C Infection Control On August 20, 2014, at 1:30 p.m., the survey team declared an Immediate Jeopardy (IJ) situation, in the presence of the Chief Executive Officer (CEO) of Culver City Campus, director of risk management, as a result of the facility's failure: 1. To ensure flexible endoscopes were stored in accordance with the Association of Peri-Operative Registered Nurse (AORN) Recommended Practices. AORN is the National Recognized Standards (NRS) the hospital identified as the standard they followed. 2. To ensure re-usable surgical instruments were packaged and stored in accordance with the AORN Standards. On August 21, 2014, at 3:45 p.m., the IJ was abated in the presence of the director of risk	{A 000}	**Culver City** **1.) Corrective Actions:** The following was implemented to ensure flexible endoscopes are stored in accordance to the AORN recommended practices: The facility purchased and installed new vented scope cabinet **(Attachment 1)** and placed in a storage area back side of surgery with adequate ventilation for proper storage of scopes; all scopes now have tip protectors to ensure tips do not touch the cabinet; all scopes are tagged after processing with indication of next date to re-process if not in use. Surgical services provided education & in-service to staff on the use of enzymatic cleaners and proper measurements **(Attachment 6);** for scope re-processing; high-level disinfection, and included competency validation and return demonstrations **(Attachment 2).** **Date of Implementation:** Scope Cabinet installed 9-15-14; Education completed on August 12, 2014 and August 21, 2014. **Monitoring Process:** Monitoring managed by daily inspection of the scopes for next date of re-processing; Daily scopes monitoring include before and after each use to ensure proper placement in scope cabinet. Weekly monitoring of all scope procedures are performed to ensure completeness and accuracy of recoding in the log **(Attachment 3)**. Log compliance will be submitted to the Regulatory Compliance Committee & Quality Council to ensure compliance with AORN standards. **Person Responsible:** OR Team/Infection Control. **Hollywood** **1.) Corrective Actions:** The following was implemented to ensure flexible endoscopes are stored in accordance to the AORN recommended practices: The facility purchased and installed new vented scope cabinet and placed in a storage area back side of surgery with adequate ventilation for proper storage of scopes **(Attachment 4)**; all scopes now have tip protectors to ensure tips do not touch the cabinet; all scopes are tagged after processing with indication of next date to re-process if not in use. Surgical services provided education & in-service to staff on the use of enzymatic cleaners and proper measurements; for scope re-processing; high-level disinfection, and included competency validation and return demonstrations **(Attachment 5).** **Date of Implementation:** Scope Cabinet installed 9-8-14; Education completed on August 11, 2014 and August 20, 2014; and repeated September 22, 2014. **Monitoring Process:** Monitoring managed by daily inspection of the scopes for next date of re-processing; Daily scopes monitoring include before and after each use to ensure proper placement in scope cabinet. Weekly monitoring of all scope procedures are performed to ensure completeness and accuracy of recoding in the log **(Attachment 7).** Log compliance will be submitted to the Regulatory Compliance Committee & Quality Council to ensure compliance with AORN standards. **Person Responsible:** OR Team/Infection Control.	8/12/2014 8/21/2014 9/15/2014 8/11/2014 8/20/2014 9/8/2014 9/22/2014

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

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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{A 000}	INITIAL COMMENTS The following reflects the findings of the Department of Public Health during the Follow-Up Visit to a Sampled Validation Survey completed on April 1, 2014. Representing the Department of Public Health: Surveyor 17030, RN, HFEN Surveyor 16281, REHS, HFE I Surveyor 10933, Nutritional Consultant Surveyor 17065, Nutritional Consultant Surveyor 25049, MD, Medical Consultant Surveyor 29775, MD, Medical Consultant Surveyor 28851, Pharm D, Pharmacy Consultant Surveyor 29643, RN, Nurse Consultant, L & C Infection Control On August 20, 2014, at 1:30 p.m., the survey team declared an Immediate Jeopardy (IJ) situation, in the presence of the Chief Executive Officer (CEO) of Culver City Campus, director of risk management, as a result of the facility's failure: 1. To ensure flexible endoscopes were stored in accordance with the Association of Peri-Operative Registered Nurse (AORN) Recommended Practices. AORN is the National Recognized Standards (NRS) the hospital identified as the standard they followed. 2. To ensure re-usable surgical instruments were packaged and stored in accordance with the AORN Standards. On August 21, 2014, at 3:45 p.m., the IJ was abated in the presence of the director of risk	{A 000}	**Culver City** **2.) Corrective Actions:** The following was implemented to ensure re-usable surgical instruments (SI) are packed & stored in accordance with the AORN recommended practices: 1) All re-usable surgical instruments (SI) were re-processed, packaged, and stored in accordance to AORN standards; 2) bin dividers purchased to ensure packages are stored up-right on 9/5/2014 **(Attachment: 8)**. 3) 5 inch stringers were purchased to ensure SI are completely open for processing & implemented on 8/25/2014 **(Attachment: 9)**; 4). 3 M Comply cards purchased and placed into service to ensure tip and lock boxes in peel packs maintain an open position for sterilization on 8/26/14 **(Attachment: 10)**; 5). Purchased new biological incubator and indicator with corresponding supplies for sterilization on 10/10/14; 6). Provided education/in-service to staff on standards for processing, packaging and storing of SI, this includes competency validation and return demonstration **(Attachment 11)**. **Date of Implementation:** August 20, 2014 Immediate Staff Education SI re-processing completed **Monitoring Process:** Monitoring will be managed once bimonthly by Infection Control rounds with ORT or RN (**Attachment 12)** with compliance reported to the Regulatory Compliance Committee & Quality Council to ensure AORN standards are maintained. **Person Responsible:** Infection Control/OR Director **Hollywood** **2.) Corrective Actions:** The following was implemented to ensure re-usable surgical instruments (SI) are packed & stored in accordance with the AORN recommended practices: 1) All re-usable surgical instruments (SI) were re-processed, packaged, and stored in accordance to standards; 2) bin dividers purchased and installed to ensure packages are stored up-right 9/5/2014 (**Attachment 13)** . 3). new instrument trays to accommodate the 5-6 inch stringers that were purchased to ensure SI are completely open for processing 8/25/2014 **(Attachment 14**); 4) tip protectors purchased and placed to prevent tears and penetration of peel packs 9/9/2014; 5). Purchased new biological incubator and indicator with corresponding supplies for sterilization 9/8/2014; **(Attachment 15)** 6). Provided education/in-service to staff on standards for processing, packaging and storing of SI, this includes competency validation and return demonstration. **(Attachment 16)** **Date of Implementation**: August 20, 2014 Immediate Education SI re-processed; Education incubator/indicator September 24, 2014 and repeated October 8, 2014 with competency validation and return demonstration **(Attachment 17**) **Monitoring Process:** Monitoring will be managed during bi-weekly IC rounds with ORT **(Attachment 12)** with compliance reported to the Regulatory Compliance Committee & Quality Council to ensure AORN standards are maintained. **Person Responsible:** Infection Control/OR Team	8/20/2014 8/20/2014

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{A 000}	Continued From page 1 management and CEO of the facility's Culver City campus.	{A 000}	Continued on page 1a.	
{A 263}	482.21 QAPI The hospital must develop, implement and maintain an effective, ongoing, hospital-wide, data-driven quality assessment and performance improvement program. The hospital's governing body must ensure that the program reflects the complexity of the hospital's organization and services; involves all hospital departments and services (including those services furnished under contract or arrangement); and focuses on indicators related to improved health outcomes and the prevention and reduction of medical errors. The hospital must maintain and demonstrate evidence of its QAPI program for review by CMS. This CONDITION is not met as evidenced by: Based on observation, record review, and interview, the hospital failed to develop, implement, and maintain an effective quality assurance performance improvement (QAPI) program as evidenced by: 1. Failure of the QAPI program to ensure the quality program assessed the effectiveness and processes of cleaning sterilizing and packaging surgical instruments, a deficiency found at the time of a validation survey three month earlier (Refer to A 283). 2. Failure of the QAPI to identify opportunities for improvement and change in the cleaning,	{A 263}	**1.) Corrective Actions (Surgical Instruments):** All re-usable surgical instruments (SI) were re-processed, packaged, and stored in accordance to AORN standards; bin dividers were purchased to ensure packages are stored up-right on 9/5/2014. 5 inch stringers were purchased to ensure SI tips and lock boxes are completely open for processing on 8/25/2014; 3M Comply cards purchased and placed into service to ensure tip and lock boxes in open position for sterilization of peel packs on 9/9/2014; Purchased new biological incubator and indicator with corresponding supplies for sterilization on 9/8/ 2014; Provided education/in-service to staff on standards for processing, packaging/storing of SI, the use of enzymatic cleaners/proper measurements for scope re-processing, and high-level disinfection to include competency validation and return demonstration **(Refer to A-000.1).** Revision to policy SCA.025 Selection and use of packing systems for sterilization with staff education (**Attachment 1)** **Date of Implementation:** Education completed August 11, 2014 and August 20, 2014 and repeated September 22, 2014 **Monitoring Process:** Monitoring will be conducted daily by the GI/OR Team and bi-weekly through IC rounds with RN or OR technician **(Refer to A-297 for attachment 1)** Compliance will be reported to the Regulatory Compliance Committee & Quality Council on a monthly basis for a minimum of 6 months or until target benchmarks of compliance is achieved to ensure the effectiveness of the processes for cleaning, sterilizing, packaging and storage of surgical instruments. Should variance from standard practice be identified, the hospital will take immediate action to improve performance, measure the success of the improvements, and monitor performance to ensure that the improvements are sustained. **Person Responsible**: Director of OR (or designee), Director of Infection Control (or designee), and Director of Quality **2).Corrective Actions (Colonoscopes):** Purchased and installed new ventilated scope cabinets and placed them in areas with adequate ventilation for proper storage of colonoscopes; all colonoscopes now have tip protectors to ensure tips do not touch the cabinets; all colonoscopes are tagged after processing to indicate the next date to re-process if not in use. Revision to policy SGI.006 Cleaning and disinfection of endoscopes with staff education (**Attachment 2)** **Date of Implementation:** Scope cabinet installed at Hollywood September 8, 2014; Scope cabinet installed at Culver City September 15, 2014	8/11/2014 8/20/2014 9/22/2014 9/8/2014 9/15/2014

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{A 263}	Continued From page 2 maintenance and storage of colonoscopes in order to reduce the risk of patient infections from an instrument contaminated by bacteria acquired from use on previous patients (Refer to A 283). 3. Failure to have an ongoing quality appraisal and performance improvement program that addressed the complexity and scope of Nutrition and Dietetic Services. This has resulted in failure to identify issues in safe food handling practices, food storage and sanitation all of which could result in foodborne illness. Additionally, departmental staff failed to recognize inadequacies in services that could lead to unmet patient nutritional needs (Refer to A 297). The cumulative effects of these systemic problems resulted in the facility inability to assure quality health care in a safe environment.	{A 263}	**Monitoring Process:** Monitoring utilizing daily inspection of colonoscopes for next date of re-processing and after each use to ensure proper placement in the scope cabinet. Weekly monitoring of all colonoscope procedures to ensure completeness and accuracy of log **(Refer to A-000.1).** Compliance will be reported to the Regulatory Compliance Committee & Quality Council on a monthly basis for a minimum period of 6 months or until targeted benchmarks of compliance is achieved and then periodically as indicated based on PI plan to ensure the effectiveness of the cleaning, maintenance, and storage of colonoscopes in an effort to mitigate potential infection risk. Should variance from standard practice be identified, the hospital will take immediate action to improve performance, measure the success of the improvements, and monitor performance to ensure that the improvements are sustained. **Person Responsible:** Director of OR (or designee), and Director of Infection Control (or designee), Director of Quality **3). Corrective Actions (Ongoing Quality Appraisal for Dietary Services):** The hospital has enhanced its QAPI program to reflect an on-going quality appraisal of the complexity and scope of Nutrition and Dietetic Services by calling for the daily and weekly monitoring of specific indicators that would detect concerns with food handling practices, food storage, sanitation, and unmet patient nutritional needs. Continued on page 3a.	
{A 283}	482.21(b)(2)(ii), (c)(1), (c)(3) QUALITY IMPROVEMENT ACTIVITIES (b) Program Data (2) [The hospital must use the data collected to -.....] (ii) Identify opportunities for improvement and changes that will lead to improvement. (c) Program Activities (1) The hospital must set priorities for its performance improvement activities that-- (i) Focus on high-risk, high-volume, or problem-prone areas; (ii) Consider the incidence, prevalence, and severity of problems in those areas; and (iii) Affect health outcomes, patient safety, and quality of care.	{A 283}		

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{A 263}	Continued From page 2 maintenance and storage of colonoscopes in order to reduce the risk of patient infections from an instrument contaminated by bacteria acquired from use on previous patients (Refer to A 283). 3. Failure to have an ongoing quality appraisal and performance improvement program that addressed the complexity and scope of Nutrition and Dietetic Services. This has resulted in failure to identify issues in safe food handling practices, food storage and sanitation all of which could result in foodborne illness. Additionally, departmental staff failed to recognize inadequacies in services that could lead to unmet patient nutritional needs (Refer to A 297). The cumulative effects of these systemic problems resulted in the facility inability to assure quality health care in a safe environment.	{A 263}	Continued from page 3 The quality appraisal consists of monitoring activity outcomes data that is submitted to the hospital's Regulatory Compliance Committee and to it Quality Council on a monthly basis. Monitoring activity consists of the following quality appraisals: (1) Correct consistency of pureed foods (pudding-like), (2) Food items evaluated for correct temperatures, (3) Food items evaluated for palatability, (4) Stock dishware/flatware used to serve patient meals, (5) Menu recipes followed verbatim, (6) Food items have a documented recipe, (7) Food recipes provide guidance on expected consistency of finished product, (8) Perishable food items dated w/opening and expiration dates, (9) Refrigerator storage space adequate (containers stored to allow ample air circulation), (10) Freezer storage temperature w/range (0 C or less), (11) Refrigerator storage temperature w/range (32F – 41F), (12) Dry storage temperature w/range (50F – 70F), (13) Menus have variety, (14) Planned menus available for special diets, (15) Menus meet the needs of the patients, (16) Recipe substitutions are evaluated for nutritional adequacy, (17) Food items are of proper portion sizes, (18) Enteral feeding administered per order, (19) Closed system used for Enteral feedings, (20) Feeding tubes are dated/timed, (21) Feeding tube "hang time" w/policy, (22) Feeding tube records evidence actual volume delivered, (23) Diet orders administered per therapeutic spreadsheet, (24) Patients receive correct diet order, (25) Unclear diet orders are clarified, (26) Sanitation practices followed (gloves changed between tasks and hand hygiene), (27) Air gaps installed on sinks, (28) Proper protection used when disposing garbage, (29) Dry wiping cloths used to dry food production equipment. **Date of Implementation:** October 28, 2014 **Monitoring Process:** Monitoring activity outcomes data **(Attachment 3)** is submitted to the hospital's Regulatory Compliance Committee on a weekly basis and to it Quality Council on a monthly basis. Further, monitoring activity outcomes data will be reported up to the hospital's MEC and Governing Board on a quarterly basis. Should variance from standard practice be identified, the hospital will take immediate action to improve performance, measure the success of the improvements, and monitor performance to ensure that the improvements are sustained. **Person (s) Responsible:** Director of Quality; Director of Dietary Services; Director of Infection Prevention	10/28/2014

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{A 283}	Continued From page 3 (3) The hospital must take actions aimed at performance improvement and, after implementing those actions, the hospital must measure its success, and track performance to ensure that improvements are sustained. This STANDARD is not met as evidenced by: Based on interview and record review, the hospital failed to develop, implement, and maintain an effective quality assurance performance improvement (QAPI) program as evidenced by: 1. Failure of the QAPI to identify opportunities for improvement and change in the cleaning, maintenance and storage of colonoscopes in order to reduce the risk of patient infections from an instrument contaminated by bacteria acquired from use on previous patients. 2. Failure of the QAPI program to ensure the quality program assessed the effectiveness and processes of cleaning, sterilizing and packaging surgical instruments. Findings: 1. On August 20, 2014 at 2:00 p.m., an interview of Physician 1 and review of the facility's Quality Council Management Meeting Summary report dated July 17, 2014, in regards to the activities of the Performance Improvement Committee of the Quality Council failed to reveal evidence of activities to identify opportunities for improvement and change in the cleaning, maintenance, and	{A 283}	**1).Corrective Actions:** In an effort to mitigate the risk of patient infections from instruments (colonscopes) that may contain bacteria acquired from the use of a previous patient, the hospital has enhanced its QAPI program to reflect an on-going quality appraisal of the complexity and scope of its sterile processing activities that would identify opportunities for improvement in the change in the cleaning, maintenance, and storage of colonoscopes. The quality appraisal consists of monitoring activity outcomes data that is submitted to the hospital's Regulatory Compliance Committee and to it Quality Council on a monthly basis. Monitoring activity consists of the following quality appraisals: (1) Flexible scopes hung in a secure vertical position housed in a ventilated cabinet, (2) Flexible scope tips contain protectors and do not touch cabinet wall, (3) Flexible scopes reprocessed before use if not used w/5 days. **Date of Implementation:** August 20, 2014 **Monitoring Process:** Monitoring activity outcomes data **(Attachment 1)** is submitted to the hospital's Regulatory Compliance Committee and to it Quality Council on a monthly basis. Further, monitoring activity outcomes data will be reported up to the hospital's MEC and Governing Board on a quarterly basis. Should variance from standard practice be identified, the hospital will take immediate action to improve performance, measure the success of the improvements, and monitor performance to ensure that the improvements are sustained. **Person (s) Responsible:** Director of Quality: Director of Operating Room; Director of Infection Prevention. **2). Corrective Actions:** In an effort to ensure the effectiveness of its processes for cleaning, sterilizing and packaging surgical instruments, the hospital has enhanced its QAPI program to reflect an on-going quality appraisal of the complexity and scope of its sterile processing activities that would identify opportunities for improvement in the management of re-usable surgical instruments to ensure that packing and storage is in accordance with AORN standards. The quality appraisal consists of monitoring activity outcomes data **(Attachment 2)** that is submitted to the hospital's Regulatory Compliance Committee and to it Quality Council on a monthly basis. Monitoring activity consists of the following quality appraisals: (1) Surgical instrument pouches stored in vertical manner, (2) Forceps blades open; tips not touching; lock boxes open; instruments hung on proper stringer, (3) Supplies stored as per AORN guidelines (not stacked). **Date of Implementation:** August 20, 2014 **Monitoring Process:** Monitoring activity outcomes data is submitted to the hospital's Regulatory Compliance Committee and to it Quality Council on a monthly basis. Further, monitoring activity outcomes data will be reported up to the hospital's MEC and Governing Board on a quarterly basis. Should variance from standard practice be identified, the hospital will take immediate action to improve performance, measure the success of the improvements, and monitor performance to ensure that the improvements are sustained. **Person (s) Responsible:** Director of Quality; Director of Operating Room; Director of Infection Prevention.	8/20/2014 8/20/2014

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{A 283}	Continued From page 4 storage of colonoscopes in order to reduce the risk of patient infections from an instrument contaminated by bacteria acquired from use on previous patients. An interview of Physician 1 on the same date and time also failed to reveal evidence of the QAPI program to ensure the quality program assessed the effectiveness and processes of cleaning, sterilizing and packaging surgical instruments (Cross reference to A 749 and A 951).	{A 283}		
{A 297}	482.21(d) QAPI PERFORMANCE IMPROVEMENT PROJECTS As part of its quality assessment and performance improvement program, the hospital must conduct performance improvement projects. (1) The number and scope of-distinct improvement projects conducted annually must be proportional to the scope and complexity of the hospital's services and operations. (2) A hospital may, as one of its projects, develop and implement an information technology system explicitly designed to improve patient safety and quality of care. This project, in its initial stage of development, does not need to demonstrate measurable improvement in indicators related to health outcomes. (3) The hospital must document what quality improvement projects are being conducted, the reasons for conducting these projects, and the measurable progress achieved on these projects. (4) A hospital is not required to participate in a QIO cooperative project, but its own projects are required to be of comparable effort.	{A 297}	**Hollywood** **1.) Corrective Actions:** The hospital has enhanced its QAPI program to ensure that its Dietary performance improvement activities extend beyond patient satisfaction surveys and minimal clinical nutrition by calling for a more robust quality appraisal of those concerns which may expose patients to foodborne illnesses and malnutrition. The quality appraisal, designed to evaluate the full scope services, detect variance and identify on-going opportunities for improvement, consists of monitoring activity outcomes data that is submitted to the hospital's Regulatory Compliance Committee and to it Quality Council on a monthly basis. Monitoring activity consists of the following quality appraisals. Dietary (1) Correct consistency of pureed foods (pudding-like), (2) Food items evaluated for correct temperatures, (3) Food items evaluated for palatability, (4) Stock dishware/flatware used to serve patient meals, (5) Menu recipes followed verbatim, (6) Food items have a documented recipe, (7) Food recipes provide guidance on expected consistency of finished product, (8) Perishable food items dated w/opening and expiration dates, (9) Refrigerator storage space adequate (containers stored to allow ample air circulation), (10) Freezer storage temperature w/range (0F or less), (11) Refrigerator storage temperature w/range (32F – 41F), (12) Dry storage temperature w/range (50F – 70F), (13) Menus have variety, (14) Planned menus available for special diets, (15) Menus meet the needs of the patients, (16) Recipe substitutions are evaluated for nutritional adequacy, (17) Food items are of proper portion sizes, (18) Enteral feeding administered per order, (19) Closed system used for Enteral feedings, (20) Feeding tubes are dated/timed, (21) Feeding tube "hang time" w/policy, (22) Feeding tube records evidence actual volume delivered, (23) Diet orders administered per therapeutic spreadsheet, (24) Patients receive correct diet order, (25) Unclear diet orders are clarified, (26) Sanitation practices followed (gloves changed between tasks and hand hygiene), (27) Air gaps installed on sinks, (28) Proper protection used when disposing garbage, (29) Dry wiping cloths used to dry food production equipment. **Date of Implementation:** October 24, 2014 **Monitoring Process:** Monitoring activity outcomes data is submitted to the hospital's Regulatory Compliance Committee	10/24/2014

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{A 297}	Continued From page 5 This STANDARD is not met as evidenced by: Hollywood, Culver City and Van Nuys Campuses In an interview on 8/21/14 beginning at 9 a.m., with Staff A (Hospital Administrator), Staff L (Director .of Food Service), RD (Registered Dietitian) 1, 2, 3 and Staff W (Director, Quality) and concurrent review of performance indicators beginning January 2014 revealed the following improvement activities: 1. At the Hollywood campus, performance improvement activities were limited to data collected through patient satisfaction surveys that included the timeliness of meals served, food temperatures and overall rating of food. With respect to clinical nutrition, care data collection included the timeliness of Registered Dietitian (RD) assessment and accuracy of diet It was noted that for 2014 the hospital's goal was met for all elements; however, the follow up action was to continue to monitor, despite the lack of identification of opportunities for improvement No new activities were identified for improvement for the current year. RD 1 acknowledged that with the majority of these indicators the department was meeting or exceeding the departmental set thresholds. She also stated that within the last several years the department had not identified new issues that may warrant a performance improvement study. It was also noted, there was no evaluation of the effectiveness of food handling systems within the department There have been deficient practices in the areas of food service operation and clinical nutrition services identified by the survey team at the initial	{A 297}	and to it Quality Council on a monthly basis. Further, monitoring activity outcomes data will be reported up to the hospital's MEC and Governing Board on a quarterly basis. Should variance from standard practice be identified, the hospital will take immediate action to improve performance, measure the success of the improvements, and monitor performance to ensure that the improvements are sustained. (**Attachment 1)** **Person (s) Responsible:** Director of Quality; Director of Dietary Services; Director of Infection Prevention. **Culver City** **2.) Corrective Actions:** The hospital has enhanced its QAPI program to ensure that it evaluates the full scope of Dietary services to ensure that **corrective action** is implemented when variance is detected and to ensure that an evaluation of the effectiveness of those **corrective action** interventions is performed. The hospital has implemented a quality appraisal that is designed to evaluate the full scope of services, detect variance and identify on-going opportunities for improvement. The quality appraisal is inclusive of on-going monitoring activity which consists of the reporting of outcomes to the hospital's Regulatory Compliance Committee and to its Quality Council on a monthly basis. Monitoring activity consists of the following quality appraisals: (1) Correct consistency of pureed foods (pudding-like), (2) Food items evaluated for correct temperatures, (3) Food items evaluated for palatability, (4) Stock dishware/flatware used to serve patient meals, (5) Menu recipes followed verbatim, (6) Food items have a documented recipe, (7) Food recipes provide guidance on expected consistency of finished product, (8) Perishable food items dated w/opening and expiration dates, (9) Refrigerator storage space adequate (containers stored to allow ample air circulation), (10) Freezer storage temperature w/range (0F or less), (11) Refrigerator storage temperature w/range (32F – 41F), (12) Dry storage temperature w/range (50F – 70F), (13) Menus have variety, (14) Planned menus available for specia diets, (15) Menus meet the needs of the patients, (16) Recipe substitutions are evaluated for nutritional adequacy, (17) Food items are of proper portion sizes, (18) Enteral feeding administered per order, (19) Closed system used for Enteral feedings, (20) Feeding tubes are dated/timed, (21) Feeding tube "hang time" w/policy, (22) Feeding tube records evidence actual volume delivered, (23) Diet orders administered per therapeutic spreadsheet, (24) Patients receive correct diet order, (25) Unclear diet orders are clarified, (26) Sanitation practices followed (gloves changed between tasks and hand hygiene), (27) Air gaps installed on sinks, (28) Proper protection used when disposing garbage, (29) Dry wiping cloths used to dry food production equipment. The hospital will continue to review its QAPI program for opportunities to further enhance it to target opportunities for improvement and mitigation of identified issues. **Date of Implementation**: October 24, 2014 **Monitoring Process:** Monitoring activity outcomes data is submitted to the hospital's Regulatory Compliance Committee and to it Quality Council on a monthly basis. Further, monitoring activity outcomes data will be reported up to the hospital's MEC and Governing Board on a quarterly basis.	10/24/2014

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{A 297}	Continued From page 6 and subsequent validation visits such as incorrec consistencies for pureed diet, equipment failures staff in competencies that could have been used to develop new performance improvement activities. 2. At the Culver City campus, review of the Performance Improvement document showed staff tracking the implementation of RD recommendations and timeliness of nutrition interventions. It was noted that while actions were put into effect in both of these instances, the effectiveness of the interventions were not fully evaluated, rather the follow up was to continue to monitor. The hospital failed to evaluate and implement **corrective actions** in areas where problems had been identified. It was also noted that since January 2014 the temperature of patient food at the time of service was reviewed and was found to be below the hospital goal. It was noted that proper refrigeration was the basis of the problem; however as of 8/21/14 the issue had not yet been fully resolved. 3. At the Van Nuys campus, the improvement activities included diet accuracy, overall rating of food, timely RD assessment, food temperatures and timeliness of meal service. It was noted that all the parameters with the exception of 1 month with respect to meal timeliness the facility met the goal for all elements. It was noted that overall the hospital failed to demonstrate a performance improvement program that fully represented the scope and nature of the departmental functions. While campus wide data was collected, the majority of the data did not demonstrate opportunities for improvement. It was also noted that in areas	{A 297}	Should variance from standard practice be identified, the hospital will take immediate action to improve performance, measure the success of the improvements, and monitor performance to ensure that the improvements are sustained. (**Attachment 1**) **Person (s) Responsible:** Director of Quality; Director of Dietary Services; Director of Infection Prevention. **Van Nuys** **3.) Corrective Actions:** The hospital has enhanced its QAPI program to ensure that it evaluates the full scope of Dietary services to ensure that **corrective action** is implemented when variance is detected and to ensure that an evaluation of the effectiveness of those **corrective action** interventions is performed. The hospital has implemented a quality appraisal that is designed to evaluate the full scope of services, detect variance and identify on-going opportunities for improvement. The quality appraisal is inclusive of on-going monitoring activity which consists of the reporting of outcomes to the hospital's Regulatory Compliance Committee and to it Quality Council on a monthly basis. Monitoring activity consists of the following quality appraisals: (1) Correct consistency of pureed foods (pudding-like), (2) Food items evaluated for correct temperatures, (3) Food items evaluated for palatability, (4) Stock dishware/flatware used to serve patient meals, (5) Menu recipes followed verbatim, (6) Food items have a documented recipe, (7) Food recipes provide guidance on expected consistency of finished product, (8) Perishable food items dated w/opening and expiration dates, (9) Refrigerator storage space adequate (containers stored to allow ample air circulation), (10) Freezer storage temperature w/range (0F or less), (11) Refrigerator storage temperature w/range (32F – 41F), (12) Dry storage temperature w/range (50F – 70F), (13) Menus have variety, (14) Planned menus available for special diets, (15) Menus meet the needs of the patients, (16) Recipe substitutions are evaluated for nutritional adequacy, (17) Food items are of proper portion sizes, (18) Enteral feeding administered per order, (19) Closed system used for Enteral feedings, (20) Feeding tubes are dated/timed, (21) Feeding tube "hang time" w/policy, (22) Feeding tube records evidence actual volume delivered, (23) Diet orders administered per therapeutic spreadsheet, (24) Patients receive correct diet order, (25) Unclear diet orders are clarified, (26) Sanitation practices followed (gloves changed between tasks and hand hygiene), (27) Air gaps installed on sinks, (28) Proper protection used when disposing garbage, (29) Dry wiping cloths used to dry food production equipment. The hospital will continue to review its QAPI program for opportunities to further enhance it to target opportunities for improvement and mitigation of identified issues. **Date of Implementation:** October 24, 2014 **Monitoring Process:** Monitoring activity outcomes data is submitted to the hospital's Regulatory Compliance Committee and to it Quality Council on a monthly basis. Further, monitoring activity outcomes data will be reported up to the hospital's MEC and Governing Board on a quarterly basis. Should variance from standard practice be identified, the hospital will take immediate action to improve performance, measure the success of the improvements, and monitor	10/24/2014

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{A 297}	Continued From page 7 where opportunities for improvement were identified, there were no timely interventions to mitigate the identified issue.	{A 297}	performance to ensure that the improvements are sustained. (**Attachment 1)** **Person (s) Responsible:** Director of Quality; Director of Dietary Services; Director of Infection Prevention.	
{A 500}	482.25(b) DELIVERY OF DRUGS In order to provide patient safety, drugs and biologicals must be controlled and distributed in accordance with applicable standards of practice, consistent with Federal and State law. This STANDARD is not met as evidenced by: Based on observations, interviews and records review, the facility failed to properly label the drawers of the fifth and fourth floors crash carts. This deficient practice had the potential to cause delay during an emergency situation that required the use of crash carts. Findings: Hollywood Campus On 8/18/14 at 10 a.m., on the fifth floor, during a crash cart inspection with Pharm 2 (director of pharmacy) , the contents of drawer #1 of the Crash Cart did not match the label affixed to the exterior of the drawer. Pharm 2 stated the nursing leadership was in the process of reorganizing the crash cart contents. At 10:20 a.m., during another crash cart inspection on the fourth floor with Pharm 2, Pharm 2 acknowledged that the label affixed to the exterior of the drawer#1 was also old and not accurate. A comparison of the crash cart content list and the label affixed to the drawers revealed that	{A 500}	**Hollywood** **1).Corrective Actions:** The fifth and fourth floor crash cart drawers have been labelled and updated with appropriate list of medications matching labels on medication drawers. Staff in servicing **(Attachment 1 & 2)** **Date of Implementation:** August 22, 2014 **Monitoring Process:** Monthly nursing unit inspection by pharmacy department to make sure medication list is in place and matches list of medications inside the crash cart. **(Attachment: 3)** **Person Responsible**: Pharmacy/ Nursing	8/22/2014

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{A 500}	Continued From page 8 three out of the thirty medications listed on the label were not on the content list. Also, one of out of the thirty medications was listed in a different strength. A review of the facility's policy and procedure, titled "Crash Cart," Number: PAT.058, dated 11/2012, indicated " ...the pharmacist shall check the drug and IV contents ... and apply a label to the outside of the cart ... A list of the crash cart medications…shall be kept on the outside of the cart ... " This is a repeat deficiency from the sample validation survey completed on 4/1/14.	{A 500}		
{A 502}	482.25(b)(2)(i) SECURE STORAGE All drugs and biologicals must be kept in a secure area, and locked when appropriate. This STANDARD is not met as evidenced by: Based on observations, interviews and documents review, the facility failed to ensure medication storage areas are accessible only to the authorized facility staff. This deficient practice had the potential for unauthorized person to access medication storage areas. Findings: Hollywood Campus On 8/18/14 at 10:15 a.m. on the fifth floor, during an inspection of the medication room with Pharm 2 (director of pharmacy), the surveyor was able to push open the door to the medication room without deactivating the keypad lock on that door.	{A 502}	**Hollywood** **1).Corrective Actions:** Medication room locks were changed to card readers. Card readers were provided to authorized personnel only. **(Attachment 1)**. Policy (PHA0.24) for "Drug administration: Who may administer and have an access to medications" was updated in September 2014 **(Attachment 2)**. Staff in-service **(Attachment 3)** **Date of Implementation:** September 18, 2014 **Monitoring Process:** Monthly nursing unit inspection **(Attachment 4)** **Person Responsible:** Pharmacy/ Nursing	9/18/2014

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{A 502}	Continued From page 9 In addition, the access door from the nursing station leading to the medication room was not locked. According to the facility policy, titled, "Storage of Medications," Number: PHA.090, dated 10/2012, " ... Medications are to be stored in locked areas not accessible to unlicensed persons ... " In reference to the California Code of Regulations, Title 22, section 70263 (q) (8)," Drugs shall be accessible only to responsible personnel designated by the hospital ..." This is a repeat deficiency from the sample validation survey completed on 4/1/14.	{A 502}		
{A 504}	482.25(b)(2)(iii) ACCESS TO LOCKED AREAS Only authorized personnel may have access to locked areas. This STANDARD is not met as evidenced by: Based on observations, interviews and documents review, the facility failed to ensure the passcode to a locked area was kept secure. There was a passcode written on a limited access door that led to a medication storage area, which made the locked area no longer secured. Findings: On 8/18/14 at 10:40 a.m., on the third floor hallway, the surveyor noticed a door with a keypad lock and a sign "Clean utility." At the top right corner of the door, there was a group of four digits written on the surface. The surveyor	{A 504}	**Hollywood** **1).Corrective Actions**: Security code written on the third floor Clean Utility door was removed immediately. **(Attachment 1)** Third floor Clean Utility room locks were changed to card readers. Card readers were provided to authorized personnel only. **Date of Implementation**: August 18, 2014 **Monitoring Process:** Monthly nursing unit inspection **Person Responsible:** Nursing	8/18/2014

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{A 504}	Continued From page 10 pointed that out to the accompanying Pharm 2 (Director of Pharmacy), Pharm 2 said the four digits were the passcode to the keypad lock for that door. Pharm 2 then proceeded to punch in the code and opened the door. Behind the door, there was the Omnicell (an automated drug cabinet). Then, around the corner, there was the medication room that stored large volumes and other miscellaneous medications that were not stored inside the Omnicell. On 8/20/14, at 10:30 a.m., the Pharm 1 (Vice President Pharmacy Operations) confirmed that there was no policy and procedure on safeguarding the access codes to limited access areas.	{A 504}		
{A 618}	482.28 FOOD AND DIETETIC SERVICES The hospital must have organized dietary services that are directed and staffed by adequate qualified personnel. However, a hospital that has a contract with an outside food management company may be found to meet this Condition of Participation if the company has a dietitian who serves the hospital on a full-time, part-time, or consultant basis, and if the company maintains at least the minimum standards specified in this section and provides for constant liaison with the hospital medical staff for recommendations on dietetic policies affecting patient treatment. This CONDITION is not met as evidenced by: Based on observation, review of facility documents and staff interviews, the hospital failed to ensure that the food and dietetic department was organized in a manner appropriate to the scope and complexity of the food service	{A 618}		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN CALIFORNIA HOSPITAL AT HOLLYWOOD	6245 DE LONGPRE AVE HOLLYWOOD, CA 90028

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{A618}	Continued From page 11 operations. As a result of the deficient practices identified during August 18-21, 2014 inspection, the hospital failed to ensure that the department was organized in a manner to ensure that dietary services met the needs of all patients as evidenced by failure to: 1. Provide organized dietetic services as evidenced by findings of unsafe food handling practices (Refer to A 620, A628). 2. Ensure meal portions were accurate, menus and preparation methods were in compliance with nationally recognized practices (Refer to A 630). 3. Plan menus for all physician ordered diets (Refer to A 628). 4. Lack of an effective system to ensure that physician ordered diets were followed (Refer to A 628). 5. Ensure safe and effective food storage/production practices (Refer to A 620, A 749). 6. Ensure adequate food on hand for use in an emergency (Refer to A 701). 7. Failure to have an ongoing quality appraisal and performance improvement program that addressed the complexity and scope of Nutrition and Dietetic Services (Refer to A 267). 8. Ensure that there was adequate ventilation and proper temperature controls in the kitchen and dry food storage areas (Refer to A 726). 9. Failure to maintain refrigerators, freezers, plate warmer and supplies to an acceptable level of safety and quality (Refer to A724, A 726). The cumulative effects of these systemic problems resulted in the facility's inability of the	{A618}	**1). Corrective Actions:** unsafe food handling: As of 10-4-14, contracted food and dietetic services management company was secured to provide a consistent organized approach to services for FNS for all three campuses. This includes a consistent organized same policies, procedures and manuals used for all three campuses. In service was provided to staff in related to proper safe food handling per the 2013 Food Code. Competency of staff was assessed individually (1:1 competency assessment) **(Attachment 1 & 2)** Competency validation **(Attachment 3)** **Date of Implementation:** 6/20/2014 to 10/23/2014 **Monitoring Process:** Food handling practices are monitored monthly by Infection Control through kitchen inspection and observation of employee's performance. **Person Responsible:** Directors of Food Service, RD, Infection Control. **2). Corrective Actions:** (Meal Portions accurate menus & preparation methods in compliance with nationally recognized standards) New menus have been implemented to include accurate portions and standardized recipes with preparation methods that meet nationally recognized standards. Food & Nutrition Policy FNS. B016 Standardized Recipes illustrating the requirement to use standardized recipes and the components of a recipe including preparation instructions has been adopted in all facilities under the license. The menus and nutritional analysis of menus were approved by the Pharmacy & Therapeutics committee, Med Executive Committee and Governing Board. Staff training included the reading of menu spreads, standardized recipes and portion control. (**Attachment 4)** **Date of Implementation**: August 22- September 16 2014 **Monitoring Process:** The meal portions and preparation methods were observed as part of the tray accuracy monitoring noting portion, taste and appearance. 100% of trays were monitored for accuracy during menu implementation until 90% or better accuracy was achieved **(Attachment 5)**. Ongoing monitoring of tray accuracy will continue to be monitored with a minimum of 100 trays per week as part of the department performance improvement program and appropriate action for compliance meets the standard of 97% trays meet accuracy standards. Results of monitoring and actions taken to improve compliance are reported monthly to the Facility Quality Council, Med Executive committee and Governing Board. **Person Responsible:** RD, Director of Dietary Department and Clinical Dietitian RD Continued on page 12a.	6/20/2014 8/22/2014

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{A 618}	Continued From page 12 hospital's food and nutrition services to direct the staff in such a manner to ensure that the nutritional needs of the patients were met in accordance with the physician's orders and acceptable standard of practice.	{A618}		
{A 620}	482.28(a)(1) DIRECTOR OF DIETARY SERVICES The hospital must have a full-time employee who- (i) Serves as director of the food and dietetic services; (ii) Is responsible for daily management of the dietary services; and (iii) Is qualified by experience or training. This STANDARD is not met as evidenced by: Based on observations, review of hospital documents, and staff interviews, the facility failed to ensure that persons in the position of food service director demonstrated authority for the direction of the food and dietary service. There were deficient practices in all three campuses in the one or more of the following areas: safety practices for food handling, emergency food supplies, personnel performance, menu planning, purchasing of foods and supplies and quality assurance performance improvement (QAPI). Findings: Hollywood Campus 1. On 8/18/14 beginning at 11:45 a.m., Dietary Staff (DS) 2 was observed preparing pureed green beans. It was noted that he placed 4 cups of cooked green beans in the blender after which he added 16 ounces of fluid. He was then	{A 620}	**All Campuses** **Corrective Action:** For Culver City facility identified a Director of Food and Nutritional Services (RD); Hollywood facility identified a Director of Food and Nutritional Services (RD); Van Nuys facility identified a Director of Food and Nutritional Services (RD). All three directors have assumed the leadership role for dietary services. **Hollywood** **1). Corrective Action:** New menus have been implemented to include accurate portions and standardized recipes with preparation methods that meet nationally recognized standards. Staff has been in-serviced on proper preparation of menu items including purees and the use of thickeners and the importance of following standardized recipes. Competency testing and return demonstration has been conducted **(Attachment 1).** Food & Nutrition Policy FNS. B016 Standardized Recipes illustrating the requirement to use standardized recipes and the components of a recipe including preparation instructions has been implemented in all three facilities. The new menus and nutritional analysis of specified portions and standardized recipes with appropriate preparation methods were approved by the committees.	

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{A 620}	Continued From page 13 observed pouring the green beans into a steam pan. The resultant texture of the item was a grainy liquid resembling runny applesauce. Concurrent observation also noted that the pureed meat was of a similar consistency. OS 2 utilized a soup ladle to portion the pureed meat and vegetables into individual plastic cups. On 8/18/14 beginning at 11:30 a.m., meal production was observed. OS 2 was preparing green beans by draining them into a colander and placing them on the steam table. There was no observation for the addition of margarine or spices to the beans. At 12:15 p.m., meal distribution was observed. It was noted that the roast beef being served was surrounded by a clear broth-like fluid and the green beans appeared to have a dried exterior texture. Review of recipe titled, 'Roast Beef' revealed that in addition to the meat the recipe called for 1 teaspoon of garlic powder and 1 teaspoon of black pepper for a 24 pound roast. While each of these spices could add flavor to the item, the quantity of 1 teaspoon each would have no discernable flavor once the item was cooked. Similarly the recipe titled, "Green Beans" called for 1 cup of margarine, 2-1/4 teaspoons of salt and % teaspoon of pepper for 75 servings. The amount of salt and pepper would have not have had any impact on the flavor of the food. On 8/18/14 at 1:05 p.m., as a result of these observations, a test tray for taste and temperature was completed. The temperatures of the items were as follows: roast beef 115° (degrees) F (Fahrenheit), green beans - 110°F milk- 52°F and tapioca- 64°F. In addition to recording food temperatures each of the items was tasted. It was noted that the roast beef and	{A 620}	**Date of Implementation:** August 22- September 16 2014 **Monitoring Process:** The portions, appearance, taste and temperatures of menu items made using specified preparation methods are observed as part of the tray quality assessment monitoring **(Attachment: 2)**. Test tray quality assessments are performed at a minimum of 3-5 times per week and results are reported monthly to Quality. **Person Responsible:** RD, Director of Dietary Department and Clinical Dietitian RD	8/22/2014

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{A 620}	Continued From page 14 green beans were lukewarm. The roast beef was not tender and both the roast beef and green beans were bland. Similarly the items intended to be served cold such as the milk were warm. A test tray was also completed for the pureed items. It was noted that the items were grainy, watery (consistency of soup) with a bland flavor. In a follow up observation on 8/18/14 beginning at 5:15 p.m., the evening meal entree consisted of roasted chicken, garden rice and carrots. It was noted that the garden rice was substituted with plain white rice. It was also noted that the consistency of the pureed items was similar to the noon meal, a liquid consistenc y: A taste sampling was done on 8/18/14 at 5:45 p.m. It was noted that the carrots and pureed rice were watery and had no flavor. The pureed chicken had a gritty texture and was not flavorful either. In a concurrent interview Staff L (Director of Food Services) stated that she had substituted plain canned chicken for the roasted. The roasted chicken and canned pureed chicken were not similar in flavor. Pureeing the roasted chicken served to patients on a regular diet would have been more flavorful than the canned pureed chicken. Document review on 8/18/14 beginning at 5:45 p.m., of the pureed green bean recipe revealed that staff should have added a food thickener to the product. It was also noted that the recipe failed to provide any guidance on the expected consistency of the finished product. According to the Academy of Nutrition and Dietetics' Nutrition Care Manual titled, "Nutrition Therapy for Pureed Diet," "Food should be "pudding-like" ...Be sure that any pureed foods prepared in advance the consistency of pudding or moist mashed	{A 620}		

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{A 620}	Continued From page 15 potatoes." Under the heading Cooking Preparation Tips it states, "when pureeing or blenderizing foods, add as little fluid initially as possible." The issue with the preparation of incorrect consistency of pureed food was identified in the previous survey. Review of departmental document titled, "Garden Rice" dated 2/5/05 noted that the rice should have contained sauteed onions, bay leaves and chicken soup base. No explanation was provided as to why the recipe for "Garden Rice" was not followed. Review of departmental policy and procedure manual on 8/18/14 failed to reveal a policy for evaluation of temperature and palatability of food items. In a concurrent interview with Staff L at 5:35 p.m., she stated the expectation was that hot food was 140°F or greater when patients receive their trays and cold foods should be 41oF or below and acknowledged that the pureed items were not tasteful. She also stated that to her knowledge there was no departmental mechanism for evaluating the quality of patient meals. She further stated she had identified the consistency of pureed items as an issue; however had not provided interventions or guidance to dietary staff on the proper preparation method and desired consistency for the pureed items. Disposable Plates During food distribution observations on 8/18/14 beginning at 3:35 p.m., all patient meals were plated using disposable plates, cups and flatware. In a concurrent interview with Staff L, she stated that staff told her the plate warmer was broken. The surveyor asked for an explanation of why a broken plate warmer would cause the hospital to	{A 620}	**Disposable Plates** **2). Corrective Action:** Available china ware in storage was put into service. Additional china plates and reusable meal tray service ware were purchased. The plate warmer was replaced **(Attachment 3).** Induction heated base unit and china plates, base and dome lids were replaced Additional stock is available to be used for increased patient census. **Date of Implementation:** 8/20/14 **Monitoring Process:** Observation of patient meal assembly to ensure that reusable service ware is used for all patients. Patient with restriction or safety concerns (exhibit aggressive behavior or isolation per policy) will be served in disposable dinnerware. **Person Responsible:** RD, Director of Dietary Department	8/20/2014

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{A 620}	Continued From page 16 utilize all disposable items. She was unable to explain the rationale in response to the use of plates in the absence of a plate warmer. She also acknowledged that during the past 2 weeks, when she took over the position, she had not observed a stock of any dishware or flatware. The use of the disposable plates does not enhance dignity and contributes to the inability to maintain food temperatures. Most food temperature maintenance systems usually includes the use of insulated container and plates that will either generate heat to keep food hot during delivery, or absorb heat to keep food cold during delivery. Disposable plates do not insulate or retain heat. Menu On 8/18/14 beginning at 5:30 p.m., it was noted that the dessert for the evening meal was listed as jello jewels. Concurrent trayline observation revealed patients received a cup portion of plain red jello. It was not clear what "jello jewels" meant on the menu and whether the menu was correctly served. In an interview with OS 3 and concurrent review of the departments' standardized recipes on 8/18/14 at 5:45 p.m., revealed that there was no recipe for this dessert item. Sanitation On 8/18/14 at 11:30 am, OS 2 was observed loading dirty trays with her gloved hands. She was also observed unloading clean trays with the same gloved hand. She was not observed to change gloves, wash her hands, and put on new gloves before proceeding to unload clean trays. A review of the hospital policy titled, "Disposable Glove Use" dated 4/25/12 indicated "Disposable gloves must be changed when dirty or ripped and	{A 620}	**Menu** **3). Corrective Action**: Menus have been implemented to include accurate portions and standardized recipes for all menu items that meet nationally recognized standards. **Date of Implementation:** September 4- September 16, 2014 **Monitoring Process:** 100% of trays are monitored for accuracy of menu implementation with 90% or better rate of compliance. Ongoing monitoring of tray will continue at a 100 trays per week as part of the department performance improvement program. The taste and temperature of patient meal trays is assessed through test tray quality assessment evaluations. Results of monitoring are reported to Quality. **Person Responsible:** RD, Director of Dietary Department and Clinical Dietitian RD **Sanitation** **4). Corrective Action:** Kitchen staff was trained on the policy of glove use and requirement to remove gloves and wash hands after handling dirty dishes and prior to handling clean dishes. Competency and return demonstration was conducted (**Attachment 4)**. Policy FNS F021 Disposable Glove Use. (**Attachment 5)** **Date of Implementation:** September 11, 2014 Oct 23, 2014 **Monitoring Process:** Competency and return demonstration on glove usage. Daily Management Food Service Rounds and the Monthly Infection Control rounding. **Person Responsible:** RD, Director of Dietary Department	9/4/2014 9/11/2014

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{A 620}	Continued From page 17 when moving from one task to another " . Culver City Campus Disposable Plates During food distribution observations on 8/19/14 beginning at 12 p.m., a large percentage of patient meals were delivered on disposable paper plates. In a concurrent interview with DS 7, he stated the patients on the behavioral health unit received paper products and as for the rest of the patients it would depend on the item. He also stated there was a limited number of non-disposable dishware. In an observation on 8/19/14 beginning at 2:45 p.m., there were less than 150 plates within the hospital. During the general dietetic observations on 8/20/14 beginning at 3:30p.m., there were greater than 10 cases of dishware in a chemical closet located in 'the loading dock area. In a concurrent interview with RD (Registered Dietitian) 3, he stated that the hospital planned to reopen the labor and delivery unit and planned to enhance the meal service for this unit. He was unable to verbalize why specifically this unit would receive non-disposable dishware, yet other inpatient units (with the exception of the behavioral health unit) would continue t6 receive disposable dishware. Hospital policy titled, "Patient Food Service" dated 5/14 noted that "Food shall be served ...with appropriate eating utensils ... " Hospital policy titled, "Objective for Patient- Resident Tray Service" dated 4/12 indicated " ...Equal emphasis will be placed on dining program regardless of the level of care." Food Storage During the food storage observation on 8/19/14 beginning at 2 p.m., there were issues	{A 620}	**Culver City** **1). Corrective Action:** Available china ware in storage was put into service. Additional china plates and reusable meal tray service ware were purchased (**Attachment1)**. Additional stock is available to be used for increased patient census. **Date of Implementation:** 8/20/14 **Monitoring Process:** Observation of patient meal assembly to ensure that reusable service ware is used for all patients. Patient with restriction or safety concerns (exhibit aggressive behavior or isolation per policy) will be served in disposable dinnerware. **Person Responsible**: RD, Director of Dietary Department	8/20/2014

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{A 620}	Continued From page 18 surrounding storage and dating of perishable foods. In Refrigerator #1, there were vegetarian hot dogs opened, no date; liquid whole eggs that were thawed, undated; 3 cases of potatoes with manufacturers' guidance to keep frozen. It was also noted there were 2 cases of raw, thawed chicken that were pulled from the freezer on 8/12/14 with a use by date of 8/22/14 (10 days later). In a concurrent interview with RD 3, he was asked to describe the holding time for thawed, raw meat products. RD 3 stated he was unsure; however would refer to the food storage guidelines. He also stated that the expectation would be that all items are labeled and dated once opened. Concurrent review of departmental document titled, "Refrigerated Storage Life of Foods" dated 3/24/14 noted that thawed meats were not to be held for a period greater than 5 days. Department policy titled, "Food Supply and Storage" dated 11/12 noted that "Orange label must be used on all foods ...Items included on label: Date, ...Expiration Date, ... " Trays During the general kitchen observations on 8/19/14 beginning at 2:50 p.m., there were greater than 10 patient meal delivery trays that were cracked and had exposed metal edges. It would be the standard of practice to ensure that all patient meal delivery utensils be free of breaks, open seams, cracks, chips, inclusions, pits, and similar imperfections (Food Code, 2013). Van Nuys Campus Food Storage During observation on 8/19/14 starting at 11:15 a.m., there were observed food storage concerns including inadequate refrigerator storage space,	{A 620}	**Food Storage** **2). Corrective Actions:** The open vegetarian hot dogs with no date were immediately discarded; liquid whole eggs that were thawed undated were discarded; 3 case of potatoes with manufacture guidance to keep frozen & 3 case of raw and thawed chicken that were pulled from freezer 8-12 to be used by 8-22-14 were discarded. All other food items in the kitchen were reviewed, labeled and dated per policy. Staff was in-serviced on labeling dating, food items and thawing with monitoring. **(Attachment-2 & 3)** **Date of Implementation:** August 19, 2014 **Monitoring Process:** Daily inspection by dietary management will be documented on the Supervisor Opening & Daily Check list **(Attachment 3)**. **Person Responsible:** RD, Director of Dietary Department and Executive Chef **Trays** **3). Corrective Actions:** Patient meal trays identified as being cracked with exposed metal edges were immediately removed from service. Replacement trays were removed from storage and put into service. Staff was in-serviced on identifying damaged trays and discarding them. **(Attachment 2)** **Date of Implementation:** October 23, 2014 **Monitoring Process:** The condition of trays will be observed as part of the Routine Infection Control (**Attachment 4**). **Person Responsible:** RD, Director of Dietary Department **Van Nuys** **1). Corrective Action:** Daily monitoring of all storage locations (refrigerators, freezers, and dry storage spaces) will be monitored by kitchen staff and recorded in a log. Rental of a refrigerator truck acting as a supplemental refrigerator storage space is replacing the out of order refrigerator on 9-5-14. **Date of Implementation:** August 22, 2014 **Monitoring Process:** Daily monitoring of refrigerated and frozen food storage locations and the dry food storage location. **Person Responsible:** RD, Director of Dietary Department	8/19/2014 10/23/2014 8/22/2014

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{A 620}	Continued From page 19 improper freezer storage temperatures, and improper dry food storage temperatures. Inadequate refrigerator space is evidenced by the stacking of food and plastic storage food containers on top of another in a manner that did not allow ample air circulation. There was another refrigerator that was labeled "Out of Order" dated 6/4/14. In an interview on 8/19/14 at 4:30p.m. with the Head of Plant Operations, he stated that two weeks earlier the hospital decided that repairing the refrigerator was not ideal because it was too expensive and replacement was more practical. One of the freezers (#5) was observed to read 23 degrees Fahrenheit. According to the hospital policy titled, "Food Storage" dated November 2012, " Frozen foods are stored in the freezer and the temperature is maintained at 0 degrees Fahrenheit or less. Produce is stored in the refrigerator and the temperature is maintained at 32 to 41 degrees Fahrenheit." Foods held at less than optimum temperatures could support the growth of microorganisms that promote spoilage and /or food borne illness. The impact of the inadequate refrigerated space was demonstrated when patients were served cottage cheese instead of milk for lunch on 8/19/14. According to the menu, the patients were to receive Tossed green salad, Baked Fish with lemon, parsley noodles, mixed vegetables, dinner roll, fresh fruit and milk for lunch. Trayline observation showed that patients were served all the items listed above and cottage cheese. In an interview with Staff L (Food Service Director), she explained that the substitution was due to refrigerator space issues. In addition, there were refrigerators/freezers stored in the dry storage	{A 620}	**Improper Freezer Storage Temperatures** **Corrective Action:** Interim measure included the attempted repair of existing freezers and the rental of a freezer truck. **(Attachment)** **Date of Implementation**: Freezer truck rented 8/21/2014 **Monitoring Process:** Daily monitoring of freezer food storage locations **Person Responsible:** RD, Director of Dietary Department, Director of Facilities Management **Corrective Action:** New Freezers were purchased and installed to replace the existing units. **Date of Implementation:** 8/29/2014 **Monitoring Process:** Daily monitoring of freezer food storage locations Monthly reporting of kitchen work order completion tracking to hospital administration. Observation of functionality via EOC rounding. Report of work order completion and Finding of EOC rounding on a monthly basis to Quality Council, Med Executive Committee and the Governing Board. **Person Responsible:** RD, Director of Dietary Department, Director of Facilities Management	8/21/2014 8/29/2014

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{A 620}	Continued From page 20 room emitting heat resulting in high room temperature. At 11:53 a.m. on 8/19/14, the temperature of the dry storage room was 88.6 degrees Fahrenheit. At 12:55 p.m., the temperature was 88 degrees Fahrenheit. The dry storage thermometer gauge had exceeded the graduated the 80 degree mark indicating that the room was warmer than 80 degrees. In a concurrent interview with Staff L, she stated that they do not monitor or keep logs of the dry storage room. According to the same policy described above, "All dry goods are stored in storeroom that is clean, dry and well ventilated ... " The dry storage room was not well-ventilated. The recommended temperature of dry storage by the Food and Drug Administration is between 50 to 70 degrees Fahrenheit. Improperly stored staple foods could result in poor quality such as deterioration of food products including rancidity and altered flavors. Menu Review of the menu for 8/18/14 through 8/19/14 for both Hollywood and Van Nuys Campuses showed continued lack of variety. Concerns with the menu were identified in the Statement of Deficiencies form the April 2014 survey. The patients continued to receive tossed salad every day at lunch. The patients on pureed diet continued to receive mashed potatoes every day for lunch and dinner. For example, at dinner on 8/19/14, the patients on pureed diet received double portions of the mashed potatoes to replace the dinner roll and steamed rice that patients on regular diets were served. In addition, green beans was offered to patients on renal diets for both lunch and dinner on 8/19/14.	{A 620}	**Improper Dry Food Storage Room Temperature** **Corrective Action:** Dry storage area temperatures are being monitored and recorded daily since August 20, 2014 **(Attachment: 1)**. To ensure FDA acceptable range of 50-70 degrees is maintained. **Date of Implementation:** 8/20/14 **Monitoring Process:** Daily monitoring of temperature of the dry food storage location. **Person Responsible:** RD, Director of Dietary Department, Director of Facilities Management **Van Nuys & Hollywood** **Menu** **Lack of Variety** **Corrective Actions**: Menus have been revised to include variety, color, and accurate portions per standardized recipes including purees per nationally recognized standards. Food & Nutrition Services Policy FNS C009 Patient Menu**.** Staff insserviced **(Attachment 2)** **Date of Implementation:** September 4- September 16, 2014 **Monitoring Process**: The revised menu is monitored by manager/supervisor during the tray quality assessment and the patient satisfaction rounds. **(Attachment 3)** **Person Responsible:** RD, Director of Dietary Department and Clinical Dietitian RD	8/20/2014 9/4/2014

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{A 620}	Continued From page 21 There was no written menu for patients on the vegetarian diet. Review of the Patient Diet Order List dated 8/19/14 showed there were two unsampled patients on vegetarian diets. Review of the menu showed that there was no planned menu for the vegetarian diet. Staff L stated in an interview on 8/19/14 that she had interviewed the patient and was "fine" with eggs and dairy. A lack of a planned menu could put the patient at risk of a diet that does not meet nutritional needs and the recommended daily allowance. Review of the hospital policy titled, "Patient Menus" dated 11/12 did not list the vegetarian diet as one of the diets on the patient menu but adds that "other diets as ordered by the physician will be provided for." The therapeutic spreadsheet which is used by dietary staff for the serving of food did not include the vegetarian diet.	{A 620}	**Lack of Vegetarian Options** **Corrective Actions:** A vegetarian menu was put into place with a variety of vegetarian options. The newly implemented menu and menu spread includes both Vegetarian and Vegan options. **Date of Implementation:** August 22, 2014 interim and permanent September 4- September 16 2014 **Monitoring Process:** The new vegetarian menu is monitored manager./supervisor during the tray quality assessment and the patient satisfaction rounds. **(Attachment 3)** **Person Responsible:** RD, Director of Dietary Department and Clinical Dietitian RD	8/22/2014 9/4/2014
{A 628}	482.28(b) DIETS Menus must meet the needs of the patients. This STANDARD is not met as evidenced by: Based on observation, review of hospital documents and staff interviews, the hospital failed to ensure that menus met the needs of two of eight patients (Patient 53 and 54) when substitutes prepared and offered were not of same nutritive value as the items that were originally planned. The hospital also failed to plan in advance menus for vegetarian and gluten-free diets; dietary staff failed to follow recipes to ensure that the nutritive value of the items were met. The lack of planning of menus in advance and failure to follow recipes put the patients at risk of receiving diets that may not be nutritionally balanced and lacking in variety.	{A 628}		

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{A 628}	Continued From page 22 Findings: Hollywood Campus During the trayline observation on 8/18/14 beginning at 11:30 a.m., there were two patients (Patient 53 and 54) one of whom had a physician ordered wheat free diet and the second with a physician ordered vegetarian diet. Wheat free diets are used to treat patients with gluten sensitivity (a protein found in grains). Gluten is found in a wide variety of foods and food additives (Mayo Clinic, 2014). It was noted that the patient with the wheat -free diet received a regular meal tray and the patient with the vegetarian diet received cottage cheese and fruit. In a concurrent interview with DS 2 (Dietary Staff), he stated that for wheat -free diets he would eliminate bread and vegetarian diets usually received items such as cottage cheese and fruit. He stated he did not have a menu spreadsheet for either of these items. In an interview on 8/18/14 at 2:30p.m., with Dietary Staff (DS) 5 she confirmed that the hospital did not have spreadsheets for gluten free or vegetarian diets. Culver City Campus During the food distribution observations on 8/19/14 beginning at 12 p.m., the substitute meal entree was a chicken enchilada. The enchilada contained chicken, corn tortilla, red sauce and a small amount of cheese melted on the top of the casserole. While there was visible chicken in the item, it did not appear that the amount of chicken was substantial in amount of protein for a main entree. It was also noted that the enchilada was cut into approximately 32 pieces and was served using a :X cup serving.	{A628}	**Hollywood** **Corrective Action:** A vegetarian and wheat free menu was put into place with a variety of options. The newly implemented menu and menu spread includes both Vegetarian and Vegan as well as wheat free options. Food Service Staff have been inserviced on the menu spreadsheet **(refer to Attachment: A-620.1 attachment 1)**. **Date of Implementation:** August 22, 2014 - September 16, 2014 **Monitoring Process:** The new menus are monitored by manager/supervisor during the tray quality assessment and the patient satisfaction rounds. **Person Responsible:** RD, Director of Dietary Department and Clinical Dietitian RD **Culver City** **Corrective Actions:** Enchilada casserole recipe was reviewed and kitchen staff inservice to follow the standardized recipe without adjustments and proper portioning of the meal. **(Attachment 1)** **Date of Implementation:** October 23, 2014 **Monitoring Process:** Daily data collection on proper preparation and portioning of the recipes (**Attachment 2).** **Person Responsible:** RD, Director of Dietary Department and RD, Clinical Nutrition Manager	8/22/2014 10/23/2014

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SOUTHERN CALIFORNIA HOSPITAL AT HOLLYWOOD	6245 DE LONGPRE AVE HOLLYWOOD, CA 90028

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{A 628}	Continued From page 23 Review of the standardized titled, "Chicken Enchilada" revealed that the recipe was intended for 24 servings. The recipe also called for greater than 2 pounds of cheese for 24 servings. While there was a light layer of melted cheese on top of the casserole there was no visible amount of cheese in the enchilada. In a concurrent interview with OS 3, she stated the chicken enchilada replaced a vegetarian entree on the menu. She also stated that likely the recipe substitution was not evaluated for nutritional adequacy rather was accepted primarily for patient acceptability. On 8/19/14 at 12:15 p.m., the edible protein was weighed and was noted to be 2 ounces. Review of departmental document showed the edible protein portion of the enchilada was 3 ounces. During an observation of food production activities on 8/19/14 beginning at 2:20 p.m., the dietary staff was preparing sandwiches for patient use. He was observed placing 3 slices of deli turkey with lettuce and 2 slices of bread. In a concurrent interview, OS 6 stated that the items would be used for a meal substitution on trayline as well as for patient snacks. On 8/20/14 at 3 p.m., OS 7 was asked to weight 3 slices of the deli turkey. It was noted the meat weighed 2 ounces. Review of the facility spreadsheet revealed that main entrees were to have 3 ounces of edible protein. Improper portion sizes would result in inadequate calories and protein which could impair wound healing resulting in longer hospital stays. The staff had failed to follow recipes and persons in position of authority had failed to ensure the recipes were followed to the menu met the	{A 628}	**Corrective Actions:** Staff was in-serviced on menu substitutions and the difference between nourishment items and meal items. **(Attachment 1 & 2)** **Date of Implementation:** October 23, 2014 **Monitoring Process**: Daily data collection on proper preparation and portioning by manager/supervisor (**Attachment 2**). **Person Responsible:** RD, Director of Dietary Department and RD, Clinical Nutrition Manager	10/23/2014

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{A 628}	Continued From page 24 nutritional needs of the patients. This is a repeat deficiency from the sampled validation survey on 4/1/14.	{A628}		
{A 630}	482.28(b)(2) DIETS Nutritional needs must be met in accordance with recognized dietary practices and in accordance with orders of the practitioner or practitioners responsible for the care of the patients. This STANDARD is not met as evidenced by: Based on observation, review of hospital documents and staff interviews, the hospital failed to ensure the nutritional needs of patients on pureed and diabetic diets (Patient 57, 58, 59, and 60) and two sample patients on tube feeding (Patient 55 and 56), in sample of eight, were in accordance with recognized practices and orders of the practitioner responsible for the care of patients. Tube feeding orders were not carried out correctly; recommended hang times for tube feeding orders were not followed, which could result in growth of microorganisms. The pureed diet was improperly prepared resulting in a watery consistency that could result in aspiration; improper preparation method also compromised the nutritive value of the food. Diabetic diets incorrectly translated to meet the caloric limits set by the physician in the diet order and unclear diet order was served without clarification with the physicians. This could result in patients receiving diets not in line with the therapy planned by the physician. Findings:	{A630}		

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{A 630}	Continued From page 25 Hollywood Campus 1. On 8/18/14 beginning at 6 p.m., Patient 55's tube feeding was running at a rate of 40 cubic centimeters (cc- a metric unit of measure). Patient 55's feeding was an open system feeding. An open system allows of addition of formula throughout the course of the day; whereas a closed system does not allow for the addition of formula (Critical Care Nutrition, 2011). It was also noted that the feeding was dated as 8/18/14; however the time the feeding was hung was not documented. It was also noted that 200 cc of formula remained in the feeding bag. In a concurrent interview and demonstration with RN 2 (Registered Nurse), she stated that she started the feeding at approximately 6 a.m., on 8/18/14. She also stated that she added 2 cans or the physician ordered supplement when the feeding was started. She further stated that when the feeding became depleted she would add additional cans of formula. In a concurrent observation of the enteral pump, the pump recorded of 112 cc's of feeding delivered. RN 2 was unable to demonstrate the amount of feeding that was delivered since it was hung on 8/18/14 at 6 a.m. Review of patient intake/output records dated 8/18/14 noted that nursing staff documented that 40 cc's of formula was delivered every hour. It was also noted that based on hospital documentation a total of 480 cc's of formula was delivered. There was an inconsistency of 368 cc's between the cumulative total of the enteral pump and the documentation in the electronic medical record. RN 33 was unable to describe the inconsistency. She also stated that she documented the physician's order in the medical	{A 630}	**Hollywood** **1.) Corrective Actions**: All open-system tube feedings have been discontinued and switched to closed system feeding; education/in-service with return demonstration provided to staff to included: 1) new closed-system feeding, 2) tube feeding orders, 3) date and hang time of feeding, 4).water flushing and 5). Proper documentation in EMR to include accurate documentation of Intake and Output. Education inservice with return demonstration was provided to staff on August 23-Sept 17, 2014. (**Attachment 1**) **Date of Implementation:** Education for tube feeding occurred August 23, 2014- September 17, 2014; closed system implemented facility wide on September 16, 2014; RD education on diet list, entering diet orders, MD orders September 17- 29, 2014 **Monitoring process:** Nursing performs audits on tube feedings **Person Responsible:** Nursing department	8/23/2014 9/16/2014 9/17/2014

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{A 630}	Continued From page 26 record, rather than the actual amount of feeding delivered. There was also no documentation of water flushes that is necessary to clean out bags prior to the addition of new feeding. Failure to perform this function could result in feedings being hung for time periods that would support bacterial growth. 2. On 8/18/14 beginning at 6:30 p.m., Patient 56 had a physician ordered enteral feeding with a rate of 40 cc's/hour. The enteral pump reading confirmed that the feeding was running at 40 cc's/hour. The feeding bag was dated 8/18/14 and timed at 6 a.m. The enteral pump revealed that 174 cc's of feeding were delivered and there was 100 cc's left in the bag. Review of clinical record for Patient 56 showed documentation of 40 cc per hour not actual volume delivered. The documentation showed more feeding had been delivered, based on the amount shown on the pump. In a concurrent interview with RN 33 on 8/18/14 she was unable to explain the total amount of feeding that was delivered from the feeding bag since 6 a.m. when the bag was hung. It could not be determined whether or not the hospital was following physicians' orders. There was also no documentation of water flushes that is necessary to clean out bags prior to the addition of new feeding. Failure to perform this function could result in feedings being hung for time periods that would support bacterial	{A 630}		

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{A 630}	Continued From page 27 growth. The hospital failed to follow manufacturer's guidelines and standards of practice for the amount of time the open enteral formula could be hung at the patient's bedside (known as "hang time") by allowing hang times of up to 12 hours when manufacturer's guidelines were for no greater than 8 hours hang time. This failure had the likely potential to result in enteral formulas with unacceptable levels of bacteria delivered to the patients and result in infections in patients receiving enteral feedings. "The A.S.P.E.N. (American Society for Parenteral and Enteral Nutrition) Enteral Practice Recommendations provides the following hang time recommendations: For reconstituted powdered formula or a formula with additives, a 4-hour hang time is recommended; For a commercially sterile, liquid formulas decanted (poured) from a can or brik-pak (similar to a juice box), an 8-hour hang time is recommended. These hang time recommendations assume the formula is kept at room temperature and is subject to minimal handling and manipulation... This information also indicates that the bag and administration set (tubing) should be flushed with water before adding additional formula." 3. On 8/18/14 beginning at 11:45 a.m., OS 2 was observed preparing pureed green beans. OS 2 placed a cups of cooked green beans in the blender after which he added 16 ounces of fluid. He was then observed pouring the green beans into a steam pan. The resultant texture of the	{A 630}	**3.) Corrective Actions:** Education of kitchen staff provided on the use of thickeners in the preparation of puree diets. **(Attachment: 3 & 4)** **Date of Implementation:** August 22- September 16, 2014 **Monitoring Process:** The puree preparation methods are monitored by management observation during the preparation of the meal weekly. **Person Responsible:** RD, Director of Dietary Department and Clinical Dietitian RD	8/22/2014

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{A 630}	Continued From page 28 item was a grainy liquid resembling runny applesauce. Concurrent observation also noted that the pureed meat was of a similar consistency. During the trayline observation, OS 2 utilized a soup ladle to portion the pureed meat and vegetables into individual plastic cups. Excessive addition of food additives alters the nutritional value of the item. In a follow-up observation on 8/18/14 beginning at 5:15 p.m. of meal production activities, the consistency of the pureed items was similar to the noon meal, a liquid consistency. Review on 8/18/14 beginning at 5:45 p.m., of the pureed green bean recipe revealed there was no guidance to add additional liquid while preparing the items. The staff should have added a food thickener to the product. Additionally, the recipe failed to provide any guidance on the expected consistency of the finished product. According to the Academy of Nutrition and Dietetics' Nutrition Care Manual titled, "Nutrition Therapy for Pureed Diet," Food should be "pudding-like" ...Be sure that any pureed foods prepared in advance are the consistency of pudding or moist mashed potatoes." Under the heading , Cooking and Preparation Tips, "when pureeing or blenderizing foods, add as little fluid initially as possible." This is a repeat deficiency. Culver City Campus 4. During review of physician ordered diets on 8/19/14 beginning at 11:30 a.m., the diets for patients with diabetes was not consistent with what was transcribed to the electronic diet entry order system. The meals were plated as a carbohydrate consistent diet which utilized meal plans without specific calorie levels, but	{A 630}	**Culver City** **4). Corrective Actions:** Diet policy called C002 "Diet Orders" was revised to provide more specific information on ordering diets including those used for diabetes reflecting consistent levels of carbohydrates throughout the day. **(Attachment 5)** **Date of Implementation:** Oct 15-17, 2014 **Monitoring Process:** Monitoring the accuracy of menu modifications including consistency of the carbohydrates meal plans using a sample of 30 menus per clerk is monitored quarterly. **(Attachment 6)** **Person Responsible:** RD, Director of Dietary Department & RD, Clinical Nutrition Manager	10/15/2014

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{A 630}	Continued From page 29	{A 630}		

incorporated consistent levels of carbohydrate throughout the day.

For example, if a physician ordered 1800 calorie American Diabetes Association (ADA) diet, the diet would get transcribed to a consistent carbohydrate meal pattern that offered 60 grams of carbohydrate (CHO) at breakfast and 75 grams of CHO at lunch and dinner. It was also noted that there was inconsistencies in how the physician ordered diabetic diets. For example, some of the 1800 calories diets were transcribed to a 4-5-5- meal pattern (indicating the number of carbohydrates per meal) and other 1800 calorie diets were transcribed as a "Diabetic Diet Consistent Carbohydrate" without an indication of the amount of carbohydrate at each meal.

In an interview on 8/19/14 beginning at 3 p.m., with Registered Dietitian (RD) 2, she stated that she was aware that the diet orders were being translated and had developed a therapeutic spreadsheet for staff to follow; however she had not implemented it.

On 8/21/14 at 5:45 p.m., the hospital provided a screenshot of the available electronic diet orders. The diabetic diet could only be ordered as a general "diabetic diet" and there was not the possibility to order it as a calorie specific or consistent carbohydrate diet. Hospital policy titled, "Diet Manual" dated 11/12 guided staff that the "diet order should be specified in terms of exact amount of restriction ... " It also noted that if the physician " is unsure of the terminology necessary for desired diet order, he/she should consult the Clinical Diet Manual ... " The policy did not reflect the practice within the department.

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{A 630}	Continued From page 30 Additionally, referring to the diet manual would not have provided physicians additional guidance for ordering diabetic diets as the document provided clinical practice recommendations rather than guidance for ordering diabetic diets within the hospital. Review of hospital document titled, "Diet Report" dated 8/19/14 noted that there were greater than 20 patients who did not receive the correct diet order. 5. During trayline observation on 8/19/14 beginning at 12 p.m., the tray ticket for 3 random patients (Patients 57, 58 and 59) guided staff to plate 5 carbohydrate selections for the noon meal. It was noted that the meal plated on each of the trays consisted of 3.5 carbohydrate selections (pineapple salsa, sweet mashed potatoes, green beans and a garden salad) rather than the diet list designation of 5 carbohydrates. In an interview on 8/19/14 beginning at 3 p.m., with DS 8, whose position was responsible for diet accuracy, he stated that the departmental policy was that if patients did not select an adequate amount of carbohydrates additional food items should be marked to increase the carbohydrate content of the meal to hospital specified parameters. Review of the therapeutic spreadsheet for the noon meal on 8/19/14 revealed that if patients did not select menu items the maximum number of carbohydrates for the noon meal would be 4 carbohydrate choices. Hospital document titled, "Diet Report" dated 8/19/14 noted that a carbohydrate consistent pattern for an 1800 calorie diet was a meal pattern of 4-5-5 for breakfast, lunch and dinner respectively.	{A 630}	**5). Corrective Actions.** The Manual for Clinical Nutrition Management (Diet Manual) was revised to include the appropriate diet Addendums. This will ensure a practice related to menu creation, nutritional adequacy, and clinical nutrition practice. **(Attachment 7)** **Date of Implementation:** 9/10/2014 to 10/4/2014 **Monitoring Process:** The kitchen staff was inserviced on the use of diabetic diet ensuring consistency with levels of carbohydrates throughout the day. **(Attachment: 7)** **Person Responsible:** RD, Director of Dietary Department and RD, Clinical Nutrition Manager	9/10/2014

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{A 630}	Continued From page 31 Van Nuys 6. Clinical Record review showed when Patient 60 was admitted his physician ordered diet was a diabetic, No Added Salt: 2000 calories, Na (sodium) 2 gram. He was served according to the Diet order list dated 8/19/14 a 2000 calorie 2 gram Na diet. The diet as ordered has two levels of sodium restriction: NAS and 2 gram sodium. The NAS, or no-added-salt diet, involves restricting sodium intake to less than 4 grams, or 4,000 milligrams per day while the 2 gram sodium involves restricting sodium intake to 2000 milligrams. The standard of practice is to clarify conflicting or unclear orders. Clinical record review did not show any clarification in the diet order by either nursing staff or registered dietitian. DFS1 stated in an interview on 8/19/14 at 3:40 p.m. that the diet served was the diet that was ordered. 7. According to the menu on 8/19/14, the following items were served for lunch: Tossed salad, Lemon Fish, mixed vegetables, parsley noodles, fresh fruit and low fat milk. During a trayline observation, on 8/19/14 at 12:50 p.m., random observation showed a patient on double portions received 2 pieces of fish and same portion of noodles, vegetables and fruit. Staff K (Director of Food Service) who was	{A 630}	**Van Nuys** **6). Corrective Action:** Food & Nutrition Services policy FNS C002 Diet Orders was revised to include the approved diet orders. Training was provided to kitchen staff, nurses and physicians concerning the clarification of diet orders. **(Attachment 5)** **Date of Implementation:** 8/21/14 and on going **Monitoring Process:** Electronic MD diet orders are compared daily to the approved diet order for accuracy and monitored by manager/supervisor **(Attachment 10)** **Person Responsible:** R.D. Food Service Director, Clinical Dietitian, RD **7). Corrective Action:** A revised policy for double portion was implemented specifying the composition of a double portion diet as stated in Food & Nutrition Service Department P&P Manual FNS C013 Special Patient Meals and Services. Kitchen staff was inserviced on the policy on double portions. (**Addendum: 8)** **Date of Implementation:** 9/4/14 **Monitoring Process**: Supervisor/manager will monitor during tray preparation accuracy of the double diet portion. **(Attachment 9)** **Person Responsible:** R.D. Food Service Director, Clinical Dietitian, RD	8/21/2014 9/4/2014

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{A 630}	Continued From page 32 present during the observation confirmed the accuracy of the meal served. Staff M (Food Service Supervisor), in a concurrent interview, stated that the patient should have received double portions of the fish and starch. Review of the hospital policy titled, "Special Patient Meals and Services" dated 7/14 indicated "a patient on double will receive a double entree plate with all the components. Typically, a hot entree with starch, vegetable, dinner roll .... " Review of the Diet List dated 8/19/14 showed that there were eight patients who had double portion as part of their diet orders. The incorrect portion sizes would result in decrease calories and overall nutrient deficit. This is a repeat deficiency from the sample validation survey on 4/1/14.	{A 630}		
{A 700}	482.41 PHYSICAL ENVIRONMENT The hospital must be constructed, arranged, and maintained to ensure the safety of the patient, and to provide facilities for diagnosis and treatment and for special hospital services appropriate to the needs of the community. This CONDITION is not met as evidenced by: Based on observation, review of facility documents and staff interview, the facility failed to meet the Condition of Participation in Physical Environment by failing to: 1. Develop and maintain the physical plant in a manner that assured the safety and well-being of patients (Refer A 701).	{A 700}	**1). Corrective Actions:** The facilities have initiated a proactive system to conduct physical plant rounds covering all patient care and non-patient care areas to address maintenance issues. **Date of Implementation:** August 2014 **Monitoring Process:** Weekly monitoring physical plant rounds and Environment of Care rounds covering patient care and non-patient care areas. In addition, daily EVS environmental rounds and periodical terminal cleaning. **Person Responsible**: Director of Engineering	08/2014

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{A 700}	Continued From page 33 2. Ensure the safety of patients and staff when it failed to ensure there were appropriate plans in place to implement its emergency preparedness program and ensure that its emergency food was properly secured. Failure to ensure maintenance of the physical environment may compromise the medical status of patient and the ability for staff to care for patients (Refer to A 701). 3. Ensure that food service equipment was maintained to assure the safety and well-being of patients (Refer to A 701). 4. Ensure an effective approved water management plan to be implemented in a widespread disaster. Failure to ensure an effective approved water management plan may compromise the medical status of patients and the ability for staff to care for patients (Refer to A 703). The cumulative effect of these systemic issues resulted in the facility's inability to ensure and provide a safe patient care environment.	{A 700}	**2). Corrective Actions:** The emergency policy and procedure was reinforced through education of dietary and physical plant staff. Education and inservice of the dietary and physical plant staff. **Date of Implementation:** October 23 2014 **Monitoring Process:** Monitor and Log Disaster food and water inventory quarterly. **Person Responsible:** Dietary and Engineering. **3). Corrective Actions**: Repairs will be done in a timely manner "same day or within 3 hours" and work orders will be processed by the Engineering Dept by priority. **Date of Implementation:** on-going. **Monitoring Process:** Work orders will be monitored daily by Engineering staff and repairs will be tracked through the work order system. **Person Responsible:** Dietary and Engineering **4). Corrective Actions:** The emergency preparedness policy and procedure on water management was reviewed and inserviced to the dietary staff and engineering. **Date of Implementation**: October 23, 2014 **Monitoring Process:** Water supplies will be monitored by dietary and engineering. **Person Responsible:** Director of Engineering, RD	10/23/2014 10/23/2014
{A 701}	482.41(a) MAINTENANCE OF PHYSICAL PLANT The condition of the physical plant and the overall hospital environment must be developed and maintained in such a manner that the safety and well-being of patients are assured. This STANDARD is not met as evidenced by: Based on observation, interview, and document review the hospital failed to ensure maintenance of the physical environment, and develop and maintain the physical plant in a manner that	{A 701}		

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{A 701}	Continued From page 34 reduced opportunities for self-harm and eliminating as many risk factors as possible in the patient's environment including fixtures that could be used as anchor points to tie to that can hold a person's weight and other conditions that could be used as opportunities for self-harm. The deficient practice had the potential to provide patients opportunities for self-harm, infection transmission, accident hazards, and rodent activity. Also, the hospital failed to ensure there were appropriate plans in place to implement its emergency preparedness program and ensure that its emergency food was properly secured. Improper storage of emergency food could result in misappropriation and loss of food items preventing use during a disaster. Findings: Hollywood campus On August 18, 2014 between 10:06 a.m. and 3:30 p.m., the following conditions existed at the Hollywood campus. 5th Floor 1. Room 509 had a 5 ft. by 4 ft. section of ceiling missing, and the room was being used for storage of Environmental Services (EVS) equipment and mattresses. During an interview at the same time as the observation, Staff D (Corporate Director of Facilities) stated the damage at the ceiling was	{A 701}	**Hollywood – 5th Floor** **1).Corrective Actions:** A permit was approved by OSHPD on September 19, 2014, Permit No. S141549-19-00 for the repair of the ceiling **(Attachment: 1)**. The OSHPD procedure of the repair is currently ongoing. **Date of Implementation**: Permit was granted on September 19, 2014. **Monitoring Process:** EOC rounds are conducted weekly on all patient care areas. **(Attachment: 2)** **Person Responsible:** Lead Engineer	9/19/2014

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{A 701}	Continued From page 35 caused by a water leak from the tube bundle of the boiler located above room 509. During an interview at the same time as the observation, Staff D stated the room was still on the license as a patient room. 2. The bathroom of room 509 had a loose toilet; missing toilet vertical flush pipe, the toilet bowl was stuffed passed the rim with paper, had a light fixture was falling off the wall, and the towel bar was missing. 1st floor 3. At Urgent Care there was an accumulation of dust and a bundled blood stained bandage with tape wedged at the top of the corridor door holding the door in the open position. Basement 4. In the Pre-Op room, a sink cabinet had missing laminate at a corner. During an interview at the same time as the observation, Staff N (Disaster Coordinator) stated he replaced the laminate at the edge of the cabinet's counter that the evaluator had pointed out on 4/1/14, and that laminate was being bought, and that the facility had a program to replace all the counters. 5. In the Pre Op room 3 of 3 gurneys had cracks in the upholstery, and 1 of 3 had a three inch tear	{A 701}	**2.).Corrective Actions:** The toilet bowl was replaced, the vertical flush valve pipe was installed, the room was cleaned, the light fixtures fixed, the towel bar replaced and the whole room repainted. **(Attachment: 3)** **Date of Implementation**: September 24, 2014 **Monitoring Process:** EOC rounds are conducted weekly in all patient care areas. **Person Responsible:** Lead Engineer **1st Floor** **3).Corrective Actions:** The tape wedge at the top of the corridor door was immediately removed and terminal cleaning was done in Urgent Care. Urgent Care staff was In-serviced on infection control and door propping **(Attachment 3)**. **Date of Implementation:** September 29, 2014 **Monitoring Process:** EOC rounds are conducted weekly in all patient care areas. **Person Responsible:** Lead Engineer **Basement** **4).Corrective Actions:** The Pre-Op room missing laminate was replaced **(Attachment 3)**. **Date of Implementation**: September 29, 2014 **Monitoring Process:** EOC rounds are conducted weekly in all patient care areas. **Person Responsible:** Lead Engineer **5).Corrective Actions:** The defective pads on the gurneys in Pre Op room 3 were replaced **(Attachment 3)**. **Date of Implementation:** October 7, 2014 **Monitoring Process:** EOC rounds are conducted weekly for all patient care areas. **Person Responsible**: Lead Engineer	9/24/2014 9/29/2014 9/29/2014 10/7/2014

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{A 701}	Continued From page 36 through the upholstery visibly exposing the foam padding beneath. 6. In Operating Room (OR) 3, the X-ray box had missing paint and rust at the frame front of the box. During an interview at the same time as the observation, Staff C (CEO) stated that he could see the rust at the X-ray box. 7. In OR 3, a cabinet had missing laminate at the edge and doors. During an interview at the same time as the observation, Staff N stated the cabinet was part of the casement work to be replaced. 8. In OR 3, the ceiling surgical lamp arm had an accumulation of dust. During an interview at the same time as the observation, Staff C stated that the surgical lamp would be over the patient. 9. In OR 2, the X-ray box's front plexi glass was loose and had tape and adhesive on the glass and frame box. 10. In OR 2, there was tape placed across a thermostat. During an interview at the same time as the observation, Staff N stated that the thermostat was an old thermostat that was no longer in use, and that the thermostat and tape needed to be removed and replaced with a cover plate.	{A 701}	**6).Corrective Actions:** The X ray box in OR 3 was refurbished. **(Attachment 3)** **Date of Implementation:** September 10, 2014 **Monitoring Process:** EOC rounds are conducted weekly on all patient care areas. **Person Responsible:** Lead Engineer	9/10/2014
			7).Corrective Actions: OR 3 the cabinet missing laminate a the edges and doors have been repaired(**Attachment 3 & 6** **Date of Implementation:** October 7, 2014 **Monitoring Process:** EOC rounds are conducted weekly for all patient care areas. **Person Responsible:** Lead Engineer	10/7/2014
			8).Corrective Actions: In OR 3 the ceiling surgical light arm and room had immediate terminal cleaning. **(Attachment 3 & 7)** **Date of Implementation:** September 10, 2014 **Monitoring Process**: EOC rounds are conducted weekly on all patient care areas. **Person Responsible**: Lead Engineer	9/10/2014
			9).Corrective Actions: In OR 2, the xray box plexi glass was replaced and fastened appropriately. **(Attachment 3)** **Date of Implementation**: September 24, 2014 **Monitoring Process**: EOC rounds is conducted weekly for all patient care areas. **Person Responsible:** Lead Engineer	9/24/2014
			10).Corrective Actions: In OR 2, Tape was removed from the thermostat and the thermostat in OR #2 was put back into service. **(Attachment 3)** **Date of Implementation:** September 11, 2014 **Monitoring Process:** EOC rounds are conducted weekly for all patient care areas. **Person Responsible:** Lead Engineer	9/11/2014

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{A 701}	Continued From page 37 11. In OR 1, the X-ray box's front plexi glass was cracked, had tape and adhesive on the glass and frame box, and had a knotted electrical cord with accumulation of dust at the knotted area of the cord, and tape at the plug. During an interview at the same time as the observation, Staff N stated that the housekeeper was supposed to unknot the electrical cord to clean it. At the same time as the interview, Staff N unknotted the cord, which then fell into the biohazard bin, which was pointed out to the Disaster Coordinator. 12. The Decontamination Room had unpainted plaster at the wall under the announcement speaker. 13. The Sterilization Room had unpainted plaster at the wall next to the paper towel dispenser. During an interview at the same time as the observation, Staff N stated that they were in the process of painting, and that the problem of having unpainted wall with exposed plaster is that the wall cannot be cleaned. 14. In the Recovery Room, there was a cabinet with peeling paint. 15. In the Recovery Room, there was a dirty braided cord at the nurse call. During an interview at the same time as the observation, Staff N stated that the cord at the nurse call needed to be replaced because it was dirty.	{A 701}	**11).Corrective Actions:** In OR 1, the plexi glass on the X ray box was replaced and the knotted electrical cord that fell in biohazardous bin was sanitized and secured to prevent tripping. **(Attachment 3)** **Date of Implementation:** September 12, 2014 **Monitoring Process:** EOC rounds are conducted weekly in all patient care areas. **Person Responsible:** Lead Engineer	9/12/2014
			12).Corrective Actions: The plaster on the wall in the Decontamination Room in Surgery Department was repainted. **(Attachment 3)** **Date of Implementation**: September 22, 2014 **Monitoring Process**: EOC rounds are conducted weekly for all patient care areas. **Person Responsible**: Lead Engineer	9/22/2014
			13).Corrective Actions: The plaster on the wall in the sterilization room, including the wall next to the paper towel dispenser, was repainted. **(Attachment 3)** **Date of Implementation**: September 22, 2014 **Monitoring Process**: EOC rounds are conducted weekly for all patient care areas. **Person Responsible**: Lead Engineer	9/22/2014
			14).Corrective Actions: The cabinets in the recovery room were repainted. **(Attachment 3 & 8)** **Date of Implementation**: September 25, 2014 **Monitoring Process**: EOC rounds are conducted weekly for all patient care areas. **Person Responsible**: Lead Engineer	9/25/2014
			15).Corrective Actions: The nurse call braided cord in the Recovery Room was replaced **(Attachment 3)**. **Date of Implementation**: Sept 5, 2014 **Monitoring Process**: EOC rounds are conducted weekly for all patient care areas. **Person Responsible**: Lead Engineer:	9/5/2014

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{A 701}	Continued From page 38 Van Nuys campus On August 19, 2014 between 8:30 a.m. and 3:30 p.m., the following conditions existed in the Van Nuys psychiatric campus. Station 1 There were fixtures throughout that could be used as anchor points to tie to that can hold a person's weight throughout the unit; including exposed plumbing pipes (water supply to toilet and sink drain line), standard faucets, and mortise hinges. 16. Patient rooms, including rooms 101, 102, 104, 105, 106, 107, 108, 109, and 110 had exposed plumbing pipes that could be used as anchors. Bathroom of room 103 was occupied during observation. Between 1:30 p.m. and 2:58 p.m., during an interview, the Lead Engineer stated that the anti-ligature plumbing covers for the P-traps would be installed no later than 3 weeks (9/12/14). At the same time during an interview, Staff B (Administrator) (Van Nuys campus) stated that the facility has two extra staff every day, in every unit monitoring the areas that could be used as anchors in every room, every 15 minutes, and that starting today (8/19/14) a monitoring form/log will be documented. 17. Patient rooms, including rooms 101, 102, 104, 105, 106, 107, 108, 109, and 110 had standard	{A 701}	**Van Nuys** **Station 1** **16).Corrective Actions**: P trap covers were installed in rooms 101, 102, 104, 105, 106, 107, 108, 109, 110 and including room 103 to cover the exposed plumbing pipes. **(Attachment)** **Date of Implementation**: completed September 12, 2014 **Monitoring Process**: EOC monitoring is conducted by Engineering weekly and by Nursing daily.**(Attachment 2)** **Person Responsible**: Director of Engineering & Nursing	9/12/2014

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{A 701}	Continued From page 39 mortise hinges that could be used as anchors. Between 1:30 p.m. and 2:58p.m., during an interview, Staff P (Lead Engineer) stated that the anti-ligature hinges would be installed no later than 5 weeks (9/26/14). At the same time during an interview, Staff B stated that the facility has two extra staff every day, in every unit monitoring the areas that could be used as anchors in every room, every 15 minutes, and that starting today (8/19/14) a monitoring form/log will be documented.	{A 701}	**17). Corrective Actions**: A third party certified company was hired to replace mortise hinges with anti-ligature hinges in rooms 101, 102, 104, 105, 106, 107, 108, 109, 110. **(Attachment 17 -29)** Originally scheduled to be done by 9/26/14, the manufacturer needed additional time to complete the back order. **Date of Implementation**: Completed October 22, 2014 **Monitoring Process**: EOC monitoring is conducted by Engineering weekly and by Nursing daily. .**(Attachment 2)** **Person Responsible**: Director of Engineering & Nursing	10/22/2014
	18. Room 101 had window blinds with an accessible cord. The cord could be used to tie onto an anchor point.		**18). Corrective Actions**: Room 101 window blind accessible cord was shortened and the blinds were secured to the base of the window. **(Attachment 9a)** **Date of Implementation**: August 19, 2014 **Monitoring Process**: EOC monitoring is conducted by Engineering weekly. .**(Attachment 2)** **Person Responsible**: Director of Engineering	8/19/2014
	19. Shower room #4 and 5 standard mortise hinges that could be used as anchors. Between 1:30 p.m. and 2:58 p.m., during an interview, Staff P stated that the anti-ligature hinges would be installed no later than 5 weeks (9/26/14). At the same time during an interview, Staff B stated that the facility has two extra staff every day, in every unit monitoring the areas that could be used as anchors in every room, every 15 minutes, and that starting today (8/19/14) a monitoring form/log will be documented.		**19). Corrective Actions**: A third party certified company was hired to replace mortise hinges with anti-ligature hinges in Shower Room #4 & #5.(**Attachment 10).** Originally scheduled to be done by 9/26/14, the manufacturer needed additional time to complete the back order. **Date of Implementation**: October 22, 2014 **Monitoring Process**: EOC monitoring is conducted by Engineering weekly and by Nursing daily. **(Attachment 2)** **Person Responsible**: Director of Engineering & nursing	10/22/2014
	20. The dining room sink had a standard faucet and exposed plumbing that could be used as anchors.		**20). Corrective Actions**: The standard faucet on the dining room sink was replaced with anti-ligature faucet and the p-trap cover was installed. **(Attachment 11)** **Date of Implementation**: Faucet - August 19, 2014; P-Trap cover – September 12, 2014 **Monitoring Process**: EOC monitoring is conducted by Engineering weekly and by Nursing daily. .**(Attachment 2)** **Person Responsible**: Director of Engineering & Nursing	8/19/2014 9/12/2014

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{A 701}	Continued From page 40 Between 1:30 p.m. and 2:58 p.m. during an interview Staff P stated that the anti-ligature plumbing covers for the P-traps would be installed no later than 3 weeks (9/12/14), and the anti-ligature faucets would be installed by the end of the day (8/19/14). At the same time during an interview, Staff B stated that the facility has two extra staff every day, in every unit monitoring the areas that could be used as anchors in every room, every 15 minutes, and that starting today (8/19/14) a monitoring form/log will be documented.	{A 701}		
	21. The dining room bathroom had a standard faucet, exposed plumbing, standard hinges, and a metal shelf that could be used as anchors. Between 1:30 p.m. and 2:58 p.m., during an interview, Staff P stated that the anti-ligature hinges would be installed no later than 5 weeks (9/26/14), the anti-ligature plumbing covers for the P-traps would be installed no later than 3 weeks (9/12/14), and the anti-ligature faucets would be installed by the end of the day (8/19/14). At the same time during an interview, Staff B stated that the facility has two extra staff every day, in every unit monitoring the areas that could be used as anchors in every room, every 15 minutes, and that starting today (8/19/14) a monitoring form/log will be documented.		**21). Corrective Actions**: Dining room bathroom standard faucet was replaced with anti-ligature faucet, the p-trap cover was installed, the metal shelf was removed and a third party certified company was hired to replace mortise hinges with anti-ligature hinges **(Attachment 12)** **Date of Implementation**: Faucet – August 19, 2014; P-Trap cover – September 12, 2014 ; Metal Shelf removed – August 19, 2014; Anti-ligature hinges - September 26, 2014. **Monitoring Process**: EOC monitoring is conducted by Engineering weekly and by Nursing daily. .**(Attachment 2)** **Person Responsible**: Director of Engineering & Nursing	8/19/2014 9/12/2014 9/26/2014
	22. The women's patient common bathroom had a standard faucet and exposed plumbing that could be used as anchors.		**22).Corrective Actions**: Women's patient common bathroom standard faucet was replaced with an anti-ligature faucet and the p –trap cover was installed to cover exposed plumbing. **Attachment 13)** **Date of Implementation**: Faucet – August 19, 2014; P-Trap cover – September 12, 2014. **Monitoring Process**: EOC monitoring is conducted by Engineering weekly and by Nursing daily. .**(Attachment 2)** **Person Responsible**: Director of Engineering & Nursing	8/19/2014 9/12/2014

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{A 701}	Continued From page 41 Between 1:30 p.m. and 2:58p.m., during an interview, Staff P stated that the anti-ligature plumbing covers for the P-traps would be installed no later than 3 weeks (9/12/14), and the anti-ligature faucets would be installed by the end of the day (8/19/14). At the same time during an interview, Staff B stated that the· facility has two extra staff every day, in every unit monitoring the areas that could be used as anchors in every room, every 15 minutes, and that starting today (8/19/1.4) a monitoring form/log will be documented. 23. The men's patient common bathroom had standard faucet and exposed plumbing that could be used as anchors. Between 1:30 p.m. and 2:58p.m., during an interview, Staff P stated that the anti-ligature plumbing covers for the P-traps would be installed no later than 3 weeks (9/12/14), and the anti-ligature faucets would be installed by the end of the day (8/19/14). At the same time during an interview, Staff B stated that the facility has two extra staff every day, in every unit monitoring the areas that could be used as anchors in every room, every 15 minutes, and that starting today (8/19/14) a monitoring form/log will be documented. 24. Patient rooms, including rooms 101, 109, and 110 had loose toilets. 25. Patient rooms, rooms 108 and 109 loose sinks.	{A 701}	**. 23). Corrective Actions**: Men's patient common bathroom standard faucet replaced with an anti-ligature faucet and the p –trap cover was installed to cover exposed plumbing. **Attachment 14)** **Date of Implementation**: Faucet – August 19, 2014; P-Trap cover – September 12, 2014 **Monitoring Process**: EOC monitoring is conducted by Engineering weekly and by Nursing daily. .**(Attachment 2)** **Person Responsible**: Director of Engineering & Nursing **24). Corrective Actions**: Toilets in rooms 101, 109 & 110 were re-secured. **(Attachment 15)** **Date of Implementation**: August 19, 2014 **Monitoring Process**: EOC monitoring is conducted by Engineering weekly and by Nursing daily. .**(Attachment 2)** **Person Responsible**: Director of Engineering & Nursing **25). Corrective Actions**: Sinks in room 108 & 109 were remounted and secured. **(Attachment 15a)** **Date of Implementation**: August 19, 2014 **Monitoring Process**: EOC monitoring is conducted by Engineering weekly and by Nursing daily. .**(Attachment 2)** **Person Responsible**: Director of Engineering & Nursing	8/19/2014 9/12/2014 8/19/2014 8/19/2014

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{A 701}	Continued From page 42 26. Patient rooms, including rooms 101 and 107 had leaking plumbing at the toilet pipes. 27. Dining room bathroom had a water leak at the toilet plumbing. Station 2 There were fixtures throughout that could be used as anchor points to tie to that can hold a person's weight throughout the unit; including exposed plumbing pipes (water supply to toilet and sink drain line), standard faucets, and mortise hinges. 28. Patient rooms, including rooms 203, 205, 207, 209, 210,211,212, 213,214, 215, 217,218, 219,220, 222, and 226 had exposed plumbing pipes that could be used as anchors. Between 1:30 p.m. and 2:58 p.m. during an interview the Lead Engineer stated that the anti-ligature plumbing covers for the P-traps would be installed no later than 3 weeks (9/12/14). At the same time during an interview, Staff B stated that the facility has two extra staff every day, in every unit monitoring the areas that could be used as anchors in every room, every 15 minutes, and that starting today (8/19/14) a monitoring form/log will be documented. 29. Patient rooms, including rooms 215, 217, 219, 220, 222, and. 226 had standard faucets that could be used as anchors. Between 1:30p.m. and 2:58p.m. during an interview the Lead Engineer stated that	{A 701}	**26). Corrective Actions**: Toilet pipes in room 101 & 107 were replaced & repaired. **(Attachment 16)** **Date of Implementation**: August 19, 2014 **Monitoring Process**: EOC monitoring is conducted by Engineering weekly and by Nursing daily. .**(Attachment 2)** **Person Responsible**: Director of Engineering & Nursing **27). Corrective Actions**: The dining room toilet plumbing pipes were repaired. **(Attachment 17)** **Date of Implementation**: August 19, 2014 **Monitoring Process**: EOC monitoring is conducted by Engineering weekly and by Nursing daily. .**(Attachment 2)** **Person Responsible**: Director of Engineering & Nursing **Station 2** **28). Corrective Actions**: P trap covers were installed in rooms 203, 205, 207, 209, 210, 211, 212, 213, 214, 215, 217, 218, 219, 220, 222 and 226 to cover exposed plumbing. **(Attachment 18)** **Date of Implementation**: August 19, 2014 **Monitoring Process**: EOC monitoring is conducted by Engineering weekly and by Nursing daily. .**(Attachment 2)** **Person Responsible**: Director of Engineering & Nursing **29). Corrective Actions**: The standard faucets were replaced with anti-ligature faucets in patient rooms 215, 217, 219, 220, 222, and 226. **(Attachment 19)** **Date of Implementation**: August 19, 2014 **Monitoring Process**: EOC monitoring is conducted by Engineering weekly and by Nursing daily. .**(Attachment 2)** **Person Responsible**: Director of Engineering & Nursing	8/19/2014 8/19/2014 8/19/2014 8/19/2014

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{A 701}	Continued From page 43 anti-ligature faucets would be installed by the end of the day (8/19/14). At the same time during an interview, Staff B stated that the facility has two extra staff every day, in every unit monitoring the areas that could be used as anchors in every room, every 15 minutes, and that starting today (8/19/14) a monitoring form/log will be documented. 30. The shaving room had a standard faucet that could be used as an anchor.	{A 701}	**30). Corrective Actions**: The standard faucet was replaced with an anti-ligature faucet in the shaving room. **(Attachment 20)** **Date of Implementation**: August 19, 2014 **Monitoring Process**: EOC monitoring is conducted by Engineering weekly and by Nursing daily. **(Attachment 2)** **Person Responsible**: Director of Engineering & Nursing	8/19/2014
	31. Patient rooms, including rooms 203, 205, 207, 209, 210, 211, 212,213,214,215,217,218, 219, 220, 222, and 226 had standard mortise hinges that could be used as anchors. Between 1:30 p.m. and 2:58 p.m., during an interview, Staff P stated that the anti-ligature hinges would be installed no later than 5 weeks (9/26/14). At the same time during an interview, Staff B stated that the facility has two extra staff every day, in every unit monitoring the areas that could be used as anchors in every room, every 15 minutes, and that starting today (8/19/14) a monitoring form/log will be documented.		**31). Corrective Actions**: A third party certified company was hired to replace mortise hinges with anti-ligature hinges in rooms 203, 205, 207, 209, 210, 211, 212, 213, 214, 215, 217, 218, 219, 220, 222, and 226. **(Attachment 21).** Originally scheduled to be done by 9/26/14, the manufacturer needed additional time to complete the back order. **Date of Implementation**: October 22, 2014, **Monitoring Process**: EOC monitoring is conducted by Engineering weekly and by Nursing daily. .**(Attachment 2) Person Responsible**: Director of Engineering & Nursing	10/22/2014
	32. Shower room #3 had mortise hinges that could be used as anchors. Between 1:30 p.m. and 2:58p.m., during an interview, Staff P stated that the anti-ligature hinges would be installed no later than 5 weeks (9/26/14). At the same time during an interview, Staff B		**32). Corrective Actions**: A third party certified company was hired to replace mortise hinges with anti-ligature hinges in Shower room #3. **(Attachment 22).** Originally scheduled to be done by 9/26/14, the manufacturer needed additional time to complete the back order. **Date of Implementation**: October 22, 2014 **Monitoring Process**: EOC monitoring is conducted by Engineering weekly and by Nursing daily. .**(Attachment 2)** **Person Responsible**: Director of Engineering & Nursing	10/22/2014

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{A 701}	Continued From page 44 stated that the facility has two extra staff every day, in every unit monitoring the areas that could be used as anchors in every room, every 15 minutes, and that starting today (8/19/14) a monitoring form/log will be documented. 33. The observation room bathroom had exposed plumbing, and standard hinges at bathroom and room doors that could be used as anchors. Between 1:30 p.m. and 2:58p.m., during an interview, Staff P stated that the anti-ligature plumbing covers for the P-traps would be installed no later than 3 weeks (9/12/14), and that the anti-ligature hinges would be installed no later than 5 weeks (9/26/14). At the same time during an interview, Staff B stated that the facility has two extra staff every day, in every unit monitoring the areas that could be used as anchors in every room, every 15 minutes, and that starting today (8/19/14) a monitoring form/log will be documented. 34. Bathroom in patient room 212 had a loose toilet. 35. Bathroom in patient room 214 had a loose sink. 36. Station 2 Patient patio had an avocado tree with branches against and over the building roof line, creating access to the roof for potential rodent activity. Outpatient (Van Nuys campus)	{A 701}	**33). Corrective Actions**: A P trap cover was installed and a third party certified company was hired to replace mortise hinges with anti-ligature hinges in the observation room bathroom. **(Attachment 23).** Originally scheduled to be done by 9/26/14, the manufacturer needed additional time to complete the back order. **Date of Implementation**: October 22, 2014 **Monitoring Process**: EOC monitoring is conducted by Engineering weekly and by Nursing daily. .**(Attachment 2)** **Person Responsible**: Director of Engineering & Nursing **34). Corrective Actions**: The toilet in room 212 was re-fastened and secured. **(Attachment 24)** **Date of Implementation**: August 19, 2014 **Monitoring Process**: EOC monitoring is conducted by Engineering weekly and by Nursing daily. .**(Attachment 2)** **Person Responsible**: Director of Engineering & Nursing **35). Corrective Actions**: The sink in room 214 was re-fastened and secured. **(Attachment 24a)** **Date of Implementation**: August 19, 2014 **Monitoring Process**: EOC monitoring is conducted by Engineering weekly and by Nursing daily. **(Attachment 2)** **Person Responsible**: Director of Engineering & Nursing **36). Corrective Actions**: The avocado tree branches at Station 2 patient patio were trimmed away from the building roof. **(Attachment 24b)** **Date of Implementation**: August 19, 2014 **Monitoring Process**: Security conducts daily monitoring of the grounds. **(Attachment 2)** **Person Responsible**: Security **Van Nuys** **Outpatient**	10/22/2014 8/19/2014 8/19/2014 8/19/2014

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{A 701}	Continued From page 45 37. Common Unisex bathroom by group meeting room II, had a standard faucet, exposed plumbing pipes and standard mortise hinges at the door that could be used as anchors. Between 1:30 p.m. and 2:58 p.m., during an interview, Staff P stated that the anti-ligature hinges would be installed no later than 5 weeks (9/26/14), the anti-ligature plumbing covers for the P-traps would be installed no later than 3 weeks (9/12/14), and the anti-ligature faucets would be installed by the end of the day (8/19/14). At the same time during an interview, Staff 8 stated that the facility has two extra staff every day, in every unit monitoring the areas that could be used as anchors in every room, every 15 minutes, and that starting today (8/19/14) a monitoring form/log will be documented. 38. Common Unisex bathroom by group meeting room II, had a water leak at the toilet's flush pipe. Culver City Campus Pavilion 6th floor Pavilion There were fixtures throughout that could be used as anchor- points to tie to that can hold a person's weight throughout the unit; including exposed plumbing pipes (water supply to toilet and sink drain line), standard faucets, and mortise hinges. 6th floor Unit A Psychiatric	{A 701}	**37). Corrective Actions**: The standard faucet was replaced with anti-ligature faucet and the p –trap cover was installed to cover exposed plumbing in the common unisex bathroom. A third party certified company was hired to replace mortise hinges with anti-ligature hinges also in the common unisex bathroom. **(Attachment 25)** **Date of Implementation**: Faucet – August 19, 2014; P-Trap cover – September 12, 2014; Anti-ligature hinges- October 22, 2014 **Monitoring Process**: EOC monitoring is conducted by Engineering weekly and by Nursing daily. **(Attachment 2)** **Person Responsible**: Director of Engineering & Nursing **38). Corrective Actions**: Loose toilets in common room bathroom by group room II loose toilet bolts were replaced & tightened. **(Attachment 25a)** **Date of Implementation**: Bolts replaced & tightened 8/19/14 **Monitoring Process**: EOC monitoring is to be done by Engineering weekly and weekly monitoring by IOP staff. **(Attachment 2)** **Person Responsible**: Director of Engineering & Director of IOP **Culver City** **6th Floor Pavilion – Unit A** **39).Corrective Actions**: P trap covers were installed in rooms 605, 606, 607, 608 and 609 to cover the exposed plumbing pipes. **(Attachment 26)** **Date of Implementation**: September 19, 2014 **Monitoring Process**: Behavioral health is conducting daily inspection of patient rooms including checking of p trap covers. In addition the monitoring of p trap covers was also added to the Bi-annual check list of the Environment of Care rounds for patient care areas. **(Attachment 27)** **Person Responsible**: Director of BHU & Director of Engineering	8/19/2014 9/12/2014 10/22/2014 8/19/2014 9/19/2014

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{A 701}	Continued From page 46 On 8/20/14 between 8:30a.m. and 9:04a.m. the following conditions existed in 6th floor Psychiatric Unit A. 39. Patient rooms, including rooms 605, 606, 607, 608, and 609 had exposed plumbing pipes that could be used as anchors. 40. Patient rooms, including rooms 602, 604, 605, 606, 607, 608, and 609 had one ligature resistant mortise hinge, and three standard mortise hinges that could be used as anchors on the doors. 41. Shower room 1 had a make-shift safety grab bar. The grab bar had two 2 inch by 1/4 inch spaces between the bar & plate that could be used as an anchor. The shower room also had standard mortise hinges. 42. Shower room 4 had a make-shift safety grab bar. The grab bar had two spaces between the bar & plate that could be used as an anchor. There were also pluming extensions at the shower head pipe that could be used as an anchor. The shower room also had standard mortise hinges. 6th floor Unit B Psychiatric On 8/20/14 between 9:04a.m. and 9:30a.m. the following conditions existed in 6th floor Psychiatric Unit B. 43. Patient rooms, including rooms 622, 624, 625, 627, 628 and 629 had exposed plumbing pipes that could be used as anchors. 44. Patient rooms, including rooms 622, 623, 624,	{A 701}	**40).Corrective Actions**: A third party certified company replaced mortise hinges with anti-ligature hinges in rooms 602, 604, 605, 606, 607, 608 and 609. **(Attachment 28)** **Date of Implementation**: Completed October 22, 2014 **Monitoring Process**: Behavioral health conducting daily inspection of patient rooms including checking of door hinges. **(Attachment 27)** **Person Responsible**: Director of Engineering & Director of BHU **41).Corrective Actions**: Shower room 1: The safety grab bar was repaired and a third party certified company replaced mortise hinges with anti-ligature hinges. **(Attachment 28)** **Date of Implementation**: September 15, 2014 and October 22, 2014, respectively. **Monitoring Process**: Behavioral health conducting daily inspection of patient rooms/shower rooms including checking of safety grab bars and door hinges. **(Attachment 27)** **Person Responsible**: Director of Engineering & Director of BHU **42).Corrective Actions**: Shower room 4: The safety grab bar was repaired and a third party certified company replaced the mortise hinges with anti-ligature hinges. **(Attachment 29)** The plumbing extension at the shower head pipe was removed. **Date of Implementation**: Grab bar repaired - September 15, 2014; Hinges replaced – October 22, 2014; Plumbing extension removed – August 22, 2014 **Monitoring Process**: Behavioral health conducting daily inspection of patient rooms/shower rooms including checking the safety grab bars, the anti-ligature hinges and the shower room in general. **(Attachment 27)** **Person Responsible**: Director of Engineering& Director of BHU **6th Floor – Unit B Psychiatric** **43).Corrective Action**s: P trap covers were installed in rooms 622, 624, 625, 627, 628 and 629 to cover the exposed plumbing pipes. **(Attachment 30)** **Date of Implementation**: September 19, 2014 **Monitoring Process**: Behavioral health conducting daily inspection of patient rooms including checking of p trap covers. **(Attachment 27)** In addition the monitoring of p trap covers was also added to the Bi-annual check list of the Environment of Care rounds for patient care areas. **(Attachment 2)** **Person Responsible**: Director of BHU & Director of Engineering **44). Corrective Action**s: A third party certified company replaced the mortise hinges with anti-ligature hinges in rooms 622, 623, 624, 625, 627, 628 and 629. **(Attachment 31)** **Date of Implementation**: October 22, 2014 **Monitoring Process**: Behavioral health conducting daily inspection of patient rooms including checking of door hinges. **(Attachment 27)** **Person Responsible**: Director of Engineering & Director of BHU	10/22/2014 9/15/2014 10/22/2014 8/22/2014 9/15/2014 10/22/2014 9/19/2014 10/22/2014

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{A 701}	Continued From page 47 625, 627, 628 and 629 had one ligature resistant mortise hinge, and three standard mortise hinges that could be used as anchors on the doors. 45. The men's common bathroom by day room had a standard faucet and an exposed plumbing pipe (P-trap) under the sink that could be used as an anchor. 6th floor Unit C Psychiatric On 8/20/14 between 9:30a.m. and 9:45a.m. the following conditions existed in 6th floor Psychiatric Unit C. 46. Patient rooms, including rooms 630, 631, 632, 634, 635, and 639/day room had exposed plumbing pipes that could be used as anchors. 47. Patient rooms, including rooms 630, 631, 632, 634, 635, 636, and 639/day room had one ligature resistant mortise hinge, and three standard mortise hinges that could be used as anchors on the doors. 48. Patient rooms, including rooms 634, 635, and 639/day room had standard faucets that could be used as anchors. 49. Patient rooms 632 and 636 had missing soap dispensers. 50. Patient room 634 had a missing soap dispenser cover. 51. Room 636 (seclusion room) had an	{A 701}	**45) Corrective Action**s: The standard faucet in the men's common bathroom was replaced with anti-ligature faucet and a p trap cover was installed to cover the exposed plumbing pipe under the sink. **(Attachment 32)** **Date of Implementation**: September 19, 2014 **Monitoring Process**: Behavioral health conducting daily inspection of patient rooms/bathrooms including checking of faucets and the p trap covers in the men's common bathroom. **(Attachment 27 & 2)**. In addition the monitoring of p trap covers and anti-ligature faucets was also added to the Bi-annual check list of the Environment of Care rounds for patient care areas. **Person Responsible**: Director of Engineering & Director of BHU.	9/19/2014
			6th Floor – Unit C Psychiatric **46). Corrective Action**s: P trap covers were installed in rooms 630, 631, 632, 634, 635 and 639 to cover the exposed plumbing pipes. **(Attachment 33)** **Date of Implementation**: September 19, 2014 **Monitoring Process**: Behavioral health is conducting daily inspection of patient rooms which includes checking of p trap covers. **(Attachment 27)** In addition the monitoring of p trap covers was also added to the Bi-annual check list of the Environment of Care rounds for patient care areas. **(Attachment 2)** **Person Responsible**: Director of BHU & Director of Engineering	9/19/2014
			47).Corrective Actions: A third party certified company replaced the mortise hinges with anti-ligature hinges in rooms 630, 631, 632, 634, 635, 636 and 639. **(Attachment 31)** **Date of Implementation**: October 22, 2014 **Monitoring Process**: Behavioral health is conducting daily inspection of patient rooms which includes checking of door hinges. **(Attachment 27)** **Person Responsible**: Director of Engineering & Director of BHU	10/22/2014
			48).Corrective Actions: The standard faucet was replaced with anti-ligature faucet in rooms. 634, 635 and 639. **(Attachment 34)** **Date of Implementation**: September 15, 2014 **Monitoring Process**: Behavioral health is conducting daily inspection of patient rooms which includes checking of faucets. **(Attachment 27).** The criteria to monitor anti-ligature faucets was also added to the check list of the Environment of Care rounds which is conducted twice a year in patient care areas. **(Attachment 2)** **Person Responsible**: Director of Engineering & Director of BHU	9/15/2014
			49).Corrective Actions: Soap dispensers were installed in rooms 632 and 636. **(Attachment 35)** **Date of Implementation**: August 20, 2014 **Monitoring Process**: Behavioral health is conducting daily inspection of patient rooms which includes checking of soap dispensers. **(Attachment 27)** **Person Responsible**: Director of Engineering & Director of BHU	8/20/2014
			50).Corrective Actions: A soap dispenser was installed in room 634. **(Attachment 36)** **Date of Implementation**: August 20, 2014 **Monitoring Process**: Behavioral health is conducting daily inspection of patient rooms which includes checking of soap dispensers. **(Attachment 27)** **Person Responsible**: Director of Engineering & Director of BHU	8/20/2014
			51).Corrective Actions: Room 636 (seclusion room) was stripped and waxed removing the dirt around the foot of the bed	

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{A 701}	Continued From page 48 accumulation of dirt around foot of the bed. 6th floor Unit D Psychiatric On 8/20/14 between 9:45a.m. and 10:05 a.m., the following conditions existed in 6th floor Psychiatric Unit D. 52. Patient rooms, including rooms 612, 614, 615, 616, 617, 619, 620, and 621 had exposed plumbing pipes that could be used as anchors. 53. Patient rooms; including rooms 610, 612, 614, 615, 616, 617, 619, 620, and 621 had one ligature resistant mortise hinge, and three standard mortise hinges that could be used as anchors on the doors. 54. Patient rooms, including rooms 620 and 621, had standard faucets that could be used as anchors. 55. Patient room 612 had a missing soap dispenser. 56. Patient room 612 had a gap between the edge of the sink counter and the wall. 57. Patient room 617 had a loose sink and damaged plaster at the wall around the sink. 58. Patient room 621 had peeling paint at the wall of the bathroom. 4th floor Rehabilitation Unit	{A 701}	**Date of Implementation**: August 20, 2014 **Monitoring Process**: Daily cleaning and rounding are conducted by EVS in the Psych Unit. In addition, detail cleaning is done every weekend. **(Attachment 37 & 38)** **Person Responsible**: Director of EVS **6th Floor – Unit D Psychiatric** **52).Corrective Action**s: P trap covers were installed in rooms 612, 614, 615, 616, 617, 619, 620 and 621 to cover the exposed plumbing pipes. **(Attachment 39)** **Date of Implementation**: September 19, 2014 **Monitoring Process**: Behavioral health is conducting daily inspection of patient rooms which includes checking of p trap covers. **(Attachment 27)** The criteria to monitor p trap covers was also added to the check list of the Environment of Care rounds which is conducted twice a year in patient care areas. **(Attachment 2)** **Person Responsible**: Director of BHU & Director of Engineering **53).Corrective Action**s: A third party certified company replaced mortise hinges with anti-ligature hinges in rooms 610, 612, 614, 615, 616, 617, 619, 620 and 621. **(Attachment 31)** **Date of Implementation**: October 22, 2014 **Monitoring Process**: Behavioral health is conducting daily inspection of patient rooms which includes checking of door hinges. **(Attachment 27)** **Person Responsible**: Director of Engineering & Director of BHU **54).Corrective Action**s: The standard faucet was replaced with anti-ligature faucet in room nos. 620 and 621. **(Attachment 40)** **Date of Implementation**: September 15, 2014 **Monitoring Process**: Behavioral health is conducting daily inspection of patient rooms which includes checking of faucets. **(Attachment 27)** The criteria to monitor anti-ligature faucets was also added to the check list of the Environment of Care rounds which is conducted twice a year in patient care areas. **(Attachment 2)** **Person Responsible**: Director of Engineering & Director of BHU **55).Corrective Action**s: A soap dispenser was installed in room 612. **(Attachment 41)** **Date of Implementation**: August 20, 2014 **Monitoring Process**: Behavioral health is conducting daily inspection of patient rooms which includes checking of soap dispensers. **(Attachment 27)** **Person Responsible**: Director of Engineering & Director of BHU **56).Corrective Action**s: Sink was remounted in room 612 which eliminated the gap between the edge of sink counter and the wall. **(Attachment 42)** **Date of Implementation**: August 26, 2014 **Monitoring Process**: Engineering conducts daily rounds covering all patient rooms in a week. **(Attachment 43)** **Person Responsible**: Director of Engineering **57).Corrective Action**s: Sink was remounted in room 617 and wall was patched and painted. **(Attachment 44)** **Date of Implementation**: August 20, 2014 **Monitoring Process**: Engineering conducts daily rounds covering all patient rooms in a week. **(Attachment 43)** **Person Responsible**: Director of Engineering **58).Corrective Action**s: The peeling paint was removed and the wall of the bathroom in room 621 was painted. **(Attachment 45)** **Date of Implementation**: August 21, 2014 **Monitoring Process**: Engineering conducts daily rounds covering all patient rooms in a week. **(Attachment 43)** **Person Responsible**: Director of Engineering	8/20/2014 9/19/2014 10/22/2014 9/15/2014 8/20/2014 8/26/2014 8/20/2014 8/21/2014

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{A 701}	Continued From page 49 59. On 8/20/14 between 10:05 a.m. and 10:23 a.m., Room 423 had a broken diffuser at the wall mounted light fixture by the door. 60. At the construction separation between the back of the 4th floor and the rehabilitation unit at the front of the 4th floor, there was a 3 foot by 5 foot section missing from the gypsum board barrier at the separation. During an interview at the same time as the observation, Staff D stated that the gypsum board barrier is supposed to go all the way up to the ceiling. 3rd floor SICU (surgical intensive care unit) 61. On 8/20/14 at 10:23 a.m., room 332Ahad adhesive paper peeling off of the head wall mounted light fixture. 3rd floor CCU (critical care unit) 62. On 8/20/14 between the time of 10:30 a.m. and 10:40 a.m., the patient rooms' safety monitor was off at the nurses' station. During an interview at the same time as the observation RN (Registered Nurse) 3 stated monitor at the nurses' station was to monitor patients in rooms 333 A through 333L, that the monitor was off because the monitor did not work, and had not worked for a few months.	{A 701}	**4th Floor Rehabilitation Unit** **59).Corrective Action**s: The light diffuser in room 423 was replaced. **(Attachment 46)** **Date of Implementation**: August 21, 2014 **Monitoring Process**: Engineering conducts daily rounds covering all patient rooms in a week. **(Attachment 47)** **Person Responsible**: Director of Engineering **60).Corrective Action**s: The 3 foot by 5 foot section of missing gypsum board was extended all the way up to the ceiling by the contractor. Construction crew and Engineering staff were given in-service on ILSM and Above Ceiling process. **(Attachment 48)** **Date of Implementation**: September 1, 2014 **Monitoring Process**: Monitoring for hazards posed by construction (**Attachment 48)** **Person Responsible**: Director of Engineering **3RD Floor SICU (Surgical Intensive Care Unit)** **61).Corrective Action**s: The adhesive paper was removed from the mounted light fixture in room 332A. **(Attachment 49)** **Date of Implementation**: August 27, 2014 **Monitoring Process**: Engineering conducts daily rounds covering all patient rooms in a week. **(Attachment 50)** **Person Responsible**: Director of Engineering **3rd Floor CCU (Critical Care Unit)** **62).Corrective Action**s: The cameras were repaired and safety monitors are back on and working in CCU. **Date of Implementation**. September 8, 2014 **Monitoring Process**: Charge nurse conducts daily monitoring using the Charge RN shift report tool. **(Attachment 51)** **Person Responsible**: Director of Nursing – Critical Care	8/21/2014 9/1/2014 8/27/2014 9/8/2014

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{A 701}	Continued From page 50 3rd floor ACU (ambulatory care unit) On 8/20/14 between 10:44 a.m. and 10:50 a.m. the following conditions existed in 3rd floor ACU. 63. There was damaged upholstery of couches in waiting area outside the X-ray room. 64. There was a one foot crack at the edge between the floor and wall in a stall of the women's common bathroom next to the waiting area outside the X-ray room. 2nd floor 65. On 8/20/14 between 11:02 a.m. and 11:35 a.m., 1 of 4 clean supplies carts was not covered in the clean supply room located across from the nurses' station. 2nd floor Southwest Telemetry 66. On 8/20/14 between 11:02 a.m. and 11:35 a.m., there was a chair in room 202 with torn upholstery.· 2nd floor Southeast Telemetry On 8/20/14 between 11:02 a.m. and 11:35 a.m. the following conditions existed on the 2nd floor Telemetry Southeast Unit. 67. Room 220 was missing a shower head at the shower stall. 68. Room 220's shower mixing valve was	{A 701}	**3rd Floor ACU (Ambulatory Care Unit)** **63).Corrective Action**s: The damaged couches in the waiting area outside the X-ray room were removed and discarded. **(Attachment 52** **Date of Implementation**: October 21, 2014 **Monitoring Process**: Furniture pieces are checked for damages and tears during the Environment of Care rounds **(Attachment 53)** **Person Responsible**: Director of Engineering **64).Corrective Action**s: The one foot crack between the edge and floor in the stall of the women's common bathroom next to waiting area outside of X-ray room was repaired **(Attachment 54)** **Date of Implementation**: September 17, 2014 **Monitoring Process**: Engineering conducts daily rounds covering all patient rooms in a week. **(Attachment 43)** **Person Responsible**: Director of Engineering **2nd Floor** **65). Corrective Action**s: Education of staff regarding clean supplies carts in clean supply room must be covered at all times. Charge Nurses to monitor compliance on each shift **(Attachment 55**). **Date of Implementation**: August 22, 2014 **Monitoring Process**: Charge Nurse Rounding on clean supplies cart covers being down and covering supplies at all times (**Attachment 56)** **Person Responsible**: Telemetry Nursing Director **2nd Floor Southwest Telemetry** **66). Corrective Action**s: Chair in room 202 was immediately removed from service and discarded. **(Attachment 57)** **Date of Implementation**: 8-20-14 was discarded. **Monitoring Process**: Charge Nurse & Staff educated to notify Environmental services to remove broken furniture & /or defective upholstery (**Attachment 55).** **Person Responsible**: Telemetry Nurse Director **2nd Floor Southeast Telemetry** **67).Corrective Action**s: The missing shower head in room 220 was replaced. **(Attachment 58)** **Date of Implementation**: August 20, 2014 **Monitoring Process**: Engineering conducts daily rounds covering all patient rooms in a week. **(Attachment 59)** **Person Responsible**: Director of Engineering **68).Corrective Action**s: The shower mixing valve in room 220 was re-reversed to correct water temperature. **(Attachment 60)** **Date of Implementation**: August 21, 2014 **Monitoring Process**: Engineering conducts daily rounds covering all patient rooms in a week. **(Attachment 59)** **Person Responsible**: Director of Engineering	10/21/2014 9/17/2014 8/22/2014 8/20/2014 8/20/2014 8/21/2014

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{A 701}	Continued From page 51 reversed. The patient in room 220 complained that there was no hot water at the shower. Troubleshooting by Staff P at the same time as the complaint revealed that the shower's mixing valve was reversed. 69. Room 221 had a three foot crack at shower stall wall. During an interview, at the same time as the observation Staff R (Lead Man) (for engineering) stated that they (the facility) did not want to replace the shower stall, but instead wanted to repair it. That they were still looking for a vendor to repair the crack at the shower stall wall, that he had called the vendor they usually use for repairs but not received a response, and that he had not called any other vendors. 70. Room 221 was missing a floor drain grate at the shower stall. 71. Room 221 had water leak at the flush pipe of the toilet. 1st floor Laboratory 72. On 8/20/14 at 11:35 a.m., there was a 3ft. by 3 ft. sign water damage and unpainted plaster at the ceiling above Centar machine in the main laboratory. Pharmacy 73. On 8/20/14 at 11:50 a.m., there were signs of water damage at 3 pharmacy ceiling light fixtures	{A 701}	**69**).**Corrective Action**s: The crack in the shower stall wall in room 221 was repaired. **(Attachment 61)** **Date of Implementation**: September 23, 2014 **Monitoring Process**: Engineering conducts daily rounds covering all patient rooms in a week. **(Attachment 59)** **Person Responsible**: Director of Engineering	9/23/2014
			70).Corrective Actions: The floor drain grate at the shower stall in room 221 was replaced. **(Attachment 62)** **Date of Implementation**: August 21, 2014 **Monitoring Process**: Engineering conducts daily rounds covering all patient rooms in a week. **(Attachment 59)** **Person Responsible**: Director of Engineering	8/21/2014
			71).Corrective Actions: The leaky flush pipe of the toilet in room 221 was replaced. **(Attachment 63)** **Date of Implementation**: August 21, 2014 **Monitoring Process**: Engineering conducts daily rounds covering all patient rooms in a week. **(Attachment 59)** **Person Responsible**: Director of Engineering	8/21/2014
			1st Floor **Laboratory** **72).Corrective Action**s: The ceiling above the Centaur machine in the Laboratory was repaired and painted. The pipe causing condensation was insulated. **(Attachment 64)** **Date of Implementation**: August 25, 2014 **Monitoring Process**: Weekly rounds are conducted by Engineering in non-patient room areas **(Attachment 65)**. Environment of Care rounds are conducted weekly covering patient care areas twice a year and non-patient care areas once a year. **Person Responsible**: Director of Engineering & EOC. **Pharmacy** **73).Corrective Action**s: The three Pharmacy light fixtures had light diffusors removed and ceiling assessed for water damage with repair. Brown stains removed off of the light fixtures. **(Attachment 66)** **Date of Implementation**: August 25, 2014	8/25/2014 8/25/2014

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{A 701}	· Continued From page 52 that included brown stains at the light diffusers and frames. Basement Operating Room (OR) 3 74. On 8/20/14 between 11:50 a.m. and 12:20 p.m.., sections of laminate were missing from the door of OR 3. Recovery Area 75. On 8/20/14 between 11:50 a.m. and 12:20 p.m., sections of laminate were missing from the nurses' station. Central Processing 76. On 8/20/14 between 11:50 a.m. and 12:20 p.m.,1 of 2 autoclaves in central processing was out of order. On 8/21/14 at 2:25p.m., during an interview Staff S (Biomed) stated that the autoclave had been out of service since 11/1/13. That he tried to repair it on 11/1/13 but it was beyond his knowledge and called a vendor, but had trouble with the vendor coming to the hospital because of the hospital's address was attached to a bankruptcy. He also stated that on 11/4/13 he found out the autoclave needed a new separator. That the vendor did not visit the facility until11/31/14, and that the purchase requisition for the separator was done on 12/10/13. That he has had the separator for a month and a half, but has had	{A 701}	**Monitoring Process**: Weekly rounds are conducted by Engineering in non-patient room areas. **(Attachment 65)**. Environment of Care rounds are conducted weekly covering patient care areas twice a year and non-patient care areas once a year. **Person Responsible**: Director of Engineering & EOC **Basement** **Operating Room (OR) 3** **74).Corrective Action**s: The laminate section on the door of OR#3 was repaired. **(Attachment 67).** **Date of Implementation**: August 28, 2014 **Monitoring Process**: Weekly rounds are conducted by Engineering in non-patient room areas **(Attachment 65).** Environment of Care rounds are conducted weekly covering patient care areas twice a year and non-patient care areas once a year. **Person Responsible**: Director of Engineering **Recovery Area** **75).Corrective Action**s: Laminate sections from the nurses' station was repaired. **(Attachment 69)** **Date of Implementation**: September 9, 2014 **Monitoring Process**: Weekly rounds are conducted by Engineering in non-patient room areas **(Attachment 68)**. Environment of Care rounds are conducted weekly covering patient care areas twice a year and non-patient care areas once a year. **Person Responsible**: Director of Engineering **Central Processing** **76).Corrective Action**s: A third party Biomed Company was hired and put autoclave #2 back into service. **(Attachment 70)** **Date of Implementation**: September 2, 2014 **Monitoring Process**: Biomed conducts semi-annual preventative maintenance on medical equipment. **(Attachment 71)** **Person Responsible**: Biomed Engineer and Director of Engineering	8/28/2014 9/9/2014 9/2/2014

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{A 701}	Continued From page 53 trouble getting the vendor to visit the hospital for repair of the autoclave because of scheduling problems. That the vendor had started working on the autoclave today (8/21/14) and would be completed with the repair in 45 minutes, and should be up and running by Monday (8/25/14). He further stated that the nine month delay in getting the autoclave repaired was in trying to find the correct separator, and that it took a while to get a purchase order. That another reason it took so long was because he had other issues to take care of and did not have a full crew. The Asset"10249 history report had entries dated 11/1/13 that indicated that the unit would not hold steam, entry dated 1/31/14 that indicated unit was checked and found to not hold steam and was informed by the vendor that the unit needed a steam separator, and were waiting on parts. The purchase requisition dated 12/10/13, had a description of steam separator as the part requisitioned. The justification noted was that autoclave II was down due to cold condensation and not holding steam, and that the separator would eliminate the problem. Per the Biomed the purchase requisition is the request for his company to give him a purchase order. The request to purchase dated 8/8/14, indicated a request to purchase a steam separator for autoclave in central supply. The justification noted was that it was for a repair/installation, that autoclave had condensation problem and needed a steam separator installed to resolve the issue. Tower	{A 701}		

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{A 701}	Continued From page 54 6th Floor Detox Unit 77. On August 21, 2014 at 8:43a.m., in room 680, there was a missing cover at the toilet paper dispenser, there was an unpainted plaster patch at the wall next to the toilet, and there was black and green slime at the bed pan washer joint. Single Story Building Exterior West Side 78. OnAugust21, 2014 between 9:10a.m. and 9:35a.m. there were seven bins at the exterior west side of the single storage building. The area was accessible through an interior door with a radiation caution sign. Three of the seven bins had cracked and broken lids on them, and contained trash in clear plastic bags that were visible through the cracked and broken areas of the lids. One of the bags was untied and open, and another bag had an accumulation of moisture in the bag. Four of the seven bins had no lids, and were empty. During an interview at the same time as the observation Staff U (Chief Nuclear Medical Technician) stated that the waste in the bins was nuclear waste from tracers and that the area was a secured area where the nuclear waste was allowed to decay. Radioactive Laboratory 79. On August 21, 2014 at 11 a.m., in the	{A 701}	**Tower** **6th Floor Detox Unit** **77).Corrective Action**s: The toilet paper dispenser was replaced, wall was painted and alkaline deposit on the bed pan washer joint was cleaned in the restroom in room 680. **(Attachment 72)** **Date of Implementation**: August 26, 2014 **Monitoring Process**: Engineering conducts daily rounds covering all patient rooms in a week. **(Attachment 73)** **Single Story Building** **Exterior West Side** **78).Corrective Action**s: The cracked containers with broken lids have been removed and discarded. New covered containers have been purchased and relocated to a secured non-public area. **(Attachment 79)** **Date of Implementation**: September 1, 2014 **Monitoring Process**: On-going. **Person Responsible**: Director of Ancillary Services & Chief Nuclear Medicine Technologist **Radioactive Laboratory** **79). Corrective Action**s: The 'bolts' on the exam table in the Nuclear Medicine exam suite have been replaced. **(Attachment 80)** **Date of Implementation**: September 1, 2014 **Monitoring Process**: On-going. **Person Responsible**: Director of Ancillary Services & Chief Nuclear Medicine Technologist	8/26/2014 9/1/2014 9/1/2014

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{A 701}	Continued From page 55 Radioactive Laboratory, (Nuclear Medicine #1) the examination table had two missing nylon fasteners replaced with metal bolts and nuts, with the end of the bolts facing up to where the patient would lie on the table. The end of one of the bolt had a sharp edge, and the nut was loose. 80. Hollywood Campus Emergency Preparedness During observation on 8/18/14 beginning at 10:45 a.m., the hospital's disaster preparedness was reviewed in the presence of Staff L (Director of Food Service). In a concurrent interview, she stated that the hospital was planning for a total of 200 patients and staff for a period of 4 days. She also stated the plan was to utilize dehydrated meal products. Review of the inventory revealed that currently the hospital had 125 meals on hand for approximately two days; however had planned to augment that supply with additionally stocked dry goods such as canned tuna. Review of current stock revealed there were 9 cans each weighing 5 pounds which would equate to 200 servings, a quantity for 1 meal. It is unclear how the hospital would implement the plan when there was no menu, staff guidance, recipes or evaluation of inventory to ensure the development of a comprehensive feeding plan that would meet the nutritional needs and could be implemented in the event of a disaster. In addition, additional review of 8/18/14 at 2:45p.m. of available fluid revealed that the hospital had insufficient quantities of dry milk. The plan as discussed would be inadequate to meet the hospital needs for four days. It was also noted that the dehydrated meal	{A 701}	**Hollywood** **80).Corrective Action**s: A plan was enacted to have on hand a minimum of 4 days of water & 7 days of foods and related supplies on hand based on population of 200. (100 licensed beds and 100 staff and others) as indicated by the policy. **(Attachment 74).** Disaster preparedness meeting minutes **(Attachment 75)** **Date of Implementation**: August 28, 2014 **Monitoring Process**: Monthly inventory inspection will be conducted. **(Attachment 76)** **Person Responsible**: Dietary Manager & Facility Management	8/28/2014

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{A 701}	Continued From page 56 products were stored in a house adjacent to the hospital building which was used as an office for engineering. There were no defined security actions taken to ensure the security of the supply. In an interview on 8/18/14 beginning at 4:30 p.m., with Staff N (Disaster Coordinator), he stated that he followed guidelines set forth by a specialty grant awarded to hospitals for disaster preparedness. He described the grant requested hospitals be self-sufficient for 3 days. He also stated that meetings were held with local hospitals and clinics; however, Staff N was unsure of the involvement of federal and/or local agencies with this hospital committee. Staff N was also asked to demonstrate membership/sponsorship of this committee. As of 8/21/14 at 2 p.m., the hospital was unable to demonstrate coordinated involvement at the local, state or federal level. There were also inconsistencies between hospital departments with respect to timeframes for self-sufficiency. This is a repeat deficiency from the sampled validation survey on April 1, 2014.	{A 701}		
{A 703}	482.41(a)(2) EMERGENCY GAS AND WATER There must be facilities for emergency gas and water supply. This STANDARD is not met as evidenced by: Based on document review and interview, the facility failed to have documented evidence of an approved system to provide emergency water and ensure an effective water management plan and supplies to be implemented in a widespread disaster.	{A 703}		

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{A 703}	Continued From page 57 This deficient practice had the potential to result in inadequate supply of drinking water and water for other purposes to all patients and staff during a disaster affecting the hospital and effectively meet the hydration and personal care needs of patients. Finding: On August 19, 2014 at 2:58p.m., during document review there was no approved written plan to provide emergency water as needed to provide care to inpatients and other persons who may come to the hospital in need of care. The facility provided a document that had a policy titled, Loss of Water Policy and procedure, Number: EMP.018, as documented evidence of a system to provide emergency water and ensure an effective water management and supplies to be implemented in a widespread disaster to effectively meet the hydration and personal care needs of patients and staff. Review of the document indicated it was not a policy in effect as evidenced by the lack of an effective date. The document indicated it had not been reviewed or approved by the EOC Committee, Quality Council, Medical Executive Committee, and Governing Body, as evidenced by a lack of dated signatures on the front page and in the Approval section (section 10.0). The document also indicated a failure to assign responsibility as evidenced by no person, department or entity identified in the Responsibility section (section 5.0). During an interview at the same time as the review, Staff D (Corporate Director of Facilities)	{A 703}	**Corrective Action**s: The Loss of Water Policy and Procedure was approved by the EOC Committee, Quality Council Committee, Medical Executive Committee and the Governing Board. **(Attachment 1)** **Date of Implementation**: EOC Committee: July 2014; Quality Council: September 2014; MEC: September 2014; Governing Board: September 2014 **Monitoring Process**: The policy will be reviewed annually and will be presented back to the committees tri-annually. **Person Responsible**: Director of Engineering	07/2014 9/2014

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{A 703}	Continued From page 58 stated the document had not yet been approved as policy, that it had only been approved by the EOC committee, was currently going through the Medical Executive Committee, and then would go to the Governing Board. This is a repeat deficiency from the sampled validation survey on April 1, 2014.	{A 703}		
{A 724}	482.41(c)(2) FACILITIES, SUPPLIES, EQUIPMENT MAINTENANCE Facilities, supplies, and equipment must be maintained to ensure an acceptable level of safety and quality. This STANDARD is not met as evidenced by: Based on observation, review of hospital documents and staff interviews, the hospital failed to maintain its refrigerators, freezers,. plate warmer and supplies to ensure an acceptable level of safety and quality. Failures resulted in storage of food at unsafe food temperature range. Safe food temperature range is 0 degrees Fahrenheit and below for frozen items and 41 degrees and below for refrigerated items. Storage of food outside of these temperature ranges could result in growth of food borne illness causing microorganisms thereby endangering the safety of patients, staff and visitors. In addition, the use of disposable ware resulted in poor maintenance of food temperatures and unpalatable food. Findings: Hollywood Campus 1. During the initial tour on 8/18/14 beginning at 10 a.m., there was a significant ice build-up within	{A 724}		

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{A 724}	Continued From page 59 the walk-in freezer. There was a large piece of ice, measuring approximately 6" (inches) x 6" x 4," adhered to the metal shelving directly below the blower. Additionally there were pieces of ice measuring from 1" to 4" adhered to the floor, mats on the floor, a buildup of ice on the blower within the unit and a frozen condensation buildup on the air curtain (plastic strips that are adhered to the interior door frame to mitigate the escaping of the cold air). It was noted that the internal thermometer read 10°F. In a concurrent interview with Dietary Staff (OS) 3, "She stated that during the past 2 weeks the unit had not been functioning properly. She also stated that the hospital had several service calls, each vendor indicated the unit was fixed; however the issues persisted with no recent attempts to further address the issue. It was also noted that this temperature depicted an unacceptable temperature (which was designated as a red color) on the thermometer. A follow up observation on 8/18/14 at 12:30 p.m., and 4 p.m., noted the freezer temperature was consistently 32°F. It would be the standard of practice to ensure equipment was maintained in a manner to keep frozen foods frozen (Food Code, 2013). In a follow up interview on 8/19/14 at 12:30 p.m., with OS 3, she stated the previous evening a different vendor evaluated the unit. She further stated she was told the unit had significant issues; however it would not be able to be accurately evaluated until the unit was empty and defrosted. Review of the service work orders dated 7/19/14 noted that the door sweep and door curtain strip required replacement and it was also noted there was an electrical issue with the door frame heater	{A 724}	**Hollywood** **1).Corrective Action**s: A third party vendor repaired the walk-in freezer to meet the temperature requirement and to eliminate ice build ups. **(Attachment 1)** **Date of Implementation**: August 18, 2014 **Monitoring Process**: Dietary staff is monitoring the freezer and refrigerator temperature twice daily. **Person Responsible**: Dietary Manager and Plant Operations	8/18/2014

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{A 724}	Continued From page 60 wire. Review of completed work order dated 7/22/14 noted that 2 out of the 3 items were repaired. There was no documentation that the heater wire repair was completed. It was also noted that the most recent work order was dated 1 month prior; however the issue continued to be unresolved. In an interview on 8/18/14 beginning at 3:30 p.m., with Staff 18, he stated he was told by the vendor that the issue was fixed; however was unable to demonstrate an effective system to ensure that identified maintenance issues were fully resolved. Review of hospital submitted document titled, "Freezer Temperature" dated 8/20/14 noted that despite repair interventions on the evening of 8/18, and early morning hours of 8/19 and 8/20 the facility document titled, "Freezer Temperature Log" dated 8/20/14 demonstrated that 6 of 8 recorded temperatures were greater than 0°F, ranging from 1-35°F. Departmental policy titled, "Temperatures of Refrigerators and Freezers" dated 12/12 noted that "Freezer temperatures shall be 0°F or less." Hospital policy titled, "Work Order Request Procedures" dated 11/12 revealed that the Director of Plant Operations was the position accountable and responsible for monitoring and enforcement of the work order request procedures. It was also noted that the work order request form was an electronic system that was accessible on all hospital computers. The policy also depicted that urgent requests would be those that a lack of action would jeopardize the operation of the medical center and procedures for resolution of urgent issues would be corrected by the fastest means possible. Staff N (Disaster Coordinator) was unable to demonstrate the implementation of the work order system for this	{A 724}		

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{A 724}	Continued From page 61 issue. Departmental policy titled, "Management of the Environment of Care" dated 11/12 noted it was the responsibility of the department director as the position responsible for maintaining safety standards. Culver City Campus 1. During general food storage observations on 8/19/14 beg.inning at 2:20p.m., in walk-in refrigerator #2, there was a circular hole of the flooring measuring approximately 6" (inches) x 6 " x 2 " exposing the wood underneath the flooring. It was also noted that at the joint where the wall and flooring met, there were multiple areas where the metal wall material was covered by a brown rust-like material, the wall material was disintegrating, exposing the wood behind the wall. Additionally it was also noted that at the plastic coating of the food storage shelves was disintegrating, exposing a brown, rust-like material that could be wiped off. In a concurrent interview with RD 3 (Registered Dietitian), he stated that he had put a repair work order for the floor; however had not noted the exposed wood on the walls. He also stated he had no response from facility operations regarding an evaluation or proposed solution to the maintenance issue. Dietary document titled "Work Order" dated 7/14/14 (1 month earlier) revealed that while the issue was identified there was no activity with respect to completion of the request. The work order also noted that the hole presented a safety risk to staff and was unsanitary. The standard of practice would be to ensure that equipment remained free of breaks, open seams, cracks, chips, inclusions, pits, and similar imperfections and was finished to have smooth welds and joints (Food Code, 2013).	{A 724}	**Culver City** **1a).Corrective Action**s: Work order was re-submitted for the circular hole in the floor of refrigerator #2. Repair has been completed. **(Attachment 2)** **Date of Implementation**: 8/21/14 **Monitoring Process**: Weekly monitoring of Work orders process. **(Attachment 3)** **Person Responsible**: RD, Director of Dietary Services & Director of Plant Management **1b) Corrective Action**s: Work order was submitted for refrigerator #2 and the repair of the joint where the wall and floor meet **(Attachment 4)** **Date of Implementation**: Work order submitted 8/21/14; repair completed on 10/21/14 **Monitoring Process**: Work orders are tracked with the FNS department for completion **Person Responsible**: RD, Director of Dietary Services & Director of Plant Management **1c) Corrective Action**s: Wiped off the brown rust like material. Replacement shelving has been ordered; will be installed upon receipt. **(Attachment 5)** **Date of Implementation**: 11/7/14 expected completion **Monitoring Process**: Work orders are tracked with the FNS department for completion. **Person Responsible**: RD, Director of Dietary Services & Director of Plant Management	8/21/2014 10/21/2014 11/7/2014

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{A 724}	Continued From page 62 In an interview on 8/20/14 at 9:20a.m., with Staff C (CEO) and A (Administrator), they stated they were recently assigned to provide leadership to the hospital and acknowledged that they were notified during the survey the scope of maintenance issues in relationship to dietetic services. Departmental policy titled, "Repairs" dated 11/12 noted that once the department files a copy of written request in the department " 4.2.4 Maintenance Department initiates repairs within 24-48 hours ... " 2. During the food service observations on 8/19/14 beginning at 12:50 p.m., there was a patient refrigerator in the behavioral health unit. It was noted that in both the refrigerator and freezer there was a build-up of unidentifiable food products. It was also noted that the gaskets on the unit had a brown discoloration, resembling rust. Additionally the gaskets were partially torn and no longer fully adhered to the unit. 3. During general kitchen observations on 8/19/14 beginning at2:50 p.m., there were greater than 10 patient meal delivery trays that were cracked and had exposed metal edges. It would be the standard of practice to ensure that all patient meal delivery utensils be free of breaks, open seams, cracks, chips, inclusions, pits, and similar imperfections (Food Code, 2013). Hospital policy titled, "Storage of Pots, Dishes, Flatware, Utensils" dated 11/12 noted that "All utensils ...equipment will be kept clean, maintained in good repair ..." 4. The plate warmer has been out of order prior to the first survey in April 2014. All patients are being served food on disposable Styrofoam	{A 724}	**2).Corrective Action**s: The Refrigerator in BHU was replaced. **(Attachment 6)** **Date of Implementation**: August 22, 2014 **Monitoring Process**: Behavioral Health conducts daily environmental rounds including inspection of refrigerators. **(Attachment 7)** **Person Responsible**: Director of BHU **3).Corrective Action**s: The meal delivery trays identified as being cracked with exposed metal edges were immediately removed from service and replaced with new ones from storage. **Date of Implementation**: August 19, 2014 **Monitoring Process**: The condition of patient meal service ware (including trays) will be observed as part of the Routine Infection Control and Food Safety Audit **(Attachment 8)**. **Person Responsible**: RD, Director of Dietary Department **4) Corrective Action**s: A new plate warmer was purchased, delivered and installed at Hollywood **(Attachment 9)** **Date of Implementation**: 9/17/2014 **Monitoring Process**: Equipment functionality is monitored via Plant Operation rounding and the work order process **Person Responsible**: RD, Director of Dietary Department and Director of Plant Management	8/22/2014 8/19/2014 9/17/2014

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{A 724}	Continued From page 63 plates. During food_ distribution observations on 8/18/14 beginning at 3:35 p.m., all patient meals were plated using disposable plates, cups and flatware. In a concurrent interview with DS 3, she stated that staff told her the plate warmer was broken. The surveyor asked for an explanation of why a broken plate warmer would cause the hospital to utilize all disposable items. She was unable to explain the rationale. 5. In response to questions about the use of plates in the absence of a plate warmer, DS 3 also acknowledged that during the past 2 weeks (when she took over the position) she had not observed a stock of any dishware or flatware. Van Nuys 6. There was a refrigerator that was labeled "Out of Order" dated 6/4/14. In an interview on 8/19/14 at 4:30p.m. with the Head of Plant Operations, he stated that two weeks earlier the hospital decided that repairing the refrigerator was not ideal because it was too expensive and replacement was more practical. 7. One of the freezers (#5) was observed to read 23 degrees Fahrenheit. The recommended temperature for a freezer is 0 degrees Fahrenheit _ and below. During the survey, arrangements were being made to bring in a refrigerated truck to store the items. It was not clear how long this freezer had not been in good working order. This is a repeat deficiency from the sampled validation survey on 4/1/14.	{A 724}	**5) Corrective Action**s: Dishware and flatware stock implemented for use and purchases made for additional stock **(Attachment 10)** **Date of Implementation**: 9/5/14 **Monitoring Process**: A monthly inventory of china and reusable service ware is maintained at par levels required to meet the facility licensed bed capacity. **(Attachment 11)** **Person Responsible**: RD, Director of Dietary Department and Directors of Plant Management **Van Nuys** **6). Corrective Action**s: Upon further assessment, it was deemed that the refrigerator was repairable and was repaired by an outside vendor. **(Attachment 12)** **Date of Implementation**: October 14, 2014 **Monitoring Process**: Equipment monitoring is conducted by Dietary. **(Attachment 13a)** **Person Responsible**: Dietary **7). Corrective Action**s: A refrigerated truck was ordered to store the items when freezer #5 was observed to read 23 degrees Fahrenheit instead of 0 degrees Fahrenheit. **(Attachment 14)**. **Date of Implementation**: August 29, 2014 **Monitoring Process**: Equipment monitoring is conducted by Dietary **(Attachment 13)** **Person Responsible**: Dietary	9/5/2014 10/14/2014 8/29/2014
A 726	482.41(c)(4) VENTILATION, LIGHT,	A 726		

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A 726	Continued From page 64 TEMPERATURE CONTROLS There must be proper ventilation, light, and temperature controls in pharmaceutical, food preparation, and other appropriate areas. This STANDARD is not met as evidenced by: Based on observation, review of facility documents and staff interviews, the hospital faile to ensure that there was adequate ventilation an proper temperature controls in the kitchen and dry food storage areas. Findings: Hollywood campus 1. During the food production and distribution observations on 8/18/14 beginning at 11:40 a.m., Dietary Staff (OS) 2 was wiping perspiration from his forehead and continuing with food distribution activities without handwashing. It was also noted that the ambient room air temperature was 85° (degrees) F (Fahrenheit). In a concurrent interview with OS 2, he stated that the room was always hot and that it was verbally mentioned to supervisory staff. He also stated that the only ventilation for the kitchen was an air vent located above the dishwasher. A follow up observation on 8/18/14 at 12:30 p.m., noted that the room temperature increased to 86.5°F. It was also noted that while there was air blowing from the vent, the air was not cool, rather was room temperature. In an interview on 8/18/14 beginning at 5:15 p.m., with Staff V (Engineering Staff), he stated that this was his second day with the campus as plant operations. He also stated that mid- afternoon an employee evaluated the unit and noted that the float which pumped water to the unit was broken. Staff V was unable to	A 726	**Hollywood** **1).Corrective Action**s: A third party vendor serviced the AC and swamp cooler that supplied the cafeteria and kitchen to meet an appropriate temperature. Staff inservices on hand hygiene **(Attachment 1 & 2)** **Date of Implementation**: 9/8/2014 **Monitoring Process**: Dietary conducts room temperature testing twice daily. **(Attachment 3)** **Person Responsible**: Dietary Manager	9/8/2014

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A 726	Continued From page 65 demonstrate that the ventilation in the kitchen was evaluated to ensure that it provided proper ventilation to dietetic services. A follow up observation on 8/18/14 at 5:35p.m., revealed an ambient air temperature in the kitchen of 86°F. 2. During the food storage observations on 8/18/14 beginning at 10:40 a.m., the ambient room temperature in the dry storage area was 74°F. It was noted that the dry storage area contained canned goods as well as dry goods such as crackers, cereals and bakery mixes. In a concurrent interview with Staff L (Director of Food Service), she stated that in accordance with the thermometer in the room the air temperature should be 70° F or below. She also acknowledged that the room thermometer gauge was in the "red" zone (for the thermometer) which depicted that the room was above the upper limit of 70°F. She also stated she was unsure of air supply to the dry storage area. It was also noted that while there was a vent in the room there was no air circulation. Van Nuys At 11:53 a.m. on 8/19/14, the ambient air temperature of the dry storage room was 88.6 degrees Fahrenheit (per surveyor thermometer). There was no visible thermometer hanging in the room. In response to the comment by the surveyor that the room seemed warm, Staff K placed a new room thermometer in the room. At 12:55 p.m., the temperature was 88 degrees Fahrenheit. The dry storage thermometer gauge had exceeded the graduated 80 degree mark indicating that the room was warmer than 80 degrees.	A 726	**2) Corrective Action**s: Storage area is now within standards of 50 to 70 degrees. Action taken to reach these temperatures includes hiring a third party certified vendor to adjust the dampers allowing the required air flow in the area. **(Attachment 1)** **Date of Implementation**: 8/25/14 **Monitoring Process**: Daily monitoring of Dry Food Storage temperatures to ensure compliance with Food Code 2013 of temperatures between 50-70 degrees. Department EOC Rounds and Monthly Infection Control and Food Safety Audits. **(Attachment 4 & 5)** **Person Responsible**: RD, Director of Dietary Department and Director of Plant Management **Van Nuys** **1) Corrective Action**s: The Dry Food storage area was moved to a location that did not contain a refrigerator/freezer unit. The Dry food storage area has been provided a thermometer with daily monitoring of temperatures to ensure compliance with Food Code 2013 temperatures range between 50-70 degrees **Date of Implementation**: 8/20/14 **Monitoring Process**: Daily monitoring of Dry Food Storage temperatures **(Attachment 6).** **Person Responsible**: RD, Director of Dietary Department and Directors of Plant Management	8/25/2014 8/20/2014

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A 726	Continued From page 66 Although there was an air vent in the room, there was a refrigerator/freezer in the room that generated heat possibly contributing to the high room temperature. In an interview with Staff K, she stated that they do not monitor or keep logs of the dry storage room. According to the same policy described above, "All dry goods are stored in storeroom that is clean, dry and well ventilated ... " The dry storage room was not well-ventilated. Improperly stored staple foods could result in poor quality such as deterioration of food products including rancidity and altered flavors. Foods held at less than optimum temperatures could support the growth of microorganisms that promote spoilage and /or food borne illness. Best practices guidelines would ensure dry food staples such as flour, crackers, cake mixes, seasonings, and canned goods should be stored in their original packages at an optimal range 50°F to 70°F. Higher temperatures speed up deterioration (Virginia, Clemson State and Ohio State Universities Cooperative Extension). While the hospital's policy titled, "Food Supply and Storage Procedures" dated 11/12 noted that dry storage areas may be maintained at temperatures ranging from 50-75°F, there were no standard of practice references to support the elevated temperature range. Departmental policy titled, "Surveillance, Prevention, and Control of Infection" dated 11/12 noted that "Adequate ventilation shall be provided in all storage areas ...Lighting, ventilation, and humidity shall be controlled to prevent the growth of microorganisms."	A 726		
{A 747}	482.42 INFECTION CONTROL	{A 747}		

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{A 747}	Continued From page 67 The hospital must provide a sanitary environment to avoid sources and transmission of infections and communicable diseases. There must be an active program for the prevention, control, and investigation of infections and communicable diseases. This CONDITION is not met as evidenced by: Based on observation, review of facility documents and staff interview, the facility failed to meet the Condition of Participation in Infection Control by failing to: 1. Provide a functional and sanitary environment for the provision of surgical services (Refer to A 749). 2. Ensure re-usable surgical instruments were sterilized and stored in accordance with the Association of Peri-Operative Registered Nurse (AORN) Standards. AORN is the National Recognized Standards (NRS) the hospital identified as the standard they followed (Refer to A 749). These deficient practices promote microbial growth and can result in contamination of sterile items. 3. Ensure effective systems for safe food handling to prevent food borne illness. This was evidenced by: a. the storing of food in refrigerators and freezers that were not maintaining temperatures by hospital policies and customary practices; b. not following tube feeding orders to prevent growth of microorganisms; c. failure to sanitize the ice machine as recommended by the	{A 747}	**1). Corrective Action**s—Monitor sanitary environment of the surgical services; 1) areas free of clutter & non-essential storage, 2) monitor the function of terminal cleaning by EVS, 3) Operating room staff completed competencies on between case cleaning. **(Attachment 1 & 2)** **Date of Implementation**: 10/23/2014 **Monitoring Process**: Twice monthly infection control rounds to review cleanliness of Surgical Services Area **(Attachment 3).** **Person Responsible**: Surgery Department, Infection Control Department **2.) Culver City**: **Corrective Action**s; All re-usable surgical instruments (SI) were re-processed, packaged, and stored in accordance to AORN standards; bin dividers purchased to ensure packages are stored up-right on 9/5/2014. 5 inch stringers were purchased to ensure SI are completely open for processing & implemented on 8/25/2014; 3 M Comply cards purchased and placed into service to ensure tip and lock boxes in peel packs maintain an open position for sterilization on 8/26/14; Purchased new biological incubator and indicator with corresponding supplies for sterilization on 10/10/14 9/8/ 2014; Provided education/in-service to staff on standards for processing, packaging and storing of SI, this includes competency validation and return demonstration **(see Attachments-A-000.2)** **Date of Implementation**: Education SI re-processed August 20, 2014 **Monitoring Process**: Monitoring will be managed during bi-monthly Infection Control rounds with ORT or RN with compliance reported to the regulatory Compliance Committee. **Person Responsible**: Infection Control/OR Director; to be completed on the EOC log and will report results to the Regulatory Compliance Committee & Quality. **2.). Hollywood: Corrective Action**: (p.68)--Failure to ensure proper packaging and storage of re-usable surgical instruments: All surgical instruments were re-processed [during the time of the initial survey] and were packaged in a way that provided for adequate sterilant contact by adding fewer instruments in the trays, removing plastic peel pouches from the trays, adding larger stringers when needed, adding tip protectors and devices to keep instruments open during reprocessing. Storage practices were also changed to prevent overcrowding and storing peel pouches on edge. **(See Attachments-A-000.2 & Attachment 4)** **Date of Implementation**: August 21, 2014 **Monitoring Process**: Infection Control bi-monthly rounds in the Operating Room areas to review storage practices (implemented 9/18/14) **(Attachment 3)** **Person Responsible**: Infection Control Department, Surgical/Central Processing **3a). Culver City: Corrective Action**: In-services provided to staff on process for improperly functioning equipment. **(Attachment 5)** **Date of Implementation**: October 23, 2014.	10/23/2014 8/20/2014 8/21/2014 10/23/2014

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{A 747}	Continued From page 68 manufacturer; d. failure to install air gaps in all the sinks in the kitchen; e. use of wiping cloths to dry food production equipment; f. disposal of garbage without proper protection; g. the unloading of clean trays in the dish washing area with same gloves that had been used to load dirty trays. These deficient practices failed to promote operational processes that support safe food handling practices may result in exposure of patients to bacteria associated with foodborne illness. Foodborne illness may result in further compromising patients' medical status and in severe instances may result in death. The cumulative effects of these systemic issues resulted in the facility's inability to ensure and provide a safe patient care environment. This is a repeat deficiency from the sampled validation survey on April 1, 2014.	{A 747}	**Monitoring Process**: Monitored daily by dietary staff **(Attachment 5)** **Person Responsible**: Dietary Director/Supervisor **3a). Van Nuys: Corrective Action**: New refrigerators and freezers were ordered and have been installed. Repairs of existing refrigerators/freezers also being conducted. In-services provided to staff on process for improperly functioning equipment. Refrigerated truck was brought in during the interim to provide adequate refrigeration while repairs and installations are carried out **(Attachment 6)** **Date of Implementation**: August 20, 2014. **Monitoring Process**: Refrigerator & Freezer Temperatures monitored daily by dietary staff **Person Responsible**: RD Director Dietary Department **3a). Hollywood. Corrective Action**: Freezer and Refrigerators were repaired. Staff in-serviced on appropriate procedures to take when equipment malfunctions **(Attachment 6)** **Date of Implementation**: August 20, 2014. **Person Responsible**: RD Director Dietary Department **3b). Culver City** G-tube feeding orders not followed **Corrective Action**: Education and in-services provided to nursing staff. **(Attachment 7)** **Date of Implementation**: July 1, 2014 **Monitoring Process**: Monitored by nursing **(Attachment 8)** **Person Responsible**: Nursing Directors **3b). Hollywood**-G-tube feeding orders not followed **Corrective action** plan: all open feeding systems were eliminated and only the closed systems are being used to prevent the growth of microorganisms. Education and in-services provided to nursing staff **(Attachment 9)** **Date of Implementation**: 9/16/14 **Monitoring Process**: Monitored by nursing and dietitians **(Attachment 10)** **Person Responsible**: Nursing Services Continued on page 69a.	8/20/2014 8/20/2014 07/01/2014 9/16/2014
{A 749}	482.42(a)(1) INFECTION CONTROL PROGRAM The infection control officer or officers must develop a system for identifying, reporting, investigating, and controlling infections and communicable diseases of patients and personnel. This STANDARD is not met as evidenced by: On August 20, 2014, at 1:30p.m., the survey team declared an Immediate Jeopardy (IJ) situation, in the presence of the Chief Executive Officer (CEO) of the Culver City Campus, director	{A 749}	**1). Culver City: Corrective Action**s: The following was implemented to ensure flexible endoscopes are stored in accordance with the AORN recommended practices: 1). Purchased and installed new vented scope cabinet and placed in area with adequate ventilation for proper storage of scopes; 2) all scopes now have tip protectors to ensure tips do not touch the cabinets; 3) all scopes are tagged after processing indicating next date to re-process if not in use.4). Provided education/in-service to staff for use of enzymatic cleaners and proper measurements; 5) for scope re-processing; high-level disinfection, this included competency validation and return demonstrations **(refer to Attachment A-000.1);** **Date of Implementation**: Scope Cabinet installed 9-15-14; Education completed on August 12, 2014 and August 21, 2014. **Monitoring Process**: Monitoring managed by daily inspection of the scopes for next date of re-processing; Daily scopes monitoring and after each use to ensure proper placement in scope cabinet; weekly monitoring of all scope procedure to ensure completeness and accuracy of log**.** Log compliance will be submitted to the Regulatory Compliance Committee & Quality Council to ensure compliance with AORN standards.	8/12/2014 8/21/2014 9/15/2014

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{A 747}	Continued From page 67 …….. 3. Ensure effective systems for safe food handling to prevent food borne illness. This was evidenced by: a. the storing of food in refrigerators and freezers that were not maintaining temperatures by hospital policies and customary practices; b. not following tube feeding orders to prevent growth of microorganisms; c. failure to sanitize the ice machine as recommended by the ……. Continued From page 68 ….. manufacturer; d. failure to install air gaps in all the sinks in the kitchen; e. use of wiping cloths to dry food production equipment; f. disposal of garbage without proper protection; g. the unloading of clean trays in the dish washing area with same gloves that had been used to load dirty trays. These deficient practices failed to promote operational processes that support safe food handling practices may result in exposure of patients to bacteria associated with foodborne illness. Foodborne illness may result in further compromising patients' medical status and in severe instances may result in death. The cumulative effects of these systemic issues resulted in the facility's inability to ensure and provide a safe patient care environment. This is a repeat deficiency from the sampled validation survey on April 1, 2014.	{A 747}	**3c).Culver City Corrective Action**: Ice machine at the Culver City campus was sanitized according to manufacturer's recommendations. **(Attachment 5)**. Staff in-services on ice machine maintenance. **Date of Implementation**: October 23, 2014 **Monitoring Process**: Will be monitored through preventative maintenance schedule and during Infection Control Rounds **Person Responsible**: Engineering, Infection Control Department, Dietary Department **3c) Van Nuys Corrective Action**: Ice machine was sanitized and placed on the Engineering Preventative Maintenance list for a regular sanitizing schedule. **(Attachment 11)** **Date of Implementation**: 10/27/14 **Monitoring Process**: Will be monitored through preventative maintenance schedule and during Infection Control Rounds **(Attachment 12)** **Person Responsible**: Director of Engineering, Infection Control **3c).Hollywood: Corrective Action**: Ice machine was sanitized and placed on the Engineering Preventative Maintenance list for a regular sanitizing schedule. **(Attachment 13)** **Date of Implementation**: August 20, 2014 **Monitoring Process**: Will be monitored through preventative maintenance schedule and during Infection Control Rounds **(Attachment 12)** **Person Responsible**: Director of Engineering, Infection Control **3d) Culver City Corrective Action**: Air gaps were installed in all food preparation sinks. Staff in-serviced on the purpose of air gaps. **(Attachment 14)** **Date of Implementation**: October 23, 2014 **Monitoring Process**: Bimonthly rounds with Infection Control and Dietary. **(Attachment 5)** **Person Responsible**: Engineering Department **3d). Van Nuys Corrective Action**: Air gaps were installed in all food prep sinks **(Attachment 15)** **Date of Implementation**: 10/20/14 **Monitoring process**: Bimonthly rounds with Infection Control and Dietary. **(Attachment 12)** **Person Responsible**: Director of Engineering **3d). Hollywood Corrective Action**: Air gaps were installed in all food prep sinks. **(Attachment 16)** **Date of Implementation**: August 22, 2014 **Monitoring process**: Bimonthly rounds with Infection Control and Dietary. **(Attachment 12)** **Person Responsible**: Director of Engineering **3. e) Culver City Corrective Action**: Education given to by Dietary supervisors regarding air drying all food production equipment **(Attachment 5)** **Date of Implementation**: 10/22/14 **Monitoring process**: Daily rounding by Dietary Supervisor, Bimonthly rounding by Infection Control and Dietary department **(Attachment 5)** **Person Responsible**: Director of Dietary, Director of Infection Control	10/23/2014 10/27/2014 8/20/2014 10/23/2014 10/20/2014 8/22/2014 10/22/2014

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{A 747}	Continued From page 67 …….. 3. Ensure effective systems for safe food handling to prevent food borne illness. This was evidenced by: a. the storing of food in refrigerators and freezers that were not maintaining temperatures by hospital policies and customary practices; b. not following tube feeding orders to prevent growth of microorganisms; c. failure to sanitize the ice machine as recommended by the ……. Continued From page 68 ….. manufacturer; d. failure to install air gaps in all the sinks in the kitchen; e. use of wiping cloths to dry food production equipment; f. disposal of garbage without proper protection; g. the unloading of clean trays in the dish washing area with same gloves that had been used to load dirty trays. These deficient practices failed to promote operational processes that support safe food handling practices may result in exposure of patients to bacteria associated with foodborne illness. Foodborne illness may result in further compromising patients' medical status and in severe instances may result in death. The cumulative effects of these systemic issues resulted in the facility's inability to ensure and provide a safe patient care environment. This is a repeat deficiency from the sampled validation survey on April 1, 2014.	{A 747}	**3e). Van Nuys Corrective Action**: Additional drying racks purchased and installed. Education given to by Dietary supervisors regarding air drying all food production equipment **(Attachment 17)** **Date of Implementation**: 10/27/14 **Monitoring Process**: Daily rounding by dietary supervisor (**Attachment 18)** **Person Responsible**: RD, Director of Dietary **3e). Hollywood Corrective Action**: Additional drying racks purchased and installed. Education given to by Dietary supervisors regarding air drying all food production equipment **(Attachment 19)** **Date of Implementation**: 10/19/14 **Monitoring process**: Daily rounding by dietary supervisor **(Attachment 18)** **Person Responsible**: RD, Director of Dietary **3f). Culver City Corrective action** plan: Staff education on the proper process of garbage disposal. **(Attachment 5)** **Date of Implementation**: October 23, 2014 **Monitoring Process**: Observations during Dietary supervisor rounds and bimonthly Infection Control rounds **(Attachment 5)** **Person Responsible**: Dietary Department, Infection Control Department **3f). Van Nuys Corrective action** plan: Staff were educated on the proper process of garbage disposal. Plastic aprons for wear during removal of garbage were purchased and put in place at. **(Attachment 20)** **Date of Implementation**: October 27, 2014 **Monitoring Process**: Observations during Dietary supervisor rounds and Infection Control rounds **(Attachment 12)** **Person Responsible**: RD, Director of Dietary **3g). Culver City Corrective Action**: In-service given on the proper use of gloves and hand hygiene when handling dirty and clean dishes. **(Attachment 5)** **Date of Implementation**: 10/27/14 **Monitoring Process**: Observations during Dietary Supervisor rounds, bimonthly Infection Control Rounds **(Attachment 5)** **Person Responsible**: Director of Dietary **3g). Van Nuys Corrective Action**: In-service given on the proper use of gloves and hand hygiene when handling dirty and clean dishes. **(Attachment 21)** **Date of Implementation**: 10/21/14 **Monitoring Process**: Observations during Dietary Supervisor rounds **(Attachment 18)** **Person Responsible**: RD, Director of Dietary **3g). Hollywood Corrective Action**: In-service given on the proper use of gloves and hand hygiene when handling dirty and clean dishes. **(Attachment 22)** **Date of Implementation**: 10/19/14 **Monitoring Process**: Observations during Dietary Supervisor rounds **(Attachment 18)** **Person Responsible**: RD, Director of Dietary	10/27/2014 10/19/2014

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{A 749}	Continued From page 69 of risk management, as a result of the facility's failure: 1. To ensure flexible endoscopes were stored in accordance with the Association of Peri-Operative Registered Nurse (AORN) Recommended Practices. AORN is the National Recognized Standards (NRS) the hospital identified as the standard they followed. 2. To ensure re-usable surgical instruments were packaged and stored in accordance with the AORN Standards. On August 21, 2014, at 3:45p.m., the IJ was abated in the presence of the director of risk management and CEO of the facility's Culver City campus. Based on observation, interview and record review, the facility failed to: 1. Ensure flexible endoscopes were stored in accordance with the Association of Peri-Operative Registered Nurse (AORN) Recommended Practices . AORN is the National Recognized Standards (NRS) the hospital identified as the standard they followed. 2. Ensure re-usable surgical instruments were packaged and stored in accordance with the Association of Peri-Operative Registered Nurse (AORN) Recommended Practices. 3. Perform one GI (Gastroenterology) Technician's competency in the use, care, and processing of flexible endoscopes and related equipment, and two CST (Central Surgical Technician)'s competency in the use of sterilization packaging systems and accessories.	{A 749}	**Person Responsible**: OR Team/Infection Control will be responsible for monitoring; Daily monitoring by GI/OR Team and weekly monitoring by Infection Control. **1). Hollywood**: **Corrective Action**: Failure to ensure flexible endoscopes were stored appropriately The following was implemented to ensure flexible endoscopes are stored in accordance with the AORN recommended practices: 1) A new scope cabinet was purchased that allows for all scopes to be hung vertically without touching each other or the bottom of the cabinet in accordance to the AORN recommended practice, 2) scope tip protectors that are breathable were purchased to protect tips where it was possible that the tip may touch the back of the cabinet or another scope, 3) Competency for GI processing and storage was conducted by the scope manufacturer, 4). all scopes are tagged with the processing date to ensure that they are processed within 5 days. **(Attachment 1)** **Date of Implementation**: September 8, 2014 (scope cabinet); August 12 & 21, 2014 & September 22, 2014 (competency) **Monitoring Process**: Biweekly Infection control rounds to review appropriate storage of equipment. **(Attachment 2)** **Person Responsible**: GI team, Infection Control **2). Culver City Corrective Action**s; All re-usable surgical instruments (SI) were re-processed, packaged, and stored in accordance to AORN standards; bin dividers purchased to ensure packages are stored up-right on 9/5/2014. 5 inch stringers were purchased to ensure SI are completely open for processing & implemented on 8/25/2014; 3 M Comply cards purchased and placed into service to ensure tip and lock boxes in peel packs maintain an open position for sterilization on 8/26/14; Purchased new biological incubator and indicator with corresponding supplies for sterilization on 10/10/14; Provided education/in-service to staff on standards for processing, packaging and storing of SI, this includes competency validation and return demonstration **(see Attachment A-000.2)** **Date of Implementation**: Education SI re-processed August 20, 2014. **Monitoring Process**: Monitoring will be managed during weekly Infection Control rounds with ORT or RN with compliance reported to the regulatory Compliance Committee. **Person Responsible**: Infection Control/OR Director; to be completed on the EOC log and will report results to the Regulatory Compliance Committee & Quality. **2) Hollywood Corrective Action**s: Paper-plastic pouches now stored in a vertical manner in accordance to AORN recommended practice. Bin dividers purchased to further aid this process, plastic, autoclavable devices are in use to ensure instruments stay open during the sterilization process. Process of use of peel-pouches changed to indicate that items are placed to allow sterilant contact and typically only 1 item placed per pouch (no more than two small items). Surgical trays were divided into several trays to ensure appropriate sterilant penetration. Larger trays were purchased to accommodate larger instruments that are more fully propped open **(Attachment 3)** **Date of Implementation**: 9/9/14 **Monitoring Process**: Infection Control biweekly rounds to review appropriate placement and use of paper-plastic pouches. Infection Control to randomly check trays prior to sterilization to ensure appropriate tray placement. **(Attachment 4)** **Person Responsible**: OR/Central Service Team, Infection Control Continued on page 70a.	8/12/2014 8/21/2014 9/8/2014 9/22/2014 8/20/2014 9/9/2014

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{A 749}	Continued From page 69 of risk management, as a result of the facility's failure: 1. To ensure flexible endoscopes were stored in accordance with the Association of Peri-Operative Registered Nurse (AORN) Recommended Practices. AORN is the National Recognized Standards (NRS) the hospital identified as the standard they followed. 2. To ensure re-usable surgical instruments were packaged and stored in accordance with the AORN Standards. On August 21, 2014, at 3:45p.m., the IJ was abated in the presence of the director of risk management and CEO of the facility's Culver City campus. Based on observation, interview and record review, the facility failed to: 1. Ensure flexible endoscopes were stored in accordance with the Association of Peri-Operative Registered Nurse (AORN) Recommended Practices . AORN is the National Recognized Standards (NRS) the hospital identified as the standard they followed. 2. Ensure re-usable surgical instruments were packaged and stored in accordance with the Association of Peri-Operative Registered Nurse (AORN) Recommended Practices. 3. Perform one GI (Gastroenterology) Technician's competency in the use, care, and processing of flexible endoscopes and related equipment, and two CST (Central Surgical Technician)'s competency in the use of sterilization packaging systems and accessories.	{A 749}	**3). Culver City Corrective Action**: Competencies were completed by the scope manufacturer for the one GI tech on the use, care and processing of flexible endoscopes. In-services with return demonstration performed on the two central service technicians on sterilization and processing of sterile instruments **(Attachment 5)** **Date of Implementation**: GI Lab Scope processing in-services, Aug 12 and Aug 21, Central processing in-service Aug 20, 2014 **Monitoring Process**: Audit of scope processing log with reporting to PI committee; infection control bimonthly OR rounding with spot checks for instrument sterilization and processing practices. **(Attachment 6)** **Person Responsible**: Nursing Services, Infection Control, OR Team **3). Hollywood Corrective Action**: Competencies were completed by the scope manufacturer for the one GI techs on the use, care and processing of flexible endoscopes. In-services were performed on the two central service technicians on sterilization and processing of sterile instruments. **(Attachment 7)** **Date of Implementation**: 9/22/14 (Scopes); 10/8/14 (Central Processing); **Monitoring Process**: Audit of scope processing log with reporting to PI committee; infection control biweekly OR rounding with spot checks for instrument sterilization and processing practices. **(Attachment 4)** **Person Responsible**: Nursing Services, Infection Control, OR Team	8/12/2014 8/20/20/2014 8/21/2014 9/22/2014 10/8/2014

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{A 749}	Continued From page 70 4. Develop those policies referred to infection control that conformed to AORN recommended practice guidelines. These deficient practices promote microbial growth and can result in contamination of sterile items. 5. Ensure there was an effective system for safe food handling to prevent food borne illness. This was evidenced by: a. the storing of food in refrigerators and freezers that were not maintaining temperatures by hospital policies and customary practices; b. not following tube feeding orders to prevent growth of microorganisms; c. failure to sanitize the ice machine as recommended by the manufacturer; d. failure to install air gaps in- all the sinks in the kitchen; e. failing to use of wiping cloths to dry food production equipment; f. failing to disposal of garbage without proper protection; g. the unloading of clean trays in the dish washing area with same gloves that had been used to load dirty trays. These deficient practices failed to promote operationa processes that support safe food handling practices may result in exposure of patients to bacteria associated with foodborne illness. Foodborne illness may result in further compromising patients' medical status and in severe instances may result in death. Findings:	{A 749}	**4). Culver City Corrective Action:** Policies reviewed and amended as needed to be more facility specific and conform to AORN recommendations. **(Attachment 8)** **Date of Implementation**: November 1, 2014 **Monitoring Process**: Annual review with tri-annual committee approval **Person Responsible**: Surgery Committee, Surgical Services Director, Nursing Services, Infection Control Team **4). Hollywood Corrective Action**: Policies reviewed and amended as needed to ensure infection control processes conform to AORN recommended practice guidelines. **(Attachment 8)** **Date of Implementation**: November 1, 2014 **Monitoring Process**: Annual review with tri-annual committee approval **Person Responsible**: Surgery Committee, Surgical Services Director, Nursing Administration, Infection Control Team **5a). Culver City Corrective Action**: In-services provided to staff on process of logging temperatures and the reporting of temperatures not meeting expected ranges per policy. **(Attachment 9)** **Date of Implementation**: October 23, 2014. **Monitoring Process**: Monitored daily by dietary staff **Person Responsible**: Dietary Director/Supervisor **5a). Van Nuys Corrective Action**: New refrigerators and freezers were ordered and have been installed. Repairs of existing refrigerators/freezers have been conducted. In-services provided to staff on process for improperly functioning equipment. Refrigerated truck was brought in during the interim to provide adequate refrigeration while repairs and installations are carried out**. (Attachment: 10)** **Date of Implementation**: August 20, 2014. **Monitoring Process**: Monitored daily by dietary staff **Person Responsible**: RD, Director of Dietary **5a). Hollywood Corrective Action**: Refrigerators were repaired. In-services provided to staff on process of logging temperatures and the reporting of temperatures not meeting expected ranges per policy. **(Attachment: 10)** **Date of Implementation**: August 20, 2014. **Monitoring Process**: Monitored daily by dietary staff **Person Responsible**: RD, Director of Dietary **5b). Culver City Corrective** Action: Education and in-services provided to nursing staff. **(Attachment 11)** **Date of Implementation**: October 23, 2014 **Monitoring Process**: Monitored by nursing and dieticians and reported monthly to PI committee **Person Responsible**: Nursing Directors **5b). Hollywood Corrective Action**: all open feeding systems were eliminated and only the closed systems are being used to prevent the growth of microorganisms. Education and in-services provided to nursing staff **(Attachment: 12)** **Date of Implementation**: 9/16/14 **Monitoring Process**: Monitored by nursing and dietitian and reported monthly to PI committee **(Attachment 12)** **Person Responsible**: Nursing Administration Continued on page 71a.	10/1/2014 10/1/2014 10/23/2014 8/20/2014 8/20/2014 10/23/2014 9/16/2014

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{A 749}	Continued From page 70 4. Develop those policies referred to infection control that conformed to AORN recommended practice guidelines. These deficient practices promote microbial growth and can result in contamination of sterile items. 5. Ensure there was an effective system for safe food handling to prevent food borne illness. This was evidenced by: a. the storing of food in refrigerators and freezers that were not maintaining temperatures by hospital policies and customary practices; b. not following tube feeding orders to prevent growth of microorganisms; c. failure to sanitize the ice machine as recommended by the manufacturer; d. failure to install air gaps in- all the sinks in the kitchen; e. failing to use of wiping cloths to dry food production equipment; f. failing to disposal of garbage without proper protection; g. the unloading of clean trays in the dish washing area with same gloves that had been used to load dirty trays. These deficient practices failed to promote operational processes that support safe food handling practices may result in exposure of patients to bacteria associated with foodborne illness. Foodborne illness may result in further compromising patients' medical status and in severe instances may result in death. Findings:	{A 749}	**5c). Culver City Corrective Action**: Ice machine was sanitized according to manufacturer's recommendations. (**Attachment 9)**. Staff in-services on ice machine maintenance. (**Attachment 9)**. **Date of Implementation**: October 23, 2014 **Monitoring Process**: Will be monitored through daily sanitation log and preventative maintenance schedule. Sanitation will also be monitored during bimonthly Infection Control and Dietary Rounds (**Attachment 9)**. **Person Responsible**: Engineering, Infection Control Department, Dietary Department **5c). Van Nuys Corrective Action**: Ice machine was sanitized and placed on the Engineering Preventative Maintenance list for a regular sanitizing schedule. **(Attachment: 13)** **Date of Implementation**: 10/27/14 **Monitoring Process**: Will be monitored through preventative maintenance schedule and during Infection Control Rounds (**Attachment 14)**. **Person Responsible**: Director of Engineering, Infection Control **5c). Hollywood Corrective Action**: Ice machine was sanitized and placed on the Engineering Preventative Maintenance list for a regular sanitizing schedule. **(Attachment: 15)** **Date of Implementation:** August 20, 2014 **Monitoring Process:** will be monitored through preventative maintenance schedule and during Infection Control Rounds **5d). Culver City Corrective Action**: Air gaps were installed in all food preparation sinks. (**Attachment: 16)**. Staff in-serviced on the purpose of air gaps. (**Attachment: 17)**. **Date of Implementation**: October 23, 2014 **Monitoring Process**: Bimonthly rounds with Infection Control and Dietary. (**Attachment: 18)**. **Person Responsible**: Engineering Department, Infection Control Department, Dietary Department **5d). Van Nuys Corrective Action**: Air gaps were installed in all food prep sinks (**Attachment: 19)**. **Date of Implementation**: 10/20/14 **Monitoring Process**: Bimonthly rounds with Infection Control and Dietary. (**Attachment: 18)**. **Person Responsible**: Director of Engineering **5d). Hollywood Corrective Action**: Air gaps were installed in all food prep sinks. (**Attachment: 20)**. **Date of Implementation**: August 22, 2014 **Monitoring Process**: Bimonthly rounds with Infection Control and Dietary. (**Attachment: 18)**. **Person Responsible**: Director of Engineering **5e). Culver City Corrective Action**: Education given to by Dietary supervisors regarding air drying all food production equipment **(Attachment: 9)** **Date of Implementation**: 10/23/14 **Monitoring process**: Daily rounding by Dietary Supervisor, Biweekly rounding by Infection Control and Dietary departments **(Attachment: 9)** **Person Responsible**: Director of Dietary, Director of Infection Control **5e). Van Nuys Corrective Action**: Additional drying racks purchased and installed. Education given to by Dietary supervisors regarding air drying all food production equipment **(Attachment: 21)** **Date of Implementation**: 10/27/14 **Monitoring Process**: Daily rounding by dietary supervisor **Person Responsible**: RD, Director of Dietary	10/23/2014 10/27/2014 08/20/2014 10/23/2014 10/20/2014 8/22/2014 10/23/2014 10/27/2014

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{A 749}	Continued From page 71 Hollywood campus 1. During the tour with Registered Nurse (RN) 1 in the Semi-Restricted and Restricted area on August 18, 2014 between 1:10 p.m. and 3 p.m., the following were observed: There were four endoscopes, stored and hung in a vertical position, in a closed cabinet, adjacent to Sterile Supply Room. There was no venting to allow air circulation around the flexible endoscopes. Two (2) of four (4) endoscopes tips were in contact with the cabinet wall with no scope protectors. During an interview with Gastroenterology Technician (GI T) 1, at the same time of the observation, she stated the flexible endoscopes should be stored in a closed cabinet with venting allows air circulation around flexible endoscopes. During an interview with RN 1 on August 18, 2014 at 2:55p.m., she stated the flexible endoscopes should be hanging in a secure vertical position without contacting with the cabinet wall. According to Perioperative Standards and Recommended Practices for 2013 of the AORN, "Recommended Practices for Cleaning and Processing Flexible Endoscopes and Endoscope Accessories:" "Recommendation IX Flexible endoscopes should be stored in a manner that protects the device from damage and minimizes microbial contamination. IX.a. Flexible endoscopes should be stored in a closed cabinet with venting allows air	{A 749}	**Hollywood** **1). Corrective Action**: A new scope cabinet was purchased that allows for all scopes to be hung vertically without touching each other or the bottom of the cabinet. In addition, scope tip protectors that are breathable were purchased to protect tips where it was possible that the tip may touch the back of the cabinet or another scope. Competency for GI processing and storage was conducted by the scope manufacturer. All scopes are tagged with the processing date to ensure that they are processed within 5 days. **(refer to Attachment: A-000.1)** **Date of Implementation**: September 8, 2014 (scope cabinet); September 22, 2014 (competency) **Monitoring Process**: Biweekly Infection control rounds to review appropriate storage of equipment. **Person Responsible**: GI team, Infection Control	9/8/2014

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{A 749}	Continued From page 72 circulation around Flexible endoscopes; hanging in a secure vertical position; with scope protectors applied if the protector does not interfere with the flexible endoscopes hanging straight or restrict the air movement around channel opening; IX.b. Flexible endoscopes should be reprocessed before use if unused for more than 5 days." Recommendation XIII Personnel should demonstrate competency in the use, care, and processing of flexible endoscopes ·and related equipment periodically and before new endoscopic equipment and/or accessories are introduced into the practice setting. 2. During the tour with RN 1 in the Semi-Restricted area and Restricted area on August 18,2014 between 10:25.m. and 11:33 a.m., the followings were observed: In OR#2: A. There were multiple blue bins with multiple paper-plastic pouch package of surgical instruments in the cabinet. The packages were not stored in a vertical manner in each bin. The packages were compressed in each bin. All instruments blades closed and tips touching. B. In a paper-plastic pouch package of two (2} babcock forceps (used for graping in surgical procedures), one babcock stacked on another. These two (2) babcock forceps blades closed and tips touching. C. A laminectomy tray (instruments used for surgery on the back) also known as a Major Tray was ready for use in the operating room. Assembled in the tray:	{A 749}	**2A) .Corrective Action**s: Paper-plastic pouches now stored in a vertical manner. Bin dividers purchased to further aid this process **(refer to Attachment: A-000.1)** **Date of Implementation**: 9/5/14 **Monitoring Process**: Infection Control bimonthly rounds to review appropriate placement and use of paper-plastic pouches **Person Responsible**: Central processing team; Infection Control **2B). Corrective Action**s: Plastic, autoclavable devices are in use to ensure instruments stay open during the sterilization process. Process of use of peel-pouches changed to indicate that items are placed to allow sterilant contact and typically only 1 item placed per pouch (no more than two small items). **(refer to Attachment: A-000.2)** **Date of Implementation** 9/9/14 **Monitoring Process**: Infection Control bimonthly rounds to review use of paper-plastic pouches **Person Responsible**: Infection control; Central processing team **2C). Corrective Action**s: Surgical trays were divided into several trays to ensure appropriate sterilant penetration. Larger trays were purchased to accommodate larger instruments that are more fully propped open utilizing the 5 in instrument stringers. **(Attachment: refer to Attachment A-000-2)** **Date of Implementation**: 8/22/14; 9/12/14 (purchase of larger trays) **Monitoring Process**: Infection Control bimonthly rounds to review appropriate placement and use of paper-plastic pouches. Infection Control to randomly check trays prior to sterilization to ensure appropriate tray placement. **Person Responsible**: Central processing team; Infection Control	9/5/2014 9/9/2014 8/22/2014 9/12/2014

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{A 749}	Continued From page 73 On the stringer (typically, approximately a foot long 3 rod type device to assist with the positioning of instruments for sterilizing), 10 hinged instruments blades closed and tips touching. During an interview with Certified Scrub Technician (CST) 1 on August 18, 2014 at 11:01 a.m., she stated the surgical instruments should not be stacked on each other to allow sterilant penetration and direct contact with the item and surfaces. A subsequent interview with Staff I and RN 1 at the same time, both stated they were following event related sterility [Concept that the sterility of an item does not change with passing of time but nay be affected by particular event (eg, amount of handling), or environmental conditions (eg, temperature, humidity)] when processing and storing of sterile surgical instruments. Both RN 1 and CST 1 stated the supplies are incorrectly stored according to the AORN Standards. According to Perioperative Standards and Recommended Practices for 2013 of the AORN, "Recommended Practices for Selection and Use of packaging Systems for Sterilization:" "Recommendation I 1. Packaging systems should be appropriate for items being sterilized. The packaging system should: maintain sterility of package contents until opened; allow sterilant penetration and direct contact with the item and surfaces, and removal of the sterilant" Culver City campus	{A 749}		

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{A 749}	Continued From page 74 3. During the tour with RN 1 in the Semi-Restricted Area on August 20, 2014 between 11 a.m. and 12 p.m., the followings were observed: A. In Central Processing Room One C (Caesarean)-Section (a surgical procedure in which one or more incisions are made through a mother's abdomen and uterus to deliver one or more babies, or, rarely, to remove a dead fetus) tray (instruments used for surgery to deliver baby) was ready for use in the operating room. Assembled in the tray: On the stringer (typically, approximately a foot long 3 rod type device to assist with the positioning of instruments for sterilizing), multiple hinged instruments blades closed and tips touching. During an interview with CST 2 and 3 on August 18, 2014 at 11:01 a.m., both stated the surgical instruments should not be stacked on each other to allow sterilant penetration and direct contact with the item and surfaces. In Sterile Supply Room There were multiple cartons (boxes) on the 3rd shelf of the cabinet with multiple sterile supplies and multiple non-sterile supplies. There was no thermometer and humidity display in the Central Sterilization. There were multiple blue bins with multiple paper-plastic pouch package of surgical instruments in the cabinet. The packages were	{A 749}	**Culver City** **Central Processing Room** **3A). Corrective Action**s: 3" Instruments stringers have been replaced with 5 " stringers to hold hinged instrument blades open and tips not touching to allow sterilant penetration and direct contact with the items and surfaces. **Date of Implementation** Aug.25, 2014 receipt of 5" stringers **(refer to Attachment: A-000.2)** **Monitoring Process**: Monitoring will be managed during bi-monthly rounds with IC and OR RN or ST Compliance Data will be reported through Regulatory Compliance Committee, IC and Quality. **Person Responsible**: Surgery Director and Director of Infection Control: **Sterile Supply Room** **3A). Corrective Action**s: All cartons have been removed from the sterile supply room. Non sterile and sterile items have been separated. A temperature and humidity gauge was present in the sterile supply room areas and readings are being recorded. Plastic – paper pouch packages have been decompressed and stored in a vertical position in the blue bins. 3M comply cards are now utilized to keep instrument blades open and prevent tips from touching. **Date of Implementation**: Aug 21, 2014 cartons removed and Aug 26, 2014 3M comply cards received, Temperature and Humidity Gauge was installed on July 26, 2014. **Monitoring Process**: Monitoring will be managed during bi-monthly rounds with IC and OR RN or ST. Compliance data will be reported through Regulatory Compliance Committee, IC and Quality. **Person Responsible**: Infection Prevention/OR/CS team	8/25/2014 7/26/2014 8/21/2014 8/26/2014

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{A 749}	Continued From page 75 not stored in a vertical manner in each bin. The packages were compressed in each bin. All instruments blades closed and tips touching. B. In Sterile Central Supply Room a. There was one paper-plastic pouch package of surgical instrument (a retractor) with discoloration on the paper-plastic pouch. There was one paper-plastic pouch package of surgical instrument dated 10/5/9. b. There were multiple blue bins with multiple paper-plastic pouch package of surgical instrument compressed in each bin. During an interview with Staff G on August 20, 2014 at 11:26 a.m., she stated there should not be any sterile supplies in this room. A subsequent interview with Staff G and J at the same time, both stated they were using event related sterility (Concept that the sterility of an item does not change with passing of time but nay be affected by particular event (eg, amount of handling), or environmental conditions (eg, temperature, humidity). Staff I stated the supplies are incorrectly stored according to the AORN Standards. According to Staff G, the temperature and humidity in the Central Sterilization Room were not monitored and recorded. According to the facility's policy and procedure dated 9/11, titled "Storage and Rotation of Sterile Supplies:" 4.1.3. Shipping cartons must never be allowed in either a clean storage area or a sterile storage area, and these containers should never be used as storage containers within these areas."	{A 749}	**Sterile Central Supply Room** **3Ba). Corrective Action**s: Peel packed instruments have been removed from the Sterile Central Supply Room **Date of Implementation** Aug 21, 2014 **Monitoring Process**: Monitoring will be managed during bi-monthly rounds with IC, OR RN and CS staff member. Compliance data will be reported through Regulatory Compliance Committee, IC and Quality. **Person Responsible**: Infection Prevention/OR/CS team: **3Bb). Corrective Action**s: Plastic – paper pouch packages have been decompressed and stored in a vertical position in the blue bins. 3M comply cards are now utilized to keep instrument blades open and prevent tips from touching **Date of Implementation**: August 26, 2014 **Monitoring Process**: Monitoring will be managed during bi-monthly IC rounds with OR RN and CS staff member. Compliance data will be reported through Regulatory Compliance Committee, IC and Quality. **Person Responsible**: Infection Prevention/OR/CS team	8/21/2014 8/26/2014

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{A 749}	Continued From page 76 According to Perioperative Standards and Recommended Practices for 2013 of the AORN, "Recommended Practices for Selection and Use of packaging Systems for Sterilization:" "Recommendation I 1. Packaging systems should be appropriate for items being sterilized. The packaging system should: maintain sterility of package contents until opened; allow sterilant penetration and direct contact with the item and surfaces, and removal of the sterilant. Recommendation V 1. Paper-plastic pouch packages should be used only for small, lightweight, low-profile items (e.g., one or two clamps, scissors). Heavy metal instruments (e.g. drills, retractors, weighted vaginal speculums) should not be sterilized in peel pouches because problems (e.g., wet packages following sterilization) and sterility maintenance problems (e.g., package seal break) may occur. Recommendation VIII Sterilized packages should be considered sterile until an event occurs to compromise the package barrier integrity. 1. Health care organizations should determine the best methods and materials for packaging sterile items, based upon the anticipated storage, handling, and environmental events that may be encountered. Loss of sterility of a package sterile item is event related. An event must occur to compromise package content sterility. Even that may affect the sterility of a package include, but not limited to, multiple handling that leads to seal breakage or loss of package integrity; compression during storage;	{A 749}		

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{A 749}	Continued From page 77 storage conditions (e.g., type of shelving, cleanliness, temperature, humidity, traffic control)" On August 20, 2014, at 1:30 p.m., the survey team declared an Immediate Jeopardy (IJ) situation, in the presence of the Chief Executive Officer (CEO) of Culver City Campus, director of risk management, as a result of the facility's failure to ensure flexible endoscopes and endoscope accessories were stored in accordance with the AORN and to ensure re-usable surgical instruments were packaged and stored in accordance with AORN Standards. On August 20, 2014, at 9:30a.m., the facility submitted a letter to respond to the immediate Jeopardy, dated August 20, 2104, disclosed all flexible endoscopes had been relocated to a properly storage area. The facility's letter indicated all re-usable surgical instruments were resterilized, repackaged and stored in accordance with the AORN Standards. On August 21, 2014, at 9:30a.m., during the tour of the facility at the Hollywood Campus with Staff E (Administrator) and RN 1, the surveyor observed all flexible endoscopes had been stored in a properly storage area and all re-usable surgical instruments were resterilized, repackaged and stored in accordance with the AORN Standards. On August 21, 2014, at 1:05 p.m., during the tour of the facility at the Culver City Campus with Staff G (Director, Perioperative) and CST 3, the surveyor observed all re-usable surgical instruments were repackaged and stored in accordance with the AORN Standards. On August 21, 2014, at 3:45p.m., the IJ was abated	{A 749}		

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{A 749}	Continued From page 78 in the presence of the director of risk management and CEO of the facility's Culver City campus. Hollywood campus 4. During the tour with Registered Nurse (RN) 1 in the Non-Restricted area on August 18, 2014 between 10:10.m. and 10:25 a.m., the followings were observed: In Pre-Op room: There were three gurneys, with multiple cracks on the mattress on #1 gurney, and multiple small size of holes on the mattress of #2 gurney, and with a approximately 3 inches long cracks and a 3 inches long plastic tap over the edge of the mattress on #3 gurney. According to Perioperative Standards and Recommended Practices for 2013 of the AORN, "Recommended Practices for Environmental Cleaning:" "Recommendation II II.b.2. Damaged or worn coverings should be replaced." 5. During the tour with RN 1 in the Semi-Restricted area and Restricted area on August 18,2014 between 10:25.m. and 11:33 a.m., the followings were observed: In OR #2, there were a C-Arm (encompasses the actual X-ray source and image intensifier) and multiple sterile supplies. According to RN 1 at that time, she stated OR #2 had been used as a storage room, instead of an operating room. Culver City campus 6. During the tour with RN 1 in the Semi-Restricted Area on August 20, 2014 between 11 a.m. and 12 p.m., the followings were	{A 749}	**Hollywood** **4). Corrective Action**: All torn and cracked gurneys were removed from unit and disposed of. New gurneys were purchased with additional purchases made to promptly replace torn gurney mattresses as needed. **(Attachment: 30)** **Date of Implementation**: 8/21/14 **Monitoring Process**: Gurneys mattresses checked for tears and cracks during biweekly infection control rounds. **Person Responsible**: Surgical staff, Infection Control **5). Corrective Action**: All stored items removed from OR #2 and room set up as a functioning OR. **(Attachment: 24)** **Date of Implementation**: August 21, 2014 **Monitoring Process**: Infection control biweekly, OR rounds **Person Responsible**: Surgery Staff, Infection Control	8/21/2014 8/21/2014

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{A 749}	Continued From page 79 observed: In Central Processing Room In the Sterile Central Supply Room, there were multiple cartons on the 3rd shelf of the cabinet with multiple sterile supplies and multiple non-sterile supplies. There was no thermometer and humidity display in the Sterile Central Supply Room. During an interview with CST 4 on August 20, 2014 at 11:48 a.m., she stated the shipping cartons should never be allowed in either a clean storage area or a sterile storage area, Staff G and H stated there should be no sterile supply in this room. According to Staff G, the temperature and humidity in the Sterile Central Supply Room were not monitored and recorded. According to the facility's policy and procedure dated 9/11, titled, "Storage and Rotation of Sterile Supplies:" 4.1.3. Shipping cartons must never be allowed in either a clean storage area or a sterile storage area, and these containers should never be used as storage containers within these areas." According to Perioperative Standards and Recommended Practices for 2013 of the AORN, "Recommended Practices for Selection and Use of packaging Systems for Sterilization:" "Recommendation VIII 2. Sterile packages should be stored under environmentally controlled conditions. Sterile storage area temperature should be controlled and not exceed 75 degree F. The humidity should not exceed 70%." "Recommendation XI	{A 749}	**Culver City** **6). Corrective Action**s: All cartons have been removed from the sterile supply room. Non sterile and sterile items have been separated. A temperature and humidity gauge was in place in the Central Processing area and readings are being recorded. Staff education on the Temperature and Humidity in Central sterilization. **(Attachment 25)** **Date of Implementation** Aug 21, 2014 cartons removed; Temperature and Humidity Gauge was installed on July 26, 2014. **Monitoring Process**: Monitoring will be managed during bi-monthly rounds with IC and OR RN or ST. Compliance data will be reported through Regulatory Compliance Committee, IC and Quality. **(Attachment 26)** **Person Responsible**: Infection Prevention/OR/CS team **2). Corrective Action**s: A temperature and humidity gauge was placed in the Central Processing area and readings are being recorded. Education provided to ensure staff competency in the use of sterilization packing systems and accessories**.** **Date of Implementation** Temperature and Humidity Gauge was installed on July 26, 2014. Education occurred: 8-20-14 **Monitoring Process**: Monitoring will be managed during bi-monthly rounds with IC and OR RN or ST. Compliance data will be reported through Regulatory Compliance Committee, IC and Quality. **Person Responsible**: Infection Prevention/OR/CS team.	8/21/2014 7/26/2014 8/20/2014

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{A 749}	Continued From page 80 Personnel should demonstrate competency in the use of sterilization packaging systems and accessories. 3. Administrative personnel should periodically assess and document the competency of personnel in the use of packaging systems, according to hospital and department policy." 7. On August 18, 2014, Staff E was requested by the evaluator to provide GIT 1's competency in the use, care, and processing of flexible endoscopes and related equipment. However, as of the exit day (8/21/14), the facility could not provide the evaluator with GIT 1's competency in the use, care, and processing of flexible endoscopes and related equipment. 8. On August 20, 2014, Staff G was requested by the evaluator to provide CST 2, 3 and 4's competency in the use of sterilization packaging systems and accessories at the same time. However, as of the exit day (8/21/14), the facility could not provide the evaluator with CST 2, 3, and 4's competency in the use of sterilization packaging systems and accessories. 9. On August 21, 2014, the facility was requested to provide policies and procedures, titled, "cleaning and processing flexible endoscopes, selection and use of packaging systems for sterilization, use and storage of paper-plastic pouch package, and use and storage of containment device (eg, rigid container, instrument cases/cassettes, organizing trays)."	{A 749}	**3).Corrective Action**s: In-service with return demonstration in the use of packaging systems and accessories was completed on Aug.20, 2014. Administrative personnel will assess and document the competency of personnel on a quarterly basis in the use of packaging systems and accessories **Date of Implementation** In-service with return demonstration Aug.20, 2014, Quarterly competency assessments will begin Nov.1, 2014 **Monitoring Process**: Competencies will be conducted and documented on a quarterly basis for the use of packaging systems and accessories. **Person Responsible**: Director of Perioperative Services **7).Corrective Action**s: Competencies in the use, care and processing of flexible endoscopes and related equipment was completed on Aug. 12 and re-inserviced with return demonstration on Aug.21, 2014. Competencies with return demonstrations were also completed on 3/10/2014 as a part of the annual evaluation process. **(Attachment 27)** **Date of Implementation**: March 3/2014 annual competency, Inservices with competencies Aug. 12 and re-inservice Aug 21 with return demonstration **Monitoring Process**: Competencies will be conducted and documented on a quarterly basis for use, care, processing and storage of flexible endoscopes **Person Responsible**: Director of Perioperative Services **8).Corrective Action**s: Competencies in the use of sterilization packaging systems and accessories were completed on Aug 20.2014 for Central Supply techs. **(refer to Attachments for A-000.2)** **Date of Implementation** Aug 20, 2014 **Monitoring Process**: Competencies will be conducted and documented on a quarterly basis for sterilization packaging systems and accessories. Compliance data will be reported through Regulatory Compliance Committee, IC and Quality. **Person Responsible**: Director Perioperative Services **9).Corrective Action**s: Policies SGI. 006 "Cleaning and Disinfection of Endoscopes" and SCS.025 " Selection and Use of Packaging Systems for Sterilization " were reviewed and amended as needed to ensure infection control processes conform to AORN recommended practice guidelines and are facility specific**. (Attachment 28)** **Date of Implementation** Nov 1, 2014 **Monitoring Process**: Policies will be reviewed and revised to reflect current standards on an annual basis. **Person Responsible**: Surgery Committee, Surgical Services Director, Nursing Administration, Infection Control Team	8/20/2014 3/2014 8/12/2014 8/21/2014 8/20/2014 11/1/2014

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{A 749}	Continued From page 81 When reviewed the policies and procedures, these were found to be generic in nature, and intended to be used by any given facility, subsequently, not to be specifically identified, modified and operationalized to a specific facility's infection control. The evidence indicated that this facility had failed to develop and provide those aforementioned requested and operationalize any of these requested policies, that referred to infection control that conformed to AORN recommended practice guidelines, an accepted national standards and guidelines. Hollywood Campus 10. On August 18, 2014 beginning at4:30 p.m., the hospitals' maintenance of the dietetic departments' ice machine was reviewed with Staff 18 and Staff L (Director of Food Service). In a concurrent interview with Staff 18, he stated that the engineering department changed the water filter and vacuumed the air filter every few months. He stated they did not complete any additional tasks and that the dietary department was responsible for cleaning/sanitation. Staff L stated the department cleaned only the ice holding bin and wiped down outside of the machine. Review of manufacturers' guidance for preventive maintenance of the ice machine called for the regular cleaning/sanitation of internal ice producing components utilizing manufacturer specified chemicals. 11. During general kitchen observations on	{A 749}	**Hollywood Campus** **10). Corrective Action**: The manufacturer's instructions for care and use of ice machines were identified and the Engineering staff used these to develop a cleaning protocol and checklist for the ice machines. The machines will be sanitized on a biannual basis and placed on the engineering preventative maintenance list for future servicing/sanitizing. **(Attachment: 29)** **Date of Implementation**: August 22, 2014 **Monitoring Process**: Listing of Ice machine sanitizing on preventative maintenance list. Review of ice machine documentation during Infection Control/ Dietary rounds. **Person Responsible**: Engineering Department, Infection Control, RD, Director of Dietary	8/22/2014

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{A 749}	Continued From page 82 8/18/14 beginning at 10:30 a.m., it was noted that there was no air gap in the food production sink. The standard of practice would be to ensure the existence of an air gap which is an unobstructed vertical space between the water outlet of food service equipment and the flood level of a fixture (Food Code, 2013). In a concurrent interview with DS (Dietary Staff) 5 she stated that a work order was generated for installation of the air gap; however she was unsure of the status of the work order. Review of facility document titled " Work Order Notification " dated 8/13/14 noted the request to "install a 1" gap in prep sink, cook sink and ice machine ... " It was also noted that on 8/14/14 the staff member assigned to the task indicated that action was taken and there was the installation of a "piping gap." The staff member who documented the work order as complete was unavailable for interview. 12. During food distribution observations on 8/18/24 from 11:30 a.m.-12:30 p.m., DS 2 was regularly using a single terry towel to wipe off food stuff from patient plates as well as the food production counter. The standard of practice would be to ensure that dry wiping cloths used for food wiping food be maintained solely for wiping food, be free of visible food particles and not be used for wiping food production surfaces (Food Code, 2013). Review of undated departmental policy and procedure manual revealed there was no policy in relationship to the proper use of wiping cloths. Culver City Campus 13. During general kitchen observation on August 19, 2014 beginning at 11:30 a.m., there was no air gap in the food production sink in the bakery area. In an interview on August 21, 2014 Staff L	{A 749}	**11). Corrective Action**: Air gaps were installed on all food prep sinks **(Attachment: 20)** **Date of Implementation**: 8/20/14 **Monitoring process**: Bimonthly rounds with Infection Control and Dietary. **Person Responsible**: Director of Engineering **12). Corrective Action**: Revision of Food & Nutrition Policy F018 Sanitizing Food Contact Surfaces requiring the use of disposable towels to be used for the purpose of improving plated food presentation by wiping off edges of plated foods. Each towel cannot be used for any other purpose. In-services conducted on discontinuation of use of terry towels on patient plates and initiation of. single-use disposable cloths. **(refer to Attachment: A-749.5 e Attachment 21)** **Date of Implementation**: 10/28/14 **Monitoring Process**: Observations by dietary supervisor/Director during tray line audits **Person Responsible**: RD, Director of Dietary **Culver City** **13).Corrective Action**s: Air gaps in the kitchen were verified to have been placed in all three food preparation sinks **(Attachment: 16)** **Date of Implementation**: 8/21/14 **Monitoring Process**: Facilities monitors maintenance issues via EOC rounds which are reported to Quality Council. **Person Responsible**: RD, Director of Dietary Department & Director, Plant Management	8/20/2014 10/28/2014 8/21/2014

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{A 749}	Continued From page 83 stated a work order was generated for engineering staff to fix to ensure that all sinks had the required air gap. She stated that 1 air gap was installed in the cold production area but did not verify completion of the work. This is a repeat deficiency from the sampled validation survey on 4/1/14.	{A 749}		
{A 940}	482.51 SURGICAL SERVICES If the hospital provides surgical services, the services must be well organized and provided in accordance with acceptable standards of practice. If outpatient surgical services are offered the services must be consistent in quality with inpatient care in accordance with the complexity of services offered. This CONDITION is not met as evidenced by: Based on observation, review of facility documents and staff interview, the facility failed to meet the Condition of Participation in Surgical Services by failing to: 1. Ensure the temperature and humidity were monitored in the autoclave room in accordance with recommendation from AAMI (Association for Advanced Medical Instrument) (Hollywood campus) (Refer to A 951). 2. Establish functional workflow patterns in the following order from potentially high contamination areas to clean areas in accordance with recommendation from AORN (Association of Peri-Operative Registered Nurse Standards. AORN is the National Recognized Standards (NRS) the hospital identified as the standard they followed (Hollywood campus)	{A 940}	**1). Corrective Action**: Temperature and humidity monitor placed in Central Processing area and temperature monitored and recorded daily according to AAMI recommendations. **(Attachment 1)**Any deviation from AAMI recommendations will be immediately reported to engineering for action. Follow up will be documented. Staff education occurred **(Attachment 2)** **Date of Implementation**: Monitor placed: October 1, 2014; Staff education on 9/24/14. **Monitoring Process**: Temperature and humidity log with compliance reported to Regulatory Compliance Committee & Quality Council **Person Responsible**: Surgery/Central processing staff//Engineering **2). Corrective Action**: Workflow patterns re-defined from high contamination areas to clean areas based on AORN recommendation as follow: instruments are pre-cleaned at the point of use, sprayed with enzymatic foam, transported with closed container into the decontamination room where instruments are decontaminated and cleaned; cleaned instruments are placed in a clean instrument tray, closed and cover and transported via clean cart to central processing through the side door (#2) to complete sterilization process. After completion of sterilization process, instruments are transported and taken out through door (#1) for storage in sterile area. Door #1 from Central processing into the main OR hallway is being used to remove sterilized equipment from central processing to the Surgical areas. Staff has been educated on the process. Revision to policy SCS.010 Flow pattern sterile processing area with staff education. **(Attachment: 3**) Staff Inservicing **(Attachment 4)** **Date of Implementation**: September 4, 2014 **Monitoring Process**: Periodic random monitoring. **Person Responsible**: Central processing team, Infection Control.	9/24/2014 10/1/2014 9/4/2014

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{A 940}	Continued From page 84 (Refer to A 951). The cumulative effects of these systemic issues resulted in the facility's inability to ensure and provide safe patient care environment. This is a repeat deficiency from the sampled validation survey on April 1, 2014.	{A 940}		
{A 951}	482.51(b) OPERATING ROOM POLICIES Surgical services must be consistent with needs and resources. Policies governing surgical care must be designed to assure the achievement and maintenance of high standards of medical practice and patient care. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to 1. Ensure the temperature and humidity were monitored in the autoclave room in accordance with recommendation from AAMI (Association for Advanced Medical Instrument) (Hollywood campus). 2. Establish functional workflow patterns from potentially high contamination areas to clean areas in accordance with recommendation from AORN (Association of Peri-Operative Registered Nurse Standards. AORN is the National Recognized Standards (NRS) the hospital identified as the standard they followed. This deficient practice promote microbial growth and can result in contamination of sterile items. Findings:	{A 951}		

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{A 951}	Continued From page 85 Hollywood campus Central Processing Room During the tour with Registered Nurse (RN) 1 in the Semi-Restricted and Restricted areas on August 18, 2014 between 1:10 p.m. and 3 p.m., the following were observed: 1. There was no thermometer and humidity display in the Central processing Room, where all surgical instruments trays were wrapped and sterilized in the steam autoclaves. According to Certified Scrub Technician (CST) 1, the temperature and humidity had not been monitored and recorded. There was no documentation that the temperature and humidity to the Central Processing Room had been monitored and recorded. During an interview with CST 1 on August 18, 2014 at 3 p.m., she stated that the temperature and humidity to the Central Processing Room had not been monitored and recorded. According to AAMI (Association for Advanced Medical Instrument) (2014) Chapter 3: Design Considerations "3.3.6.5 Temperature General work areas should have a temperature controlled between 20oc and 23°C (68°F and 73°F). The decontamination area should have a temperature controlled between 16°C and 18°C (60°F and 65°F). The temperature in sterilization equipment access rooms should be controlled between 24°C and 29°C (75°F and 85°F) or as recommended by the equipment manufacturer. The temperature in sterile storage and personnel support areas (e.g., toilets, showers, locker rooms) may be as high as 24°C (75°F). Independent monitors should be located in each	{A 951}	**1). Corrective Action**: Temperature and humidity monitor wa placed in Central Processing area. Temperature and humidit is monitored and recorded daily. Any deviation from established normal range of temperatures will be immediately reported to engineering for action. Follow up will be documented. Staff has been educated to the process. **(Attachment 1)** Processing personnel in each work area are responsible for monitoring and recording the temperature to ensure that the correct temperature is being achieved. **Date of Implementation**: October 1, 2014 **Monitoring Process**: Temperature and humidity log **(refer to A-940.2 attachment 1)** **Person Responsible**: Surgery/Central processing staff/Engineering	10/1/2014

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{A 951}	Continued From page 86 of the areas where temperature should be controlled; temperature should be recorded daily. Processing personnel in each work area are responsible for monitoring and recording the temperature to ensure that the correct temperature is being achieved." 2. The dirty surgical instruments were decontaminated in other room and transported into the entrance of the Central Processing Room for preparation, packaging , and sterilization processing. The surgical instruments were transported through the same entrance, where the decontaminated surgical instruments were transported into, and were distributed to the OR #1 for surgical procedures after they were sterilized in the steam autoclave. During an interview with RN 1 on August 18, 2014 at 3 p.m., she stated the functional workflow patterns should be following the order from potentially high contamination areas to clean areas. According to Perioperative Standards and Recommended Practices for 2013 of the AORN, "Sterilization :" "Recommendation III lll.b.2. Functional workflow patterns should be established in the following order from potentially high contamination areas to clean areas: 1. Decontamination area, 2. Preparation and packaging, 3. Sterilization processing, 4. Sterile storage, and	{A951}	**2). Corrective Action**: Workflow re-defined as follow: instruments are pre-cleaned at the point of use, sprayed with enzymatic foam, transported with closed container into the decontamination room where instruments are decontaminated and cleaned; cleaned instruments are placed in a clean instrument tray, closed and cover and transported via clean cart to central processing through the side door (#2) to complete sterilization process. After completion of sterilization process, instruments are transported and taken out through door (#1) for storage in sterile area. Door #1 from Central processing into the main OR hallway is being used to remove sterilized equipment from central processing to the Surgical areas. Staff has been educated on the process **Attachment 2) Date of Implementation**: September 4, 2014 **Monitoring Process**: Periodic random monitoring. **Person Responsible**: Central processing team, Infection Control	9/4/2014

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{A 951}	Continued From page 87 5. Clean distribution On August 21, 2014, the facility was requested to provide policies and procedures, titled, "Functional workflow patterns." When reviewed the policies and procedures titled, "Flow pattern-Sterile Processing Areas," these was found not to be specifically identified, modified and operationalized to a surgical service. The evidence indicated that this facility had failed to develop and provide those aforementioned requested and operationalize any of the requested policy, that referred to surgical services that conformed to AORN recommended practice guidelines, an accepted national standards and guidelines. This is a repeat deficiency from the sampled validation survey on 4/1/14.	{A 951}		

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{K 000}	INITIAL COMMENTS This facility was surveyed under the Life Safety Code NFPA 101, 2000 Edition, Chapter 19, Existing Health Care Occupancies, and other applicable codes. Representing the Department of Public Health: Evaluator ID #16281, REHS, HFE I, REHS, CFII The following represents the findings of the Department of Public Health during a Life Safety Code Survey Follow-Up Visit pursuant to a Full Sample Validation Survey completed on April 1, 2014.	{K 000}		
{K 018}	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1% inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities.	{K 018}		

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

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{K 018}	Continued From page 1 This STANDARD is not met as evidenced by: Based on observation and interview, the hospital failed to ensure two corridor doors could resist the passage of smoke, and that there was no impediment to the closing of a corridor door. The deficiency had the potential to permit the passage of smoke, flame, or gases during a fire. Findings: Hollywood Campus Basement 1.) On August 18, 2014 at 11:30 a.m., the doctors' break/locker room had a %" diameter penetration through the solid wood corridor door of at a fire rated exit corridor. During an interview at the same time as the observation, the Disaster Coordinator stated that the corridor was a fire rated exit corridor. This is a repeat deficiency; on 4/1/14, during a Sample Validation survey, the facility received a deficiency for having a corridor door in a condition that could not resist the passage of smoke. First Floor 2.) At 12:25 p.m., the Urgent Care door at a fire exit corridor was held fully open by a bundled bandage with tape wedged between the top of the door and door frame. This is a repeat deficiency; on 4/1/14 during a	{K 018}	**Hollywood Campus** **Basement** **1. Corrective Actions:** The corridor door was repaired on August 26, 2014. The Engineering Department has added the basement doors to their quarterly door inspection, which will be tracked using the Fire Door Quarterly Inspection Log **(Attachment 1).** All engineers were in-serviced on the policy titled "Fire Door" for proper visual inspection of the doors. **(Attachment 2 and 3).** **Date of Implementation:** August 26, 2014. **Monitoring Process:** The basement corridor doors were added to Engineering's quarterly monitoring. After 100% compliance is achieved in two consecutive quarters, monitoring will be complete. **Person Responsible:** Director of Engineering & Lead Engineer **First Floor** **2. Corrective Actions:** The Engineering Department held an in-service with the Urgent Care, EVS and Security staff on the current Fire Life Safety policies that prohibit the doors from being held open. **(Attachment 4 & 5)** **Date of Implementation:** Staffing in-service was held on August 26, 2014. The door will be monitored daily, beginning September 1, 2014.	8/26/2014 8/26/2014 9/1/2014

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{K 018}	Continued From page 2 sampled validation survey the facility received a deficiency for having a corridor door that was impeded from closing. Culver City Campus Pavilion 6th floor Unit C Psychiatric 3.) On 8/20/14 between 9:30a.m. and 9:45a.m., the Dutch corridor door at nurses station C had an aluminum floor threshold with no indication of a fire rating at the meeting edges of the upper and lower leaves. The door was not equipped with an astragal, a rabbet, or a bevel with the same fire rating as the door at the meeting edges of the upper and lower leaves. Closer observation revealed the labels that indicate the fire rating had been removed from the door and door frame. During an interview at the same time as the observation, the Nursing director of P6 (Psychiatric 6) stated, the metal piece (threshold) was placed there yesterday (8/19/14). This is a repeat deficiency; on 4/1/14 during a Sampled Validation survey, the facility received a deficiency for having a corridor Dutch door with no astragal.	{K 018}	Continued from page 2 **Monitoring Process:** The door will be monitored daily, beginning September 1, 2014 **(Attachment 6)**. The door will be monitored for thirty (30) consecutive days. After achieving 100% compliance for sixty (60) days, monitoring will be discontinued. **Person Responsible:** Director of Engineering & Lead Engineer. **Culver City Campus** **6th Floor Unit C** **3. Corrective Actions:** The Engineering Department contacted a third party certification company to re-rate and label the Dutch doors. An astragal was placed on the Dutch doors to achieve the proper certification. **Date of Implementation:** The Dutch doors were re-certified on October 8, 2014. **Monitoring Process:** During the first quarter, the Dutch door will be monitored for tampering, astragal placement and labeling. When 100% is reached continuous monitoring will occur as a part of EOC weekly rounds, covering patient care areas twice a year. **(Attachment 7)** **Person Responsible:** Director of Engineering & Lead Engineer.	10/8/2014
{K 025}	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each	{K 025}		

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{K 025}	Continued From page 3 floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 This STANDARD is not met as evidenced by: Based on observation and interview, the hospital failed to ensure smoke barriers were maintained with a half hour fire resistance by having missing gypsum board at corridor smoke barrier wall, and a penetration through a construction separation wall. The deficiency had the potential to reduce the time the corridor smoke barrier wall had to withstand a fire exposure, and permit the passage of smoke, flame, or gases through the construction separation wall during a fire. Findings: Van Nuys Campus Station 2 1.) On 8/19/14, at Station 2 15ft. a gypsum board was missing from one side of a corridor smoke barrier wall exposing the wood framing members. The area missing the gypsum board was located above the drop down ceiling, above the observation and dictation room, both of which had 20 minute rated fire doors. At the same time as the interview, the Head Engineer stated that the wall was a 30 minute rated fire wall that needed to have dry wall on	{K 025}	**Van Nuys Campus** **Station 2** **1. Corrective Actions:** The Engineering Department attained help from a third party for remediation of fire penetrations throughout the facility. The Engineering staff was also in-serviced on the use of the approved above ceiling work permit and quarterly fire wall and smoke penetration Inspection Preventive Maintenance. **Date of Implementation:** The work of remediation was completed on October 22, 2014. The Engineering staff was in-serviced on above ceiling work permits on August 25, 2014. **(Attachment 8, 9, 10, 11)** **Monitoring Process:** The Engineers will monitor their smoke and fire walls for penetrations on a quarterly basis **(Attachment 12).**	8/22/2014 10/22/2014

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{K 025}	Continued From page 4 both sides of the wall. Culver City Campus Pavilion 4th floor Rehabilitation Unit 2.) On 8/20/14 between 10:05 a.m. and 10:23 a.m., at the construction separation between the back of the 4th floor and the rehabilitation unit at the front of the 4th floor, there was a 3 foot by 5 foot section missing from the gypsum board barrier at the separation. During an interview at the same time as the observation, the Corporate Director of Facilities stated that the gypsum board barrier was supposed to go all the way up to the ceiling. This is a repeat deficiency; on 4/1/14 during a Sampled Validation survey, the facility received a deficiency for having unsealed penetrations through the gypsum board barrier at the construction separation between the back of the 4th floor and the rehabilitation unit at the front of the 4th floor.	{K 025}	Continued from page 4 The above ceiling work permit will be used for all work done above ceiling to monitor and assure fire walls are always 100% compliant. **Person Responsible:** Director of Engineering & Lead Engineer **Culver City Campus** **4th Floor Rehabilitation Unit** **2. Corrective Actions:** The Engineering Department repaired the fire penetrations throughout the facility. The Engineering staff was also in-serviced on the use of the approved above ceiling work permit and quarterly fire wall and smoke penetration Inspection Preventive Maintenance. **Date of Implementation:** The work of remediation was completed on August 25, 2014. The Engineers were in-serviced on above ceiling work, as well as fire and smoke wall penetration inspection preventive maintenance on the same date **(Attachment 13)** **Monitoring Process:** The Engineers will monitor their smoke and fire walls for penetrations on a quarterly basis **(Attachment 14).** The above ceiling work permit will be used for all work done above ceiling to monitor and assure fire walls are always 100% compliant. **Person Responsible:** Director of Engineering & Lead Engineer.	8/25/2014
{K 027}	NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6,	{K 027}		

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{K 027}	Continued From page 5 19.3.7.7 This STANDARD is not met as evidenced by: Based on observation and interview, the hospital failed to ensure a cross corridor door automatically self closed when the fire alarm system was activated. The deficiency had the potential to permit the passage of smoke, flame, or gases during a fire, and permit drafts which could spread fire rapidly. Finding: Hollywood Campus First Floor On August 18, 2014 at 12:37 p.m., a cross corridor door located on the first floor, between Urgent Care and the kitchen, failed to close upon activation of the fire alarm system. Closer observation revealed the magnetically held door released upon activation of the fire alarm system, but failed to close. Further observation revealed the door was stuck to the floor. At the same time as the observation, the Corporate Director of Facilities stated that the door failed to close because of wax built up on the floor. At 1:20 p.m., after the wax build up was removed from the floor, the door was retested by again activating the fire alarm system. The door released from the magnetic holder and closed.	{K 027}	**Hollywood Campus** **First Floor** **1. Corrective Actions:** The Engineering Department in-serviced the EVS staff on the excessive use of wax and the need to pay extra attention to the cross corridor doors for assurance of proper closing. **Date of Implementation:** The EVS staff was in-serviced on August 18, 2014 **(Attachment 15).** **Monitoring Process:** The Engineering and EVS staff will monitor cross corridor doors for excessive wax. A floor cleaning schedule has been created for the monitoring of these doors. The floors will be monitored for two rounds of cleaning; monitoring will discontinue after two rounds of cleaning result in doors not sticking. **Person Responsible:** Director of Engineering & Lead Engineer	8/18/2014

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{K 027}	Continued From page 6 This is a repeat deficiency; on 4/1/14 during a Sampled Validation survey, the facility received a deficiency for the same cross corridor door not closing during a test of the fire alarm system.	{K 027}		
{K 052}	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 This STANDARD is not met as evidenced by: NFPA 72 National Fire Alarm Code, 1999 Edition 7-3.2 Testing. Testing shall be performed in accordance with the schedules in Chapter 7 or more often if required by the authority having jurisdiction. If automatic testing is performed at least weekly by a remotely monitored fire alarm control unit specifically listed for the application, the manual testing frequency shall be permitted to be extended to annual. Table 7-3.2 shall apply.	{K 052}		

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{K 052}	Continued From page 7 Exception: Devices or equipment that are inaccessible for safety considerations (for example, continuous process operations, energized electrical equipment, radiation, and excessive height) shall be tested during scheduled shutdowns if approved by the authority having jurisdiction but shall not be tested more than every 18 months. Table 7-3.2 Testing Frequencies 5. Batteries - Central Station Facilities c. Sealed Lead-Acid Type 1. Charger Test- Monthly, Quarterly 2. Discharge Test (30 minutes)- Monthly 3. Load Voltage Test - Monthly 6. Batteries - Fire Alarm System c. Sealed Lead-Acid Type 1. Charger Test - Annually 2. Discharge Test (30 minutes) -Annually 3. Load Voltage Test - Semiannually The Code was not met as evidenced by: Culver City Campus Based on document review, and interview, the hospital failed to ensure the batteries of the fire alarm system were tested at the frequencies indicated by NFPA 72. The deficiency had the potential to not supply backup power to the fire alarm system.	{K 052}		

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{K 052}	Continued From page 8 Finding: On August 21, 2014 at 10:30 a.m., during document review, there was no documented evidence the fire alarm system batteries were routinely tested. During an interview, at the same time as the document review, the Lead Man stated that the fire alarm system had sealed lead acid batteries, and that the load voltage tests of the batteries was not being conducted.	{K 052}	**Culver City Campus** **1. Corrective Actions:** The Engineering Department has revised their monthly preventive maintenance to include the monitoring and testing of the fire alarm batteries. The batteries will also be replaced after the second year of use. **Date of Implementation:** The policy and procedure was revised on August, 25, 2014. **Monitoring Process:** The Engineering staff will monitor the batteries on a monthly basis and replace every two years. **(Attachment 16).** **Person Responsible:** Director of Engineering & Lead Engineer	8/25/2014
{K 054}	NFPA 101 LIFE SAFETY CODE STANDARD All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3 This STANDARD is not met as evidenced by: NFPA 72 National Fire Alarm Code 1999 Edition 2-1.3.2 In all cases, initiating devices shall be supported independently of their attachment to the circuit conductor. The Code was not met as evidenced by: Based on observation and interview, the hospital failed to ensure that a required smoke detector (initiating device) was maintained as required by having a dismounted smoke head suspended by its electrical wires. The deficiency had the potential to impair the operation of the initiating device circuit.	{K 054}		

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{K 054}	Continued From page 9 conceivably resulting in loss of life or property because of fire alarm failure. Copper used in wiring conductors is not formulated to serve as a mechanical support. Copper fatigues over time if placed under mechanical stress, resulting in increasing brittleness and increasing electrical resistance. Ultimately, the fatigued conductor either breaks or its resistance becomes too high to allow the initiating device to function properly. Finding: Culver City Campus Pavilion 6th floor Unit C Psychiatric On 8/20/14 between 9:30a.m. and 9:45a.m., in room 636, there was a smoke detector head that was detached from its base, supported only by its electrical wires. During an interview at the same time as the observation, the Director of Engineering acknowledged the smoke detector head was supported by its wires, and stated the head would be repaired to be supported by its base or it would be replaced. This is a repeat deficiency; on 4/1/14 during a Sampled Validation survey, the facility received a deficiency for having a smoke detector that was pulled of a wall.	{K 054}	**<u>Culver City Campus</u>** **<u>6th Floor Unit C Psychiatric</u>** **Corrective Actions:** The smoke detector in Room 636 was immediately remounted to its base. **Date of Implementation:** The smoke detector was remounted on August 20, 2014. **Monitoring Process:** The Engineering Department conducts weekly visual inspections to ensure secure mounting of smoke detectors. **(Attachment 17).** **Person Responsible:** Director of Engineering & Lead Engineer	8/20/2014
{K 130}	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY-NOT ON 2786	{K 130}		

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{K 130}	Continued From page 10 This STANDARD is not met as evidenced by: NFPA 99 Standard for Health Care Facilities 1999 Edition 4-3.1.1.1 Cylinder and Container Management. Cylinders in service and in storage shall be individually secured and located to prevent falling or being knocked over. 4-3.5.2.1(b)24. Even if they are considered empty, cylinders shall never be used as rollers, supports, or for any purpose other than that for which they are intended by the supplier. 4.3.5.2.2(b)2. If stored within the same enclosure, empty cylinders shall be segregated from full cylinders. Empty cylinders shall be marked to avoid confusion and delay if a full cylinder is needed hurriedly. 8-3.1.11.2 Storage for nonflammable gases less than 3000 ft3 (85 m3). (h) Cylinder or container restraint shall meet 4-3.5.2.1(b)27. 4-3.5.2.1(b)27. Freestanding cylinders shall be properly chained or supported in a proper cylinder stand or cart. These Standards was not met as evidenced by: Based on observation and interview, the hospital failed to ensure oxygen cylinders were properly chained or supported in proper cylinder stands or carts. The deficiency had the potential to create a	{K 130}		

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{K 130}	Continued From page 11 mechanical hazard. If a cylinder falls, the valve could snap off and/or if the cylinder is cracked open and the cylinder has a sudden, uncontrollable release of its contents, it could be propelled rapidly and/or violently. Findings: Culver City Campus Exterior Oxygen Cylinder Storage On August 21, 2014 at 9:10a.m. the following conditions existed at the exterior oxygen (02) cylinder storage area. 1.) Two 02 (a non-flammable gas) cylinders were lying on their sides on the ground with a metal hand truck on top of them. During an interview, at the same time as the observation, the Head Engineer stated that the cylinders should have been in racks, stands or secured by chains. 2.) One 02 cylinder was free standing and unsecured. During an interview, at the same time as the observation, the Head Engineer stated that the cylinder should have been in a rack, stand or secured by a chain. This is a repeat deficiency; on 4/1/14 during a Sample Validation survey, the facility received a deficiency for having free standing oxygen cylinders that were not supported or chained throughout the hospital, including the exterior oxygen storage area.	{K 130}	**Culver City Campus** **Exterior Cylinder Storage** **1. Corrective Actions:** The cylinders were immediately put back onto the appropriate rack. A daily surveillance procedure has been implemented to check for inappropriate or unsafe storage. Staff was in-serviced on O_2 tank safety, monitoring and surveillance. **(Attachment 18)** **Date of Implementation:** August 21, 2014. **Monitoring Process:** A twice daily check log has been implemented to ensure tanks are secured safely and in the appropriate locations. Monitoring log is effective starting October 1, 2014. **(Attachment 19)** **Person Responsible:** Respiratory Therapy Clinical Coordinator **2. Corrective Actions:** The cylinder was immediately put back onto the appropriate rack. Additional racks have been ordered to ensure O_2 cylinders throughout the facility will be properly secured. **Date of Implementation:** August 21, 2014. **Monitoring Process:** Cylinders are monitored during morning and afternoon daily rounds. **(Attachment 19)** **Person Responsible:** Respiratory Therapy Clinical Coordinator	8/21/2014 10/1/2014 8/21/2014

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			Continued from page 12	
{K 130}	Continued From page 12 3.) One Argon (a non-flammable gas) cylinder was free standing unsecured. During an interview, at the same time as the observation, the Head Engineer identified the cylinder as an argon cylinder and stated that the cylinder should have been in a rack, stand or secured by a chain. 4.) There were ten full 02 cylinders stored on the empty cylinder side of the cylinder storage area. A sign on the wall identified the section as the empty cylinder section of the 02 storage area. During an interview, at the same time as the observation, the Head Engineer identified the cylinders as full cylinders and stated that the should been stored on the full side.	{K 130}	**3. Corrective Actions:** The cylinder was immediately put back onto the appropriate rack. Additional racks have been ordered to ensure O_2 cylinders throughout the facility will be properly secured. **Date of Implementation:** August 21, 2014 **Monitoring Process:** Cylinders are monitored during morning and afternoon daily rounds. **(Attachment 19** **Person Responsible:** Respiratory Therapy Clinical Coordinator **4. Corrective Actions:** Areas for storage of full and empty tank in the tank storage cage have been clearly marked. Additional racks have been ordered to segregate full tanks from empty tanks. **Date of Implementation:** August 21, 2014 **Monitoring Process:** Cylinders are monitored during monitoring and afternoon daily rounds. **(Attachment 19)** **Person Responsible:** Respiratory Therapy Clinical Coordinator & Senior Transportation Coordinator	8/21/2014 8/21/2014
{K 147}	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: NFPA 70 National Electrical Code (NEC) 1999 Edition 400-8. Uses not permitted. Unless specifically permitted in Section 400-7, flexible cords and cables shall not be used for the following: (1) As a substitute for the fixed wiring of a structure 400-9. Splices. Flexible cord shall be used only in continuous lengths without splice or tap where	{K 147}		

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{K 147}	Continued From page 13 initially installed in applications permitted by section 400-7(a). The repair of hard-service cord and junior hard-service cord (see Trade Name column in Table 400-4) No. 14 and larger shall permitted if conductors are spliced in accordance with Section 110-14-(b) and the completed splice retains the insulation, outer sheath properties, and usage characteristics of the cord being spliced. These requirements were not met as evidenced by: Based on observation and interview, the hospital had an extension cord in use as permanent wiring. The deficiency had the potential to present a fire safety hazard. The National Electrical Code (NEC) stipulates that temporary wiring is to be removed immediately upon completion of construction or other purpose (i.e. remodeling, maintenance, repair, and demolition) for which the wiring was installed. Finding: Culver City Campus Single Story Building On August 21, 2014, at 9:35a.m., there was an extension cord being used as permanent wiring at the exterior west side of the single story building. A mini drop amplifier was connected to the extension cord. During an interview, at the same time as the observation, the Lead Engineer stated that the	{K 147}	**Culver City Campus** **Single Story Building** **1. Corrective Actions:** The Engineering Department removed the extension cord and repaired the existing outlet at the location. The Engineering staff was in-serviced on the use of extension cords. **(Attachment 20)** **Date of Implementation:** Repairs to existing outlet were complete on August 21, 2014. Staff in-service was conducted on August 25, 2014. **Monitoring Process:** The receptacle will be monitored for the next two (2) months, after that, it will be monitored annually during EOC rounds. **Person Responsible:** Director of Engineering & Lead Engineer	8/21/2014 8/25/2014

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{K 147}	Continued From page 14 extension cord should not have been in use as permanent wiring. This is a repeat deficiency; on 4/1/14 during a Sampled Validation survey, the facility received a deficiency for using extension cords as permanent wiring.	{K 147}		

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E 000	Initial Comments The following reflects the findings of the Department of Public Health during a Complaint Investigation. Intake Number: CA00404848 Inspection was limited to the specific complaint investigation and does not represent the findings of a full inspection of the facility. Representing the Department of Public Health: Surveyor 16281 One deficiency was issued to intake CA00404848.	E 000		
E 2429	T22 DIV5 CH1 ART8-70855 Mechanical Systems Heating, air conditioning and ventilating systems shall be maintained in operating condition to provide a comfortable temperature and to meet the new construction requirements in effect at the time plans were approved for the facility. This Statute is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure the air conditioning equipment was maintained to provide a comfortable temperature, and failed to adhere to its Patient Room Temperature Control Policy by having temperatures in patient care areas that were outside the hospital's target temperature range. According to the Centers for Disease Control (CDC), Extreme Heat Prevention Guide – Part 1, last reviewed: May 31, 2012. Elderly people (65 years and older), infants and children and people	E 2429		

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E 2429	Continued From page 1 with chronic medical conditions are more prone to heat stress. Air-conditioning is the number one protective factor against heat-related illness and death. Finding: On July 17, 2012 at 2:30 p.m., a complaint visit was conducted at the hospital regarding a complaint allegation that the hospitals air conditioning system was not working. The hospital census was 64. At 2:45 p.m., the Disaster Coordinator stated that half the time he works as the hospital engineer. He stated that the facility had two chillers a 100 ton and a 15 ton. That the 100 ton chiller would sometimes shut off and turn on again, that it happened for three consecutive days and then it was decided to change the parts the air conditioning service vendor had recommended. That the parts were changed on the compressor yesterday (7/8/14) by the vendor. That it fixed the problems at first but that there were other problems such as holes in the water circulation pipe which were discovered in the process of servicing the chiller. He also stated that the whole hospital was affected by the problems with the 100 ton chiller except for the basement. That the last time the air conditioning was not working was Monday afternoon (7/7/14). Between a 3:15 p.m. and 4:07 p.m., on July 17, 2014, samples of room temperatures were taken by the Disaster Coordinator using a infrared temperature gun with a lowest temperature	E 2429	**Corrective Actions:** To assure prompt actions, the facility has hired a Lead Engineer to alleviate response time and management from the Disaster Coordinator. The facility has reached a maintenance agreement with a third party for monthly service to the chiller. In the event that the chiller goes down, the facility will call for portable units and also call the IOR to contact the CO for emergency approval process of an on-site temporary chiller as the repairs are completed. The facility has in-serviced the engineering department on the new policy, implemented in March 2014, and will be auditing findings on a bi-weekly basis. The facility has also implemented a preventive maintenance program, which will be performed on a quarterly basis. **Date of Implementation:** The Lead Engineer was hired on August 14, 2014. The third party agreement was implemented on September 19, 2014. In-services were conducted and audits began on August 25, 2014. Redline Air's quarterly preventive maintenance program will commence on September 18, 2014. **Monitoring Process:** Temperature Log is monitored bi-weekly. Engineering will be conducting mechanical rounds on a daily basis. Quarterly preventive maintenance program by Redline Air. **Person Responsible:** Lead Engineer and Engineering department.	8/14/2014 8/25/2014 9/18/2014 9/19/2014

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E2429	Continued From page 2 reading of 68.3 degrees Fahrenheit and the highest temperature reading of 80.0 degrees Fahrenheit as follows: 6th floor 1. The respiratory therapy room was 72.6 degrees Fahrenheit. 5th floor (Med Surge Unit) 2. Room 510 was 72.2 degrees Fahrenheit. 3. Room 505 was 70.9 degrees Fahrenheit. 4. Room 501 was 68.9 degrees Fahrenheit. 4th floor (Med Surge Unit) 5. Room 409 was 72.7 degrees Fahrenheit. 6. Room 406 was 71.0 degrees Fahrenheit. 7. Room 401 was 78.9 degrees Fahrenheit. 3rd floor 8. Room 307 part of the Med Surge Unit, was 70.9 degrees Fahrenheit. 9. The CCU was 80.0 degrees Fahrenheit. 10. The ICU was 68.3 degrees Fahrenheit. 11. Room 301 was 69.0 degrees Fahrenheit. 2nd floor (currently not occupied by patients) 12. Room 202 was 68.7 degrees Fahrenheit.	E 2429		

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E 2429	Continued From page 3 13. Room 201 was 72.4 degrees Fahrenheit. 1st floor 14. The Urgent Care room was 70.9 degrees Fahrenheit. 15. The kitchen was 73.2 degrees Fahrenheit. Basement 16. The corridor to surgery was 77.3 degrees Fahrenheit. Two of fourteen sampled rooms (401 and the CCU), and the surgery corridor were above the hospitals target temperature range. At the same time as the observation four of six patients interviewed (Patients 1, 2, 3 and 4) stated their rooms were hot or warm. Patient 1 stated, “It’s hot, it may be my because of my medication, but its better than the other day.” Patient 2 stated, “It’s warm in here.” Patient 3 stated, “Gets hot at night.” Patient 4 stated, “It’s hot in the room.” Also, at the same time as the observation, during an interview, the Disaster Coordinator stated that the temperature that was out of range in room 401 was a thermostat issue because the thermostat was set too high. Between 4:07 p.m. and 5:02 p.m., during document review, policy number UTL-086, titled,	E 2429		

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E 2429	Continued From page 4 "Patient Room Temperature Control," with an effective date of 3/20/2014 indicated that the heating, air conditioning, and ventilation systems shall be maintained in operating condition to provide a comfortable temperature based on Title 24 Mechanical Code (Ref. Table 325.0). The policy indicated that the target temperature range was 68 to 77 degrees (Fahrenheit) (Title 24, Table 325.0). The policy indicated that the objective was to establish an effective and compliant temperature control system that can be monitored in all general patient care areas of the facility, and indicated the procedure was that on the day determined readings would be taken and logged as part of the daily rounds on non-critical patient care areas. That the readings were to be taken from two points within the patient room, and at the bedside level for every HVAC unit service area, every two weeks, twice per day (7:00 a.m. and 2:00 p.m.) A review of the Daily Mechanical Inspections log from July 1 to 9, 2014, indicated that on July 2, 3, 5 and 6, 2014, the air conditioning was malfunctioning. A review of the Hospital wide Temperature Log for July 1, 2, 4, 5, 6, 7, 8 and 9, 2014, indicated that on July 2, 4, 5, 7, 6, 8, and 9 2014, the temperature in patient areas throughout the hospital were above the hospital's target temperature range of 68 to 77 degrees Fahrenheit. Per the log on July 2, 2014, at 9 a.m., the measured temperatures of 22 of 24 areas, including patient areas in the hospital were between 77.1 and 78.6 degrees Fahrenheit.	E 2429		

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E 2429	Continued From page 5 Per the log on July 4, 2014, at 11 a.m., the measured temperatures of 52 of 52 areas, including patient areas in the hospital were between 78.0 and 83.1 degrees Fahrenheit. Per the log on July 5, 2014, at 8 a.m., the measured temperatures of 59 of 59 areas, including patient areas in the hospital were between 79.0 and 83.1 degrees Fahrenheit. Per the log on July 6, 2014, at 11 a.m., the measured temperatures of 49 of 49 areas, patient areas in the hospital were between 79.0 and 85.1 degrees Fahrenheit. Per the log on July 7, 2014, time not indicated, the measured temperatures of 4 of 48 areas, including patient areas in the hospital were above the hospital's target temperature range. Room 305, and the third and fourth floor hallways, were 78 degrees Fahrenheit. Per a log on July 8, 2014, time not indicated, the measured temperatures of 3 of 51 areas, including patient areas in the hospital were above the hospital's target temperature range. Room 301, 410 and 506, were 78 degrees Fahrenheit. Per a second log on July 8, 2014, at 11:14 a.m., the measured temperatures of 60 of 63 areas, including patient areas in the hospital were between 78.1 and 88.8 degrees Fahrenheit. Per the log on July 9, 2014, time not indicated, the measured temperature of 2 of 51 areas, including patient areas in the hospital was above the hospital's target temperature range. Room 309 was 78 degrees Fahrenheit. The facility did not provide Hospital wide	E 2429		

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E 2429	Continued From page 6 Temperature Logs for July 3, 2014, or any other documented evidence temperature measurements of patient areas were taken, or that the hospital patient areas were within the hospital's target temperature range on July 3, 2014. At 2:50 p.m., during an interview, the Disaster Coordinator had stated that the temperature is usually monitored every day but that currently they were monitoring the temperature three times a day. There was no documented evidence provided the temperature was being monitored three times a day, evidence of daily monitoring twice a day was provided for 1 of 9 days, and evidence of daily monitoring once a day was provided for 7 of 9 days. The Disaster Coordinator was not aware that the hospital had a Patient Room Temperature Control policy. At 4:40 p.m., during an interview, the Chief Engineer stated that every morning he checks that the chiller is running at between 50 to 58 degrees Fahrenheit but that the patient rooms are only checked when the nurses call if there is a problem, and that the temperatures are not logged unless there is a problem. He also stated that the target temperature range he checks for is 60 to 72 degrees Fahrenheit. The Chief Engineer was not aware that the hospital had a Patient Room Temperature Control policy. A review of rental agreements dated July 2, 5, 6, and 7, 2014 indicated that twenty portable spot coolers (air conditioners) were rented by the hospital. During an interview, at the same time as the	A 2429		

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E 2429	Continued From page 7 document review, the Administrator stated that twenty nine portable spot coolers were rented and placed throughout the hospital, primarily in patient areas. A review of the description of work form from the air conditioning service vendor dated July 7, 2014, indicated the technician installed hot gas discharge thermostat and suction line freeze stat, rebuilt, reinstalled the compressor and aligned, evacuated, opened all valves, replaced liquid line driers, started system, set oil pressure safety at 25 psi and tested OK, system running good with 21 degree superheat – 6 degree subcooling and 60 psi net oil pressure, changed oil after one hour will return to change again. A review of the description of work form from the air conditioning service vendor dated July 8, 2014, indicated the technician ran flexible conduit and wiring from suction line freezes stat and discharge line T-stat at 180 degrees Fahrenheit and freeze stat at 40 degrees Fahrenheit, replaced bad condenser fan motor and fan blade, verified rotation and operations OK, monitored chiller operations, adjusted to unload at 59 psi, will return to change oil and driers.	E 2429		

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{A 000}	INITIAL COMMENTS The following reflects the findings of the Department of Public Health during a focused revisit following a Complaint Validation Survey (Intake Number CA00429647) completed on 2/5/15 with Condition of Participation (CoP) CFR 482.41 Physical Environment not met. The focused revisit was completed on 6/4/15. Representing the Department of Public Health: Surveyor 16281, REHS, CFI 1, HFE I	{A 000}		
{A 701}	482.41(a) MAINTENANCE OF PHYSICAL PLANT The condition of the physical plant and the overall hospital environment must be developed and maintained in such a manner that the safety and well-being of patients are assured. This STANDARD is not met as evidenced by: Based on observation, interview, and document review, the hospital failed to provide a permanent air system to operate continuously and provide balanced air-supply to patient rooms for the 2nd, front of 3rd (SDU), 4th, 5th, and 6th floors, provide a Construction Final (CF) for the new temporary air handler and fire alarm control panel, and provide self-closing area separation fire doors. The deficiencies had the potential to permit the spread of smoke and gases during a fire, and not provide a permanent provision of balanced air-supply to patient rooms on the 2nd, front of 3rd, 4th, 5th, and 6th floors. Findings:	{A 701}	1. Corrective Action: The ability to remove relays that would allow bypass of the air handlers has been permanently eliminated. With the installation of the new fire panel, the relays are now designed to fail safe. This means that should someone remove or tamper with the relays, the air handlers will automatically shut down, which will immediately stop air flow in the ventilation system. The fire system has been fully tested by Culver City Fire Dept and Inspector of Record, to insure that in the event of a fire or smoke alarm, both the permanent and temporary air handler will shut down. Attachment's •OSHPD CO 8/19/2015 Certificate of Occupancy for use of Temporary Air Handler •OSHPD FV 6/30/15 indicating we will be able to obtain Construction Final once the replacement air handler is installed and temporary air handler is removed. •OSHPD Notice of Start of Construction for New Permanent Air Handler •OSHPD VR 6/3/15 indicating all devices have been tested	06/22/2015

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

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

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{A 701}	Continued From page 1 1. On 6/4/15 the evaluator conducted a follow up visit for a complaint validation survey dated 2/5/15, for a fire that occurred on the roof, and at air handler 2 of the pavilion building on 1/29/15, during roofing work. Relays at the air handler control panel had been disconnected, permitting air handlers 1 and 2 to not shut down with the presence of smoke, dispersing smoke from the roof and air handler 2 to other areas and floors of the pavilion. On 6/4/15 at 10 a.m., during an interview, the VP of Corporate Facilities Operations stated that with the new design of the fire alarm control panel (FACP), if the relays are disconnected, air handler 1, and the replacement for air handler 2, when installed, will shut down and activate an alarm at the FACP. At 10:38 a.m., there was a new temporary air handler, and new ducting on the roof of the pavilion building. There was a work crew on the roof, a hot works permit #5218589 dated 6/2/15 with an expiration date of 6/5/15 at 4 p.m., for roofing patch back was posted on the air duct frame, and a fire watch was being conducted at the work site. During an interview at the same time as the observation, the VP of Corporate Facilities Operations stated that the air handler was temporary and could not be used as the permanent because it did not meet the seismic requirements of a permanent air handler, but that the new air ducting the temporary air handler was connected to was the new permanent ducting. At 10:50 a.m., during an interview, the Fire Alarm	{A 701}	•OSHPD FV 6/22/15 indicating OSHPD Fire Marshall issuing Occupancy for use of the Fire Alarm System •OSHPD CO Fire panel Certificate of Occupancy 6/22/15 2.Plan for Improvement: By making the modifications described above, the deficiency has been permanently corrected. 3.Expected Completion date: This is complete, please see attached Certificate of Occupancy from OSHPD. Project # S142962-19-00 4. Demonstrated hospital Improvement Actions: Not only has this deficiency been eliminated, the air handlers will immediately shut down should the relays be removed or tampered with. The fire panel will also alarm indicating a problem with a relay. 5. Responsible Person: Dean Morford, Director of Facilities Operations.	

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{A 701}	Continued From page 2 System Vendor/Technician present on site, stated that both relays at the air handler control panel are now wired fail safe so that if the relays are disconnected, air handler 1, and the replacement for air handler 2, when installed, will shut down and activate a visual and audible alarm at the FACP and annunciator panels located at the basement and lobby of the pavilion building, and PBX of the tower building. The Fire Alarm System Vendor/Technician also stated that the temporary air handler does not shut down when the relays are disconnected because that air handler is not controlled by the relays, but that the temporary air handler will shut down with the activation of any smoke detector in the building, and that once installed the permanent air handler replacing air handler 2 will be controlled by the relays, and will also shut down when the relays are disconnected. During an observation at the same time as the interview, engineering staff demonstrated the shutting down of air handler 1 by disconnecting a relay from the air handler control panel. At 1:25 p.m., during document review, there was an Office of Statewide Health Planning and Development (OSHPD) permit, and Certificate of Occupancy (CO) from the OSHPD Fire Life Safety Officer (FLSO) dated 5/28/15, but there was no Construction Final (CF) for the new temporary air handler. There was no documented evidence of submitted architect drawings, OSHPD permit, contracts, and completion timeline for the installation of the permanent air handler replacing air handler 2. There was an OSHPD Verified Compliance Report (VR) dated 6/3/15 for the replacement of the FACP, but there was no acceptance test and CF for the new FACP.	{A 701}		

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{A 701}	Continued From page 3 During an interview at the same time as the document review, the VP of Corporate Facilities Operations stated that there was not a CF for the new FACP because the hospital is waiting for the OSHPD FLSO for the CF. On 6/9/15, a copy of an OSHPD FLSO Field Visit (FV) dated 6/8/15, was provided by the VP of Corporate Facilities Operations, that indicated the FACP project was 80% complete, that with the exception of minor "punch-list" items the scope of work had been inspected and accepted by the Inspector of Record (IOR) and is ready for the required acceptance testing with the Authority Having Jurisdiction (AHJ) or OSHPD. That the OSHPD Fire Marshall has agreed to accept any testing that has been witnessed and accepted by personnel from the Culver City Fire Department in lieu of testing with the OSHPD Fire Marshall. 2. On 6/4/15 the evaluator conducted a follow up visit for a complaint validation survey dated 2/5/15. As a result of the complaint validation survey dated 2/5/15 it was revealed through review of the local fire departments undated Fire Investigation Report regarding a fire incident at the hospital on 1/29/15, that self-closing area separation fire doors had been removed from the fourth and fifth floors, and that an OTC (Order to Comply) for replacement of the doors had been issued. On 6/4/15 at 11:29 a.m., on the 5th floor, the VP of Corporate Facilities Operations identified a cross corridor door frame near room 533 as one of the areas where the doors were missing. There were no cross corridor doors within the door frame.	{A 701}	1. Corrective Action: A project to replace/install new door was opened with OSHPD. This project has been completed. The testing of the doors was included with the new fire panel project, conducted by the Culver City Fire Dept and Inspector of Record.	07/01/2015

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{A 701}	Continued From page 4 During an interview at the same time as the observation, the VP of Corporate Facilities Operations stated that construction on the fire doors should start in 3 weeks (6/25/15) and be completed by 7/6/15. At 11:42 a.m., on the 5th floor, the VP of Corporate Facilities Operations identified a cross corridor door frame near room 523 as one of the areas where the doors were missing. There were no cross corridor doors within the door frame. Between 11:42 a.m. and 12:07 p.m., on the 4th floor, the VP of Corporate Facilities Operations identified a cross corridor door frame near room 423 as one of the areas where the doors were missing. There were no cross corridor doors within the door frame. During document review, there was an application to OSHPD for the installation of cross-corridor doors at the second, third, fourth and fifth floors. Review of a Gantt chart for the installation of the doors indicated the installation of the doors would start on 6/18/15 on the 2nd floor, 6/29/15 on the 4th floor, and 7/2/15 on the 5th floor, and would finish on 6/18/15 on the 2nd floor, 7/1/15 on the 4th floor, and 7/6/15 on the 5th floor, with OSHPD final approvals between 7/7/15 and 7/13/15. On 6/5/15, a copy of purchase order for 6 doors and 3 frames, dated 6/5/15, was provided by the VP of Corporate Facilities Operations.	{A 701}	•OSHPD Application for New Project 1/30/15 •OSHPD Notice of Construction 4/31/15 •Door Order 6/5/15 •OSHPD CO 7/1/15 Certificate of Occupancy •Quarterly Door Inspection (Not due until 10/15) 2.Plan for Improvement The doors will be added to the Quarterly Door Inspection Program. 1st inspection will be October 2015. 3.Expected completion Date: Project is complete, please Certificate Occupancy Project # S150397-19-00- SCH Door Installation 4.Demonstrated hospital Improvement Actions: The doors have been added to the Quarterly Door Inspection Program. 5. Responsible person: Mark Stultz, Director of Facilities Operations.	
A 724	482.41(c)(2) FACILITIES, SUPPLIES, EQUIPMENT MAINTENANCE	A 724		

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	050135	A. BUILDING _____ B. WING _____	R 06/04/2015

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A 724	Continued From page 5 Facilities, supplies, and equipment must be maintained to ensure an acceptable level of safety and quality. This STANDARD is not met as evidenced by: Based on observation, and interview, the hospital staff failed to ensure the hospital was maintained to ensure an acceptable level of safety for patients, staff and visitors, by having a water leak at the ceiling of a nurses' station. The deficiency had the potential for the water with contaminants within it, from running through the area between the roof and the 6th floor ceiling, to act as a conductor of electricity, and the electrical wires and/or box touched by the water from the leak had the potential for electrical short, arcs and other failures. Findings: On 6/4/15 at 11:19 a.m., at the 6th floor nurses' station there was water leaking from above the drop down suspended ceiling into a receptacle below. Closer observation revealed the water was dripping from an electrical box containing wires that was connected to an electrical conduit. During an interview at the same time as the observation, the VP of Corporate Facilities Operations stated that the leak originated at the roof from a steam line for a boiler, and that it would be repaired in the afternoon. During another interview also at the same time as the observation, the Director of Facilities stated that the leak was discovered that morning.	A 724	1. Corrective Action: The temporary plan of correction was to place a pipe clamp on the leaking pipe and contain dripping water. The permanent solution involved obtaining a proposal from a vendor for repair of the 4" water line and faulty shutoff valve. Part of the process was to schedule a shutdown of the building heating system hot water. Attachments •Engineering work order 6/4/14 indicating work repair •RF MacDonald Proposal for repair 6/22/15 •Repair P.O. •RF MacDonald Work Ticket – indication repair completion 8/11. 2. Plan for improvement: Water leaks cannot be predicted, as leaks occur, the Facilities Operations Center is notified and a work order is generated to repair. 3. Expected Completion Date: Temporary repairs were completed on 6/4/2015. Permanent repairs were completed on 8/11/2015. Please see attached work orders, proposal for repair from R.F. MacDonald, Purchase Order to perform work and work order ticket form R.F. MacDonald. 4. Demonstrated Hospital Improvement Actions: Utility failures are reported to the EOC committee, EOC reports are reported to the Quality Council Committee. 5. Responsible Person(s): Dean Morford, Director of Facilities Operations, Mark Stultz, VP of Corporate Facilities Operations, and Toby Davis, Director of the Behavioral Health Unit.	06/04/2015

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{K 000}	INITIAL COMMENTS The following reflects the findings of the Department of Public Health during a focused revisit following a Complaint Validation Life Safety Code Survey (Intake Number CA00429647) completed on 2/5/15 with Condition of Participation (CoP) CFR 482.41 Physical Environment not met. The focused revisit was completed on 6/4/15. Representing the Department of Public Health: Surveyor 16281, REHS, CFI 1, HFE I	{K 000}		
{K 067}	NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2 This STANDARD is not met as evidenced by: NFPA 90A, Standard for the Installation of Air Conditioning and Ventilating Systems. 2-3.11.1 Egress Corridors in health care, detention and correctional and residential occupancies shall not be used as a portion of a supply, return, or exhaust air system serving adjoining areas. An air transfer opening(s) shall not be permitted in walls or in doors separating egress corridors from adjoining areas. Exception No. 1: Toilet rooms, bathrooms, shower rooms, sink closets, and similar auxiliary	{K 067}		

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

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{K 067}	Continued From page 1 spaces opening directly onto the egress corridor. Exception No. 2: Where door clearances do not exceed those specified for fire doors in NFPA 80, Standard for Fire Doors and Fire Windows, air transfer caused by pressure differentials shall be permitted. Exception No. 3: Use of egress corridors as part of the engineered smoke control system. Exception No. 4: In detention and correctional occupancies with corridor separations of open construction (e.g. grating doors or grating partitions). 4-3.1 Smoke dampers shall be controlled by an automatic alarm initiating device. Smoke dampers shall be permitted to be positioned manually from a command station. 4-4.1 All automatic shutdown devices shall be tested annually. 4-4.3 Smoke detectors provided as required by 4-4.2 shall automatically stop their respective fan(s) on detecting the presence of smoke. NFPA 101 Code for Safety to Life from Fire in Buildings and Structures 2000 Edition 9.2.1 Air Conditioning, Heating, Ventilating Ductwork, and Related Equipment. Air conditioning, heating, ventilating ductwork, and related equipment shall be in accordance with NFPA 90A, Standard for the Installation of Air-Conditioning and Ventilating Systems, or NFPA 90B, Standard for the Installation of Warm Air Heating and Air-Conditioning Systems, as	{K 067}		

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{K 067}	Continued From page 2 applicable, unless existing installations, which shall be permitted to be continued in service, subject to approval by the authority having jurisdiction. 9.3.1* General. Smoke control systems, where required or permitted by Chapters 11 through 42, shall have an approved maintenance and testing program to ensure operational integrity. The purpose of such smoke control systems shall be to confine smoke to the general area of fire origin and maintain use of the means of egress system. 9.6.5.1 A fire alarm and control system, where required by another section of this Code, shall be arranged to actuate automatically the control functions necessary to make the protected premises safer for building occupants. 9.6.5.2 Where required by another section of this Code, the following functions shall be actuated by the complete fire alarm system: (1) Release of hold-open devices for doors or other opening protectives (2) Stairwell or elevator shaft pressurization (3) Smoke management or smoke control systems (4) Emergency lighting control (5) Unlocking of doors 19.3.4.4 Emergency Control. Operation of any activating device in the required fire alarm system shall be arranged to accomplish automatically any control functions to be performed by that device. (See 9.6.5.) 19.5.2.1 Heating, ventilating, and air conditioning shall comply with the provisions of Section 9.2 and shall be installed in accordance with the	{K 067}		

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{K 067}	Continued From page 3 manufacturer's specifications. These codes and standards were not met as evidenced by: Based on observation, interview and document review, the facility failed to failed to ensure that all automatic shutdown devices were tested annually. The facility used corridors as plenums. The deficiencies had the potential to permit accelerated spread of smoke and gases during a fire. Findings: 1. On 6/4/15 the evaluator conducted a follow up visit for a complaint validation survey dated 2/5/15, for a fire that occurred on the roof, and at air handler 2 of the pavilion building on 1/29/15. Relays at the air handler control panel were found to have been disconnected, permitting air handlers 1 and 2 to not shut down with the presence of smoke, dispersing smoke from the roof and air handler 2, to other areas and floors of the pavilion. During the complaint validation survey dated 2/5/15, review of fire alarm system inspection and test reports dated 7/28/14, and 4/24/13, indicated there was no documented evidence that the duct detectors for air handlers 1 and 2 at the 7th floor penthouse were inspected and tested. The last documented evidence of duct smoke detectors for air handler one and two being inspected was on 3/20/12. On 6/4/15 at 1:25 p.m., during document review, there was no documented evidence that the duct	{K 067}	1. Corrective Action: The ability to remove relays that would allow bypass of the air handlers has been permanently eliminated. With the installation of the new fire panel, the relays are now designed to fail safe. This means that s hould someone remove or tamper with the relays, the air handlers will automatically shut down, which will immediately stop air flow in the ventilation system. The fire system has been fully tested by Culver City Fire Dept and Inspector of Record, to insure that in the event of a fire or smoke alarm, both the permanent and temporary air handler will shut down. The new fire panel, smoke detectors, Fire dampers and smoke dampers were completely tested and signed off by the Culver City Fire Dept. Please see OSHPD Field Visit Report dated 6/22/15. Attachment's: •OSHPD CO 8/19/2015 Certificate of Occupancy for use of Temporary Air Handler •OSHPD FV 6/30/15 indicating we will be able to obtain Construction Final once the replacement air handler is installed and temporary air handler is removed.	06/22/2015

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{K 067}	Continued From page 4 detectors for air handlers at the 7th floor penthouse were inspected and tested. There was also no documented evidence of any inspection and testing of duct detectors for the new temporary air handler. During an interview, at the same time as the document review the VP of Corporate Facilities Operations stated that the Fire Alarm System Vendor/Technician has been testing the automatic shutdown devices continuously during the installation of the new fire alarm control panel and new temporary air handler, and that Fire Alarm System Vendor/Technician will retest the automatic shutdown devices again at the end of the project, and provide a written report. 2. On 6/4/15 the evaluator conducted a follow up visit for a complaint validation survey dated 2/5/15. As a result of the complaint validation survey dated 2/5/15 it was revealed through interview of the Lead Man, and review of the tower building's supply and exhaust conveyance document, that Tower floors 4, 5, and 6 (T-4, T-5, and T-6) had plenums as part of the buildings air distribution system. T-6, was a Med-Detox unit. T-5 had been used as turn around space to house patients while the cleaning from the fire incident was done at the Pavilion. T-4 was not on the facility's license and was not used for patients. T-2 was completely ducted and did not have a plenum as part of the floors air distribution system.	{K 067}	•OSHPD Notice of Start of Construction for New Permanent Air Handler. •OSHPD VR 6/3/15 indicating all devices have been tested •OSHPD FV 6/22/15 indicating OSHPD Fire Marshall issuing Occupancy for use of the Fire Alarm System. 2. Plan for Improvement: By making the modifications described above, the deficiency has been permanently corrected. 3. Expected Completion Date: This is complete, please see attached Certificate of Occupancy from OSHPD. Project # S142962-19-00 Issued by Fire Life Safety Officer. 4. Demonstrated Hospital Improvement Actions: Not only has this deficiency been eliminated, the air handlers will immediately shut down should the relays be removed or tampered with. The fire panel will also alarm indicating a problem with a relay. 5. Responsible Person(s): Dean Morford, Director of Facilities Operations, and Mark Stultz, VP of Corporate Facilities Operations.	

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{K 067}	Continued From page 5 The egress (exit) corridors of T-4, T-5, and T-6 were the same corridors used as a portion of the air supply (plenums). T-2, T-4, T-5, and T-6 were not sprinklered. T-2, T-4, T-5, and T-6 had smoke detectors in the corridors including at the elevator lobby. T-2, T-5, and T-6 had smoke detectors in the rooms. T-4 did not have smoke detectors in the rooms. On 6/4/15 at 1:25 p.m., during document review, OSHPD Verification Compliance Report dated 2/24/14 indicated that the Inspector of Record (IOR) inspected and tested the new fire alarm control panel and system in the "Tower Building" to be in full operation. That every device in the system had been tested and inspected for alarm, trouble, supervisory, ground fault, end of line voltage drop, air handler shut down, damper activation/operation, and dialer verification. During an interview, the VP of Corporate Facilities Operations stated that nothing had changed in the Tower building since the complaint validation survey dated 2/5/15. Per CMS S&C-06-18 letter dated 5/26/06, NFPA 90A, "Installation of Air Conditioning and Ventilating Systems" document, 1999 Edition prohibits egress (exit) corridors in health care occupancies from being used as a portion of the supply, return or exhaust air system serving adjoining areas (2-3.11.1, 1999 ed.). This prohibits the corridor from being used as a plenum.	{K 067}	1. Corrective Action: The hospital is requesting a variance for this deficiency. As per CMS S&C-06-18 criteria, citing a review of the fire alarm system pertaining to the corridor protection. The existing system, as installed and tested, contains full corridor coverage, with smoke detectors, and is interconnected to the existing ventilation system. Attachment •Description of Tower Building HVAC – Gevork Consulting Engineering 4/30/15. •Description of fire and smoke alarm interaction with ventilation System. 2. Plan for Improvement: The hospital is requesting a variance for this deficiency. 3. Expected Completion Date: The hospital is requesting a variance for this deficiency. 4. Demonstrated Hospital Improvement Actions: The mechanical system will be part of the annual fire system testing. 5. Responsible Person: Dean Morford, Director of Facilities.	04/30/2015

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{K 067}	Continued From page 6 The CMS S&C-06-18 letter dated 5/26/06, also indicated that in the cases where it is determined that the corridor is being used as a plenum and the deficiency is cited at tag K-067, a waiver may be granted. The letter further indicated that one of the criteria that should be used when considering the waiver request is that for partially sprinklered or unsprinklered buildings. if the zone with the corridor plenum is protected by a complete corridor smoke detection system, and there is provision for automatic fan shut down upon detection of smoke and activation of the building fire alarm system, a waiver may be recommended.	{K 067}		

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A 000	INITIAL COMMENTS The following reflects the findings of the Department of Public Health during a Full Sampled Validation Survey. Representing the Department of Public Health: Surveyor 17030, RN, HFEN Surveyor 11683, RN HFEN Surveyor 25524, RN, HFEN Surveyor 16281, REHS, HFE I Surveyor 14041, REHS, HFE I Surveyor 10933, Nutritional Consultant Surveyor 25049, Nutritional Consultant Surveyor 25049, MD, Medical Consultant Surveyor 29775, MD, Medical Consultant Surveyor 28851, Pharm D, Pharmacy Consultant Surveyor 32022, Pharm D, Pharmacy Consultant Total Population: 315 Total Sample Size: 52 On March 26, 2014, at 4:20 p.m., the survey team declared an Immediate Jeopardy (IJ) situation, in the presence of the chief nursing officer, director of risk management, and administrator of facility's Van Nuys campus, as a result of the facility's failure: To ensure the patients received care in an environment that assured the safety of the well-being of the patients in the facility's Psychiatric Unit 1 and Unit 2. On March 26, 2014, at 6 p.m., the IJ was abated in the presence of the director of risk management and administrator of the facility's Van Nuys campus.	A 000		

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A 043	482.12 GOVERNING BODY There must be an effective governing body that is legally responsible for the conduct of the hospital. If a hospital does not have an organized governing body, the persons legally responsible for the conduct of the hospital must carry out the functions specified in this part that pertain to the governing body ... This CONDITION is not met as evidenced by: Based on observation, interview, and record review, the facility's Governing Body failed to provide oversight for the operations of the hospital by failing to meet the following Condition of Participation: 1. For Patient Rights by the facility's inability to ensure and provide patients• rights in a safe patient care environment. (Refer to A 0115) 2. For Nursing Services the facility's failure to provide nursing services in safe patient care environment (refer to A 0385) 3. For Pharmaceutical Services, the facility's inability to ensure and provide Pharmacy services in a safe patient care environment. (Refer to A 0490) 4. Food and Dietetic Services, the facility's failure to provide organized dietetic services as evidenced by findings of unsafe food handling practices and inadequate supervision of the dietary department menus that were in compliance with nationally recognized practices, effective system to ensure that physician ordered diets were followed, adequate food and water were on hand for use in an emergency and policies and procedures, spreadsheets for the distribution of food. (refer to A 0618) 5. Physical Environment, the facility failed to	A 043	**ALL THREE CAMPUSES** **1-7). Corrective Actions**: Development of a roll up report **(see Addendum 1)** reflecting operations of the three campuses to ensure oversight and monitoring of Patient Right's, Nursing Services, Pharmaceutical Services, Food and Dietetic Services, Physical Environment, Infection Control & Surgical Services. **Date of Implementation:** First report to Governing Board will be July 1, 2014. **Monitoring Process:** All three campuses will monitor and report indicators for Patient Right's, Nursing Services, Pharmaceutical Services, Food and Dietetic Services, Physical Environment, Infection Control & Surgical Services. This report will be a standing agenda item for the three campuses. Report will be presented to the Quality Council, the Medical Executive Committee and the Governing Board. **Person Responsible:** Data gathering will occur by the appropriate Directors and reported to ACNO of each facility with the Quality Director and Executive CNO to aggregation and analysis data for final report through the committee process.	7/1/2014

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A 043	Continued From page 2 develop and maintain the physical plant in a manner that assured the safety of well-being of patients (Refer to A 0700) 6. Infection Control, the facility failed to develop an effective system for identifying, reporting and controlling infections on all three campuses. (Refer to A 0747) 7.Surgical Services, the facility's inability to provide safe and effective surgical services. (Refer to A 0940) The cumulative effects of these systemic failures resulted in the hospital's governing body inability to maintain appropriate oversight to assure quality health care in safe environment.	A 043	(continued from page 2)	
A 115	482.13 PATIENT RIGHTS A hospital must protect and promote each patient's rights. This CONDITION is not met as evidenced by: Based on observation, interview and document review, the facility failed to meet the Condition of Participation in Patient Right by failing to: 1. Ensure that 1 of 52 sampled patients (Patient 27) had the right to participate in the implementation of her care (Refer to A 130). 2. Ensure the patients were provided personal privacy while receiving care in the facility as well as patient's personal information for 1 of 52 sample patients and 2 randomly selected patients (Patients 53 and 60). This deficient practice violated the patient's right to personal privacy during care and to personal information (Refer to A 143).	A 115	**ALL THREE CAMPUSES:** **1).Corrective Actions:** Revision to policy PAT.001 Admission Assessment/Interdisciplinary Plan of Care to strengthen patient participation in care planning including management of patient pain levels. **Date of Implementation:** Staff in servicing beginning on June 19, 2014 with expected completion in 30 days. **Monitoring Process:** Monitoring of patient participation in their plan of care will be incorporated into the Patient Right's/Safety Rounds for the clinical areas of the three campuses. **Person Responsible:** Data gathering will occur by the appropriate Directors and reported to the Quality Director and Executive CNO for aggregation and analysis. **2).Corrective Actions**: Monitoring clinical units for maintaining patient privacy and access to patient health information (PHI). Computer Auto-logoff function enhanced to activate at 2 mins of inactivity across all three campuses. Implemented at Culver City on 3-26-14 and at Hollywood & Van Nuys will be completed on July 1, 2014. Audits performed by IT Dept are to reflect 100% compliance with maintaining 2 min auto-log off feature. **Date of Implementation:** Culver City implementation on March 26, 2014 & will be completed on July 1, 2014 for Hollywood & Van Nuys. **Monitoring Process:** Quarterly, the Culver City Security Specialist or technician will perform a review of the user templates in the McKesson Paragon Security application**.** Using the Logon Maintenance screen, Application Time-out values will be verified that they are set to 2 minutes for all clinical personnel who access patient information in open areas that would possibly compromise the privacy of patient data. The McKesson Paragon Security application is only accessible by the Information Systems personnel. Quarterly, the Hollywood & Van Nuys Security Specialist or technician will perform a similar review of the user templates in All Scripts. **Person Responsible:** Information Systems Directors	6/19/2014 3/26/2014

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	050135	A. BUILDING **01 – SOUTHERN CALIFORNIA HOSPITAL AT HOLLYWOOD** B. WING _____	**04/01/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN CALIFORNIA HOSPITAL AT HOLLYWOOD	**6245 DE LONGPRE AVE** **HOLLYWOOD, CA 90028**

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A 115	Continued From page 3 3. Ensure the patients received care in an environment that assured the safety of the well-being of the patients in the facility's psychiatric Unit 1 and 2 by: a. Having locksets on the bathroom doors that were lockable from the inside and required an emergency key to unlock from the outside in the bathroom of Patient 45 in Unit 1 and 16 patient bathrooms in Unit 2 and placed the 34 patients residing in the 16 rooms at risk for harm/injury. b. Failing to provide a closer observation such as a 1:1 observation to Patient 45, who presented with acute suicidal ideation as per facility's policies and procedures. Patient 45, who was identified as a suicide risk, was inside her bathroom and the door was locked. Patient 45 made two knots on both ends of a gown, placed it on top of the door sill and shut the door. Patient 45 locked the door when a staff member called out her name. The mental health worker tried to open the door, banged on the door and finally the door opened. The twisted gown and the patient slid to the floor. The patient was coughing and rubbing her neck. Patient 45 was transferred to a locked unit (Unit 2). (Refer to A 144) 4.Ensure that the staff protect each patient from any forms of abuse by ensuring the hospital staff had ongoing training program regarding abuse, neglect and related reporting requirements, including prevention, intervention, and detection. This deficient practice had the potential for not ensuring the patients are protected from all forms of abuse, neglect or harassment (Refer to A 145).	A 115	(Continued from page 3) **VAN NUYS** **3a) Corrective Actions:** All patients' bathroom locksets on both Unit 1 and Unit 2 were removed on 3/26/14 and new "pass through" door handle (non-lockable type) installed. Staff was in-serviced beginning 3/26/14 on the removal of "lockable type" door handles and replaced with the "non-lockable type "door handle on all patient bathroom doors to ensure patient safety. **Date of Implementation:** 3/26/14 **Monitoring Process:** On 4/16/14 we upgraded our visual inspection of the environment of care. We have implemented the "Licensed Staff EOC Safety Rounds" (coverage includes nurses station, contraband room, laundry room, etc.) and "Mental Health Worker EOC Safety Rounds" (coverage includes all patients rooms and bathrooms). These rounds are done twice daily to ensure safety throughout the units. Electronic Service Requests are filled out and sent to Engineering Department for any repairs or concerns. **Person Responsible:** Director of Engineering and Director of Nursing **3b) Corrective Actions**: Revisions made to Policy BHU.053 Precautions (under "Van Nuys Facility Specific: Suicide Precaution") to reflect the procedure (using the Suicide Potential Rating Scale) of which the Van Nuys facility had been following when assigning a level of suicide precautions during the patient's admission process. **Date of Implementation**: 6/16/14 **Monitoring Process:** Staff will be in serviced on utilizing the "Suicide Precautions Documentation Monitoring Checklist" tool and the "Suicide Potential Rating Scale". The checklist tool will be completed by the RN staff, given to the supervisor and/or nurse manager for monitoring when the need for a 1:1 with staff arises. This ensures that staff is utilizing both tools to take appropriate suicide precautions. **Person Responsible:** Nursing Director, Nurse Manager, and Supervisors **All Three Campuses** **4) Corrective Actions:** New hires will receive training regarding patient abuse, neglect, and reporting requirements as a part of their new hire onboarding process and at the New Hire Orientation (Initial Orientation Essentials 2014 and answer key. Existing employees at Culver City will receive the training as part of the Skills Fair which is held annually in the month of October; refer to the Culver City Skills Fair. For Hollywood and Van Nuys enhancement of the Annual Update Self-study guide, 2014 Annual update test, and Mandated abuse reporting training test. **Date of Implementation:** New hire training will begin with the next new hire orientation on Monday June 23, 2014 for Culver City. New hire training and test implemented on June 17, 2014. With Annual update sessions will commence in September, 2014 at Hollywood/Van Nuys locations. **Monitoring Process:** New hire orientation attendance is monitored through Human Resources and compliance with the Annual Skills Fair is monitored through the Education department. The Annual Skills fair will be held in October 2014. **Person Responsible:** Human Resources and Education departments.	3/26/2014 6/16/2014 6/17/2014 9/1/2014

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A 115	Continued From page 4 The cumulative effect of these systemic issues resulted in the facility's inability to ensure and provide a safe patient care environment.	A 115		
A 130	482.13(B) (1) PATIENT RIGHTS PARTICIPATION IN CARE PLANNING The patient has the right to participate in the development and implementation of his or her plan of care. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure 1 of 52 sampled patients (Patient 27) had the right to participate in the implementation of her care. Patient 27 complained of back pain to Licensed Vocational Nurse (LVN) 2 and wanted a pain medication. According to Patient 27, LVN stated, "You have to wait. I was there to chart while you were sleeping." Patient 27 stated LVN 2 refused to administer pain medication to her at that time of her request. This deficient practice failed to promote the right of the patient to participate in her care. Findings: During an interview with Patient 27 on March 24, 2014 at 5:20 p.m., she stated she complained of itching and back pain, pain scale was 10, (Pain scaled from 1 to 10 and 10 being the worst) to LVN 2 at 10:20 a.m. and wanted a pain medication. According to Patient 27, LVN stated, "You have to wait. I was there to chart while you were sleeping.' Patient 27 stated LVN 2 refused to administer pain medication to her at that time of her request.	A 130		

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A 130	Continued From page 5 The History and Physical report was reviewed and disclosed the patient was admitted on March 22, 2014, with left arm pain and history of end stage renal disease with hemodialysis treatment. According to the History and Physical report, the patient's dialysis access was on her left upper arm. A review of the Physician's Order Sheet disclosed "BenadryL 50 mg (milligram) IVP (intravenous PUSH) Q (every) 6 hour PRN (as needed) for itching" and "Dialudid 1 mg IVP Q 4 hours PRN for pain" were prescribed on March 22, 2014 at 6:30 a.m. The eMAR (electronic Medication Administration Record) was reviewed and disclosed that both Benadryl (for itching) and dialudid (for pain) were administered to Patient 27 at 11 a.m. During an interview with Staff R on March 24, 2014 at 5:45 p.m., he stated the facility would not tolerate LVN 2's behavior for not allowing Patient 27 to participate in the implementation of her care.	A 130	(continued from page 5) **CULVER CITY** **Corrective Actions:** Policy PAT.001 Admission Assessment/Interdisciplinary Plan of Care strengthened to reflect the patient participation in their care planning. Re-Educate all nursing staff on patient's to participate in the development and implementation of his/her pain management. Nursing staff to provide hourly rounds using the 5 "Ps" focuses on PAIN, POTTY, POSITION /PRIVACY and POSSESSIONS. All Nursing staff will complete Patient focused Sensitivity Training to include understanding of pain management. **Date of Implementation**: Policy to Medical Staff Dept. for Approval through Medicine Comm., Medical Exec Committee and Governing Board. Draft policy rolled out to staff June 18, 2014. Start education on 4/30/2014 full implementation within 30 days. **Monitoring Process:** Pt Liaison will conduct 30 random patient round observations per month to ensure 5 P's, sensitivity, and privacy is done on each unit. Findings of the rounds will be reported to the specific nursing director for corrective action. A monthly report will be provided to the Quality Department monthly. **Person Responsible:** Nursing Leadership for each department.	4/30/2014 6/18/2014
A 143	482.13(c)(1) PATIENT RIGHTS: PERSNAL PRIVACY The patient has the right to personal privacy. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure the patients were provided personal privacy while receiving care in the facility as well as patient's personal information for 1 of 52 sample patients (Patient 22) and 2 randomly selected patients (Patients 53 and 60). This deficient practice violated the patient's right to	A 143		

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A 143	Continued From page 6 personal privacy during care and to personal information. Findings: 1. On March 24, 2014, in the facility's Hollywood campus, the following was observed: a. At 10 a.m., during the initial tour of the 3rd floor, a cart was left unattended. The cart contained a bottle labeled Lothalamate Meglumine Injections USPS Cysto-Conray IM II, a cardex with a patient name and date of birth, a marker, couple of alcohol pads and primary plumset. During an interview with the respiratory therapist (RT), he stated he should not have left the cart which contained medication, supplies and especially the cardex with the patient name and date of birth. He stated he left the cart and went to check on a patient prior to a procedure. b. At 11:35 a.m., during provision of care observation, Registered Nurse 9RN) 28 did not fully draw the privacy curtain when conducting a body check on the randomly selected patient (Patient 53). The patient was wearing a diaper and was exposed from the waist down. The patient was in view of staff members and people passing by and by the nurses station. During a concurrent interview, RN 28 stated the privacy curtain should have been drawn to provide the patient with privacy.	A 143	(Continued from page 6) **HOLLYWOOD** **1a). Corrective Actions**: Staff meeting and education held with Respiratory staff to include securing 02 tanks in proper and designated locations, ensure that no meds and patient identifiers are left on carts or EKG machines. **Date of Implementation:** March 25, 2014 **Monitoring Process:** Will be monitored by RT lead and RT staff daily and to be included in EOC rounds **Person Responsible:** Respiratory Department **1b). Corrective Actions**: Education provided to include Patient rights and privacy. EOC rounds on all nursing department, replaced any missing curtains and ensure appropriate size and length **Date of Implementation:** Education provided April 3-5, 2014; EOC/missing curtains replaced March 27, 2014 **Monitoring Process:** Monitoring will be managed through daily rounds and EOC rounds **Person Responsible:** Nursing leadership in each department and EOC members, ENG, EVS	3/25/2014 3/27/2014 4/3/2014

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A 143	Continued From page 7 c. At 2:30 p.m., during an initial tour of the Urgent Care Unit, there were five (5) patients awaiting for the disposition of their visits. Patient 22 was seen at 10:05 a.m. for pain on bilateral legs. The patient also manifested behavior such as talking out loud continuously with agitated features. During a concurrent interview, RN 29 stated the patient could have been provided a calmer and private environment at the time the patient was manifesting agitation and talking out loud to self. d. At 12:40 p.m., during an observation tour of the Medical/Surgical floor, the randomly selected patient (Patient 60) was lying in bed. The patient was exposed from the waist down, the patient was wearing a diaper, and was in full view of the facility staff members passing by the patient's room. During a concurrent interview, RN 31, who was observed passing by patient's room, stated she would be checking the patients for privacy issues as she was conducting her rounds. 2. In the facility's Culver City campus, on March 25, 2014, at 9:50 a.m., during a tour of the unit, Patient 52 was observed in his room lying in bed. His hospital gown was raised up to his waist exposing his diapers, thighs and legs. RN 13 was observed seating by the hallway across from the patient's room and working on	A 143	(Continued from page 7) **1c). Corrective Actions:** Waiting room created and triage room created in the urgent care to provide privacy and for those patients waiting for disposition and waiting to be seen. **Date of Implementation:** March 28, 2014 **Monitoring Process:** Monitoring will be managed by urgent care staff, nursing supervisor will perform hourly rounding in Urgent care **Person Responsible:** Nursing Leadership and EOC members, ENG **1d).Corrective Actions:** Education provided to include Patient rights and privacy. EOC rounds on all nursing department, replaced any missing curtains and ensure appropriate size and length. **Date of Implementation:** Education provided April 3-5, 2014; EOC/missing curtains replaced March 27, 2014 **Monitoring Process:** Monitoring will be managed through daily rounds and EOC rounds **Person Responsible:** Nursing leadership in each department, Environment of care, Engineering, & Environmental Services. **CULVER CITY** **2a) Corrective Actions**: Re-Educate all nursing staff on patient's right to personal privacy and our responsibility to ensure patient privacy. Nursing staff will provide hourly round using the 5 "Ps" focuses on PAIN, POTTY, POSITION /PRIVACY and POSSESSIONS. All Nursing staff will complete Patient focused Sensitivity Training and will receive a certificate upon completion. Patient Liaison will conduct daily rounds to ensure patient's privacy rights are upheld. **Date of implementation**: Start education on 4/30/2014 full implementation on **Monitoring Process:** Pt liaison will conduct 30 patient round observations per month to ensure 5 P's, sensitivity, and privacy is done on each unit. Findings of the rounds will be reported to the specific nursing director for corrective action. A monthly report will be reported to the Quality Department monthly. Super users are collecting data on pain scale prior and after receiving pain medication this information is also sent to the quality department monthly. **Person Responsible:** Nursing Leadership from each department **2b) Corrective Actions:** Policy PAT.025 Patient Rights and Responsibilities and Procedure strengthened to reflect the patient's right to personal privacy. Computer Auto-logoff function enhanced to activate at 2 mins of inactivity. Implemented on 3-26-14. Audits performed by IT Dept. reflect 100% compliance with maintaining 2 min auto-log off feature. **Date of Implementation:** Revised policy to Medical Staff Dept. for Approval through Quality Council, Medicine Committee, Medical Exec Committee and Governing Board. Draft policy rolled out to staff June 18, 2014	3/28/2014 3/27/2014 4/3/2014 4/30/2014 6/18/2014

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A 143	Continued From page 8 the computer. The patient was in full view of the licensed nurse. The environmental staff and other facility staff members were observed passing by the hallway while patient lay exposed in view of them. RN 13 stood up and went to attend to a patient in another room and left the computer screen showing with a patient name, visit ID number and other information that relates to the patient. During a concurrent interview, RN 13 stated that she was not aware the patient was exposed. She further stated that she should have exited the computer screen with patient's information before she went to another patient's room.	A 143	(continued from page 8) **Monitoring Process**: On a quarterly basis, the Security Specialist or technician will perform a review of the user templates in the McKesson Paragon Security application. Through the Logon Maintenance screen, Application Time-out values will be verified that they are set to 2 minutes for all clinical personnel who must access patient information in open areas that would possibly compromise the privacy of patient data. The McKesson Paragon Security application is only accessible by the Information Systems personnel. **Person Responsible:** Nursing Leadership for each department; Information Systems Department Security Specialist or technician. **HOLLYWOOD** **Corrective Actions**: EMR Education/re-training provided to include utilizing 'suspend' function as manual log-off procedure. Computer Auto-logoff function will be enhanced to activate at 2 mins of inactivity, target date of completion in 30 days July 17, 2014. Re-education started June 18, 2014 will be completed June 30, 2014. **Date of Implementation**: Education provided April 16, 2014 full implementation May 6, 2014 and target date as of July 17, 2014 after upgrade; re-education started June 18, 2014 to be completed June 30, 2014 **Monitoring Process:** Audits by IT Dept. to reflect 100% compliance with maintaining 2 min auto-log off feature.	4/16/2014
A 144	482.13(c)(2) PATIENT RIGHTS: CARE IN SAFE SETTING The patient has the right to receive care in a safe setting. This STANDARD is not met as evidenced by: On March 26, 2014, at 4:20 p.m., the survey team declared an Immediate Jeopardy (IJ) situation, in the presence of the chief nursing officer, director of risk management, and administrator of facility's Van Nuys campus, as a result of the facility's failure: To ensure the patients received care in an environment that assured the safety of the well-being of the patient's in the facility's Psychiatric Unit 1 and 2. On March 26, 2014, at 6 p.m., the IJ was abated in the presence of the director of risk management and the administrator of the facility's	A 144		

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A 144	Continued From page 9 Van Nuys campus. Based on observation, interview and record review, the facility failed to ensure the patients received care in an environment that assured the safety of the well-being of the patients in the facility's psychiatric Unit 1 and 2 by: 1. Having locksets on the bathroom doors that were lockable from the inside and required an emergency key to unlock from the outside in the bathroom of Patient 45 in Unit 1 and 16 patient bathrooms in Unit 2 and laced the 34 patients residing in the 16 rooms at risk for harm/injury. 2. Failing to provide a closer observation such as a 1:1 observation to Patient 45, who presented with acute suicidal ideation as per facility's policies and procedures. Patient 45, who was identified as a suicide risk, was inside her bathroom and the door was locked. Patient 45 made two knots on both ends of a gown, placed it on top of the door sill and shut the door Patient 45 locked the door when a staff member called out her name. The mental health worker tried to open to door, banged on the door and finally the door opened. The twisted gown and the patient slid to the floor. The patient was coughing and rubbing her neck. Patient 45 was transferred to a locked unit (Unit 2). Findings: 1. On March 24, 2014, at 11:20 a.m., during an initial tour of the activity room of the locked unit (Unit 2) in the facility's psychiatric campus, Patient 45 was observed sitting in a chair and talking with another patient. During an	A 144	(Continued from page 9) **Van Nuys** **1).Corrective Actions:** All patients' bathroom locksets on both Unit 1 and Unit 2 were removed on 3/26/14 and new "pass through" door handle (non-lockable type) installed. Staff was in-serviced beginning 3/26/14 on the removal of "lockable type" door handles and replaced with the "non-lockable type "door handle on all patient bathroom doors to ensure patient safety. **Date of Implementation:** 3/26/14 **Monitoring Process:** Since 4/16/14 we upgraded our visual inspection of the environment of care. We have implemented the "Licensed Staff EOC Safety Rounds" (coverage includes nurses station, contraband room, laundry room, etc.) and "Mental Health Worker EOC Safety Rounds" (coverage includes all patients rooms and bathrooms). These rounds are done twice daily to ensure safety throughout the units. Electronic Service Requests are filled out and sent to Engineering Department for any repairs or concerns. **Person Responsible:** Director of Engineering and Director of Nursing **2).Corrective Actions:** Policy PAT.025 Patient Rights and Responsibilities and Procedure strengthened to reflect the patient's right to receive care in a safe setting. Revision made to Policy BHU.053 Precautions (under "Van Nuys Facility Specific: Suicide Precaution") to reflect the procedure (using the Suicide Potential Rating Scale) of which the Van Nuys facility will follow when assigning a level of suicide precautions during the patient's admission process. **Date of Implementation**: 6/16/14 **Monitoring Process:** Staff will be in serviced on utilizing the "Suicide Precautions Documentation Monitoring Checklist" tool and the "Suicide Potential Rating Scale" The checklist tool will be completed by the RN staff, given to the supervisor and/or nurse manager for monitoring when the need for a 1:1 with staff arises. This ensures that staff is utilizing both tools to take appropriate suicide precautions. **Person Responsible:** Nursing Director, Nurse Manager, and Supervisors	3/26/2014 6/16/2014

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A 144	Continued From page 10 interview at the same time of the observation, Mental Health Worker (MHW) 1 stated Patient 45 was on a 1:1 (observed by one staff member at all times) observation because the patient had attempted to hang herself on Friday (March 21, 2014). On March 24, 2014, Patient 45's medical record was reviewed. The Admission Psych Note Nursing dated March 20, 2014, at 4:52 p.m., disclosed Patient 45 was admitted from an acute care hospital via ambulance, on a voluntary status, and her chief complaint was depression with suicidal ideations and plan to overdose. Patient 45's mental status included uncooperative, guarded, eye contact was inconsistent, hopeless/helpless, depressed, anxious, irritable, and with a flat affect. The Interdisciplinary Patient Progress Record dated March 21, 2014, at 5 a.m., disclosed "Patient appeared to sleep well through the night. Patient had no signs of distress. Continue to monitor for safety." The interdisciplinary Patient Progress Record dated March 21, 2014, at 11:05 a.m., disclosed "Patient had very poor visibility in the milieu." Patient 45's mood was blunt (failure of a person to display emotion affect) and depressed. Patient 45 ate breakfast then went to her room to sleep. Patient 45 refused group therapy despite the prompts, non-social with peers, guarded, and suspicious on approach. The interdisciplinary Patient Progress Record dated March 21, 2014, at 6 p.m., disclosed Patient 45 was noted with episodes of crying and anxious. Patient 45 required prompting with her	A 144		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN CALIFORNIA HOSPITAL AT HOLLYWOOD	**6245 DE LONGPRE AVE HOLLYWOOD, CA 90028**

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A 144	Continued From page 11 medications and to attend group therapy. Her appearance was unkempt and disheveled. Patient 45 had poor grooming. The staff indicated “will continue to monitor for safety.” A review of the facility’s report disclosed an incident occurred on March 21, 2014, at 8:15 p.m., in Unit 1 (open unit) in Patient 45’s bathroom. MHW 2 was conducting visual inspection of Patient 45’s room and Patient 45 was not in the room. Patient 45 was in the bathroom and the door was locked. MHW 2 observed part of Patient 45’s gown was hanging at the top of the door. As MHW 2 approached the bathroom door, he called out Patient 45’s name. The door was completely locked and he (MHW 2) was unable to open the door. MHW 2 heard a loud thump sound coming from the bathroom and heard gurgling sounds coming from Patient 45. MHW 2 yelled, “Code Blue, Nurse” as he banged on the bathroom door. The bathroom door opened and Patient 45 “landed on the floor.” A nurse came in the room and assessed Patient 45. The Interdisciplinary Patient Progress Record documented by the Registered Nurse (RN) dated March 21, 2014, at 8:10 p.m., disclosed Patient 45 was inside her bathroom and the door was locked. Patient 45 made two (2) knots on both ends of a gown, placed it on top of the door sill and shut the door. As the MHW attempted to call her name, Patient 45 locked the door. Patient 45 made a loud thump sound and began making choking sounds. Code Blue (life threatening medical emergency) was called. The MHW continued to try to open the door, banged on the door and finally the door opened. The twisted gown and the patient slid to the floor. Patient 45	A 144		

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A 144	Continued From page 12 was coughing and rubbing her neck. Patient 45 was awake and responding that she was able to breathe. The physician was notified and Patient 45 was transferred to Unit 2 (locked unit). On March 24, 2014, at 12:25 p.m., during an interview with Staff H (assistant chief nursing officer), he stated Patient 45 was placed on 1:1 observation for safety and the action plan for the incident was pending. Staff H stated there were no changes to the lock of the bathroom door of Patient 45. An interview with Staff H and Staff M (maintenance supervisor) was conducted on March 25, 2014, between the hours of 8:45 a.m. and 11:20 a.m. When asked about how to prevent this incident from occurring, Staff H stated there was no action plan yet until the quality/risk department reviews the incident. At 11:20 a.m., Staff M stated he was aware of Patient 45's incident. Staff M stated that there was a "pin" key at the nurses' station to unlock the patients' bathrooms. Staff M stated that after the renovation in this unit, there was no written policy regarding the use of pin key to the patients' bathrooms. Staff M further stated the nurses were aware and should have communicated to each other. Staff M stated, "I told the use of the pin key to one nurse and I assumed she would pass it on to other nurses." On March 25, 2014, between the hour or 8:45 a.m. and 9 a.m., an observation of Room 108's bathroom door revealed a lockset on the bathroom door that was lockable from the inside. During a concurrent interview, RN 8 stated the "pin" key was kept in the Medication Room and at the nurses' station. When asked to show the "pin"	A 144		

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A 144	Continued From page 13 key, RN 8 did not present the key to the surveyor. On March 25, 2014, between the hours of 8:30 a.m. and 11:00 a.m., the patient room bathrooms in Unit 2 (locked unit), including those in Rooms 203, 205, 207, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 222, 226, had locksets on the bathroom doors that were lockable from the inside and required an emergency key to unlock them from the outside. On March 25, 2014, between the hour 10:15 a.m. and 11:00 a.m., during interviews of two RN at Unit 2 nurses station, RN 23 stated we don't have the pin (emergency key) and RN 24 stated, "I don't know where the pin is." A review of the facility's census list for March 24, 2014 for Unit 2 (locked unit) disclosed there were 34 patients residing in the sixteen (16) patient rooms of Unit 2 (Rooms 203, 205, 207, 209, 210, 211, 212, 213, 214, 215, 217, 218, 219, 220, 222 and 226). Each patient room had a bathroom. The census lists indicated that for the census on March 24, 2014, there were 20 patients in Unit 1 and 35 patients in Unit 2. For the census on March 25, 2014, there were 16 patients in Unit 1 and 33 patients in Unit 2. For the census on March 26, 2014, there were 21 patients in Unit 1 and 35 patients in Unit 2. On March 26, 2014, at 4:20 p.m., the survey team declared an Immediate Jeopardy situation, in the	A 144		

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A 144	Continued From page 14 presence of the chief nursing officer director of risk management, and administrator of facility's Van Nuys campus, as a result of the facility's failure to ensure the patients received care in an environment that assured the safety of the well-being of the patients in the facility's psychiatric campus by not having locksets on the bathroom doors that were lockable form the inside and required an emergency key to unlock from the outside. On March 26, 2014 at 5:35 p.m., the administrator provided photographs of room 108's bathroom with the lock removed. On March 26, 2014, at 6 p.m., the IJ was abated in the presence of the director of risk management and the administrator of Van Nuys campus. A review of the facility's letter to the Immediate Jeopardy, dated March 26, 2014, disclosed one (1) patient bathroom on Unit 1 (room 108) and sixteen (16) patient bathrooms on Unit 2 (locked unit), in which the door, when locked from the inside, could not easily be opened from the outside without a special key. The staff did not have access to the key and that they had to contact maintenance to open the door. The facility's letter indicated the corrective actions included removing the door locks from 16 patient bathrooms on Unit 2 (locked unit). The staff would be inserviced on the short term plan beginning the evening of March 26 2014. On March 27, 2014, at 10:15 a.m., during a tour of the facility at the Van Nuys campus with the hospital administrator and the vice president of	A 144		

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A 144	Continued From page 15 pharmacy operations ,the surveyors observed that all bathroom door locks in the patient rooms of Unit 1 and 2 have been removed. The hospital administrator started new locks were ordered. 2. On March 24, 2014, Patient 45's medical record was reviewed. The Admission Psych Note Nursing dated March 20, 2014, at 4:52 p.m., disclosed Patient 45 was admitted from an acute care hospital via ambulance, on a voluntary status, and her chief complaint was depression with suicidal ideations and plan to overdose. Patient 45's mental status included uncooperative, guarded, eye contact was inconsistent, hopeless/helpless, depressed, anxious, irritable, and with a flat affect. The Interdisciplinary Patient Progress Record dated March 21, 2014, at 5 a.m., disclosed "Patient appeared to sleep well through the night. Patient had no signs of distress. Continue to monitor for safety." The Interdisciplinary Patient Progress Record dated March 21, 2014, at 11:05 a.m., disclosed "Patient had very poor visibility in the milieu" Patient 45's mood was blunt (failure of a person to display emotion affect) and depressed. Patient 45 ate breakfast then went to her room to sleep. Patient 45 refused group therapy despite the prompts, non-social with peers, guarded, and suspicious on approach. The Interdisciplinary Patient Progress Record dated March 21, 2014, at 6 p.m., indicated Patient 45 was noted with episodes of crying and anxious. Patient 45 required prompting with her	A 144		

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A 144	Continued From page 16 medications and to attend group therapy. Her appearance was unkempt and disheveled. Patient 45 had poor grooming. The staff indicated “will continue to monitor for safety.” A review of the facility’s report disclosed an incident occurred on March 21, 2014, at 8:15 p.m., in Unit 1 (open unit) in Patient 45’s bathroom. MHW 2 was conducting visual inspection of Patient 45’s room and Patient 45 was not in the room. Patient 45 was in the bathroom and the door was locked. MHW 2 observed part of Patient 45’s gown was hanging at the top of the door. As MHW 2 approached the bathroom door, he called out Patient 45’s name. The door was completely locked and he (MHW 2) was unable to open the door. MHW 2 heard a loud thump sound coming from the bathroom and heard gurgling sounds coming from Patient 45. MHW 2 yelled, “Code Blue, Nurse” as he banged on the bathroom door. The bathroom door opened and Patient 45 “landed on the floor.” A nurse came in the room and assessed Patient 45. The Interdisciplinary Patient Progress Record documented by the Registered Nurse (RN) dated March 21, 2014, at 8:10 p.m., disclosed Patient 45 was inside her bathroom and the door was locked. Patient 45 made two (2) knots on both ends of a gown, placed it on top of the door sill and shut the door. As the MHW attempted to call her name, Patient 45 locked the door. Patient 45 made a loud thump sound and began making choking sounds. Code Blue (life threatening medical emergency) was called. The MHW continued to try to open the door, banged on the door and finally the door opened. The twisted gown and the patient slid to the floor.	A 144		

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A 144	Continued From page 17 Patient 45 was coughing and rubbing her neck. Patient 45 was awake and responding that she was able to breathe. The physician was notified and Patient 45 was transferred to Unit 2. According to the Admission Psych Note Nursing dated March 20, 2014, at 4:52 p.m., Patient 45 was screened for suicide risk. Patient 45's suicide total score was 13. The Risk Screen section of the Admission Psych Note dated March 20, 2014, indicated the score from 10 to 19 is under "Suicide Precaution 1" which indicated the patient required every 15 minutes monitoring. A review of the Patient Close Observation Status dated March 21, 2014 from 12 a.m. to 11:45 a.m. to 8:15 p.m., revealed the staff conducted a visual inspection to Patient 45 every 15 minutes, instead of a 1 to 1 observation. Additionally, the Admission Psych Note Nursing dated March 20, 2014, at 4:52 p.m., indicated Patient 45 had recent (acute) previous attempts of suicide ideation within the past 36 hours, prior to admission. According to the facility's policy and procedure titled, "Admission Criteria," dated November 2012, under General Admission Procedures Section 4.2.57. disclosed any patient that presented with acute suicidal ideation and required a 1:1 based on the suicide potential rating scale, shall be admitted to a unit with a staff member present as 1:1 observation. A review of the facility's policy and procedure titled, "Precautions" dated November 2012, stipulated the purpose of the policy was to assure heightened awareness of special identified	A 144		

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A 144	Continued From page 18 circumstances that could impact patient safety. The objectives of the policy included to assess each patient for suicide potential and to provide monitoring accordingly to the level of determined suicide risk. The procedure for Suicide Precaution (SP) 4.2.14 disclosed the patients who scored at an intermediate risk for Suicide Precaution with a score of 10 to 19 shall have closer observations initiated. The precaution will be noted as “Suicide Precaution 1.” An email communication from Staff B (corporate vice president/quality risk management) dated April 9, 2014, at 4:22 p.m., disclosed closer observations meant that the patient would have 1 to 1 observation.	A 144		
A 145	482.13(c)(3) PATIENT RIGHTS: FREE FROM ABUSE/HARASSMENT The patient has the right to be free from all forms of abuse or harassment. This STANDARD is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure that the staff protect each patient from any forms of abuse by ensuring the hospital staff had ongoing training regarding abuse, neglect and related reporting requirements, including prevention, intervention, and detection. This deficient practice had the potential for not ensuring the patients are protected from all forms of abuse, neglect or harassment. Findings: On March 24, 2014, at 11:02 a.m., a review of the employee files indicated that 2 of 5 files did not	A 145	**ALL THREE CAMPUSES** **Corrective Actions:** New hires will receive training regarding patient abuse, neglect, and reporting requirements as a part of their new hire onboarding process and at the New Hire Orientation (Initial Orientation Essentials 2014 and answer key. Existing employees at Culver City will receive the training as part of the Skills Fair which is held annually in the month of October; refer to the Culver City Skills Fair.For Hollywood and Van Nuys enhancement of the Annual Update Self-study guide, 2014 Annual update test, and Mandated abuse reporting training test**.** **Date of Implementation**: New hire training will begin with the next new hire orientation on Monday June 23, 2014 for Culver City. New hire training and test implemented on June 17, 2014. Annual update sessions will commence in September, 2014 at Hollywood/Van Nuys locations. **Monitoring Process:** New hire orientation attendance is monitored through Human Resources and compliance with the Annual Skills Fair is monitored through the Education department. The Annual Skills fair will be held in October 2014. **Person Responsible:** Human Resources and Education departments.	6/17/2014

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A 145	Continued From page 19 have documentation that the employees received ongoing abuse training. During an interview with Human Resources Staff 1, she stated the employees had abuse training during their initial orientation. She further stated there was no ongoing training after orientation which provided all employees with information regarding abuse prevention. In addition, the employee files indicated some employees were hired in 2003 and 2008 and there was no ongoing training for abuse and neglect, and related reporting requirements. An email communication dated April 9, 2014, at 4:22 p.m., from Staff B (corporate vice president/quality risk management) provided two (2) POLICIES AND PROCEDURES ON Domestic Violence Assessment and Reporting dated April 2007 and Social Services dated November 2012. However, there was no documented evidence that addressed staff training on abuse prevention on an ongoing basis.	A 145	(Continued from page 19)	
A 385	482.23 NURSING SERVICES The hospital must have an organized nursing service that provides 24-hour nursing services. The nursing services must be furnished or supervised by a registered nurse. This CONDITION is not met as evidenced by: Based on observation, interview and document review, the facility failed to meet the Condition of Participation in Nursing Services by failing to: 1. Having a monitor technician to provide continuous electrocardiographic (ECG) monitoring for 10 patients that required ECG telemetry monitoring (continuous monitoring of a	A 385	**Culver City** **1).Corrective Actions:** Effective immediately (6-12-14) ICU, CCU & SDU are consistently staffed with a Monitor Tech 24 hours a day/7 days a week for all units with cardiac monitors or Telemetry systems. The Monitor Tech for each unit is reflected on the Staffing Assignment record for each shift **.**The Staffing Matrix guiding staffing levels has been adjusted to ensure monitor tech for ICU, CCU & SDU for each shift. **Date of Implementation:** June 12, 2014 **Monitoring Process:** Daily review of staffing to ensure Monitor Tech for each functioning ICU & CCU each shift. **Person Responsible:** Nursing Director of Critical Care Units & House Supervisors.	6/12/2014

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A 385	Continued From page 20 patient's heart rate and rhythm at a remote location) in the Critical Care Unit (CCU) and Surgical Intensive Care Unit (ICU). This deficient practice had the potential for not detecting abnormal heart rhythm timely which could result to life threatening heart condition that required immediate intervention (Refer to A 392). 2. Provide non-pharmacological interventions for managing Patient 22's pain (Refer to A 395). This deficient practice had the potential for not meeting the physical and mental needs of the patient. 3. Ensure Patient 24's bedside did not have medications and supplies for a wound treatment. This deficient practice had the potential for administering the cleanser and supplies for the treatment of Patient 24's wound which may not be concordance with the physician's order (Refer to A 395). 4. Document the wound type, size, and depth during the initial assessment and reassessment, failing to reassess the wounds on March 16 and 23, 2014, and failing to provide treatments as ordered by the physician on Patient 14's left food pressure ulcer from March 7 to March 20, 2014 (a total of 11 days). This deficient practice had the potential to result in delay of the healing of the pressure ulcer (Refer to A 395). 4. Provide oral care to Patient 16 who was dependent on staff in his activities of daily living and was observed with dry lips and mouth odor. This deficient practice did not maintain the patient's oral hygiene and had the potential to result in undetected problems in the patient's oral	A 385	(Continued from page 20) **2).Corrective Actions**: Re-Educate all nursing staff on patient's right to personal privacy and our responsibility to ensure patient privacy. Nursing staff will provide hourly round using the 5 "Ps" focuses on PAIN, POTTY, POSSISON /PRIVACY and POSSESSIONS. All Nursing staff will complete Patient focused Sensitivity including non-RX comfort measures Patient Liaison will conduct daily rounds to ensure patient's privacy rights are upheld. **Date of implementation:** Start education on 4/30/2014 with full implementation within 30 days. **Monitoring Process:** Patient liaison will conduct 30 patient round observations per month to ensure 5 P's, sensitivity, and privacy is done on each unit. Findings of the rounds will be reported to the specific nursing director for corrective action. A monthly report will be reported to the Quality Department monthly. Super users are collecting data on pain scale prior and after receiving pain medication this information is also sent to the quality department monthly **Person Responsible**: Nursing Leadership from each department **3).Corrective Actions:** (Patient # 24) Re-education of nursing staff related to proper securing and storage of medications utilizing self-study module & policy "Mediation Storage PHA.045. **Date of Implementation:** 06/13/2014 **Monitoring Process**: Education will be monitored by certification upon completion of online self-study module. Wound Management Team Member to perform thirty Patient room audits, per month including location and securing of medications and products each month. Any issue of non-adherence will be addressed to the individual staff and referred to Quality department for further intervention as necessary including education and progressive disciplinary action. **Person Responsible:** Wound Management Team. **4).Corrective Actions:** Re-education of nursing staff related to wound characteristics as shown in wound photographs; to include size (LxWxD), shape, drainage, color, odor. (See Wound Record Attachment and Policy revision WOU.001. Educate nursing staff with regard to documentation of wound care treatment in McKesson under "integumentary tab." **Date of Implementation:** 6/13/2014 **Monitoring Process**: Wound Management Team Member to audit photo documentation on 30 wound record during patient rounds.Any issue of non-adherence will be addressed to the individual staff and referred to Quality department for further intervention as necessary including education and progressive disciplinary action. In addition, Wound Management Team Member to perform thirty audits, per month including documentation of treatments. **Person Responsible:** Wound Management Team. **4a). Corrective Actions:** Re - Educate all Registered nurses on supervising and evaluating the care for each patient. Nursing staff will provide hourly rounds using the 5 "Ps" focuses on PAIN, POTTY, POSITION /PRIVACY and POSSESSIONS. All Nursing staff will complete Patient focused Sensitivity Training including the importance of patient hygiene. **Date of implementation:** start education on 6/16/2014 full implementation within 30 days. **Monitoring Process:** On-line self-study module: Certification upon completion. . **Person Responsible**: Nursing Leadership from each department	4/30/2014 6/13/2014 6/13/2014 6/16/2014

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A 385	Continued From page 21 cavity. (Refer to A 395). 5. Ensure Patient 17 admitted to the psychiatric unit as ordered by the physician when there was bed available in accordance with the facility's census report for the psychiatric unit. This deficient practice had the potential for not meeting the psycho-social needs of the patient (Refer to A 395). 6. Ensure Patient 18 was administered Lisinopril medication (treat elevated blood pressure) as ordered by the physician. This deficient practice failed to ensure the physician's order for Lisinopril medication was implemented for Patient 18 (Refer to A 395). 7. Ensure Patient 15 was administered Risperdal medication (psychoactive medication) as ordered by the physician. This deficient practice did not ensure the physician's order for Risperdal medication was implemented for Patient 18 and had the potential for not meeting the psycho-social needs of the patient (Refer to A 395). 8. Evaluate Patient 45 after she had attempted to hang herself in the bathroom. This deficient practice had the potential for not identifying any physical condition related to her attempt to hang herself which may required interventions (Refer to A 395). 9. Ensure the nursing staff developed and kept current a nursing care plan for 8 of 52 sample patients (Patient 14, 25, 26, 29, 31, 32, 45 and 46). This deficient practice had the potential for not providing appropriate interventions to meet the needs of each patient (Refer to A 396).	A 385	(Continued from page 21) **5).Corrective Actions**: Policy Scope of Service- Emergency Department/urgent care #SOS.013 When it is anticipated that psychiatric patients will wait greater than 23 hours for a bed placement, calls are made to psychiatric facilities in other areas to determine if an appropriate bed is available and an evaluation shall be done for possible transfer and placement**.** Total census for BHU was 70 on March 23 & 24. On March 25, 2014, beds 624A & 624B were out of service because of plumbing concerns resulting in the flooding of the room. Bed 603A & 603B were also out of service due to bed bug infestation. All 4 beds were not in service House supervisors will monitor and track bed availability to decrease ER wait times. During the time bed placement is pending, patients are monitored under close observation. ER Staff will follow BHU.006 Close Observation Policy**.** **Date of Implementation:** 4/30/2014 **Monitoring Process:** House Supervisors monitor bed availability throughout the day utilizing the bed tracker system. At 6am, 3pm, 6pm, & 9pm, the house supervisor records the hospital census on the Supervisor ANS report**.** **Person Responsible:** House Supervisor /Nursing leadership **CULVER CITY** **6&7). Corrective Actions**: All nursing staff re-educated with self-study module to validate that physician orders have been noted, examined, and verified. Caregivers must use SBAR and provide the opportunity to use read-back techniques and medications orders received must be read back by the receiver. 24 hour order/chart check policy & procedure PAT.059 implemented that mandates documentation of chart review before 7am each day. **Date of Implementation:** 5/18/2014 **Monitoring Process**: Random audit of 30 charts will be done per nursing unit aggregated data will be sent to the Quality Dept., non-compliance will result in progressive discipline actions. **Person Responsible**: Nursing Leadership **8) Corrective Actions:** Re-educate all Registered Nurses on the importance of Head to Toe Assessment immediately after any patient placed on 1:1 with staff. In-service staff and provide the "Suicide Precaution Documentation Monitoring Checklist" tool which includes a "head to toe assessment" section for check off. **Date of Implementation:** 6/16/14 **Monitoring Process:** Director of Nursing and/or designee will conduct monitoring activity on the checklist tool submitted by staff the same day the incident occurs to ensure that the requirements and documentation monitoring tool has been completed to include the (head to toe)physical assessment. **Person Responsible:** Nursing Director, Nurse Manager, and Supervisors **9) Corrective Actions:** Re-educate/in-service the night shift staff on the existing "Nightly Chart Audit". This audit includes a check off section for "Nursing Care Plan/Pain. Re-educate the supervisors who perform the already existing audit "Pain Management Audit Monitoring Tool". Re-educate supervisors to complete the treatment plan for pain as needed while auditing. Policy PAT.001 Admission Assessment/Interdisciplinary Plan of Care strengthened the development of care plans and maintaining current nursing care plan for each patient. Enhancement/ development of electronic care plans for pressure ulcers, contact isolation, suicidal risk, hemodialysis treatments, seizure disorders and chronic pain. **Date of Implementation:** 6/16/14 **Monitoring Process:** The Nursing Director and/or designee will implement monitoring by auditing of pain medication orders every (24) hours. Auditing will begin with (10) random charts per day with target compliance set at 100%. Super Users will assist by auditing a minimum of 30 charts a month and report findings to quality department. **Person Responsible:** Nursing Director	4/30/2014 5/18/2014 6/16/2014 6/16/2014

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	050135	A. BUILDING **01 – SOUTHERN CALIFORNIA HOSPITAL AT HOLLYWOOD** B. WING _____	**04/01/2014**

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SOUTHERN CALIFORNIA HOSPITAL AT HOLLYWOOD	**6245 DE LONGPRE AVE HOLLYWOOD, CA 90028**

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A 385	Continued From page 22 10. Ensure the patient would only receive medications or supplement that were prescribed by the physician for 1 of 52 sample patients (Patient 7). This deficient practice resulted in Patient 7 receiving a dietary supplement that was not ordered by the physician (Refer to A 405). The cumulative effect of these systemic issues resulted in the facility's inability to ensure and provide a safe patient care environment.	A 385	(Continued from page 22) **10).Corrective Actions:** Development of PAT.059 24 hour Order/Chart Check policy to ensure patient records are consistently reviewed to validate orders and ensure they are carried out as well as to identify any discrepancies or inaccuracies between orders and actual patient care. Will also ensure documentation has occurred for any medications, treatments, or tests not performed and the explanation as to why. **Date of Implementation:** June 23, 2013 **Monitoring Process:** Monitoring of compliance with random review of 30 patient medical records a month for clinical areas with reporting to the Quality Council. **Person Responsible:** Nursing Director	6/23/2014
A 392	482.23(b) STAFFING AND DELIVERY OF CARE The nursing service must have adequate numbers of licensed registered nurses, licensed practical (vocational) nurses, and other personnel to provide nursing care to all patients as needed. There must be supervisory and staff personnel for each department or nursing unit to ensure, when needed, the immediate availability of a registered nurse for bedside care of any patient. This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the facility failed to have a monitor technician to provide continuous electrocardiographic (ECG) monitoring for 10 patients that required ECG telemetry monitoring (continuous monitoring of a patient's heart rate and rhythm at a remote location) in the Critical Care Unit (CCU) and Surgical Intensive Care Unit (SICU). This deficient practice had the potential for not detecting abnormal heart rhythm timely which could result to life threatening heart condition that required immediate intervention. Findings:	A 392	**CULVER CITY** **Corrective Actions:** Effective immediately (6-12-14) ICU, CCU & SDU are consistently staffed with a Monitor Tech 24 hours a day/7 days a week for all units with cardiac monitors or Telemetry systems. The Monitor Tech for each unit is reflected on the Staffing Assignment record for each shift. The Staffing Matrix guiding staffing levels has been adjusted to ensure monitor tech for ICU, CCU & SDU for each shift **Date of Implementation:** 6-12-2014 **Monitoring Process:** Daily review of staffing to ensure Monitor Tech for each functioning ICU & CCU each shift. **Person Responsible:** Nursing Director of Critical Care Units & House Supervisors.	6/12/2014

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A 392	Continued From page 23 During the tour in the SICU of the facility's Culver City campus on March 26, 2014, between 10 a.m. and 10;25 a.m., Registered Nurse (RN) 4 sat in front of the central EKG monitor station. During the concurrent interview, RN 4 stated she monitors the central EKG and there was no technician to monitor the central EKG at the station. According to RN 4, she and other ICU staff had to take turns to monitor the central EKG in the SICU. During the tour in the CCU on March 26, 2014, between 10:25 a.m. and 11:30 a.m., RN 4 sat in front of the central EKG monitor. During the concurrent interview, RN 4 stated there was no technician to monitor the central EKG at the station. According to RN 4, she and other ICU staff had to take turns to monitor the central EKG in the CCU. According to Staff G (assistant chief nursing officer), RN 4 was assigned to be the EKG Technician. However, according to RN 4, she had to relieve the ten (10) staff from the SICU, CCU, and SDU (Step-Down Unit) for their lunch breaks. The SICU Patient Assignment on March 26, 2014, for the day shift (7 a.m. to 7 p.m.) disclosed RN 4 was assigned as the charge nurse. There were 3 SICU nurses to take care of 5 patients. A review of the CCU Patient Assignment on March 26, 2014, for the day shift (7 a.m. to 7 p.m.) disclosed RN 4 was assigned as the charge nurse. There were 3 CCU nurses to take care of 5 patients. The SDU Patient Assignment on March 26, 2014, for the day shift (7 a.m. to 7 p.m.) disclosed RN 4 was assigned as the charge nurse. There were 2	A 392		

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A 392	Continued From page 24 SDU nurses to take care of 6 patients. There was no documentation in the assignment sheets that an EKG technician was assigned to monitor the central EKG station for the patients in the SICU, CCU and SDU.	A 392		
A 395	482.23(b)(3) RN SUPERVISION OF NURSING CARE A registered nurse must supervise and evaluate the nursing care for each patient. This STANDARD is not met as evidenced by: Based on record review, observation and interview, the facility failed to supervise and evaluate the nursing care for 8 of 52 sampled patients (Patients 14, 15, 16, 17, 18, 22, 24 and 45) by failing to: 1. Provide non-pharmacological interventions for managing Patient 22's pain (Refer to A 395). This deficient practice had the potential for not meeting the physical and mental needs of the patient. 2. Ensure Patient 24's bedside did not have cleanser and supplies for a wound treatment left unattended. This deficient practice had the potential for administering the cleanser and supplies for the treatment of Patient 24's wound which may not be inaccordance with the physician's order. 3. Document the wound type, size, and depth during the initial assessment and reassessment. Failing to reassess the wound on March 16 and 23, 2014, and failing to provide treatments as ordered by the physician on Patient 14's left foot pressure ulcer (localized injuries to the skin	A 395	**HOLLYWOOD** **1). Corrective Actions**: Review Scope of Practice to clearly delineate expected standards for nursing care Education/in-service provided to include patient rights, general care guidelines, general assessment, reassessment and intervention, patient evaluation, care plans, accurate and complete documentation. Re-education started June 18, 2014 will be completed June 30, 2014 **Date of Implementation:** April 19, 22, 2014; re-education June 18, 2014 to be completed June 30, 2014 **Monitoring Process:** Monitoring will be managed through Nursing rounds and monthly audits; data will be reported to PI, Quality Council and MEC **Person Responsible:** Nursing leadership on each department and senior leadership **2). Corrective Actions:** April 21-23, 2014 education/in-service provided to include general care guidelines, review of policy PHA.052 Preparing and Administration of Medications, and any unlabeled medication must not be used. Pharmacy will label all medications. **Date of Implementation:** May 1, 2014 **Monitoring Process:** Monitoring will be managed through nursing rounds and pharmacy rounds **Person Responsible:** Nursing leadership in each department and pharmacy **Culver City** **3) Corrective Actions:** Re-education of nursing staff related to wound characteristics as shown in wound photographs; to include size (LxWxD), shape, drainage, color, odor. (See Wound Record Attachment and Policy revision WOU.001). Re- educate nursing staff with regard to documentation of wound care treatment in McKesson under "integumentary tab." **Date of Implementation:** 6/13/2014 **Monitoring Process:** Wound Management Team Member to audit photo documentation on 30 wound record during patient rounds. Any issue of non-adherence will be addressed to the individual staff and referred to Quality department for further intervention as necessary including education and progressive disciplinary action. In addition, Wound Management Team Member to perform thirty audits, per month including documentation of treatments. **Person Responsible:** Wound Management Team.	4/19/2014 5/1/2014 6/13/2014

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A 395	Continued From page 25 and/or underlying tissue that usually occur over a bony prominence as a result of pressure, or pressure in combination) from March 7 to March 20, 2014 (a total of 11 days). This deficient practice had the potential to result in delay of the healing of the pressure ulcer (Refer to A 395). 4. Provide oral care to Patient 16 who was dependent on staff in his activities of daily living and was observed with dry lips and having mouth odor This deficient practice resulted in poor oral care for Patient 16. (Refer to A 395). 5. Ensure Patient 17 admitted to the psychiatric unit as ordered by the physician when there was bed available in accordance with the facility's census report for the psychiatric unit. This deficient practice had the potential for not meeting the safety of the patient and others (Refer to A 395). 6. Ensure Patient 18 was administered Lisinopril medication (treat elevated blood pressure) as ordered by the physician. This deficient practice had the potential to result in an elevated blood pressure for Patient 18. (Refer to 395). 7. Ensure Patient 15 was administered Risperdal medication (psychoactive medication) as ordered by the physician. This deficient practice did not ensure the physician's order for Risperdal medication was implemented for Patient 18 and had the potential for not meeting the psycho-social needs of the patient (Refer to A 395). 8. Evaluate Patient 45 after she had attempted to hang herself in the bathroom. This deficient	A 395	(Continued from page 25) **4) Corrective Actions:** Re - Educate all Registered nurses on supervising and evaluating the care for each patient. Nursing staff will provide hourly rounds using the 5 "Ps" focuses on PAIN, POTTY, POSITION /PRIVACY and POSSESSIONS. All Nursing staff will complete Patient focused Sensitivity Training including the importance of patient hygiene. **Date of implementation:** start re-education on 6/16/2014 full implementation within 30 days. **Monitoring Process:** Patient liaison will conduct 30 patient round observations per month to ensure 5 P's, sensitivity, and privacy is done on each unit. Findings of the rounds will be reported to the specific nursing director for corrective action. A monthly report will be reported to the Quality Department monthly. Super users are collecting data on pain scale prior and after receiving pain medication this information is also sent to the quality department monthly. **Person Responsible:** Nursing Leadership from each department **5) Corrective Actions**: Policy Scope of Service- Emergency Department/urgent care #SOS.013 When it is anticipated that psychiatric patients will wait greater than 23 hours for a bed placement, calls shall be made to psychiatric facilities in other areas to determine if an appropriate bed is available and an evaluation shall be done for possible transfer and placement . Total census for BHU was 70 there was no bed availability for March 23, 24,of 2014. On March 25, the BHU had to take 4 beds out of service, beds A and B from 624 due to sink overflowing and flooding room and 603A and 603B closed due to bed bug infestation For care safety and welfare of our patients the beds could not be used until the bed bug situation Addendum could be ratified o improve transparency of bed availability the house supervisors have use of electronic bed tracking system that allows for transparency of bed availability and bed status: occupied –dirty-clean House supervisors will monitor and track bed availability to decrease ER wait times. During the time bed placement is pending patients are monitored under close observation. Staff will follow BHU .006 Close Observation Policy **Date of Implementation**: 4/30/2014 **Monitoring Process**: House Supervisors monitor bed availability throughout the day by bed tracker. At 6am 3pm 6pm 9pm the house supervisors record the hospital census **Person Responsible:** House Supervisor /Nursing leadership **6) Corrective Actions:** The pharmacy program will add standardized blood pressure parameters of when to hold a blood pressure medication. These will appear on the E-MAR for every blood pressure medication. **Date of Implementation:** 7/1/2014 **Monitoring Process**: N/A **Person Responsible**: VP of Pharmacy Operations or designee **7) Corrective Actions:** Re-educate/in-service the night shift staff on the existing "Nightly Chart Audit". **Date of Implementation:** 6/16/14 **Monitoring Process:** The Nursing Director and/or designee will implement monitoring by auditing of medication orders every (24) hours. Auditing will begin with (10) random charts per day with target compliance set at 100%. Report findings to Quality Department on a quarterly basis. **Person Responsible:** Nursing Director **VAN NUYS** **8) Corrective Actions:** Re-educate all Registered Nurses on the importance of Head to Toe Assessment immediately after any patient placed on 1:1 with staff. In-service staff and provide the "Suicide Precaution Documentation Monitoring Checklist" tool which includes a "head to toe assessment" section for check off. **Date of Implementation:** 6/16/14	6/16/2014 4/30/2014 7/1/2014 6/16/2014 6/16/2014

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A 395	Continued From page 26 practice had the potential of not identifying any physical condition related to her attempt to hand herself, which may required interventions (Refer to A 395). Findings: 1. In the facility's Hollywood campus, a review of the open medical record of Patient 22 indicated the patient was admitted to the facility's urgent care on March 24, 2014, at 9:27 a.m., for complaint of pain in bilateral legs and verbalizing of suicidal ideation's with a plan to run into traffic. At 9:50 a.m., the medical record documented Patient 22 was assessed for pain with a pain level of 9 and 10 being the worst. A review of the facility's Urgent Care Physician Report Order, dated March 24, 2014, indicated there was no order for pain medication. There was also no documentation the licensed nurse had provided non-pharmacological interventions for managing the patient's pain. During a concurrent interview, Staff E reviewed the clinical record and stated there was no documentation of an order for pain medication and that the staff provided nay non-pharmacological interventions for managing the patient's pain. 2. On March 24, 2014, at 11 a.m., during the tour, an observation in Patient 24's room, Hollywood campus, there was a plastic container with two	A 395	(Continued from page 26) **Monitoring Process:** Director of Nursing and/or designee will conduct monitoring activity on the checklist tool submitted by staff the same day the incident occurs to ensure that the requirements and documentation monitoring tool has been completed to include the (head to toe)physical assessment. **Person Responsible:** Nursing Director, Nurse Manager, and Supervisors	

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A 395	Continued From page 27 bottles of Sure Prep skin barrier spray, a container of hydrogel skin integrity, a plastic cup of pink colored cream and wound cleanser on the patient's bedside stand. During a concurrent interview, RN 20 stated the topical medications were used for wound treatment. RN 30 stated the plastic cup that contained pink colored cream was Calazime cream, which should not be left at the bedside and should be discarded after it was used. A review of Patient 24's medical record indicated there was no physician's order for the hydrogel. 3. On March 25, 2014, at 10 a.m., during an observation tour in the unit of the facility's Culver City campus, Patient 14 was resting in bed, awake, alert, oriented, and was watching television. During a concurrent interview, Patient 14 stated she had a recent fall prior to admission and sustained open wounds. A review of the Admission Face Sheet indicated Patient 14 was admitted to the facility on March 4, 2014, with diagnoses that included bilateral lower leg pain with swelling, anemia, edema (swelling) and hypotension (low blood pressure). A review of the facility's policy on Wound Report Procedure SAA.092 stipulated the following: a. Initiate the Wound Report Immediately and place in the medical record. b. Document on the Wound Report Form, at least	A 395		

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A 395	Continued From page 28 weekly, the wound location, size, depth, drainage, appearance, odor and progress. The Initial Nursing Admission Assessment indicated the patient had two (2) Stage II pressure ulcers on the mid back and left leg. The Impaired Skin Integrity Record on admission (March 4, 2014) indicated there were photographs of the patient's wounds on the the left heel, right knee, left foot, right heel, right buttocks, and left back. The record did not specify the type of wound (pressure, arterial/venous ulcer, etc), size, stage and other wound characteristics. Additionally, a review of the physician's orders for March 4, 2014, indicated there was no treatment orders for the wound on the right knee and pressure ulcer on the mid-back. The medical record also failed to indicated documentation the wounds were reassessed weekly for the week of March 16 and 23, 2014. A review of the Impaired Skin Integrity Record dated March 9, 2014, indicate a reassessment of the wounds that indicated the following: a. The photograph showed the patient's right buttocks pressure ulcer Stage II, pink/red in color, intact surrounding skin and had no necrotic tissue, odor, or drainage. There was no documentation of the size and shape of the pressure ulcer as indicated on the Impaired Skin Integrity Record.	A 395		

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A 395	Continued From page 29 b. The photograph showed the left knee skin tear/abrasion, pink/red in color, intact on the surrounding skin and had no necrotic tissue, odor, or drainage. There was no documentation of the size and shape of the wound as indicated on the Impaired Skin Integrity Record. c. The photograph showed the mid-back pressure ulcer, Stage II to III, intact surrounding skin, pink/red in color and had no necrotic tissue, odor, or drainage. The pressure ulcer was cleansed with wound spray, hydrogel was applied and covered with dressing. There was no documentation of the size of the pressure ulcer. d. The photograph showed a right heel wound. There was no documentation of the type of wound, stage, size, and other wound characteristics. e. The photograph showed a left foot wound. There was no documentation of the type of wound, stage, size, and other wound characteristics. f. The photograph showed a left heel wound. There was no documentation of the type of wound, stage, size, and other wound characteristics. a further review of Patient 14's medical record indicated the treatments as ordered by the physician on the pressure ulcers were not done on the following days: March 7 8, 9, 10, 12, 14, 15, 16, 17, 19 and 20, 2014.	A 395		

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A 395	Continued From page 30 4. On March 25, 2014, at 10:30 a.m., during a tour of the unit with Staff G, Patient 16 was observed lying bed with bilateral rails up and there was a sign posted on the wall that indicated nothing by mouth (NPO). There was a foul odor emanating from the patient's mouth. The patient's lips were dry and the patient was receiving oxygen via nasal cannula. During a concurrent interview, Licensed Vocational Nurse (LVN) 4, stated she was in Patient 16's room 10 minutes ago and was not aware the patient needed oral care. A review of Patient 16's clinical record indicated the patient was admitted to the facility on March 24, 2014 for abdominal pain, seizure disorder, encephalopathy and constipation. The Admission Assessment Inquiry indicated the patient was dependent in his activities of daily living such a bathing, grooming and oral care, however, the patient's level of consciousness is confused. 5. On March 26, 2014, at 9:15 a.m., during the tour of the emergency department (ER) with Staff N, Patient 17 was observed in bed, awake, alert, oriented, wearing hat and sunglasses. During a concurrent interview Patient 17, stated she lived in a skilled nursing facility, and went to the emergency room (ER) because of a pain in	A 395		

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A 395	Continued From page 31 the right side of her body. Patient 17 stated she had been in the emergency room for a couple of days. A review of Patient 17's clinical record indicated she was admitted to the emergency room (ER) on March 23, 2014, with diagnosis of aggressive psychiatric evaluation for aggressiveness. The patient had been in ER for 3 days. During a concurrent interview, RN 14 stated the patient had been in the ER for three days because they were waiting for an available inpatient bed in the psychiatric unit. On March 3, 2014, the physician ordered the patient be admitted to Psychiatric 6 unit. According to the facility's policy and procedure on the Scope of Service –Emergency Department/Urgent Care dated June 26, 2013, indicated mechanism for identifying patient care needs, included psychiatric patients with admission orders that are awaiting an available bed will be held in either the main ER or in the ER Overflow area pending bed availability. The Census Report for the facility's Psychiatric Unit was reviewed with Staff B and indicated on March 23, 2014, there were three available Psychiatric beds in the seclusion unit. On March 24, 25, 2014, there were three available Psychiatric beds in the seclusion unit. On March 24 and 25, 2014, there were three available beds in the seclusion unit. On March 25, 2014, there were four beds available in the locked unit. Staff B stated the patient could have been transferred and/or admitted to the inpatient unit when there	A 395		

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A 395	Continued From page 32 was an available bed. Staff B stated the goal for the patient was to get her out of the ER and admitted to the unit. Further review of Patient 17's clinical record indicated on March 25, 2014, at 4:32 p.m., there was a room available for the patient in the Psych 6 unit, and will call for report. At 5:29 p.m., the documentation in the clinical record indicated the transfer for Patient 17 was changed per the charge nurse due to no bed availability that day. 6. On March 26, 2014, at 2:15 p.m., during the tour of the unit, Patient 18 was observed in bed with an intravenous line {IV} into the vein by a heplock (tube inserted into a vein, but capped) on the right hand. The Admission Facesheet indicated the patient was admitted to the facility on March 14, 2014, with diagnosis of chest pain. The physician's order, dated March 14, 2014, indicated Lisinopril 20 milligram (mg) tablet to administer 40 mg, once a day orally for hypertension (High blood pressure). The physician order did not indicate an order to obtain a blood pressure reading and to hold the medication when the blood pressure was too low. A review of the Medication Administration Record (MAR), dated March 15, 2014, indicated Lisinopril medication was not given to the patient. During a concurrent interview, RN 15 stated she did not give the Lisinopril to the patient at that time because her blood pressure was 109/69. The RN was not able to show documentation the	A 395		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	050135	C. BUILDING **01 – SOUTHERN CALIFORNIA HOSPITAL AT HOLLYWOOD** D. WING _____	**04/01/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN CALIFORNIA HOSPITAL AT HOLLYWOOD	**6245 DE LONGPRE AVE HOLLYWOOD, CA 90028**

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A 395	Continued From page 33 physician was notified of the patient's blood pressure. 7. The clinical record indicated Patient 15 was admitted to the facility on March 19, 2014, with the chief complaint of urinary tract infection and a psych evaluation for agitation. On March 20, 2014, the physician's order indicated Risperdal (antipsychotic medication) 1 mg via gastrostomy tube (GT) every morning and 2 mg via GT in the afternoon. A review of the medication administration record (MAR) dated from March 21 through March 25, 2014, there was no documented evidence Risperdal was administered to the patient. On March 27, 2014, a review of the clinical record and an interview with the pharmacist failed to show documentation the order for Risperdal was carried out. 8. A review of the facility's report disclosed an incident occurred on March 21, 2014, at 8:15 p.m., in Unit 1 (open unit) in Patient 45's bathroom. MHW 2 was conducting a visual inspection and Patient 45 was not in the room. Patient 45 was in the bathroom and the door was locked. MHW 2 observed part of Patient 45's gown was hanging at the top of the door. As MHW 2 approached the bathroom door, he called out Patient 45's name. The door was completely locked and he (MHW 2) was unable to open the door MHW 2 heard a loud thump sound coming from the bathroom and heard gurgling sounds coming from Patient 45. MHW 2 yelled, "Code	A 395		

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A 395	Continued From page 34 Blue, Nurse" as he banged on the bathroom door. The bathroom door opened and Patient 45 "landed on the floor." A nurse came in the room and assessed Patient 45. On March 24, 2014, at 12:15 p.m., an interview was conducted with Staff H regarding the registered nurse (RN) assessment after the incident. Staff H reviewed the report and stated the RN did not conduct a physical assessment of Patient 45 after the incident. Staff H stated the RN should have documented an assessment of Patient 45. He further stated Patient 45 was place on 1:1 for safety after the incident.	A 395		
A 396	482.23(b)(4) NURSING CARE PLAN The hospital must ensure that the nursing staff develops, and keeps current, a nursing care plan for each patient. The nursing care plan may be part of an interdisciplinary care plan. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure nursing staff developed and kept current nursing care plans for 8 of 52 sampled patients (Patient 14, 25, 26, 29, 31, 32, 45 and 46). 1. Patient 14, who had pressure ulcers, there was no care plan interventions to address the actual wounds/pressure ulcers to ensure the plan of care was effective for wound healing. 2. Patient 25, there were no care plans developed to manage the patient's care while in contact isolation and required hemodialysis treatments.	A 396	**Culver City** **1-6) Corrective Actions:** Policy PAT.001 Admission Assessment/Interdisciplinary Plan of Care strengthened the development of care plans and maintaining current nursing care plan for each patient**.** Enhancement/development of electronic care plans for pressure ulcers, contact isolation, suicidal risk, hemodialysis treatments, seizure disorders and chronic pain. Educate nursing staff to create a care plan in EMR specific to skin integrity, during time of admission, evaluation, and updates on a daily basis. Policy revision WOU.001 **Date of Implementation**: 6/13/2014 with completion in 30 days. **Monitoring Process:** Auditing audit a minimum of 30 charts a month by Super Users with a report to the Quality Department on a quarterly basis. **Person Responsible:** Nursing Directors	6/13/2014

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	050135	C. BUILDING **01 – SOUTHERN CALIFORNIA HOSPITAL AT HOLLYWOOD** D. WING	**04/01/2014**

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A 396	Continued From page 25 3. Patient 26, there was no care plan developed for managing Patient 26 who had seizure disorder. 4. Patient 29, there was no care plan for the patient's care while in contact isolation. 5. Patient 31, there was no care plan developed for the care while the patient was in contact isolation and receiving hemodialysis treatments. 6. Patient 32, there was no care plan developed for the care while the for contact isolation. 7. Patient 45, who was assessed as a suicidal risk, the care plan was no revised or updated to address the patient's current status requiring 1:1 observation. 8. Patient 46, who had chronic pain, the care plan was not developed or initiated upon admission, but six days after admission. These deficient practices had the potential for not meeting the physical and mental needs of each patient. Findings: 1. A review of the Admission Face Sheet indicated Patient 14 was admitted to the facility on March 4, 2014, with diagnoses that included bilateral lower leg pain with swelling, anemia, edema (swelling) and hypotension (low blood pressure). A review of the care plan dated March 4, 2014,	A 396	(Continued from page 35) **HOLLYWOOD** **1,2,3) Corrective Actions:** Policy PAT.001 Admission Assessment/Interdisciplinary Plan of Care strengthened the development of care plans and maintaining current nursing care plan for each patient. Enhancement and development of electronic care plans for pressure ulcers, contact isolation, suicidal risk, hemodialysis treatments, seizure disorders and chronic pain. EMR Education/re-training provided beginning April 16, 2014 thru May 5, 2014 to include accurate and complete documentation of initial, care plan updates, and upon discharge utilizing the existing care plan modules **Date of Implementation:** Daily concurrent review of care plans on all patients performed beginning April 1, 2014, beginning May 1, 2014 review 30 random charts; re-training beginning June 18, 2014 thru June 30, 2014. **Monitoring Process:** Monitoring will be managed by review of 30 random charts by nursing; data will be reported through Quality Department. **Person Responsible:** Nursing Leadership **Van Nuys** **7) Corrective Actions:** Re-educate all Registered Nurses on the importance of creating a plan of care and updating the treatment plan immediately after placing a patient on a 1:1 with staff. In-service staff and provide the "Suicide Precaution Documentation Monitoring Checklist" tool which includes a check off section for "Patient Treatment Plan" updated/revised to address the change of patient acuity. **Date of Implementation:** 6/16/14 **Monitoring Process:** Director of Nursing and/or designee will conduct monitoring activity on the checklist tool submitted by staff the same day the incident occurs to ensure that the requirements and documentation monitoring tool has been completed to include updating/revising of the patient treatment plan. **Person Responsible:** Nursing Director, Nurse Manager, and Supervisors **8) Corrective Actions:** Re-educate/inservice the night shift staff on the existing "Nightly Chart Audit". This audit includes a check off section for "Nursing Care Plan/Pain". Re-educate the supervisors who perform the already existing audit "Pain Management Audit Monitoring Tool". Re-educate supervisors to complete the treatment plan for pain as needed while auditing. **Date of Implementation**: 6/16/14 **Monitoring Process:** The Nursing Director and/or designee will implement monitoring by auditing of pain medication orders every (24) hours. Auditing will begin with (10) random charts per day with target compliance set at 100%. **Person Responsible:** Nursing Director	4/1/2014 6/16/2014 6/16/2014

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A 396	Continued From page 36 indicated impairment of skin integrity. The care plan did not address specific interventions for Patient 14's actual wounds/pressure ulcers to ensure the plan of care was effective. On March 27, 2014, at 8 a.m., a review of the electronic record was conducted with Registered Nurse (RN) 12. During a concurrent interview, RN 12 stated the plan of care was initiated but failed to indicate the interventions to be undertaken to heal and prevent the wounds/pressure ulcers from getting worst. 2. During the initial tour with RN 1 and 2, in the mixed unit of Definitive Observation Unit (DOU) and the Medical-Surgical unit of the Hollywood campus on March 24, 2014 between the time of 11:15 a.m. and 11:45 a.m., Patient 25 was observed resting on the bed and there was a sign that indicated "Contact Isolation" posted by the door. According to RN 2, Patient 25 was placed in the room for MRSA (methicillin resistant staphylococcus aureus is a bacteria that causes infection that are resistant to some antibiotics) contact isolation. RN 2 also stated Patient 26 had an AV fistula (dialysis access site) on her left arm for hemodialysis treatment. A review of the electronic clinical record was conducted with Licensed Vocational Nurse (LVN) 1 disclosed there were no care plans developed for managing Patient 25 who was on contact isolation and who required hemodialysis treatment. During an interview with LVN 1 on March 24, 2014 at 12:20 p.m., she stated the nursing staff failed to develop the care plans for contact	A 396		

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A 396	Continued From page 37 isolation and hemodialysis. 3. A review of the clinical record indicated Patient 26 was admitted on March 15, 2014, with a diagnosis of seizure disorder. A review of the electronic clinical record was conducted with LVN 1 disclosed there was no care plan developed for managing Patient 26 who had seizure disorder. During an interview with LVN 1 on March 24, 2014 at 12:20 p.m., she stated the nursing staffs failed to develop the care plan for the patient's seizure disorder. 4. During the initial tour with RN 3 in the Medical-Surgical Unit of the Culver City campus on March 25, 2014 between the hours of 10:55 a.m. and 11:35 a.m., Patient 29 was observed resting on the bed with a sign that indicated "Contact isolation" posted by the door. According to RN 3, Patient 29 was placed in the room for MRSA contact isolation. However, the electronic clinical record was reviewed with RN 2 and indicated there was no care plan for contact isolation. 5. During the initial tour with RN 4 in the Surgical Intensive Care Unit (SICU) of the Culver City campus on March 26, 2014, between 10 a.m. and 10:25 a.m., Patient 31 was observed resting on the bed with a sign that indicated "Contact	A 396		

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A 396	Continued From page 38 Isolation" posted by the door. RN 4 also stated Patient 31 underwent the hemodialysis treatment. According to RN 4, Patient 31 was placed in the room for MRSA contact isolation. However, the electronic clinical record was reviewed with RN 4 and indicated there was no care plan for contact isolation and hemodialysis. During the concurrent interview with RN 4 on March 26, 2014 at 10:25 a.m., she stated the nursing staff failed to develop the care plans for contact isolation and hemodialysis. 6. During the initial tour with RN 4 in the Critical Care Unit (CCU) of the Culver City campus on March 26, 2014 between the time of 10:25 a.m. and 11:35 a.m., Patient 32 was observed resting on the bed with a sign that indicated "Contact Isolation" by the door. According to RN 4, Patient 32 was placed in the room for MRSA contact isolation. However, the electronic clinical record was reviewed with RN 4 and disclosed there was no care plan for contact isolation for Patient 32. During an interview with RN 4 on March 26, 2014 at 10:25 a.m., she stated the nursing staff failed to develop the care plans for contact isolation and hemodialysis. 7. A review of the facility's report indicated an incident occurred on March 21, 2014, at 8:15 p.m., in Unit 1 (open unit) bathroom. Mental Health Worker (MHW) 2 was conducting a visual inspection in the room and Patient 45 was not in the room. Patient 45 was in the bathroom and the	A 396		

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A 396	Continued From page 39 door was locked. MHW 2 observed part of Patient 45's gown was hanging at the top of the door. As MHW 2 approached the bathroom door, he called out Patient 45's name. The door was completely locked and he (MHW 2) was unable to open the door. MHW 2 heard a loud thump sound coming from the bathroom and heard gurgling sounds coming from Patient 45. MHW 2 yelled, "Code Blue, Nurse" as he banged on the bathroom door. The bathroom door opened and Patient 45 "landed on the floor." On March 24, 2014, at 8:15 a.m., a review of the patient's medical record was conducted with Staff I. During a concurrent interview, Staff I stated there was care plan, dated March 20, 2014, titled, "Potential for Self Harm as evidenced by Suicidal Ideation, with a Plan to Overdose." The short term goal was that the patient will report "urge to harm self." The long term goal was the patient will not harm self during hospitalization. The nursing interventions included encourage verbalizing thoughts and needs. Monitor for safety. However, the care plan was not revised to address Patient 45's current status of level of observation which was a 1 to 1 observation. 8. During an interview with RN 8 on March 25, 2014, at 9 a.m., she reviewed Patient 46's clinical record and stated she was unable to find a care plan for the pain management. A review of the Admission Face Sheet indicated Patient 46 was admitted to the facility on March 18, 2014. The History and Physical dated March 19, 2014 disclose Patient 46 had chronic back pain. The physician's orders dated March 21, 2014 indicated the patient was receiving Robaxin (muscle relaxant) 750 milligrams (mg) one by	A 396		

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	050135	E. BUILDING **01 – SOUTHERN CALIFORNIA HOSPITAL AT HOLLYWOOD** F. WING	**04/01/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN CALIFORNIA HOSPITAL AT HOLLYWOOD	**6245 DE LONGPRE AVE** **HOLLYWOOD, CA 90028**

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A 396	Continued From page 40 mouth twice a day and Flexeril (muscle relaxant) 10 mg one by mouth twice a day. The care plan titled, “Alteration in comfort due to Pain – Chronic; dated March 24, 2014, indicated the pain was described as chronic low back pain. However, the care plan was not developed or initiated upon the patient’s admission on March 18, 2014, until six days after admission. According to a facility’s policy titled Interdisciplinary Treatment Plan and Update Scheduling dated November 2012 disclose dot ensure each client admitted to the facility has a written, individualized treatment plan based on assessments of clinical needs. All medical problems requiring interventions shall be entered on the Interdisciplinary Treatment Plan (IDT) Problem List and a care plan for the identified plan shall be initiated by the RN. Furthermore, within the first 72 hours the IDT Team shall meet to discuss the patient’s needs.	A 396		
A 405	482.23(c)(1), (c)(1)(i) & © (2) ADMINISTRATION OF DRUGS (1) Drugs and biologicals must be prepared and administered in accordance with Federal and State laws, the orders of the practitioner or practitioners responsible for the patient’s care as specified under §482.12(c), and accepted standards of practice. (i) Drugs and biologicals may be prepared and administered on the orders of other practitioners not specified under §482.12(c) only if such practitioners are acting in accordance with State law, including scope of practice laws, hospital policies, and medical staff bylaws, rules, and regulations.	A 405	**Culver City** **Corrective Actions:** All nursing staff re-educated with self-study module to validate that physician orders have been noted, examined, and verified. Caregivers must use SBAR and provide the opportunity to use read-back techniques and medications orders received must be read back by the receiver. 24 hour order/chart check policy & procedure PAT.059 implemented that mandates documentation of chart review before 7am each day. **Date of Implementation**: 5/18/2014 **Monitoring Process:** Random audit of 30 charts for each nursing unit with report to Quality Department on a quarterly basis. **Person Responsible**: Nursing Leadership	5/18/2014

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A 405	Continued From page 41 (2) All drugs and biologicals must be administered by, or under supervision of, nursing or other personnel in accordance with Federal and State laws and regulations, including applicable licensing requirements, and in accordance with the approved medical staff policies and procedures. This STANDARD is not met as evidenced by: Based on observations, interviews and record review, the facility failed to ensure patient would only receive medications or supplement that were prescribed by the physician for 1 of 52 sample patients (Patient 7). This deficient practice resulted in Patient 7 receiving a dietary supplement that was not ordered by the physician. Findings: On March 26, 2014 at 9:30 a.m., in the Telemetry Unit of the Culver City campus, during a medication pass for Patient 7, the patient received one tablet of the dietary supplement Zinc Sulfate 220 milligrams (mg) but could not locate the physician's order for the zinc sulfate in the patient's chart. On March 26, 2014 at 10:45 a.m., the director of pharmacy (Pharmacist 2) confirmed he was unable to find the Zinc Sulfate order in Patient 7's chart. On March 26, 2014 at 11 a.m., the vice president pharmacy operations (Pharmacist 1) could not find the Zinc Sulfate order in the Patient 7's chart. A review of the Nutrition Recommendation Form	A 405		

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A 405	Continued From page 42 for Patient 7, dated March 25, 2014 at 8:16 a.m., indicated a handwritten check mark in the check box for “Vitamins and Minerals” and another handwritten check mark in the check box for “Multivitamin mineral one table PO (orally) daily.” However, there was no marking by the check box for “Zinc Sulfate 220 mg.” A review of the fax copy of the “Nutrition Recommendation Form” dated March 24, 2014 at 1:05 p.m. indicated the pharmacy received the order on March 25, 2014 at 8:16 a.m. A review of the electronic Medication Administration Record (eMAR) for March 25, 2014, indicated Patient 7 received one Zinc Sulfate 220 mg tablet on March 25, 2014 at 9 a.m. As of the medication pass observed on March 26, 2014 at 9:30 a.m., a total of two doses of Zinc Sulfate 220 mg tablets were given to Patient 7. On March 26, 2014 at 11:23 a.m., an interview with Pharmacist 1 indicated a staff pharmacist misread the Nutrition Recommendation form as Zinc Sulfate being included because of the long handwritten check mark for the multivitamin with mineral, which was located directly above it on the pre-printed Nutrition Recommendation Form. At 1:42 p.m., on March 26, 2014, Pharmacist 1 stated there was no policy and procedure for the chart check process performed by the nursing staff that would verify eMAR with actual physician orders. At 1:49 p.m. on March 26, 2014, during an interview, RN 10 described the process for the 12	A 405		

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A 405	Continued From page 43 hour chart check performed at shift change. The nurses performing the chart check would receive a report from a "supervising nurse," they would then confirm physician orders the chart with eMAR and verify in computer program. She stated "This is a routine protocol." She also described the 12 hour nursing shifts as 7 a.m. to 7 p.m. and 7 p.m. to 7 a.m. On March 28, 2014 at 11:53 a.m., during a follow-up interview, RN 10 stated the nurses responsible for their patients should have caught the medication entry error during the chart check process. A review of the policy and procedure dated 10/2013, titled, "Drug Distribution and Control" Number: PHA.025 dated "10/2012,"indicated "The Pharmacy department shall distribute medication and control the use of medication as follows: Review all medications orders for appropriateness and safety with respect to the current medication profile." A review of the policy and procedure dated 11/2012, titled, "Hand Off Communications," Number: PAT.043, "indicated"…A "hand off" communication is an interactive process of passing patient-specific information from one caregiver to another or from one team of caregivers to another for the purpose of ensuring the continuity and safety of the patient's care … This provides the caregivers an opportunity to verify information by using read-back techniques. Critical test results and medication orders received shall be read back by the receiver. The occurrence of the read back shall be documented in the medical record."	A 405		

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A 432 A 432	Continued From page 44 482.24(a) ORGANIZATION AND STAFFING The organization of the medical record service must be appropriate to the scope and complexity of the services performed. The hospital must employ adequate personnel to ensure prompt completion, filing, and retrieval of records. This STANDARD is not met as evidence by: Based on medical record review and medical records staff interview, the facility failed to ensure that physician orders were authenticated and that medical records were completed in a timely manner as evidenced by lack of an effective system to ensure authentication and medical records completion of telephone orders at the Van Nuys campus. This deficient practice had the potential to result in delays of pertinent information being available for continuing patient care. Findings: Patient 13 was admitted to the Van Nuys campus on March 25, 2014 with diagnosis including exacerbation of depression (a mood disorder in which feelings of sadness, loss, anger or frustration interfere with everyday life for weeks or longer). The physicians' admission diet order dated March 25, 2014, was a no added salt diet. In an interview on March 27, 2014 beginning at 3 p.m., (Administrative Staff) Staff 7 stated if there is no physician on site when patients are admitted both the medical doctor and the psychiatrist are contacted for telephone admitting orders, including diet orders. Staff 7 stated the orders were then put into the electronic medical record. Upon completion of order entry the medication	A 432 A 432	**Van Nuys** **FINDING 1:** ***Patient 13 Dietary Orders*** **Corrective Actions:** An internal review of dietary processes identified handwritten dietary recommendations were placed into the patient's medical record and not reviewed in a timely manner. The following improvements have been implemented: • All physicians are required to input orders via the Computerized Physician Order Entry System (CPOE). • All dietary recommendations are required to be input into the electronic medical record (EMR). Input of a dietary recommendation into the EMR triggers a "flag" of a pending diet recommendation and prompts appropriate follow-up for a physician's order to finalize said dietary recommendation. • The Dietary Department will monitor all diet orders, executed as a result of a diet recommendation, to ensure all diet orders are appropriately fulfilled. Audit results will be reported to the hospital's Pharmacy and Therapeutics Committee, Quality Council, Medical Executive Committee, and Governing Board. **Date of Implementation** • Internal review of the dietary processes was conducted April through June 2014. • Mandatory input of dietary recommendations into the EMR completed July 22, 2014 for the Culver City campus and August 1, 2014 for the Van Nuys and Hollywood campuses. • Physicians mandated to input orders via CPOE by July 15, 2014 for the Hollywood and Van Nuys campuses and by August 18, 2014 for the Culver City campus. • Super-users have been hired and trained to support physician adoption and training. Physician CPOE training commenced June 25, 2014. **Monitoring Process:** • The Dietary Department will monitor all diet orders, executed as a result of a diet recommendation, to ensure diet orders are appropriately fulfilled. Audit results will be reported to the hospital's Pharmacy and Therapeutics Committee, Quality Council, Medical Executive Committee, and Governing Board. • Compliance will be gauged by reviewing the number of diet recommendations generated (denominator), and of those, the number of orders written and executed (numerator) • Targeted compliance is 90% • Monitoring activity will commence for a period not to exceed 4 months or until optimal compliance is achieved and sustained. • Random audits will be performed thereafter. • Results of the audits will be reported to the hospital's Pharmacy and Therapeutics Committee, Quality Council, Medical Executive Committee, and Governing Board. **Person Responsible:** Director of Dietary/Food Services or designee. **Finding 2, 3 and 4 –** ***Interview with (Administrative Staff) Staff 7, Staff 8, and Staff 9 (Health Information Manager)*** **Corrective Actions:** An internal assessment identified that incomplete (signed, dated, and timed) physician's orders in the system existed primarily due to the slow rate of physician adoption to the EMR. Physicians not logging into the EMR system did not receive a prompt of incomplete orders in the system. Once a physician logs into the EMR a system generated prompt requires the physician to appropriately disposition (sign or refuse with reason) each unsigned order. When the physician authenticates an order, the system automatically dates and times the order.	4/15/2014 7/22/2014 8/1/2014 7/15/2014 8/18/2014 6/25/2014

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	050135	E. BUILDING **01 – SOUTHERN CALIFORNIA HOSPITAL AT HOLLYWOOD** F. WING _____	**04/01/2014**

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A 432	Continued From page 45 order were printed and faxed to the pharmacy for implementation and eventual physician signature. All remaining orders and patient care documentation was maintained in the electronic medical record. She further stated that the intent would be for physicians to electronically authenticate all telephone orders and that each time a physician logged there was a reminder screen that depicted the number of orders that required reviewing. She also acknowledged that physicians did not routinely authenticate orders that were in the electronic medical record. In an interview on March 27, 2014 beginning at 3:40 p.m., Staff 8 was asked to describe the medical record auditing process. She stated the current electronic record was implemented in June 2013 and she routinely requests physicians' sign their orders. Staff 8 stated the orders were reviewed and those that were in the paper format, which were primarily medication orders were reviewed. Staff 8 determine the number of electronic telephone orders that were not authenticated within the last 30 days. In a follow up observation on March 27, 2014 at 4:14 p.m., Staff 7 as able to demonstrate the number of orders that were not authenticated for a random physician. It was noted on the screen shot being viewed the physician had 199 orders that required authentication. In an interview on March 28, 2014 at 9:15 a.m., Staff 9 (Health Information Manager) (HIM) stated the department audited elements such as history and physicals; operative reports and authentication of physicians' orders. Staff 9 stated the authentication of orders was limited to those that were printed; there was no audit of orders that may have been directly entered into	A 432	(Continued from page 45) The following improvements have been implemented: • Physicians mandated to input orders via CPOE by July 15, 2014 for the Hollywood and Van Nuys campuses and by August 18, 2014 for the Culver City campus. • Additional CPOE physician training commenced at the Hollywood, Van Nuys, and Culver City campuses on June 25, 2014. • Previous to the CPOE mandate, the Chief of Staff issued a memo, dated June 13, 2014, to All Medical and Allied Staff Members to serve as a reminder notice that pursuant to the Medical Staff Rules and Regulations that all orders and progress notes must be signed, dated, and timed. • Non-compliance discussed and corrective actions addressed at medical department meetings and the Medical Executive Committee (MEC). • Medical Staff leadership will continue to monitor progress and work with Administration to improve compliance with documentation standards. • Audit results will be reported to the hospital's Quality Council, Medical Executive Committee, and Governing Board. **Date of Implementation** • Super-users have been hired and trained to support physician adoption and training. Physician CPOE training commenced June 25, 2014. • Physicians mandated to input orders via CPOE by July 15, 2014 for the Hollywood and Van Nuys campuses and by August 18, 2014 for the Culver City campus. • Previous to the CPOE mandate, the Chief of Staff issued a memo, dated June 13, 2014, to All Medical and Allied Staff Members to serve as a reminder notice that pursuant to the Medical Staff Rules and Regulations that all orders and progress notes must be signed, dated, and timed. • Non-compliance discussed and corrective actions addressed at medical department meetings and the Medical Executive Committee (MEC). • Medical Staff leadership will continue to monitor progress and work with Administration to improve compliance with documentation standards. • Audit results will be reported to the hospital's Quality Council, Medical Executive Committee, and Governing Board. **Monitoring Process:** • The HIM Manager and/or designee will conduct monthly audits of patient charts to review for the completion of all physician orders (timed, dated, and signed). • Numerator = Number of complete physician orders (timed, dated, and signed) / Denominator – Number of total physician orders reviewed. • The sample size will be based on monthly discharges, per the following guidelines: o Sample all cases for a population size of fewer than 30 cases o Sample 30 cases for a population size of 30–100 cases o Sample 50 cases for a population size of 101–500 cases o Sample 70 cases for a population size of more than 500 cases • Targeted compliance is 90% • Monitoring activity will commence for a period not to exceed 4 months or until optimal compliance is achieved and sustained. • Random audits will be performed thereafter. • Results of the audits will be reported to the hospital's Quality Council, Medical Executive Committee, and Governing Board. **Person Responsible:** HIM Administrator and/or designee	6/25/2014 7/15/2014 8/18/2014 6/13/2014

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A 432	Continued From page 46 the electronic medical record. He also acknowledged that in the Culver City campus and Hollywood campus staff was instructed to print out all physicians' orders. He was unaware that the Van Nuys campus was not printing orders. Hospital document titled "General Medical Staff Rules and Regulations" dated 12/4/13 noted that it was the responsibility of the attending physician for the clinical accuracy and timely completion of the medical record. The rules also noted "The medical record shall be completed promptly and authenticated by signature by a physician…"	A 432		
A 454	482.24(c)(1) CONTENT OF RECORD: ORDERS DATED & SIGNED All orders, including verbal orders, must be dated, timed, and authenticated promptly by the ordering practitioner or by another practitioner who is responsible for the care of the patient only if such a practitioner is acting in accordance with State law, including scope-of-practice bylaws, rules, and regulations. This STANDARD is not met as evidenced by; Based on record review and interview, the facility failed to ensure the verbal orders of the physicians were dated, timed, and authenticated promptly by the ordering practitioner, as in accordance with the facility's Medical Staff Rules & Regulations for 6 of 52 sampled patients (Patient 15, 18, 25, 26, 29, and 32). This deficient practice had the potential for the physician orders not to be complete and accurate. Findings:	A 454	**ALL THREE CAMPUSES** **Findings 1-5 Corrective Actions:** An internal assessment identified that incomplete (signed, dated, and timed) physician's orders in the system existed primarily due to the slow rate of physician adoption to the EMR. Physicians not logging into the EMR system did not receive a prompt of incomplete orders in the system. Once a physician logs into the EMR a system generated prompt requires the physician to appropriately disposition (sign or refuse with reason) each unsigned order. When the physician authenticates an order, the system automatically dates and times the order. The following improvements have been implemented: • Physicians mandated to input orders via CPOE by July 15, 2014 for the Hollywood and Van Nuys campuses and by August 18, 2014 for the Culver City campus. • Previous to the CPOE mandate, the Chief of Staff issued a memo, dated June 13, 2014, to All Medical and Allied Staff Members to serve as a reminder notice that pursuant to the Medical Staff Rules and Regulations that all orders and progress notes must be signed, dated, and timed. • Non-compliance discussed and corrective actions addressed at medical department meetings and the Medical Executive Committee (MEC). • Medical Staff leadership will continue to monitor progress and work with Administration to improve compliance with documentation standards. • Audit results will be reported to the hospital's Quality Council, Medical Executive Committee, and Governing Board. **Date of Implementation:** • Super-users have been hired and trained to support physician adoption and training. Physician CPOE training commenced June 25, 2014. • Physicians mandated to input orders via CPOE by July 15, 2014 for the Hollywood and Van Nuys campuses and by August 18, 2014 for the Culver City campus. • Previous to the CPOE mandate, the Chief of Staff issued a memo, dated June 13, 2014, to All Medical and Allied Staff Members to serve as a reminder notice that pursuant to the Medical Staff Rules and Regulations that all orders and progress notes must be signed, dated, and timed.	6/25/2014 7/15/2014 8/18/2014 6/13/2014

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A 454	Continued From page 47 1. In the DOU (Definitive Observation Unit) of the Hollywood campus on March 24, 2014, a review of the physician's order sheet for Patient 25 disclosed one telephone order received on March 15, 2014 at 4:15 p.m. was not dated, timed, and authenticated by the ordering practitioner. Two telephone orders dated March 22, 2014 were not timed and authenticated by the ordering practitioner. A review of the physician's order sheet for Patient 26 disclosed one telephone order dated March 21, 2014 at 12:25 p.m. was not dated, timed, and authenticated by the ordering practitioner. During the concurrent interview with Registered Nurse 9RN) 1, she stated the physicians failed to date, time and authenticated the telephone orders for Patient 25 and 26. 2. During the initial tour with Staff C and RN 3 in the Medical/Surgical Unit of the Culver City campus on March 25, 2014 between 10:55 a.m. and 11:35 a.m., a review of the physician's order sheet for Patient 29 disclosed the telephone order received on March 19, 2014 at 8:45 a.m. and 10 p.m., March 2014 at 9:30 a.m., March 21, 2014 at 10 a.m. and March 24, 2014 at 7 a.m., were not dated, timed, and authenticated by the ordering practitioner. During the concurrent interview with Staff C, she stated the physicians failed to date, time and authenticated the telephone orders for Patient 29. 3. During the initial tour with Staff C and RN 4 in the CCU (Critical Care Unit) of the Culver City campus on March 26, 2014 between 10 a.m. and 10:30 a.m., the physician's order sheet for Patient	A 454	(continued from page 47) • Non-compliance discussed and corrective actions addressed at medical department meetings and the Medical Executive Committee (MEC). • Medical Staff leadership will continue to monitor progress and work with Administration to improve compliance with documentation standards. Audit results will be reported to the hospital's Quality Council, Medical Executive Committee, and Governing Board. **Monitoring Process:** • The HIM Manager and/or designee will conduct monthly audits of patient charts to review for the completion of all physician orders (timed, dated, and signed). • Numerator = Number of complete physician orders (timed, dated, and signed) / Denominator – Number of total physician orders reviewed. • The sample size will be based on monthly discharges, per the following guidelines: o Sample all cases for a population size of fewer than 30 cases o Sample 30 cases for a population size of 30–100 cases o Sample 50 cases for a population size of 101–500 cases o Sample 70 cases for a population size of more than 500 cases • Targeted compliance is 90% • Monitoring activity will commence for a period not to exceed 4 months or until optimal compliance is achieved and sustained. • Random audits will be performed thereafter. • Audit results will be reported to the hospital's Quality Council, Medical Executive Committee, and Governing Board. **Person Responsible**: HIM Administrator and/or designee.	

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A 454	Continued From page 48 32 was reviewed and disclosed the telephone order received on February 29, 2014 was not dated, timed, and authenticated by the ordering practitioner. During the concurrent interview with Staff C ,she stated the physicians failed to date, time and authenticated the telephone orders for Patient 32. 4. During the initial tour with Staff C and RN 6 in the Telemetry Unit of the Culver City campus on March 26, 2014 between 2:12 p.m. and 3:30 p.m., the physician's order sheet for Patient 32 was reviewed and disclosed the telephone order for admission medications was not dated, timed, and authenticated by the ordering practitioner. During the concurrent interview with Staff C, she stated the physicians failed to date, time and authenticated the telephone orders for Patient 34. According to the Medical Staff Rules & Regulations approved by the Governing Board on December 4, 2013, page 29, number 13: ORDERS, 13.2 "All medication order shall be signed within 48 hours." 5.On March 27, 2014, at 2:45 p.m., in the Culver City campus, during a review of the following patient medical records with RN 16 revealed the following: a. Patient 18's Progress Notes dated March 22 through 25, 2014, were signed, dated but not timed by the physician.	A 454		

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A 454	Continued From page 49 b. Patient 15's physician telephone orders dated March 22-25, 2014 were not signed, dated and timed by the physician. The telephone orders were Haldol 5 mg IM, Ativan 2 mg IM every 6 hours as needed for agitation and Benadryl 50 mg During a concurrent interview, RN 16 stated there was no time, date and signature by the physician.	A 454		
A 458	482.24(c)(4)(i)(A) CONTENT OF RECORD: HISTORY & PHYSICAL All records must document the following, as appropriate: (i) Evidence of— (A) A medical history and physical examination completed and documented no more than 30 days before or 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services. The medical history and physical examination must be placed in the patient's medical record within 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure the medical history and physical examination were completed within 24 hours after admission for 4 of 52 sampled patients (Patient 12, 29, 33 and 34). This deficient practice had the potential to affect the patient's course of treatments. Findings:	A 458	**All Three Campuses** **1-3 Corrective Actions:** • Non-compliance discussed and corrective actions addressed at the Medical Executive Committee (MEC). • The Chief of Staff issued a memo, dated June 19, 2014, to All Medical and Allied Staff Members to serve as a reminder notice that pursuant to the Medical Staff Rules and Regulations that a medical history and physical examination must be completed and documented no more than 30 days before or 24 hours after admission or registration, but prior to surgery or procedure requiring anesthesia services. The medical history and physical examination must be placed in the patient's medical record within 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services. • Medical Staff leadership will continue to monitor progress and work with Administration to improve compliance with documentation standards. • Audit results reported to the hospital's Quality and Medical Record Committee and Medical Executive Committee. **Date of Implementation:** • Non-compliance discussed and corrective actions addressed at the Medical Executive Committee meeting on June 17, 2014.	6/17/2014

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A 458	Continued From page 50 1. During the initial tour with Staff C and Registered Nurse (RN) 3 in the Medical-Surgical Unit of the Culver City campus n March 25, 2014 between 10:55 a.m. and 11;35 a.m., the clinical record for Patient 29 was reviewed and disclosed there was no medical history and physical examination since the patient was admitted on March 18, 2014. 2. During the initial tour with Staff C and RN 4 in the SDU (Step-Down Unit) of the Culver City campus on March 26, 2014 between 11:35 a.m. and 12:20 p.m., the clinical record for Patient 12 was reviewed and disclosed the medical history and physical examination had been transcribed on March 18, 2014 but not authenticated by the physician since admission on March 13, 2014. During the concurrent interview with Staff C, she stated the physicians failed to complete the medical history and physical examination within 24-hours of admission for Patient 12. According to Staff B, the medical history and physical examination for Patient 12 should have been authenticated by the physician for completion. 3. During the initial tour with Staff C and RN 6 in the Telemetry Unit of the Culver City campus on March 26, 2014 between the time of 2:12 p.m. and 3:30 p.m., the clinical record for Patient 33 was reviewed and disclosed there was no medical history and physical examination since the patient was admitted on March 18, 2014. Additionally, the clinical record for Patient 34 was reviewed and disclosed the medical history and physical examination was transcribed on March 5, 2014, but not authenticated by the physician since the patient was admitted on March 5, 2014.	A 458	(Continued from page 50) • Chief of Staff communication dated June 19, 2014. • Monitoring of H&P's – ongoing • Audit results reported to the hospital's Quality and Medical Record Committee and Medical Executive Committee – June 2014 and quarterly as required. **Monitoring Process:** • The HIM Manager and/or designee will conduct monthly audits of patient charts to review for the timely completion of history and physical examinations. • Numerator = Number of history and physical present no more than 30 days prior to admission or 24 hours after admission or registration but prior to surgery / Denominator – Number of total charts reviewed. • The sample size will be based on monthly discharges, per the following guidelines: o Sample all cases for a population size of fewer than 30 cases o Sample 30 cases for a population size of 30–100 cases o Sample 50 cases for a population size of 101–500 cases o Sample 70 cases for a population size of more than 500 cases • Targeted compliance is 90% • Monitoring activity will commence for a period not to exceed 4 months to ensure that compliance is achieved and sustained. • Random audits will be performed thereafter. • Results of the audits will be reported to the hospital's Quality and Medical Record Committee and Medical Executive Committee. **Person Responsible:** HIM Administrator and/or designee.	6/19/2014 6/2014

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A 458	Continued From page 51 During the concurrent interview with Staff C, stated the medical history and physical examination for Patient 33 should have been authenticated by the physician for completion. According to the Medical Staff Rules & Regulations approved by the Governing Board on December 4, 2013, Page 32, "14.3 A complete history and physical examination, performed by a qualified physician or by another individual approved for such privilege based on demonstrated competence, within the scope of his/her license, shall be recorded on all patients within 24-hours of admission."	A 458		
A 467	482.24(c)(2)(vi) CONTENT OF RECORD: ORDERS, NOTES, REPORTS [All records must document the following, as appropriate:] All practitioner's orders, nursing notes, reports of treatment, medication records, radiology and laboratory reports, and vital signs and other information necessary to monitor the patient's condition. This STANDARD is not met as evidenced by: Based on review of electronic and paper clinical record review, staff interviews and review of hospital policies and procedures, the facility failed to ensure that the records of 6 out of 52 sampled patients and one (1) randomly selected patient reviewed contained the appropriate information to monitor the progress and condition of the patients (Patients 8, 9, 10, 11, 12 and 14). This deficient practice had the potential for the patients not able to receive appropriate care.	A 467		

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A 467	Continued From page 52 Findings: 1. Patient 11 was admitted on March 9, 2014 with diagnoses including congestive heart failure, hypertension (high blood pressure), diabetes (a condition in which a person has high blood sugar) and chronic kidney disease (a gradual loss of kidney function). The physician ordered a 1500 to 1800 calorie diet on admission. The physician also ordered a fluid restriction of less than 1500 cubic centiliters (cc) on admission. This order was no transcribed as part of the diet order and so the fluid restriction was not implemented as part of the order until three days after admission on March 12, 2014, when the registered dietitian (RD 1) noticed it as an incomplete order while conducting a nutritional assessment on Patient 11. In between the three days the fluid restriction was no implemented, Patient 11 was ordered Boost, a nutritional supplement, three times a day with meals. He received this in addition to the 2000 cc of fluid which is part of his diet, an additional 7320 cc from three boxes of Boost. Clinical record review showed that Patient 11 was refusing dialysis (treatment that does some of the things healthy kidney does) which would have alleviated the fluid his body was retaining. Laboratory values on March 26, 2014 showed that his kidneys were working well and cleaning out toxins in his body. His blood urea nitrogen was 65 (normal 7 to 20) and creatinine was 5.0 (normal 0.6 – 1.3). The physician had ordered daily weights also as part of the admission orders but nursing staff	A 467	**CULVER CITY** **1).Corrective Actions:** All nursing staff will be re-educated on proper I & O documentation, obtaining weights and documentation of weights. Super users will notify RNs of any discrepancies. RNs will correct discrepancies. SuperUsers are qualified clinical staff with extensive competencies in electronic clinical documentation. They are available on site 24 hrs. a day/ 7 days a week. **Date of Implementation**: 6-19-2014 with full implementation in 30 days. **Monitoring Process**: Super Users will monitor and collect data on a minimum of 200 charts a month and outcomes will be reported up to the Quality Council on a monthly basis. Any level of non-compliance will be reported to the Nursing Director for immediate corrective action. **Person Responsible:** Clinical Education Coordinator/Informatics	6/19/2014

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A 467	Continued From page 53 failed to weigh the patient. As of March 26, 2014, daily weights had not been completed on Patient 11, seventeen days after the order had been placed. Monitoring the weight is one of the ways a physician could monitor how much fluid the body is retaining. This is of significance because Patient 11 suffered from both congestive heart failure and kidney failure, two conditions in which excessive fluid retention is detrimental. 2. Patient 10 was admitted with diagnoses including decubitus ulcer, sacral and bottom. There were several pictures of the different wounds Patient 10 had but there was no description. There had been orders for a wound consult by the physician however, there was no description of the wounds y the wound consultant. Documentation in the RD notes describes these wounds as Stage III, Stage IV and unstageable wounds. In an interview with Staff 13 (Wound Consultant) on March 26, 2014 via telephone, he stated that the hospital policy was by photographic documentation and the present time no other documentation was being done. Review of the hospital policy titled "Management of Skin Integrity- Care of the Patient" dated August 2010 of which the Wound Consultant was the contributor, did not support his assertions. This policy required under the section "Documentation" specific information to be included. These included location, depth, Stage, drainage, presence of necrotic or non-viable tissue among other documentation. In an interview with a charge nurse on one of the Medical-Surgical floors on March 26, 2014 at approximately 3:00 p.m., she provided a poster	A 467	(Continued from page 53) **2).Corrective Actions:** Documentation by Wound Management team is entered in Physician Progress note section of medical record. This documentation will include stage, location, depth, drainage, presence of necrotic or non-viable tissue, and other descriptors as relevant to the specific wounds and follow up notes will be done as needed. Treatment recommendations entered in CPOE are also described in progress note. **Date of Implementation:** 6/13/2014 **Monitoring Process**: Wound Management Team Member to audit wound care progress note on 30 wound records. Any issue of non-adherence will be addressed to the individual staff and referred to Quality department for further intervention as necessary including education and progressive disciplinary action**.** **Person Responsible**: Wound Care Management team	6/13/2014

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	050135	G. BUILDING **01 – SOUTHERN CALIFORNIA HOSPITAL AT HOLLYWOOD** H. WING	**04/01/2014**

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A 467	Continued From page 54 titled “Documentation of Pressure Ulcer Care” that outlined in detail what documentation was required for pressure ulcer care. The information contradicted the information provided the Wound Consultant. The hospital failed to ensure that all information necessary to assess the care of a patient with pressure ulcer was properly documented. 3. Patient 12 was admitted with diagnosis including pneumonia (an infection in the lungs) and hypoxia (a low level of oxygen in tissues and blood). Electronic medical record review was conducted on March 26, 2014 beginning at 2 p.m. Admission diet order dated March 13, 2014 was a cardiac diet. A physician’s order dated March 24, 2012 was for tube feeding through a nasogastric tube (tube through the nose inserted in the stomach for feeding) with Diabetasource (a supplement for patients with diabetes) at a rate of 20 cc (cubic centiliter)/hour. A follow up order dated March 26, 2014 requested water via the NG tube, 150 cc (a metric unit of measure) every 6 hours. The tube feeding was ordered on March 24, 2014, at 3 p.m. An observation of the tube feeding was conducted on March 26, 2014 at 3:00 p.m. It was noted that the tube feeding pump was off. It was also noted that the feeding bad or the tubing was not dated and/or labeled; the volume in the bag at the time of hanging was 1,000 cc and there was approximately 300 cc left. It was also noted that a new bag of Diabetasource was lying on the patient’s bedside table. In a concurrent interview with the director of food services (Staff 3), she stated that the dietary department sent up tube feedings every day at lunch that included labels which were intended to be placed on the tube	A 467	(Continued from page 54) **3).Corrective Actions:** Policy VAS.005 and Policy PAT.057. Re-educate nursing staff: All Feeding bags, IV bags and all tubing must be labeled date and timed and initialed. Hands on competencies for clinical areas that have feeding pump utilization to include pump set up, settings, steps to clearing pump, documentation of amounts provided to patient. Return demonstration will be required to demonstrate competency. **Date of implementation:** 8/16/2014 full implementation **Monitoring Process:** Nursing Leadership from each department will monitor proper labeling of IV bags, Feeding bags and all tubing. Audit of feeding pump settings. Data will be collected on a 30 random patients a month and reported to the Quality Council on a monthly basis. Any level of non-compliance will be reported to the Nursing Director for immediate corrective action. **Person Responsible:** Unit Nursing Director	8/16/2014

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A 467	Continued From page 55 feeding when it was hung. In an interview with RN 17, she stated that she reset the pump at 12 p.m. (3 hours prior). She also stated that she cleared the pump at 12 p.m. and turned the pump off shortly before 3 p.m. to provide personal care and probably forgot to turn it back on. Review of medical record document titled “Daily Assessment Inquiry” dated March 24, 2014 at 8 p.m. was the first time that the tube feeding was noted; however there was no documentation in the electronic medical record when the feeding was actually hung. It was also noted that the actual amount of feeding that was being delivered was not accurately recorded and/or the documentation noted the physician’s order of 20cc/hour. For example on March 26, 2014 at 6 a.m. the amount of tube feeding delivered was recorded as 240cc. Follow up documentation dated March 26, 2014 at 12 p.m., noted an entry of 200 cc. If the feeding was running per the physician’s order, the pump should have read either 360 cc (if the pump was not cleared at the 6am entry) or 120 cc for the 12 p.m. entry rather than the documented 200 cc. In an interview on March 24, 2014 at 2:15 p.m., RN 17 was unable to explain the discrepancy. In a concurrent interview with Staff 3, she acknowledged that the feeding was not likely delivered per the physician’s order. 4. Patient 9 was admitted with diagnoses including anemia (low blood iron), insulin dependent diabetes, sacral decubitus, (open sore on the top of the upper buttocks), end stage renal disease (the kidneys are not able to work at a	A 467	(continued from page 55) **4).Corrective Actions:** (Patient #9) Documentation by Wound Management team is entered in Physician Progress note section of medical record. This documentation will include stage, location, depth, drainage, presence of necrotic or non-viable tissue, and other descriptors as relevant to the specific wounds and follow up notes will be done as needed. Treatment recommendations entered in CPOE are also described in progress note.	

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A 467	Continued From page 56 level for day – to day life) with dialysis. Electronic record review showed on March 24, 2014 at 12:25 a.m., there was an order for Novasource Renal, (a specialized feeding for patients with kidney disease) Give 20 milliliters (ml)/hour via PEG (percutaneous endoscopic gastrostomy tube). There were additional instructions “every evening hours.” RN 18 stated in an interview at approximately 5:45 p.m. on March 24, 2014, on the definition of “evening hours” was 7 p.m. to 7 a.m. The hospital staff was not able to provide evidence as to the definition of evening hours. Inspection of the tube feeding at approximately 5:50 p.m. showed a feeding bag hung in the patient’s room with approximately 150 ml of a light brown colored liquid left in the bag. The tube feeding bag had a blue colored cap which indicated that the tube feeding was poured into the bag. The bag was dated “March 24, 2014”, it was not timed. It could not be determined how long the bag had been hung and how much Patient 9 had received. Review of electronic record flow sheets for March 23, 2014 at 6:30 a.m. showed 120 cc was given to the patient. There was additional documentation for 0700 shift, 120 cc was entered as total. Based on the time the order was written on March 23, 2014 and the definition of evening hours by the RN, Patient 9 should have received a total of between 120 and 140 cc on March 23, 2014 by 6:30 a.m. and no feeding for the 0700 shift. Nursing staff failed to accurately document what care it had provided.	A 467	(Continued from page 56) **Date of Implementation:** 6/13/2014 **Monitoring Process:** Wound Management Team Member to audit wound care progress note on 30 wound records. Any issue of non-adherence will be addressed to the individual staff and referred to Quality department for further intervention as necessary including education and progressive disciplinary action. **Person Responsible:** Wound Care Management team	6/13/2014

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A 467	Continued From page 57 There was no description for the wound on Patient 9. There were pictures but no other information on size, staging, depth and other pertinent information that would be valuable to other professionals providing care to this Patient. According to the hospital policy titled, "Management of Skin Integrity – Care of the Patient" dated August 2010 "skin integrity, assessment and treatment is an interdisciplinary responsibility." The physician, registered nurse, physical therapist, food and nutrition, case managers and home health staff were listed as responsible for the care of the patient with pressure ulcer. The lack of adequate documentation would prevent these other professionals from providing adequate care for the patient. 5. Patient 8 was admitted with diagnoses including diabetes mellitus, hypertension (high blood pressure) and asthma. Review of admitting orders revealed that there was no order for his diet. Electronic record review on March 27, 2014 revealed that an order was entered for a No Added Salt later than evening by one of the nurses. RN 20 stated that she received an order but was not sure if the verbal order had been faxed to the physician for authentication as it is customary to do with medical orders. There was no documented evidence that the nurse had called the physician to receive a diet order. Comments made by other unidentified nurses on the unit revealed that they use information on diet orders from previous admission to determine diet orders when physicians do not add diet orders. There was no telephone order authentication by the admitting physician either in the electronic	A 467	(Continued from page 57) **5).Corrective Actions**: All nursing staff re-educated with self-study module to validate that physician orders have been noted, examined, and verified. Caregivers must use SBAR and provide the opportunity to use read-back techniques and medications orders received must be read back by the receiver. 24 hour order/chart check policy & procedure PAT.059 implemented that mandates documentation of chart review before 7am each day. **Date of Implementation:** 5/18/2014 **Monitoring Process**: Random audit of 30 charts will be done per nursing unit. **Person Responsible:** Nursing Leadership	5/18/2014

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A 467	Continued From page 58 paper record. According to the Hospital policy titled “telephone and verbal orders” dated July 2004, states “Telephone orders are to be written and read back too physicians to clarify.” 6. Review of the hospital Diet report for March 26, 2014, showed height and weight information on several patients (sampled and randomly selected) that were inaccurate and unrealistic. For example, Patient 10’s weight was entered as 2615 pounds, Patient 9’s height was documented as 66 centimeters (cm) or 2 feet 2 inches. A randomly selected patient’s height was similarly entered as 67 cm or 2 feet 6 inches. All of these patients were adults with no history of amputation. Information on height and weight is valuable to examine response to therapy and administration of medication. The facility failed to ensure that documented information was accurate. 7. On March 27, 2014, at 9 a.m., Patient 14’s medical record was reviewed. The verbal physician order dated March 7, 2014, indicated to transfuse one unit of packed red blood cells. The consent form dated March 7, 2014, indicated the patient had signed the consent. On the same day, the patient received the blood transfusion. Further review of the transfusion record failed to indicate documentation that the section on the suspected transfusion reaction was checked. During a concurrent interview RN 12 stated the section on suspected transfusion reaction of the	A 467	(Continued from page 58) **6).Corrective Actions:** Re-education of all nursing staff on timely and accurate collection and documentation of patient height and weights in accordance to hospital policies and physician orders. Evaluation performed regarding ability to implement critical value settings in electronic medical record for Heights and Weights. This feature is currently NOT available but this will be reviewed during system upgrades. **Date of Implementation:** 6/20/2014 with completion over next 30 days. **Monitoring Process:** Data will be collected on a 30 random patients a month and reported to the Quality Council on a monthly basis. Any level of non-compliance will be reported to the Nursing Director for immediate corrective action. **Person Responsible**: Nursing Leadership **7). Corrective Actions:** The blood bank section implemented a new process in which all blood transfusion form are to be returned to Blood bank within 4 hours of completion of transfusion. The forms are to be delivered and brought down to the Blood bank department by the charge nurse for the patient that had been transfused. This is to be presented to the CLS on duty in Blood bank and is to be inspected on the spot by both lab and nursing. **Date of Implementation:** 5/16/2014 **Monitoring Process:** Weekly **Person Responsible:** Lab supervisor; Lab Director	6/20/2014 5/16/2014

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A 467	Continued From page 59 transfusion record should have been filled out.	A 467		
A 468	482.24(c)(2)(vii) CONTENT OF RECORD: DISCHARGE SUMMARY {All records must document the following, as appropriate:} Discharge summary with outcome of hospitalization, disposition of care and provisions for follow-up care. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure the discharge summary with outcome of hospitalization, disposition of case, and provision for follow-up care, was completed for 1 of 52 sampled patients (Patient 43). This deficient practice had the potential for not assuring proper continuity of care. Findings: A review of the closed record on March 27, 2014 with Staff B indicate Patient 43 was admitted to the facility on November 19, 2013, and discharged on December 3, 203. A review of the closed record revealed there was no documentation the discharge summary with outcome of hospitalization, disposition of the case, and provision for follow-up care was completed by the physician as of March 28, 2014. During the interview with Staff B on March 28, 2014 at 9:15 a.m., she stated the discharge summary with outcome of hospitalization, disposition of the case, and provision for follow-up care, had not been complete by the	A 468	**All Three Campuses** **1-3 Corrective Actions:** • Non-compliance discussed and corrective actions addressed at the Medical Executive Committee (MEC). • The Chief of Staff issued a memo, dated June 19, 2014, to All Medical and Allied Staff Members to serve as a reminder notice that pursuant to the Medical Staff Rules and Regulations that a Discharge Summary with outcome of hospitalization, disposition or care and provisions for follow-up care shall be provided by the responsible practitioner and completed within fourteen (14) days after the patient's discharge. The memo further stated that Medical Staff will be uncompromising in enforcing suspension that result from incomplete and/or delinquent medical records • Medical Staff leadership will continue to monitor progress and work with Administration to improve compliance with documentation standards. • Audit results reported to the hospital's Quality and Medical Record Committee and Medical Executive Committee. **Date of Implementation:** • Non-compliance discussed and corrective actions addressed at the Medical Executive Committee meeting on June 17, 2014. • Chief of Staff communication dated June 19, 2014. • Monitoring of completion of Discharge Summaries – ongoing • Audit results reported to the hospital's Quality and Medical Record Committee and Medical Executive Committee – June 2014 and quarterly as required. **Monitoring Process:** • The HIM Manager and/or designee will conduct monthly audits of patient charts to review for the timely completion of Discharge Summaries. • Numerator = Number of discharge summaries completed within 14 days / Denominator – Total number of discharged charts reviewed. • The sample size will be based on monthly discharges, per the following guidelines: o Sample all cases for a population size of fewer than 30 cases	6/17/2014 6/19/2014 6/2014

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A 468	Continued From page 60 physician. According to the Medical Staff Rules & Regulations approved by the Governing Board on December 4, 2013, page 34, 14.18 Completion of the Record, 14.18.1 "In accordance with regulatory standards, medical records shall be completed within two (2) weeks following the patient's discharge.---"	A 468	(Continued from page 60) o Sample 30 cases for a population size of 30–100 cases o Sample 50 cases for a population size of 101–500 cases o Sample 70 cases for a population size of more than 500 cases • Targeted compliance is 90% • Monitoring activity will commence for a period not to exceed 4 months to ensure that compliance is achieved and sustained. • Random audits will be performed thereafter. • Results of the audits will be reported to the hospital's Quality and Medical Record Committee and Medical Executive Committee. **Person Responsible:** HIM Administrator and/or designee	
A 490	482.25 PHARMACEUTICAL SERVICES The hospital must have pharmaceutical services that meet the needs of the patients. The institution must have a pharmacy directed by a registered pharmacist or a drug storage area under competent supervision. The medical staff is responsible for developing policies and procedures that minimize drug errors. This function may be delegated to the hospital's organized pharmaceutical service. This CONDITION is not met as evidenced by: Based on observations, interviews, and records review, the facility failed to ensure and provide services that meet the needs of its patients. The facility failed to meet Condition of Participation for Pharmaceutical Services by failing: 1. Properly label the drawers of the CCU and ICU crash carts. (Hollywood campus) (Refer to A 0500). 2. Properly label three tubes of external ointment found in an open tray of the crash carts (Hollywood campus) (Refer to A 0500). 3. Ensure the ICU Crash Cart Contents Log was readily available. (Hollywood campus) (Refer to A	A 490	**HOLLYWOOD** **1). Corrective Actions:** Standardize all crash carts to include appropriate labels on each drawer with corresponding items and to include list of medications on the drawer. **Date of Implementation:** Will be completed in 30 days, expected date July 17, 2014 **Monitoring Process:** Monitoring will be managed by daily crash cart checks, monthly review by pharmacy and as needed during crash cart exchange **Person Responsible**: Pharmacy and Nursing Leadership in each department **2). Corrective Actions:** Standardize all crash carts, place lubricating jelly inside the drawer with the appropriate labels on each drawer and with all corresponding items. April 21-23, 2014 Education provided included review of policy PHA.052 Preparing and Administration of Medications; any unlabeled medication must not be used. Pharmacy will label all medications. **Date of Implementation:** Target date of completion in 30 days July 17, 2014. **Monitoring Process:** Monitoring will be managed by daily crash cart checks, monthly review by pharmacy and as needed during crash cart exchange. **Person Responsible:** Pharmacy and Nursing Leadership in each department. **3). Corrective Actions:** Standardize all crash carts to include appropriate labels on each drawer with corresponding items and to include list of medications on the drawer. April 21-23, 2014 education provided included review of policy PAT.058 Crash cart and crash cart checks to include presence of crash cart logs on corresponding cart **Date of Implementation:** Target date of completion will be in 30 days July 17, 2014 **Monitoring Process:** Monitoring will be managed by daily crash cart checks, monthly review by pharmacy and as needed during crash cart exchange **Person Responsible:** Pharmacy Department and Nursing Leadership in each department	7/17/2014 7/17/2014 4/21/2014 7/17/2014

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A 490	Continued From page 61 0500). 4. Ensure all components of a specialized emergency supply for the treatment of malignant hyperthermia are immediately accessible. (Culver City campus) (Refer to A 0500). 5. Ensure its patient would not receive medication or supplement that was not prescribed by the physician (Culver City) (Refer to A 0500). 6. Implement its policy and procedures for the use of a single-dose single-use ampule/vial (Culver City campus) (Refer to A 0500). 7. Ensure all medication orders in the Emergency Department be reviewed or verified by a pharmacist for therapeutic appropriateness prior to administration or at least retrospectively in cases of life-threatening emergency (Culver City campus) (Refer to A 0500). 8. Implement its policy and procedure on the safeguard of lock codes to a medication room (Hollywood campus) (Refer to A 0502). 9. Ensure drug storage areas are accessible only to authorized facility staff (Hollywood campus) (Refer to A 0502). 10. Ensure outdated medication in the refrigerator was not available for patient use (Van Nuy campus) (Refer to A 0505). The cumulative effect of these systemic issues resulted in the facility's inability ensure and provide a safe patient care environment.	A 490	(Continued from page 61) **CULVER CITY** **4.) Corrective Actions:** Ensure all components of a specialized emergency supply for the treatment of malignant hyperthermia are immediately accessible. Malignant hyperthermia kit contents will be added to the monthly Pharmacist Unit Inspection. The malignant hyperthermia items that are refrigerated will be packaged in a kit labeled "Malignant Hyperthermia" and stored in the appropriate refrigerator. **Date of Implementation**: Completed 6/17/14 **Monitoring Process:** Malignant hyperthermia kit will be checked during monthly unit inspections per P&Ps **Person Responsible:** VP of Pharmacy or designee **5).Corrective Actions**: All nursing staff re-educated to validate that physician orders have been noted, examined, and verified. Caregivers must use SBAR and provide the opportunity to use read-back techniques and medications orders received must be read back by the receiver. **Date of Implementation:** 5/18/2014 **Monitoring Process:** Random audit of 30 charts will be done per nursing unit aggregated data will be sent to the Quality Dept, non-compliance will result in progressive discipline actions. **Person Responsible**: Nursing Leadership **6).Corrective Actions:** Implement its policy and procedure "Medication: Care & Handling" SAN.019 for use of single dose vials. Policy revised to be clear on the use of single dose vials. Policy will be sent to medical staff. **Date of Implementation:** July 1st 2014 **Monitoring Process:** DOP or designee will review anesthesia cart sheets, and will check that the SDVs are being used one time only. Any violations will be reported the Quality Counsel. **Person Responsible:** VP of Pharmacy or designee **7).Corrective Actions:** Ensure all medication orders in the Emergency Department be reviewed or verified by the pharmacist for therapeutic appropriateness prior to administration or at least retrospectively in case of life threatening emergency. All ED medication orders will be reviewed by a pharmacist prior to administration, with the exception of emergency medications, in which the orders will be reviewed retrospectively. Emergency medications will be defined as those that are time critical according to hospital P&Ps. These include antibiotics, IV seizure medications, pain medications and other emergency stat medications. Drugs not deemed as non-emergency medication will not be overridable in the automated drug dispensing machine. (ADM) **Date of Implementation:** July 1st 2014 **Monitoring Process:** DOP or designee will review the overridden medications retrospectively for appropriateness. Results will be reported to Quality Counsel. **Person Responsible**: VP of Pharmacy or designee **HOLLYWOOD** **8-9). Corrective Actions**: Inspected all medication rooms to ensure no codes are written on walls, doors and no signs posted indicating the code number for entry. 3rd floor medication room door entry re-painted and signs removed. Plans to change medication room access with ID badge reader to ensure only authorized personnel will have access to med room. Education provided to include review of policy, medication room access by authorized personnel and room to remain closed at all times **Date of Implementation:** April 21- 23, 2014 **Monitoring Process:** Monitoring will be managed through daily nursing rounds and to include in EOC rounds **Person Responsible:** Nursing Leadership in each department, EOC members, ENG, HR, pharmacy **VAN NUYS** **10).Corrective Actions:** Ensure outdated medication in the refrigerator was not available for patient use. All multiple dose vials will be checked in the Pharmacist Monthly Unit Inspection. At the end of the month all MDVs will be replaced. **Date of Implementation:** 7/1/2014 **Monitoring Process:** MDVs will be checked upon Pharmacist Monthly unit inspection. Any discrepancies will be reported to Quality Counsel. **Person Responsible:** VP of Pharmacy or designee	6/17/2014 5/18/2014 7/1/2014 7/1/2014 4/21/2014 7/1/2014
A 500	482.25(b) DELIVERY OF DRUGS	A 500		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 500	Continued From page 62 In order to provide patient safety, drugs and biologicals must be controlled and distributed in accordance with applicable standards of practice, consistent with Federal and State law. This STANDARD is not met as evidenced by: Based on observations, interviews and records review, the facility failed to: 1. Properly label the drawers of the CCU and ICU crash carts (Hollywood campus). This deficient practice had the potential for not easily accessing emergency drugs and equipment that are used to treat a person's medical emergency. 2. Properly label three tubes of external ointment found in an open tray of the crash carts (Hollywood campus). This deficient practice had the potential for the staff to use unlabeled ointments to the patients. 3. Ensure the ICU Crash Cart Contents Log was readily available (Hollywood campus). This deficient practice had the potential for administering the cleaner and supplies for the treatment of Patient 24's wound which may not be inaccordance with the physician's order. 4. Ensure all components of a specialized emergency supply for the treatment of Malignant Hyperthermia are immediately accessible (Culver City campus). This deficient practice could result in not providing appropriate interventions for managing the patient with malignant hyperthermia, a deadly adverse outcome. 5. Ensure its patient would not receive medication or supplement that was not prescribed by the	A 500	**Hollywood** **1). Corrective Actions:** Standardize all crash carts, to ensure appropriate label outside the drawers with corresponding items listed **Date of Implementation:** Target date of completion in 30 days July 17, 2014 **Monitoring Process:** Monitoring will be managed through daily crash cart checks, monthly review by pharmacy and as needed during crash cart exchange **Person Responsible:** Pharmacy and Nursing Leadership in each department **2). Corrective Actions:** Standardize all crash carts, place lubricating jelly inside and all meds and all corresponding items in the drawer with the appropriate label outside the drawer. April 21-23, 2014 education provided included review of policy PHA.052 Preparing and Administration of Medications; any unlabeled medication must not be used and discarded. Pharmacy will label all medications **(see Addendum 30, 30a).** **Date of Implementation:** Label of meds implemented immediately by pharmacy, Target date of completion for crash cart standardization in 30 days July 17, 2014 Monitoring Process: Monitoring will be managed through daily crash cart checks, monthly review by pharmacy and as needed during crash cart exchange **Person Responsible:** Pharmacy and Nursing Leadership in each department **3). Corrective Actions:** Standardize all crash carts to include appropriate labels on each drawer with corresponding items and to include list of medications April 21-23, 2014 education provided included review of policy PAT.058 Crash cart and crash cart checks to include presence of crash cart logs on corresponding cart **(see Addendum 30, 30a).** **Date of Implementation:** Target date of completion will be in 30 days July 17, 2014 **Monitoring Process:** Monitoring will be managed through daily crash cart checks, monthly review by pharmacy and as needed during crash cart exchange	7/17/2014 7/17/2014 7/17/2014

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	050135	I. BUILDING **01 – SOUTHERN CALIFORNIA HOSPITAL AT HOLLYWOOD** J. WING	**04/01/2014**

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A 500	Continued From page 63 physician (Culver City campus). This deficient practice resulted in the patient receiving 2 doses of Zinc Sulfate (dietary supplement) that not ordered by the physician and did not promote safety in the patient's medication therapy. 6. Follow its policy and procedures for the use of a single-dose single-use ampule/vial (Culver City campus). 7. Ensure all medication orders in the Emergency Department be reviewed or verified by a pharmacist for therapeutic appropriateness prior to administration or at least retrospectively in cases of life-threatening emergency. This deficient practice had the potential to result in adverse drug events. Findings: 1. On March 27, 2014 at 12:53 p.m. on the third floor, the contents of drawers 2, 3, 4 and 6 of the CCU Crash Cart did not match the label affixed to the exterior of each drawer. A review of the facility's policy and procedure, titled "Crash Cart," Number: PAT.058, dated 11/2012, indicated "…the pharmacist shall check the drug and IV contents …and apply a label to the outside of the cart … A list of the crash cart medications … shall be kept on the outside of the cart …' 2. On March 27, 2014 at 12:59 p.m., on the third floor, the surveyor observed and identified two used, unlabeled 4-ounce tubes of lubricating jelly in the external open side tray of the CCU Crash Cart; one used, unlabeled 4-ounce tube of	A 500	(Continued from page 63) **Person Responsible:** Pharmacy and Nursing Leadership in each department **Culver City** **4) Corrective Actions:** Ensure all components of a specialized emergency supply for the treatment of malignant hyperthermia are immediately accessible. Malignant hyperthermia kit contents will be added to the monthly Pharmacist Unit Inspection. The malignant hyperthermia items that are refrigerated will be packaged in a kit labeled "Malignant Hyperthermia" and stored in the appropriate refrigerator. (P&P attached). In addition, Policy SAN.018 has been revised to include the Malignant Hyperthermia cart monthly check will include checking the refrigerated medications for Malignant Hyperthermia**. (see Addendums 31, 31a, 31b)** A designated area in the OR refrigerator has been labeled "IV Normal saline for malignant hyperthermia. **Date of Implementation:** Completed 6/17/14, July 14, 2014 Revised Policy to be submitted to the Surgery and Anesthesia Committee Meeting for approval process. **Monitoring Process:** The Director of Perioperative Services and/or designee will conduct monthly monitoring activity to include the verification of the refrigerated IV Normal Saline as a part of the routine check of the Malignant Hyperthermia cart. Compliance data will be reported to the Medication Safety Committee and the Quality Council on a quarterly basis until optimal compliance is achieved. In addition, malignant hyperthermia kit will be checked during monthly unit inspections per P&Ps **(see Addendum 31, 31a)** **Person Responsible:** Director Perioperative Services, Director of Pharmacy **5).Corrective Actions:** All nursing staff re-educated to validate that physician orders have been noted, examined, and verified. Caregivers must use SBAR and provide the opportunity to use read-back techniques and medications orders received must be read back by the receiver **Date of Implementation:** 5/18/2014	7/14/2014 5/18/2014

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A 500	Continued From page 64 lubricating jelly in the external open side tray of the ICU Crash Cart. A review of the facility's policy and procedure, titled, "Preparing and Administration of Medication", Number; PHA.052, dated "02/2012", indicated "…An unlabeled medication must never be used …" 3. On March 27, 2014 at 12:59 p.m., on the third floor, Nurse 1 failed to located the ICU Crash Cart Contents Log that would disclose the contents of the crash cart. A review of the facility's policy and procedure, titled "Crash Cart," Number: PAT.058, dated 11/2012, indicated "…A list of the crash cart medications… shall be kept on the outside of the cart…" 4. Malignant hyperthermia (MH) is a rare but potentially lethal adverse effect of a commonly used general anesthetic gases and succinylcholine; succinylcholine is a muscle relaxant used by physicians during emergency procedure to insert artificial airways [intubation] into patients with extreme difficulty in breathing. A defined list of supply has been published by the Malignant Hyperthermia Association of the United States (MHAUS) and the Association of Peri-Operative Registered Nurses (AORN), two nationally recognized organizations that set standards of care for this rare but deadly adverse medical outcome. On March 25, 2014, at 11 a.m., in the surgery department, both the director of peri-operative services (Staff J) and the chief nursing officer (Staff F) confirmed that there was no iced saline	A 500	(Continued from page 64) **Monitoring Process:** Random audit of 30 charts will be done per nursing unit **Person Responsible:** Nursing Leadership **6).Corrective Actions**: Implement its policy and procedure for use of single dose vials. Policy revised to be clear on the use of single dose vials. Policy will be sent to medical staff. **Date of Implementation:** July 1st 2014, Policy revised 5/5/2014, Revised Policy will be submitted through committee approval process. **Monitoring Process:** DOP or designee will review anesthesia cart sheets, and will check that the SDVs are being used one time only. Any violations will be reported the Quality Counsel. Anesthesiologists will be re-educated on the appropriate use of single use/dose vials. The hospital's Anesthesia policy Medication, Care and Handling Number: SAN.019 policy will be revised to include the following statement: Medications labeled as "single dose" or "single use" is meant for use in a single patient for a single case/procedure/injection; because they typically lack antimicrobial preservative **(see Addendum 32).** **Person Responsible:** VP of Pharmacy or designee, Director Perioperative Services, Director of Anesthesia, and Director of Infection Prevention **7).Corrective Actions:** All ED medication orders will be reviewed by a pharmacist prior to administration, with the exception of emergency medications, in which the orders will be reviewed retrospectively. Emergency medications will be defined as those that are time critical according to hospital P&Ps. These include antibiotics, IV seizure medications, pain medications and other emergency stat medications. Drugs not deemed as non-emergency medication will not be overridable in the automated drug dispensing machine. **Date of Implementation:** July 1st 2014 **Monitoring Process:** DOP or designee will review the overridden medications retrospectively for appropriateness. Results will be reported to Quality Counsel.	7/1/2014 7/1/2014

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A 500	Continued From page 65 available as part of the emergency supply for the treatment of Malignant Hyperthermia. On March 25, 2014 at 2:45 p.m. in the Emergency Room, during an interview, the director of the emergency room and one emergency staff (Staff N) indicated that they did not have the required iced saline (sodium chloride 0.9%) bags for the Malignant Hyperthermia kit. On March 25, 2014 at 2:50 p.m. in the emergency room, the clinical pharmacist (Rx 4) stated that the saline for the Malignant Hyperthermia cart would be provided by the central supply. According to the facility policy, titled “Malignant Hyperthermia Cart,” Number: PHA.090; dated “10/2012,” the MH kit should include “Sodium Chloride 0.9% 2 liters (refrigerator).” The same policy also delineated the treatment regimen include initiate cooling with IV (intravenously administered) iced saline solution at a rate of 1000 ml (milliliter) per 10 min (minute) for 30 minutes, which indicates at least three bags of iced saline should be available. According to the facility policy, titled “Malignant Hyperthermia,” Number: SAN.018, dated “11/2012,” the facility should have iced IV saline immediately available. Both policies listed MHAUS as reference. 5. On March 26, 2014 at 9:30 a.m. in the Telemetry Unit, a surveyor observed a medication pass for one patient, Patient 7. The surveyor observed that the Patient 7 received one tablet of the dietary supplement Zinc Sulfate 220 mg but could not locate the physician’s order in the	A 500	(Continued from page 65) **Person Responsible:** VP of Pharmacy or designee	

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A 500	Continued From page 66 patient's chart. On March 25, 2014 at 10:45 a.m., Rx 3 confirmed he did not find the Zinc Sulfate order in the Patient 7's chart. On March 26, 2014 at 11 a.m., Rx 1 could not find the Zinc Sulfate order in the Patient 7's chart. A review of the Nutrition Recommendation Form for Patient 7 dated March 25, 2014 at 8:16 a.m. indicated a handwritten check mark in the check box for "Vitamins and Minerals" and another handwritten check mark in the check box for "Multivitamin mineral 1 tablet PO (orally) daily." However, there was no marking by the check box for "Zinc Sulfate 220 mg." A review of the fax copy of the "Nutrition Recommendation Form" dated March 24, 2014 at 1:05 p.m., indicated the pharmacy received the order on March 25, 2014 at 8:16 a.m. when the pharmacy received the order. A review of the electronic Medication Administration Record (eMAR) for March 25, 2014, the day before, indicated that Patient 7 received one Zinc Sulfate 220 mg tablet on March 25, 2014 at 9 a.m. As of the medication pass observed on March 26, 2014 at 9:30 a.m., a total of two doses of Zinc Sulfate 220 mg tablets were given to Patient 7. On March 26, 2014 at 11:23 a.m., an interview with (Pharmacist 1) indicated that a staff pharmacist misread the Nutrition Recommendation form as that Zinc Sulfate being included because of the long handwritten check	A 500		

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A 500	Continued From page 67 mark for the multivitamin with mineral, which was located directly above it on the pre-printed Nutrition Recommendation Form. At 1:42 p.m., Pharmacist 1 stated that there was no policy and procedure for the chart check process performed by the nursing staff that would verify eMAR with actual physician orders. At 1:49 p.m. during an interview, RN 10 described the process for the 12 hour chart check performed at shift change. The nruses performing the chart check would receive a report from a "supervising nurse," they would then confirm physician orders the chart with eMAR and would verify in computer program. She stated "This is a routine protocol." She also described the 12 hour nursing shifts as 7 a.m. to 7 p.m. and 7 p.m. to 7 a.m. On March 28, 2014 at 11:53 a.m., during a follow-up interview, RN 10 stated that the nurses responsible for their patients should have caught the medication entry error during the chart check process. A review of the policy and procedure titled, "Drug Distribution and Control", Number: PHA.025 dated "10/2012" , indicated "…The Pharmacy department shall distribute medication and control the use of medication as follow: … Review all medications orders for appropriateness and safety with respect to the current medication profile …" A review of the policy and procedure titled, "Hand Off Communications," Number: PAT.043, dated "11/2012", indicated "…A "hand off" communication is an interactive process of	A 500		

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A 500	Continued From page 68 passing patient-specific information from one caregivers to another or from one team of caregivers to another for the purpose of ensuring the continuity and safety of the patient's care…This provides the caregivers an opportunity to verify information by using read-back techniques. Critical test results and medication orders received shall be read back by the receiver. The occurrence of the read back shall be documented in the medical record." 6. On March 24, 2014 at 11:29 a.m., a review of the Anesthesia Controlled Drug Record, dated "March 18, 19, 19 and 21, 2014" indicated that a Fentanyl 250 mg per 5 milliliter (ml) ampule was used for two different patients, that half of the content was used for Patient 3, marked as "0.5" and half the content was used for Patient 2, marked as "0.5." The inventory count indicated the beginning count of 10 ampules and the ending balance of 9 ampules. The Anesthesia Record dated March 19, 2014 for Patient 3 showed that the Anesthesiologist administered Fentanyl 100 micrograms (mcg) at approximately 10:15 a.m. and 25 mcg at approximately 11:15 a.m., total 125 mcg. The Anesthesia Record dated March 19, 2014 for Patient 2 showed that the same Anesthesiologist administered Fentanyl 50 mcg at approximately 11:45 a.m. and 75 mcg at approximately 12:15 p.m., total 125 mcg. The manufacturer's package insert indicated "Fentanyl Citrate Injection…is preservative-free and available as …5 ml Single Dose ampules.	A 500		

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A 500	Continued From page 69 On March 25, 2014, at 11:36 a.m., the DOP confirmed those fentanyl ampules are single-use and should not be shared between patients. On March 28, 2014 at 11:20 a.m., during an interview, when the surveyor showed the Anesthesia Controlled Drug Record and the use of the single dose ampule on two different patients to the Director of Infection Prevention and Control, she responded “What does this have to do with me?” On March 28, 2014 at 11:25 a.m. during an interview, the facility contracted Hospital Epidemiologist (Staff P) stated the single use ampule is not to be used for more than one patient. On March 28, 2014 at 12:45 p.m., a review of the facility policy and procedure titled “Medication, Care and Handling,” Number: SAN.019, dated “11/2012”, indicated “…Each patient is medicated with either single dose or multiple dose vials. The remainder of each of the multi-dose vial is discarded after each patient.” When the surveyor asked Rx 1 (Pharmacist 1) to clarify this policy, she stated the policy should read “The remainder of each of the single dose vial is discarded after each patient.” A review of the policy and procedure titled “Handling of Multidose/Single Dose Vials and IV Compounding (Low Risk Condition) Outside Laminar Flow Hood”, Number: PHA.090, dated “10/2012” indicated “…Single Dose vials/ampoules should be discarded soon after opening and not stored… Opened single dose ampoules hsall not be stored for any time period	A 500		

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A 500	Continued From page 70 …" 7. On March 25, 2014, at 10:15 a.m., during an discussion of the medication process, Rx 3 (Pharmacist 3) stated the pharmacy department does not review or reconcile medication removal report from the automated dispensing cabinet (ADC) located in the emergency department. At 3:15 p.m., Rx 3 also stated the pharmacy department does not regularly review the medication orders prescribed in the emergency room for therapeutic appropriateness. The department received an unknown percentage of those orders but not all. The pharmacy would receive orders for medications that were not stocked in the ADC located in the emergency room. On March 26, 2014, at 9:30 p.m., during another discussion, Rx 3 stated the current computer system does not have the capability to tally or report the physician orders prescribed in the emergency room. Rx 3 could not find out how many prescriptions had been sent to the pharmacy for verification. According to a nationally recognized professional association, American Society of Health-System Pharmacists (ASHP, which published numerous authoritative guidelines in pharmacy practice referred by the industry as the standard of practices), the guideline titled "Minimum Standard for Pharmacies in Hospitals" , dated 4/13/2012, indicated "All medication orders shall be prospectively reviewed by a pharmacist and assessed in relation to pertinent patient and clinical information before the first dose is administered or made available in an automated	A 500		

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A 500	Continued From page 71 dispensing device, except in emergent situation.. There shall be a procedure for retrospective review of these orders." The guideline further suggested "use of {ADC] shall be structured so as to not hinder the pharmacist's review of (and opportunity to intervene in) medication orders before the administration of first doses …" According to the facility policy, titled "Drug Distribution and Control," Number: PHA.025, dated "10/2012" , "..The pharmacy department shall…review all medications orders for appropriateness and safety with respect to the current medication profile.	A 500		
A 502	482.25(b)(2)(i) SECURE STORAGE All drugs and biologicals must be kept in a secure area, and locked when appropriate. This STANDARD is not met as evidenced by: Based on observations, interviews and documents review, the facility failed to: 1. Implement its policy and procedure on the safeguard of lock codes to a medication room (Hollywood campus). 2. Ensure drug storage areas are accessible only to authorized facility staff (Hollywood campus). These deficient practices had the potential for unauthorized persons access to drugs and intravenous solution in the facility's medication room and drug storage room. Findings: 1. On March 27, 2014 at 1:05 p.m. on the third floor, the surveyors observed the Head nurse of the ICU punching in the lock code for the	A 502	**Hollywood** **1).Corrective Actions:** Inspected all medication rooms to ensure no codes are written on walls, doors and no signs posted indicating the code number for entry. 3rd floor medication room door entry re-painted and signs removed. Plans to change medication room access with ID badge reader to ensure only authorized personnel will have access to med room. Education provided April 21- 23, 2014 to include review of policy, medication room access by authorized personnel and room to remain closed at all times **(see Addendum 33, 33a)** **Date of Implementation**: March 27, 2014, full implementation of badge reader will be in 30 days July 17, 2014 **Monitoring Process**: Monitoring will be managed through daily nursing rounds and to include in EOC rounds **Person Responsible:** Nursing Leadership in each department, EOC members, ENG, HR, pharmacy **2).Corrective Actions:** Inspected all medication rooms to ensure no codes are written on walls, doors and no signs posted indicating the code number for entry. 3rd floor medication room door entry re-painted and signs removed.	3/27/2014

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A 502	Continued From page 72 medication room and simultaneously noticed the four-digit security code was handwritten on a sheet of paper taped to the exterior of the medication room door. Adjacent to this sheet of paper was a sign taped to the inside of the glass window of the secure medication room door that stated “Keep Doors Closed & Do Not Write the Lock Codes on Walls or Doors or This Sign.” The four numbers handwritten on the paper was the lock code. She then removed the sign and discarded it. 2. On March 27, 2014 at 1:55 p.m., on the sixth floor, the surveyor observed the double-door to the Purchasing/Central Supply Room was left wide open with a doorstop. For eight minutes, from 1:55 p.m. to 2:03 p.m., the pharmacy surveyors and Rx 1 (Pharmacist 1) visited the pharmacy across the hallway. Upon leaving the pharmacy at 2:03 p.m., the surveyor observed that the Purchasing/Central Supply Room door was still open. The surveyors and the VPPO entered the Purchasing/Central Supply Room and called out to see if anyone was present, but no one answered. The Purchasing/Central Supply Room was left unattended for approximately eight minutes if not longer. Rx 1 identified cases of I.V. bags (D51/2NS), syringes, and the drug lidocaine in the crash cart kits. A few minutes later, Staff Q walked in and stated he had gone for three to four minutes.” On March 27, 2014 at 2:36 p.m., on the third floor, Rx 1 identified that the door of the secure medication room with a self-closing door mechanism did not completely close.	A 502	(Continued from page 72) Plans to change medication room access with ID badge reader to ensure only authorized personnel will have access to med room. Education provided April 21- 23, 2014 to include review of policy, medication room access by authorized personnel and room to remain closed at all times **(see Addendum 33, 33a).** **Date of Implementation:** March 27, 2014, full implementation of badge reader will be in 30 days July 17, 2014. **Monitoring Process:** Monitoring will be managed through daily nursing rounds and to include in EOC rounds. **Person Responsible:** Nursing Leadership in each department, EOC members, ENG, HR, pharmacy	3/27/2014

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A 502	Continued From page 73 On March 27, 2014 at 2:36 p.m., two surveyors noted that the access door from the nursing station leading to the secure medication room was not locked while another access door from the hallway was locked with a security code lock. On March 27, 2014 at 3:12 p.m., Rx 1 confirmed that the facility could not produce a policy and procedure for the security of the Purchasing/Central Supply Room. On March 27, 2014 at 3:37 p.m., on the third floor, the secure medication room door was ajar and not securely closed. The surveyor made three attempts within one minute but the door failed to close. Rx 1 also made three more attempts in the next minute and the door failed to close. According to the facility policy, titled “Security of Medications Outside the Main Pharmacy”, Number PHA.084, dated “10/2012” , “…All drug storage areas are lockable. All drug storage areas are locked when not in use…”	A 502		
A 505	482.25(b)(3 UNUSABLE DRUGS NOT USED Outdated, mislabeled or otherwise unusable drugs and biologicals must not be available for patient use. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure an outdated medication, such as Tuberculin purified protein derivative, PPD (skin test to determine if a person had been exposed to tuberculosis, a contagious lung infection) was not in the medication refrigerator, available for patient use. This deficient practice had the potential for	A 505	**Van Nuys** **Corrective Actions:** Ensure outdated medication in the refrigerator was not available for patient us. All multiple dose vials will be checked in the Pharmacist Monthly Unit Inspection. At the end of the month all MDVs will be replaced. **Date of Implementation**: 6/16/2014 **Monitoring Process:** MDVs will be checked upon Pharmacist Monthly unit inspection. Any discrepancies will be reported to Quality Counsel**. (see Addendum31a)** **Person Responsible:** Director of Pharmacy	6/16/2014

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	050135	K. BUILDING **01 – SOUTHERN CALIFORNIA HOSPITAL AT HOLLYWOOD** L. WING _____	**04/01/2014**

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SOUTHERN CALIFORNIA HOSPITAL AT HOLLYWOOD	**6245 DE LONGPRE AVE HOLLYWOOD, CA 90028**

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A 505	Continued From page 74 administering an outdated Tuberculin PPD, to the patients Findings: On March 2, 2014, at 10:30 a.m., during a medication room inspection, in the Unit 2 of the facility's psychiatric campus, the medication refrigerator had one Tuberculin (TB 5 units) ampule with an expiration date of November 23, 2013. Licensed Vocational Nurse (LVN) 3 stated the Tuberculin should have been discarded and should have reordered.	A 505		
A 592	482.27(b) POTENTIALLY INFECIOUS BLOOD/BLOOD PRODUCTS Standard: Potentially infectious blood and blood products. (1) Potentially human immunodeficiency virus (HIV) infectious blood and blood components. Potentially HIV infectious blood and blood components are prior to collections from a donor – (i) Who tested negative at the time of donation but tests reactive for evidence of HIV infection on a later donation; (ii) Who tests positive on the supplemental (additional, more specific) test or other follow-up testing required by FDA; and (iii) For whom the timing of seroconversion cannot be precisely estimated. (2) Potentially hepatitis C virus (HCV) infectious blood and blood components. Potentially HCV infectious blood and blood components are the blood and blood components identified in 21 CFR 610.47.	A 592	**Culver City** **1-8) Corrective Actions:** Look Back Policy BBK.207 **(see Addendum 34)** has been amended to include the hospitals responsibility to the patient if the physician cannot be contacted or located as stated in Procedural notes number 1. **Date of Implementation:** This policy has been approved and implemented on April 2nd 2014. **Monitoring Process**: A monitoring process has been put in effect to address the number of recalled blood products and if there is any need for the clinicians' to be notified also being monitored is if there are any failed attempts to the clinicians. **Person Responsible:** Laboratory Supervisor, Laboratory Director	4/2/2014

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A 592	Continued From page 75 (3) Services furnished by an outside blood collecting establishment. If a hospital regularly uses the services of an outside blood collecting establishment, it must have an agreement with the blood collecting establishment that governs the procurement, transfer, and availability of blood and blood components. The agreement must require that the blood collecting establishment notify the hospital – (i) Within 3 calendar days if the blood collecting establishment supplied blood and blood components collected from a donor who tested negative at the time of donation but tests reactive for evidence of HIV or HCV infection on a later donation or who is determined to be at increased risk for transmitting HIV or HCV infection; (ii) Within 45 days of the test, of the results of the supplemental (additional, more specific) test for HIV or HCV, as relevant, or other follow-up testing required by FDA; (iii) Within 3 calendar days after the blood collecting establishment supplied blood and blood components collected from an infectious donor, whenever records are available, as set forth at 21 CFR 610.48(b)(3). (4) Quarantine of blood and blood components pending completion of testing. If the blood collecting establishment (either internal or under an agreement) notifies the hospital of the reactive HIV or HCV screening test results, the hospital must determine the disposition of the blood or blood component and quarantine all blood and blood components from previous donations in inventory. (i) If the blood collecting establishment notifies the hospital that the result of the supplemental (additional, more specific) test or other follow-up			

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A 592	Continued From page 76 testing required by FDA is negative, absent other informative test results, the hospital may release the blood and blood components from quarantine. (ii) If the blood collecting establishment notifies the hospital that the result of the supplemental (additional, more specific) test or other follow-up testing required by FDA is positive, the hospital must – (A) Dispose of the blood and blood components; and (B) Notify the transfusion recipients as set forth in paragraph (b)(6) of this section. (iii) If the blood collecting establishment notifies the hospital that the result of the supplemental (additional, more specific) test or other follow-up testing required by FDA is indeterminate, the hospital must destroy or label prior collections of blood or blood components held in quarantine as set fors at 21 CFR 610.46(b)(2), 610.47(b)(2), and 610.48(c)(2). (5) Recordkeeping by the hospital. The hospital must maintain – (i) Records of the source and disposition of all units of blood and blood components for at least 10 years from the date of disposition in a manner that permits prompt retrieval; and (ii) A fully funded plan to transfer these records to another hospital or other entity if such hospital ceases operation for any reason. (6) Patient notification. If the hospital has administered potentially HIV or HCV infectious blood or blood components (either directly through its own blood collecting establishment or under an agreement) or released such blood or blood components to another entity or appropriate individual, the hospital must take the following	A 592		

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A 592	Continued From page 77 actions: (i) Make reasonable attempts to notify the patient, or to notify the attending physician who ordered the blood or blood component and ask the physician to notify the patient, or other individual as permitted under paragraph (b)(10) of this section, that potentially HIV or HCV infectious blood or blood components were transfused to the patient and that there may be a need for HIV or HCV testing and counseling. (ii) If the physician is unavailable or declines to make the notification, make reasonable attempts to give this notification to the patient, legal guardian or relative. (iii) Document in the patient's medical record the notification or attempts to give the required notification. (7) Timeframe for notification. (i) For donors tested on or after February 20, 2008. For notifications resulting from donors tested on or after February 20, 2008 as set forth at 21 CFR 610.46 and 21 CFR 610.47 the notification effort begins when the blood collecting establishment notifies the hospital that is received potentially HIV or HCV infectious blood and blood components. The hospital must make reasonable attempts to give notification over a period of 12 weeks unless – (A) The patient is located and notified; or (B) The hospital is unable to locate the patient and documents in the patient's medical record the extenuating circumstances beyond the hospital's control that caused the notification timeframe to exceed 12 weeks. (ii) For donors tested before February 20, 2008. For notifications from donors tested before February 20, 2008 as set forth at 21 CFR	A 592		

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A 592	Continued From 78 610.48(b) and (c), the notification effort begins when the blood collecting establishment notifies the hospital that it received potentially HCV infectious blood and blood components. The hospital must make reasonable attempts to give notification and must complete the actions within 1 year of the date on which the hospital received notification from the outside blood collecting establishment. (8) Content of notification. The notification must include the following information: (i) A basic explanation of the need for HIV or HCV testing and counseling. (ii) Enough oral or written information so that an informed decision can be made about whether to obtain HIV or HCV testing and counseling (iii) A list of programs or places where the person can obtain HIV or HCV testing and counseling, including any requirements or restrictions the program may impose. (9) Policies and procedures. The hospital must establish policies and procedures for notification and documentation that conform to Federal, State, and local laws, including requirements for the confidentiality of medical records and other patient information. (10) Notification to legal representative or relative. If the patient has been adjudged incompetent by a State court, the physician or hospital must notify a legal representative designated in accordance with State law. If the patient is competent, but State law permits a legal representative or relative to receive the information on the patient's behalf, the physician or hospital must notify the patient or his or her legal representative or	A 592		

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A 592	Continued From page 79 relative. For possible HIV infectious transfusion recipients that are deceased, the physician or hospital must inform the deceased patient's legal representative or relative. If the patient is a minor, the parents or legal guardian must be notified. (11) Applicability. HCV notification requirements resulting from donors tested before February 20, 2008 as set forth at 21 CFR 610.48 will expire on August 24, 2015. This STANDARD is not met as evidenced by: Based on document review and interview, the facility failed to have a written procedure for the hospital making reasonable attempts to notify a patient that was potentially administered HIV or HCV infectious blood or blood components if the patients physician was unavailable or declined to make the notification. This deficient practice had the potential for not informing the patient regarding the need for HIV or HCV testing and counseling. Finding: On March 31, 2014, between 10:54 a.m. and 11:55 a.m., accompanied by Staff 14 (director of laboratory and pathology) and Staff 15 (lab supervisor), a review of the hospital's policies and procedures titled, Lookback Policy SOP #2324A (Number BB14) dated effective July 2002; Lookback Programs HIV, HTLV I/II, SOP 2325B (P&P 15) (Number BBK-203) dated effective October 2002; and Lookback Program Recall Notification (Number BBK0204) dated effective July 2002 revealed there was no procedure for the hospital to notify a patient that was potentially administered HIV or HCV infectious blood or	A 592		

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A 592	Continued From page 80 blood components if the patient's physician was unavailable or declined to make the notification. At the same time, as the review, Staff 14 and Staff 15 were informed that the hospital's Lookback Program Recall Notification policy and procedure did not indicate the hospital's procedure to notify a patient that was potentially administered HIV or HCV infectious blood or blood components if the patients physician was unavailable or declined to make the notification. During concurrent interview, when asked what the hospital's procedure was to notify the patient if the patient's doctor was not available or if the patient's doctor refused to notify the patient, the lab supervisor stated the procedure for the hospital was that the blood bank drafts a letter and the lab sends it to the pathologist to sign off on and the lab mails it to the clinician (patient's doctor) and that the clinician will follow through. Neither the director of laboratory and pathology or the lab supervisor provided the hospital's procedure for the hospital making reasonable attempts to notify a patient that was potentially administered HIV or HCV infectious blood or blood components if the patient's physician was unavailable or decline to make the notification.	A 592		
A 618	482.28 FOOD AND DIETETIC SERVICES The hospital must have organized dietary services that are directed and staffed by adequate qualified personnel. However, a hospital that has a contract with an outside food management company may be found to meet this Condition of Participation if the company has a	A 618	**Hollywood** **1) Corrective Actions:** Prior director was replaced with a new Director of Dietary at both locations, Hollywood and Van Nuys. **Hollywood:** A full-time consulting Director of Dietary Department, RD was appointed to provide oversight of the dietary department. A full-time Food Services Supervisor was appointed to oversee the day to day operations of dietary department. A clinical dietitian and a per diem Registered Dietitian provide clinical support. **Date of implementation:** July 31, 2014	7/31/2014

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A 618	Continued From page 81 dietitian who serves the hospital on a full-time, part-time, or consultant basis, and if the company maintains at least the minimum standards specified in this section and provides for constant liaison with the hospital medical staff for recommendations on dietetic policies affecting patient treatment. This CONDITION is not met as evidenced by: Based on observation, review of facility documents and staff interview, the facility failed to meet the Condition of Participation in Food and Dietetic Services by failing to: 1. Provide organized dietetic services as evidenced by findings of unsafe food handling practices and inadequate supervision of the dietary department (Refer to A 619, A 620, A 621, A 628). 2. Ensure accurate nutritional analysis of regular and therapeutic menus, menus that were in compliance with nationally recognized practices (Refer to A 630). 3. Have menus for all physician ordered diets (Refer A to 628). 4. Have effective system to ensure that physician ordered diets were followed (Refer A to 629). 5. Ensure safe and effective food storage/production practices (Refer to A 620). 6. Ensure adequate food and water were on hand for use in an emergency (Refer to A 703). 7. Have policies and procedures, spreadsheets for the distribution of food.	A 618	(Continued from page 81) **Van Nuys:** A full time Director of Dietary Department, RD was placed to provide oversight of dietary department. A full time Food Services supervisor continues to oversee the day to day operations of dietary department. A per diem clinical dietitian is available for clinical support as needed. **Date of implementation:** July 31, 2014 **Both Hollywood and Van Nuys:** Additionally, a contract is in process to retain a Food Service Management company to permanently operate the Food & Nutrition Services Department at both the Hollywood and Van Nuys campuses. This contract will include safe food handling and sanitation compliance requirements to meet all State, Federal, and DNV regulatory requirements. A General Consultant and Chef Consultant are also working between both institutions. A contract is in process with a letter of intent given to retain a Food Service Management company to permanently operate the Food & Nutrition Services Department at both Hollywood and Van Nuys. This contract will include food safe handling and sanitation compliance requirement to meet all State, Federal and DNV regulatory requirements. **Date of Implementation:** Initial correction from May 19, 2014-June 16, 2014. Additional staff of Consulting RD Director and Consulting Staff to meet Organizational needs implemented July 31, 2014. Contract Company Agreement scheduled to start October 1, 2014. **Monitoring Process:** The hospital's leadership will ensure that the Dietary Department is staffed with competent and appropriately credentialed supervisory coverage at all times. The Food & Nutrition Services Contract will be reviewed for service level compliance and regulatory standards on an annual basis by Hospital Administration and the Quality Council for recommendation for continuation. **Person Responsible:** Administrators at both Southern California Hospital at Hollywood and Van Nuys. **2) Corrective Actions:** Menus have been analyzed to meet at least 90% of DRI for all diets with the exception of those noted in the diet manual or addendums as being unable to reach such levels due to their dietary restrictions. An alternate menu or meal substitution with nutritionally equivalent options are available **Date of Implementation:** September 10, 2014 **Monitoring Process:** The nutritional analysis of menus as served are approved by the Med Executive Committee and Governing Board. Patient satisfaction is monitored to determine patient acceptance of menus provided. . **Person Responsible**: RD, Director of Dietary Department and Clinical Dietitian RD **3) Corrective Actions:** Menus are available for all standard physician ordered diets. Diets other than those on the standard list of diets will be calculated as needed by a Registered Dietitian. **Date of Implementation:** September 10, 2014 **Monitoring Process:** Review of nutritional analysis of menus as served are approved by the Med Executive Committee and Governing Board. **Person Responsible:** RD, Director of Dietary Department and Clinical Dietitian RD	7/31/2014 5/19/2014 7/31/2014 10/1/2014 9/10/2014 9/10/2014

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A 618	Continued From page 82 8. Development of menus that were consistent with nutrient parameters as approved by the hospitals' Medical Executive Committee. (Refer to A 631). The cumulative effect of these systemic issues resulted in the facility's inability to ensure and provide a safe patient care environment.	A 618	(Continued from page 81) **4) Corrective Actions:** Implementation of Mandatory CPOE diet order entry and standardization of diet orders available in the system to be in compliance with the facility diet manuals. Dietitians write diet order clarification/recommendations when discrepancies are identified. **Date of Implementation:** September 10, 2014 Continued on Page 83a.	9/10/2014
A 619	482.28(a) ORGANIZATION Organization This STANDARD is not met as evidenced by: Based on observation, review of hospital documents and staff interviews, the hospital failed to ensure that the food and dietetic services department was properly organized. The person in the position of leadership in two of the three campuses had too many responsibilities, lacked the proper education and training appropriate to the scope and complexity of the food service operations. These failures resulted in deficient practices that affected the quality of care being provided due to failure to meet the nutritional needs of patients, lack of policies and procedures and poor food safety practices. Findings: During an interview on March 24, 2014 with (food service director), Staff 2 revealed that he had responsibilities for four of five hospitals owned by the licensee. His office was not based in any of the hospitals being inspected. The name badge on his shirt did not reflect the name of the hospitals being surveyed but the other two	A 619	**Hollywood & Van Nuys** A Registered Dietitian Director of Food and Nutrition Services was recruited, interviewed, hired or promoted to ensure qualified and competent staff was in place. Responsibilities include: • Provides adequate overall supervision, • Oversight of patient services and menu, • Develops and ensures provision of ongoing training and development of department staff, • Maintains equipment in working order by notifying maintenance of needed repairs and administration for capital replacement, • Demonstrates knowledge of infection control, sanitation and HACCP guidelines related to safe food handling practices to ensure quality and safety of food services. **Corrective Actions:** Prior director was replaced with a new Director of Dietary at both locations, Hollywood and Van Nuys. **Hollywood:** A full-time consulting Director of Dietary Department, RD was appointed to provide oversight of the dietary department. A full-time Food Services Supervisor was appointed to oversee the day to day operations of dietary department. A clinical dietitian and a per diem Registered Dietitian provide clinical support. **Date of implementation**: July 31, 2014 **Van Nuys:** A full time Director of Dietary Department, RD was placed to provide oversight of dietary department. A full time Food Services supervisor continues to oversee the day to day operations of dietary department. A per diem clinical dietitian is available for clinical support as needed. **Date of implementation:** July 31, 2014 **Both Hollywood and Van Nuys:** Additionally, a contract is in process to retain a Food Service Management company to permanently operate the Food & Nutrition Services Department at both the Hollywood and Van Nuys campuses. This contract will include safe food handling and sanitation compliance requirements to meet all State, Federal, and DNV regulatory requirements. A General Consultant and Chef Consultant are also working between both institutions. A contract is in process with a letter of intent given to retain a Food Service Management company to permanently operate the Food & Nutrition Services Department at both Hollywood and Van Nuys. This contract will include food safe handling and sanitation compliance requirement to meet all State, Federal and DNV regulatory requirements.	7/31/2014 7/31/2014

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A 619	Continued From page 83 hospitals that was owned by the licensee. The hospital being surveyed had three campuses of which he had responsibilities for two. He explained that he visits all the hospitals and is helped by the food service supervisors in some of the hospitals. Of the two hospitals he was responsible for only one had a supervisor, who had started three weeks earlier, when he was not visiting the campus. Observations and review of hospital documents revealed that he was not responsible for the day to day management of either of the campuses. The lack of leadership and supervision of dietary staff was evident in the identified concerns about food ordering, failure to follow menu, improperly maintained food service equipment, lack of policies and procedures, poor food safety practices, Food Ordering At the Hollywood campus, there was inadequate food on hand to meet state requirements of seven days of staples and two days of perishable foods. There was inadequate food on hand to meet patient's need in an emergency. Staff 2 stated in an interview at approximately 3:00p.m. on March 24, 2014 that food he ordered food once per week. This ordering procedure results in food supplies being low and running the risk of inadequate food if the delivery were delayed or interrupted due to catastrophic reasons. DS (dietary staff) 4 was unable to provide information on a product he had prepared when there were concerns about appropriateness for patients on renal diet. (Cross reference A 0622). There was about half box (50 lbs.) of sprouting potatoes. Review of the shipping order showed that the item had been ordered two weeks earlier and had	A 619	(Continued from page 83) **Date of Implementation:** Initial correction from May 19, 2014-June 16, 2014. Additional staff of Consulting RD Director and Consulting Staff to meet Organizational needs implemented July 31, 2014. Contract Company Agreement scheduled to start October 1, 2014. **Monitoring Process:** The hospital's leadership will ensure that the Dietary Department is staffed with competent and appropriately credentialed supervisory coverage at all times. The Food & Nutrition Services Contract will be reviewed for service level compliance and regulatory standards on an annual basis by Hospital Administration and the Quality Council for recommendation for continuation. **Person Responsible:** Administrators at both Southern California Hospital at Hollywood and Van Nuys. **2a) Food Ordering** **Corrective Actions:** **Hollywood:** Food Delivery frequency has been increased to 3 days per week. Sufficient items are on hand to meet the needs of the menu as served for 7 days of staples and 2 days of perishables. Frequency of Deliveries will continue to be adjusted as needed to ensure minimum food requirements are met. **Van Nuys:** Food delivery frequency has been revised to meet 7 days of staples and 2 days of perishables. Frequency of perishable food deliveries was reviewed and adjusted. Additional adjustments will be made after equipment is repaired and/or replaced allowing for less frequent deliveries A disaster menu and supplies for patients were adjusted to meet the needs of the facility. Disaster food and supplies for patients have been received. A disaster plan to include staff and others is being developed and food products ordered accordingly. Once the plan is finalized, staff will be trained on its use. **Date of implementation**: August 4, 2014, with a completion date of August 29, 2014 **2b) Renal diets:** Food items for Renal and other therapeutic diets are maintained to ensure compliance with 7 days of staples and 2 days of perishables. **Date of implementation:** August 4, 2014	5/19/2014 7/31/2014 10/1/2014 8/4/2014 8/4/2014

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 619	Continued From page 84 not been used and /or stored properly. There were no pasteurized eggs on hand, but there was fried eggs on the menu, improper cooking of the eggs could result in the exposure of patients who may be already immune-compromised be exposed to bacteria that could cause food borne illness. According to the hospital policy on food supplies dated 11/2012, there should be no less than a one week supply of staple food and less than two days' supply of perishable foods. In addition, the policy states that food is purchased in accordance to the needs of the menu and any items requested for special needs or nourishment of the patient in quantity and quality to ensure sufficient amounts for the number of patients or guests to be served. Menu The cooks had not been following the menu. On March 24, 2014, the lunch menu for patients on regular diet, had the following items: Tossed green salad with dressing, Roast beef or Chef salad, Baked Potato with sour cream, green beans, dinner roll, margarine, tapioca pudding and milk. Items prepared were roast beef, confetti rice, mixed vegetables with broccoli, noodles, macaroni salad and milk. It was not clear why the menu was not followed. Other items served were not identified in the therapeutic spreadsheet. There were no scoop sizes being used to serve vegetables, noodles to ensure that patients were served the correct amount. Review of the hospital policy and procedure titled "General Requirements for Food" dated 11/12 states "The Clinical Dietitian shall be responsible for substituting food so that the patient has adequate quality and quantity." The Clinical Dietitian was	A 619	(Continued from page 84) **2c) Food storage:** Spoiled food products were immediately discarded and proper storage of food items according to FDA Food Code 2013 has been implemented. Produce is ordered, stored and utilized in a timely manner to avoid spoilage. **Date of implementation:** August 4, 2014 **2 d) Pasteurized eggs:** Non-pasteurized eggs were discontinued. Only pasteurized Eggs are now ordered in place of non-pasteurized shell eggs. No non-pasteurized eggs are to be purchased or used in the future. **Date of Implementation**: Pasteurized eggs in use as of 7/21/14 **Training for food ordering 2 a, b, c and d:** Staff was trained and competency tested on proper storage of food. **Date of Implementation:** July 31, 2014 **Monitoring Process: Food ordering for a, b, c and d:** Weekly ordering inventory to ensure adequate menu supplies are on hand and only pasteurized eggs are ordered. . Monthly inventory for adequate emergency supplies will be compared to the "Disaster Inventory Sheet". Results of disaster supply inventory levels will be reported to the hospital's EOC Committee, Quality Council, and Governing Board on a quarterly basis. **Person Responsible:** RD, Director of Dietary Department **Hollywood & Van Nuys** **3) Menu:** **a) Menu spread not available and portion sizes not followed:** **Corrective Actions:** Copy of the current menu spread was immediately posted on tray line and reviewed with staff. Dietary Staff was in-serviced on menu comprehension, serving sizes, portions and following therapeutic requirements as shown on menu. Menu books have been provided to the Dietary staff for referencing menu items for each type of diet and portions sizes required. **b) Menu substitution:** **Corrective Actions:** The Food Service staff and Supervisor were in-serviced to consult Registered Dietitians for proper food substitution. Dietary staff was provided a routine substitution list on proper food substitution. **c) Policy for double portions, small portions and consistency of pureed foods:** **Corrective Actions:** A procedure was developed and implemented for double and small portion meals and staff was in-serviced. Staff was instructed on the proper preparation and service of puree food items. **Date of Implementation:** Training initiated June 17 and completed July 31, 2014. **Monitoring Process:** Return Demonstration/Comprehension competencies completed by July 31, 2014 and on a bi-annual basis. If staff is found to be incompetent, additional training will be provided and competency reassessed. Competency records will be maintained in employee files. Tray audits will be performed 3-5 times per week to ensure diet tray accuracy and compliance with the menu in relation to portion sizes and food items, appropriate food substitutions and food preparation procedures including pureed diets. Results of audit activity will be reported to the hospital's Quality Council, MEC, and Governing Board on a quarterly basis. Additional training will be provided based on the results of the audits. **Person Responsible:** RD, Director of Dietary Department	8/4/2014 7/21/2014 7/31/2014 6/17/2014

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A 619	Continued From page 85 not consulted in the determination of substitutes being made. Dietary Staff did not provide diet as planned. Portion sizes were incorrect, items were missing. The therapeutic spreadsheet did not match the menu. There were no policies in place to validate that correct procedures were being followed. There was no policy for small portions. Incorrect consistency of pureed food was prepared was too watery. Policies and Procedures Dietary staff did not follow safe food practices. The roast that had been prepared the day before was not properly monitored to ensure that it was cooled to prevent the growth on bacteria that could cause food borne illness. The kitchen had never used cooling logs to monitor the temperature of leftovers and previously cooked large cuts of meat. There was no written policy on proper cooling. Staff Training OS (Dietary Staff) 3 was observed at approximately 11:20 a.m., on March 24, 2014, returning to the kitchen after emptying the garbage still wearing his apron. The correct procedure is to remove the apron prior to emptying the garbage to prevent cross contamination of his apron. There were food items in the refrigerator that had not been dated. Frozen items in the freezer were not stored in a manner to prevent cross contamination, fresh or ready to eat products were stored below raw meats. Dietary staff was not able to correctly calibrate	A 619	(Continued from page 85) **4) Policies and Procedures cooling:** **Corrective Actions:** A Food Cooling Procedure and Log were created and implemented to ensure the appropriate cooling of food products to prevent bacteria growth according FDA Food Code 2013. The need for Hot food cooling has been limited by preparing all food items on the day of service. All leftover food items are discarded after each meal. Ongoing training is provided to staff on food safety and food cooling procedures with emphasis on time and temperature, food temperature danger zones, food cooling process and corrective action to take when time and temperature are not within acceptable range as per FDA Food Code 2013. Food Cooling Log with acceptable HACCP procedures and standards was implemented and appropriate corrective actions are taken when temperatures are not within acceptable range and recorded on food cooling log. A policy regarding Food Cooling has been written and reviewed and is being approved by MEC and Governing Board. **Date of Implementation:** April 28,2014 training, September 10, 2014 Policy approval **Monitoring Process:** An audit of the Cooling Logs will be conducted on a weekly basis to ensure that leftover and previously cooked foods are not being cooled. . Results of audit activity will be reported to the hospital's Quality Council, MEC, and Governing Board on a quarterly basis. **Person Responsible:** RD, Director of Dietary Department. **HOLLYWOOD:** **5) Staff training:** **a) Garbage removal:** **Corrective Actions:** Dietary Staff was in-serviced on the hospital's policy requiring the removal of aprons prior to discarding waste. **b) Labeling and dating:** **Corrective Actions:** Products were immediately labeled and dated or discarded. Staff was in-serviced on proper labeling and dating of food items. **c) Storage of food resulting in cross-contamination:** **Corrective Actions:** Raw foods were immediately stored on bottom shelves. Staff was in-serviced on proper storage of food according FDA Food Code 2013 including raw meats must be stored at the bottom and ready to eat food items on top to prevent cross contamination. Organized training program was developed to prevent cross contamination. Staff was trained regarding preventing cross-contamination and ensuring food safety. All Food Service staff is required to have a food handler's card. **Date of Implementation:** In-service provided on April 28, 2014 through May 31. Additional training on policy revisions to be completed for all staff by September 10 , 2014 **Monitoring:** All Food Service staff is required to obtain a Food Handlers Card. Food safety and sanitation training with competency testing was implemented. In addition, initial staff competencies of all staff to be completed by July 31, 2014. Bi-annual validation of staff competency will be completed twice yearly and placed in employee files.	4/28/2014 4/28/2014

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A 619	Continued From page 86 thermometers. The posted log did not have clear instructions on thermometer calibration. Food equipment stored away as clean was no properly cleaned. Yellow colored cutting board was badly stained with black colored substance in the grooves of the cut marks was observed being used for meal preparation. The interior components of the ice machine had not been cleaned as recommended by the manufacturer. There were several equipment including the dish machine and plate warmer that was not working resulting in the use of paper plates for patients in the hospitals. The plate warmer had not been working for over week according to OS 4. The dish machine that had been identified as being broken was used by OS 3 to wash cooking utensils. At the Van Nuys Campus, there were similar concerns with food ordering and inadequate supplies for use during emergency, menu/ therapeutic spreadsheets not available, poor food safety practices, Staff Training During initial tour on March 27, 2014 beginning at 8 a.m., it was noted that there were four cases of 4-ounce juices with the manufacturers' guidance to "keep frozen" printed on the outside of cartons. It was noted there was an undated, opened case, containing thawed juice. In a concurrent interview with Staff 3, she stated she had just started her position as supervisor and was unsure of the operational processes in the department. She also stated that she was unsure of the expiration date of the juices as it was not printed on the carton. Further review of the manufacturers guidance printed on the carton	A 619	(Continued from page 86) **d) Thermometer calibration:** **Corrective Actions:** Staff was in-serviced on how to calibrate thermometers and record on log to ensure food temperatures are recorded accurately for compliance with food safety. **e) Cleaning of small equipment:** **Corrective Actions:** Blender was immediately re-cleaned. Staff was in-serviced on proper ware washing. **f) Cutting board:** **Corrective Actions:** Yellow cutting board with black stain was immediately discarded. Staff was in-serviced on when to notify management for replacement of cutting boards that are stained or have deep grooves. **g) Ice-machine: Refer to A749** **Corrective Actions:** Cleaning of the ice machine will be monitored to ensure timely completion. Preventative maintenance was set up twice a year by facilities per manufacturer guidelines. Unit is disassembled and internal components (water curtain, water trough, water level probe, ice thickness probe, water distribution tube) are cleaned and sanitized before reassembly. **Date of Implementation:** Service scheduled for August 2014; to re-occur every six months. **Monitoring Process:** Cleaning/sanitizing of ice machine (twice yearly) is documented on log sheet attached to unit. Bi-monthly audits of kitchen and food storage practices with immediate correction and on the job training of staff. **Person Responsible:** Director of Facilities & Director of Food & Nutrition **h) Equipment not working:** **Dish-machine** Corrective Actions: Dish-machine was repaired. Staff was trained regarding the proper wash and final rinse temperatures for the dish-machine and the proper reporting procedures when equipment is not working. When dish-machine is not working, all ware washing will be processed using 3 compartment sinks. **Plate warmer: Refer to A724** **Corrective Actions:** The plate warmer has been determined to be un-repairable and has been removed from the department. Equipment is being specified via meetings with vendors and bids are in the process of being obtained for replacement equipment and an order will be placed. Food temperatures are being monitored to ensure food safety compliance. **Date of Implementation:** Policy and Procedures for all departmental processes will be completed by September 10, 2014. In service dates on manual ware washing will be completed by August 15, 2014. A new plate warmer for the Hollywood campus will be ordered prior to 9/10/14. The Dish machine was repaired on 3/27/14. **Monitoring Process:** Monthly monitoring using Food Service bi-monthly kitchen audits including observations for equipment functionality. **Person Responsible:** RD, Director of Dietary Department **Van Nuys** **6). Staff training:** **Corrective Actions:** Frozen juices kept after 10 days were immediately discarded. Staff was retrained on food handling and storage procedures. The procedure for dating food items was implemented to ensure expired food products were discarded in a timely manner. **Date of Implementation:** In-service began April 28, 2014; Initial staff competency validation completed by July 31, 2012 for all Food Service Staff. Training on revised Food Handling and Storage procedures will be completed by September 10, 2014	8/10/2014 3/27/2014 8/15/2014 9/10/2014 4/28/2014 7/31/2014 9/10/2014

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A 619	Continued From page 87 revealed that the juices expired 10 days after they were thawed. The hospital did not have a dating system to ensure that expired juices were not served to patients. Menu The posted menu in the kitchen was for a Renal CCHO (consistent carbohydrate diet) and not a regular diet as is the standard of practice. The hospital did not have any patients on Renal CCHO diet. The therapeutic spreadsheet for that day's meal was not available to validate that the patients were being served the proper diets. Patients were served scrambled eggs, hash browns, bagel or English muffin, sausage, milk, juice. Several food trays were observed with an usually large amount of food. Staff 1 stated on March 27, 2014 at approximately 9:50a.m. that those patients had orders for double portions. She stated there was no policy on double portions and that patients are given just what the patients want. They provide them every item times two. She stated patients “want double meats not salads”. There was no policy provided on double portions. Staff 2 stated in an interview on March 27, 2014 at approximately 10:00 a.m., that keeping the menus, spreadsheets and policies and procedure was a challenge because former employees who were disciplined would remove them from the department as retaliation. Items served to the patients did not match what was on the “menu.” On March 27, 2014, according to the menu, bread pudding was to be offered for lunch. DS 5 was observed dishing out	A 619	(Continued from page 87) **Monitoring Process:** Monitoring will be conducted through bi-monthly kitchen audits to ensure food storage and handling procedures are being implemented. **Person Responsible:** RD, Director of Dietary Department **7) Menu:** **a) Menu posted** **Corrective Actions:** Copy of the current menu spread was immediately posted on tray line and reviewed with staff. Food Service Staff was in-serviced on menu comprehension, serving sizes, portions and following therapeutic requirements as shown on menu. Menu books have been provided to the Dietary staff for referencing menu items for each type of diet and portions sizes required. Staff was also instructed not to remove any menus posted and to immediately report to management if any menus were missing. **b) Policy for double portions, small portions and consistency of pureed food:** **Corrective Actions:** A procedure was developed and implemented for double and small portion meals and staff was in-serviced. Staff was instructed on the proper preparation and service of puree food items. **c) Menu substitution:** **Corrective Actions:** The Food Service staff and Supervisor were in-serviced to consult Registered Dietitians for proper food substitution. Dietary staff was provided a routine substitution list on proper food substitution. **Date of Implementation:** Training initiated June 17 and completed July 31, 2014. **Monitoring Process:** Return Demonstration/Comprehension competencies completed by July 31, 2014 and on a bi-annual basis. If staff is found to be incompetent, additional training will be provided and competency reassessed. Competency records will be maintained in employee files. Tray audits will be performed 3-5 times per week to ensure diet tray accuracy and compliance with the menu in relation to portion sizes and food items, appropriate food substitutions and food preparation procedures including pureed diets. Results of audit activity will be reported to the hospital’s Quality Council, MEC, and Governing Board on a quarterly basis. Additional training will be provided based on the results of the audits. **Person Responsible:** RD, Director of Dietary Department	6/17/2014

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A 619	Continued From page 88 vanilla pudding. In an interview at approximately 10:30 a.m., OS 5 stated she had checked the refrigerator and there was no bread pudding and Staff 2 had asked her to substitute vanilla pudding for the bread pudding. Hospital policy titled "General Requirements for Food" dated 11/12 states, "The Clinical Dietitian shall be responsible for substituting food so that the patient has adequate quality and quantity." The Clinical Dietitian was not consulted in the determination of substitutes being made (Cross refer A 0701). There was no documented evidence presented to show that the dietary staff received adequate training. Review of the personnel record for Staff 2 revealed there were educational requirements for the position based on the job description. The person currently in the position does not currently meet any of the requirements. In an interview with Staff 12 (Director of Human Resources) on March 27, 2014 at approximately 2:30 p.m., she acknowledged that based on the documents in the file, it appeared Staff 2 did not meet the minimum educational qualifications. She stated that she was unable to provide an explanation as she was not the Human resources Director when the decision was made. The hospital hired and gave responsibilities to the DFS (Director of Food Service) that was not appropriate to the scope and complexity of the food service operations.	A 619	(continued from page 88) **8. Staff received adequate training:** **Corrective Actions:** The unqualified food service director was removed from his position at both the Van Nuys and Hollywood campuses and replaced with qualified individuals. Training records, indicating the date and time and duration of the training and subject matter covered, are being retained in personnel files. The department is in the process of reviewing and revising all food service job descriptions as necessary ensuring individuals in positions meet the minimum requirements for the position. **Date of Implementation**: In-services began April 28, 2014 and training records are maintained in personnel files. Qualified directors were in place July 31, 2014. Job description revisions will be completed by September 10, 2104. **Monitoring Process**: The process for ensuring the appointment of qualified personnel will be monitored by the department directors and HR review on an annual basis to ensure that the staff meet the minimum qualification for the positions held. **Person Responsible:** Directors of Dietary Departments and HR Department	4/28/2014 7/31/2014 9/10/2014
A 621	482.28(a)(2) QUALIFIED DIETITIAN There must be a qualified dietitian, full-time,	A 621		

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A 621	Continued From page 89 part-time, or on a consultant basis. This STANDARD is not met as evidenced by: Based on observation, review of hospital documents and staff interviews, the facility failed to ensure that adequate provisions were made to ensure that the hours of the registered dietitian (RD) was adequate to meet the needs of the patients on two of three campuses. These failures resulted in the RD's inability to supervise the nutritional aspects of patient care. Finding: Review of the documents in the personnel record for the registered dietitian job description revealed that she was hired in 2005 as a clinical dietitian to cover two hospitals. A review of a position description/Performance Appraisal for the Position of Clinical Dietitian dated 04/2006 indicated that development, evaluation and approval of menus were included in the responsibilities. Observation and implementation of proper food handling and storage to assure safe quality nutrition; evaluate food served for conformance to dietary prescription was also listed as responsibilities. However, there was an Employee Status change, approved in 1/2014 by the administrator, for the position to change from Clinical Dietitian to Dietitian. This Status change did not include a job description for the position of Dietitian. Review of the menus for both the Hollywood and Van Nuys campuses showed the name another registered dietitian (RD), who was not an employee of either hospital, indicating approval of the menu. The menus had not been approved by the hospital RD. The therapeutic spreadsheet	A 621	**Hollywood & Van Nuys** **1. Qualified staff :** Corrective Actions: The organizational structure of Food and Nutrition Services department was reviewed and revised to ensure competent leadership and staff compliance to safe food handling and sanitation practices. – A Registered Dietitian Director of Food and Nutrition Services was recruited, interviewed, hired or promoted to ensure qualified and competent staff was in place. Pertinent responsibilities include: • Provides adequate overall supervision, • Oversight of patient services and menu, • Develops and ensures provision of ongoing training and development of department staff, • Maintains equipment in working order by notifying maintenance of needed repairs and administration for capital replacement, • Demonstrates knowledge of infection control, sanitation and HACCP guidelines related to safe food handling practices to ensure quality and safety of food services. Organization chart was revised to reflect supervisors and clinical dietitians (RD) reporting to the RD Food Service director who in turn reports to hospital administrator. Job descriptions for all positions are in place. **Hollywood:** A full-time consulting Director of Dietary Department, RD was appointed to provide oversight of the dietary department. A full-time Food Services Supervisor was appointed to oversee the day to day operations of dietary department. A clinical Registered dietitian and per diem Registered Dietitian are in place to provide clinical support. **Date of implementation**: July 31, 2014 **Van Nuys:** A full time Director of Dietary Department, RD was placed to provide oversight of dietary department as well as clinical support. A full time Food Services supervisor continues to oversee the day to day operations of dietary department. A per diem clinical Registered Dietitian is available on an as needed basis. **Date of implementation:** July 31, 2014 **Both Hollywood and Van Nuys:** Additionally, a contract is in process to retain a Food Service Management company to permanently operate the Food & Nutrition Services Department at both the Hollywood and Van Nuys campuses. This contract will include safe food handling and sanitation compliance requirements to meet all State, Federal, and DNV regulatory requirements. **Date of Implementation:** July 31, 2014 **Monitoring Process:** The hospital's leadership will ensure that the Dietary Department is staffed with competent and appropriately credentialed supervisory coverage at all times. The Food & Nutrition Services Contract will be reviewed for service level compliance and regulatory standards on an annual basis by Hospital Administration and the Quality Council for recommendation for continuation. **Person Responsible:** Administrators of Southern California Hospital at Hollywood and Van Nuys. **2) Menu:** **a) Menus approved:** **Corrective Actions:** RD Clinical Dietitian approved and signed the menus for use in the facility. Menus were posted on tray line and reviewed with staff. Food Service Staff was in-serviced on menu comprehension, serving sizes, portions and following therapeutic requirements as shown on menu. Additionally, newly appointed RD Food Service Directors have reviewed and signed the facilities' menus.	7/31/2014 7/31/2014 7/31/2014

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A 621	Continued From page 90 A 621 was not complete and/or available for use during tray line operation, thereby leaving dietary staff (cooks and aides) to determine food choices. The menus were not in compliance with hospital policy and state regulations which require use of select menus. According to the hospital policy titled, " menu," "The regular diet consists of a selective one -week cycle. Select menus are menus with food options which allows patients to select menu items that they would like to eat." Copies of select menus were stored on a shelf in the kitchen and not offered to patients. The menus lacked variety and color. There were mashed potatoes on the menu every day for lunch and dinner. White rice is on the menu four of seven days per week for lunch; white or Spanish rice seven of seven days at dinner. For example, one of the meals had 'Veil pamejon" (veal parmesan) Chicken Chinese salad, mashed potatoes, white rice, veggies, chicken rice soup, pound cake, pears. These items were white to off-white. The menu was not followed either at Hollywood or Van Nuys campuses. Substitutions and changes were made by staff with limited knowledge and training on appropriate substitution. Items that may not be appropriate on a diet were served. Hospital policy titled Menu states " ... All diet changes must be approved by a registered dietitian. Another policy states "The Clinical Dietitian shall be responsible for substituting food so that the patient has adequate quality and quantity." The Clinical Dietitian was not consulted in the determination of substitutes being made. In an interview with AD 1 (Registered Dietitian) on March 24 and March 27, 2014, she stated that	A 621	(Continued from page 90) **Date of implementation:** April 10, 2014, 8/2014 **b) Non-select menus:** **Corrective Actions:** In addition to the current non-select menu, an alternate choice menu was developed by a registered dietitian and implemented. Food service staff was trained on the execution of the alternate choice menu. **Date of implementation**: April 10, 2014 **c) Lack of variety and color:** **Corrective Actions:** Current menus are under revision to ensure variety and color and patient acceptance. Patient satisfaction tool is currently in place to monitor patients meal acceptance. Results of current Patient Satisfaction data concerning food service are exceeding benchmarks. **Date of implementation:** September 10, 2014 **d) Menu substitution clarification:** **Corrective Actions:** The Food Service staff and Supervisor were in-serviced to consult Registered Dietitians for proper food substitution. Dietary staff was provided a routine substitution list on proper food substitution. **Date of implementation:** July 31, 2014 **e) Food Service Director responsibilities:** **Corrective Actions:** The organizational structure of Food and Nutrition Services department was reviewed and revised to ensure competent leadership and staff compliance to safe food handling and sanitation practices. Job duties are defined in the job descriptions/performance appraisals.	4/10/2014 9/10/2014 7/31/2014

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A 621	Continued From page 91 she was not involved in the day to day operation or oversight of the food service operation because she believed it was not in her scope of work. Regarding the menu, nutrient analysis and therapeutic spreadsheet, she stated that the menu had been written by the registered dietitian from the other hospitals owned by the licensee and so she had not participated in the menu development. She stated she had no prior knowledge of the issues that had been identified during the survey because she had concentrated on clinical nutrition responsibilities for two hospitals. She further stated it was not possible to complete some of the responsibilities outlined in the position description/Performance Appraisal because she shuttled daily between the two hospitals completing nutrition assessments. Review of the personnel record of the registered dietitian revealed that her last job evaluation was conducted by the director of food services. It was assessed as satisfactory. According to the hospital organizational structure she reported to the hospital administrator and not the director of food service. In an interview with the Staff 12 (Human Resources Manager) on March 27, 2014 at approximately 2:00 p.m., she was unable to provide an explanation of why the Director of Food Services without a formal education and education in food and nutrition was allowed to evaluate the competency of the registered dietitian with an advanced degree (cross reference A 0622, A 0628, A 0619).	A 621	(Continued from page 91) A Registered Dietitian Director of Food and Nutrition Services was recruited, interviewed, hired or promoted to ensure qualified and competent staff was in place. Pertinent responsibilities include: • Provides adequate overall supervision, • Oversight of patient services and menu, • Develops and ensures provision of ongoing training and development of department staff, • Maintains equipment in working order by notifying maintenance of needed repairs and administration for capital replacement, • Demonstrates knowledge of infection control, sanitation and HACCP guidelines related to safe food handling practices to ensure quality and safety of food services. Organization chart was revised to reflect supervisors and clinical dietitians (RD) reporting to the RD Food Service director who in turn reports to hospital administrator. Job descriptions for all positions are in place. The Food Service Director who is an RD will be responsible for reviewing the job performance of the clinical RDs. HR will be responsible for ensuring the Food Service Director RD's job performance is evaluated by consulting RD or RD peer review. **Date of implementation:** July 31, 2014 **Monitoring Process:** The hospital's leadership will ensure that the Dietary Department is staffed with competent and appropriately credentialed supervisory coverage.. **Person Responsible:** Human Resources Director Staff training for menus and menu substitution process with Return Demonstration/Comprehension competencies completed by July 31, 2014. Tray audits will be performed 3-5 times per week to ensure diet tray accuracy and compliance with the menu in relation to portion sizes and food items, appropriate food substitutions and food preparation procedures including pureed diets. Results of audit activity will be reported to the hospital's Quality Council, MEC, and Governing Board on a quarterly basis. Additional training will be provided based on the results of the audits. **Person Responsible:** Food Service Directors	7/31/2014
A 622	482.28(a)(3) COMPETENT DIETARY STAFF There must be administrative and technical personnel competent in their respective duties. This STANDARD is not met as evidenced by:	A 622	**Hollywood & Van Nuys :** **Corrective Actions:** The organizational structure of Food and Nutrition Services department was reviewed and revised to ensure competent leadership and staff compliance to providing physician diet order administration, safe food handling and sanitation practices.	

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A 622	Continued From page 92 Based on observation, review of facility documents and staff interviews, the hospital failed to ensure that its dietary staff was competent in their duties in the dietetic service area when they were unable to properly calibrate food thermometers, prepare pureed diet to the correct consistency, serve patients correct diets. These failures resulted in improper sanitation and food handling practices that could cause food borne illness. It also resulted in patients receiving incorrect diets and less nutrition than was ordered by their physicians and planned by the dietitian. Findings: Hollywood campus At approximately 11:20 a.m., on March 24, 2014, there was a discrepancy of approximately 60 degrees between the recorded food temperatures of the hospital staff and that of the surveyor. The pasta was 122 degrees Fahrenheit (F), but recorded as 162 degrees in the hospital log. Rice was 182 degrees F and recorded as 172 degrees F. As a result of these discrepancies, hospital staff was asked to recalibrate its thermometer. A review of the posted "Thermometer Calibration Daily Log Sheet" for March 2014 showed the thermometer had been calibrated earlier that morning at 8:10 a.m. and it read 32 degrees F. The correct procedure to calibrate a bi-metallic thermometer in ice is to immerse thermometer in a 50/50 ice to water ratio. After approximately, three minutes, read thermometer. If thermometer temperature is not 32 (+/- 2) degrees F the thermometer is recalibrated in ice by turning the dial to 32 degrees. During observation of the calibration process,	A 622	(Continued from page 92) A Registered Dietitian Director of Food and Nutrition Services was recruited, interviewed, hired or promoted to ensure qualified and competent staff was in place. Pertinent responsibilities include: • Provides adequate overall supervision, • Oversight of patient services and menu, • Develops and ensures provision of ongoing training and development of department staff, • Maintains equipment in working order by notifying maintenance of needed repairs and administration for capital replacement, • Demonstrates knowledge of infection control, sanitation and HACCP guidelines related to safe food handling practices to ensure quality and safety of food services. Organization chart was revised to reflect supervisors and clinical dietitians (RD) reporting to the RD Food Service director who in turn reports to hospital administrator. Job descriptions for all positions are in place. **Hollywood:** A full-time consulting Director of Dietary Department, RD was appointed to provide oversight of the dietary department. A full-time Food Services Supervisor was appointed to oversee the day to day operations of dietary department. A clinical Registered dietitian and per diem Registered Dietitian are in place to provide clinical support. **Van Nuys:** A full time Director of Dietary Department, RD was placed to provide oversight of dietary department as well as clinical support. A full time Food Services supervisor continues to oversee the day to day operations of dietary department. A per diem clinical Registered Dietitian is available on an as needed basis. **Date of Implementation**: July 31, 2014 Current Food Service staff competency levels were assessed and thereafter will be assessed on a bi-annual basis including skills found lacking during this survey process. After appropriate training and retraining, those staff found to not reach minimum competency requirements, will either be placed in positions that they meet competency levels or if not trainable, will be replaced. **Date of Implementation:** July 31, 2014 **Both Hollywood and Van Nuys:** Additionally, a contract is in process to retain a Food Service Management company to permanently operate the Food & Nutrition Services Department at both the Hollywood and Van Nuys campuses. This contract will include safe food handling and sanitation compliance requirements to meet all State, Federal, and DNV regulatory requirements. Current Management & Supervisory staff probationary competency levels will be assessed. Appropriate actions will be taken as a result of those initial competency assessments. **Date of Implementation:** September 10, 2014.	7/31/2014 7/31/2014 9/10/2014

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A 622	Continued From page 93 Staff 2 (Food Service Director) who was present read the temperature of the thermometer out loud as “32 degrees” when it was 24 degrees F. When the error was pointed out to him, he then proceeded to recalibrate the thermometer out of the ice water mixture by turning the dial to 32 degrees F. The Calibration procedure on the log directs staff to adjust the dial of the bi-metallic thermometer if the dial does not read 32 degrees F. However, the instructions on the “Thermometer Calibration Daily Log Sheet” did not explain that it needs to remain in the ice and water mixture. During the meal service at approximately 12:15 p.m. on March 24, 2014, a tray for a patient on pureed diet was observed placed on the cart for distribution to the floor. The plate of the unsampled patient contained three small plastic souffle cups. In each cup was pureed meat, pureed vegetable and mashed potatoes. The amounts served appeared smaller than would be expected for an adult. Measurement of the food revealed the meat and vegetables were each 2 oz. The mashed potato was 2/5 c. The consistency of the meat and vegetables was that of soup or liquefied pureed. The correct consistency of pureed food is that of mashed potatoes. In addition, based on the review of the therapeutic spreadsheet presented by hospital staff for that meal, it showed for the pureed diet, the patient did not receive adequate amounts of food. The pureed tray should have received 3 ounces pureed meat (not 2 ounces), 4 ounces vegetables (not 2ounces), 6 ounces soup, amount of mashed potato was not stated, pureed dinner roll, ½ c	A 622	(Continued from page 93) **Monitoring Process:** The hospital’s leadership and Human Resources Department will ensure that the Dietary Department is staffed with appropriately credentialed and competent registered dietitians, Certified Dietary Managers, supervisors, cooks, diet aides and food service workers through the initial hiring, orientation and performance evaluation processes. The new Food & Nutrition Services Contract will be reviewed for service level compliance and regulatory standards on an annual basis by Hospital Administration and the Quality Council for recommendation for continuation. **Person Responsible:** Administrators and Human Resource professionals of Southern California Hospital at Hollywood and Van Nuys and Director of Dietary Departments.	

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A 622	Continued From page 94 tapioca pudding and 8 ounces lowfat milk. Another random observation at approximately 12:45 p.m. showed a tray served with food for a patient on a renal diet. The following items were served: Macaroni salad, mandarin oranges in light syrup, confetti rice, chicken, mixed vegetables with broccoli, 1 pat margarine, tapioca pudding and cater blend. The items on the tray were different than was on the spreadsheet approved by the registered dietitian. According to the spreadsheet, a patient on a renal 2 gram sodium, 2 gram potassium diet should have received tossed green salad with dressing (no tomato) 3 ounces meat,% cup green beans, 1dinner roll, 2 pats margarine. The concern is that these items as served such as oranges and broccoli which could be high in potassium and may not be appropriate on the diet. Earlier, the kitchen staff has placed a bowl of cream of chicken soup on the tray for a patient on renal diet. The soup was not observed on the tray for this random patient when the recipe for the soup was requested. The recipe or nutritional information was never provided because the cook stated he no longer had any cans of the product that was used. The concern with the product was that it may contain milk or milk products. Milk contains phosphorus, a mineral that could cause softening of the bones in a patient with impaired kidney function. An interview was conducted at approximately 1:00 p.m. with DS 6 In response to her abilities and knowledge to accurately serve the renal diet in the absence of the spreadsheet (the spreadsheet was not available on the tray line for use to serve the patients during tray line	A 622		

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A 622	Continued From page 95 operation), she indicated that she knew the diets well because she "knows her job" The hospital did not provide documentation that the dietary staff had been properly trained to correctly serve the diets as planned. DS 7 was observed dishing out applesauce at approximately 12:30 p.m. on March 24, 2014, she was observed to use a #12 scoop or 1/3 cup. The usual serving size for applesauce or most fruits is ½ cup. There was no guide to determine the proper size for the applesauce. There was no applesauce on the menu for that day. Review of personnel records for all the Dietary staff showed that all were evaluated in the past year for job related competencies. All were evaluated as a satisfactory based on returned demonstration and verbalization of procedure.	A 622		
A 628	482.28(b) DIETS Menus must meet the needs of the patients. This STANDARD is not met as evidenced by: Based on observation, review of hospital menu, policies and procedures and staff interviews, the hospital failed to ensure that its menus met the nutritional needs of its patients. Portion sizes and correct consistency were not provided to patients. There was no menu written for patients on double portions, substitutions were left to the discretion of the cooks during meal service. There were unsampled patients that did not receive diets as ordered by their physicians or according to recognized professional practices. The deficient practice had the potential for compromising patients' nutritional status.	A 628		

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A 628	Continued From page 96 Hollywood campus 1. During meal service at approximately 12:15 p.m., on March 24, 2014, a tray for a patient on pureed diet was observed placed on the cart for distribution to the floor. The plate of the unsampled patient contained three small plastic souffle cups. In each cup was pureed meat, pureed vegetable and mashed potatoes. The amounts served appeared smaller than would be expected for an adult. Measurement of the food revealed the meat and vegetables were each 2 oz. The mashed potato was 2/5 c. The consistency of the meat and vegetables was that of soup or liquefied pureed. The correct consistency of pureed food is that of mashed potatoes. In addition, based on the review of the therapeutic spreadsheet presented by hospital staff for that meal, it showed for the pureed diet, the patient did not receive adequate amounts of food. The pureed tray should have received 3 ounces pureed meat (not 2 ounces), 4 ounces vegetables (not 2ounces), 6 ounces soup, amount of mashed potato was not stated, pureed dinner roll, ½ c tapioca pudding and 8 ounces lowfat milk. 2. Another random observation at approximately 12:45 p.m. showed a tray served with food for a patient on a renal diet. The following items were served: Macaroni salad, mandarin oranges in light syrup, confetti rice, chicken, mixed vegetables with broccoli, 1 pat margarine, tapioca pudding and cater blend. The items on the tray were different than was on the spreadsheet approved by the registered dietitian. According to the spreadsheet, a patient on a renal 2 gram sodium, 2 gram potassium diet should have	A 628	(Continued from page 96) **Hollywood** **1) Pureed food:** **Corrective Actions:** Food service staff was educated on proper preparation of pureed food using food thickener and portioning of pureed food items. **Date of Implementation:** May 19, 2014 **2) Renal diet:** **Corrective Actions:** Incorrect food items on the Renal Diet patient trays were replaced with appropriate food items.	5/19/2014

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A 628	Continued From page 97 received tossed green salad with dressing (no tomato)· 3 ounces meat, %cup green beans, 1 dinner roll, 2 pats margarine. The concern is that these items as served such as oranges and broccoli which could be high in potassium and may not be appropriate on the diet. 3. Earlier, the kitchen staff has placed a bowl of cream of chicken soup on the tray for a patient on renal diet. The soup was not observed on the tray for this random patient when the recipe for the soup was requested. The recipe or nutritional information was never provided because the cook stated he no longer had any cans of the product that was used. The concern with the product was that it may contain milk or milk products. Milk contains phosphorus, a mineral that could cause softening of the bones in a patient with impaired kidney function. Culver City campus During tray line observation on March 25, 2014 at approximately 11:45 a.m., several patient trays had pieces of the main entree, pork loin. The portion size of the slices fluctuated from tray to tray with some tray receiving about half of what other trays received. Review of the therapeutic spreadsheet revealed that the portion size for the entree was 3 ounces. One of the trays with a small piece of meat was examined and weighed. The pork loin weighed 1-1/2 ounces, half of what the menu had called for. During the same trayline observation, the tray card of an unsampled patient was examined. The items doubled on the tray were pork loin and mashed potatoes. Review of the spreadsheet did	A 628	(Continued from page 97) **3) Renal diet appropriate food item:** **Corrective Actions**: Food service staff was trained on following the menu spread including therapeutic diets and any substitutions must be approved by RD dietitian. Dietary staff was in-serviced on appropriate portion sizes, correct consistency, menu reading and following therapeutic diet requirements including small and double portions. Menu books were provided to the dietary staff for reference to ensure accurate patient tray preparation. In addition a simplified "snap shot" of items to be used in the prep area was created and posted. Additional changes to these processes will be implemented and staff trained based on audit results. **Date of Implementation:** May 19, 2014 and April 30, 2014 to June 5, 2014. Initial Competency completed by 7/31/14.Additional process training to be completed and competency assessed by September 10-, 2014 **Monitoring Process:** Biannual return Demonstration/Comprehension competencies will be conducted on all food service staff at Hollywood and maintained in employee files. Tray audits will be performed 3-5 times per week to ensure diet tray accuracy and compliance with prescribed menu. Results of audit activity will be reported to the hospital's Quality Council, MEC, and Governing Board on a quarterly basis. **Person Responsible:** RD, Director of Dietary Department **Culver City** **1. Menu portion sizes:** **Corrective Actions:** The inaccurate portion of pork loin was immediately corrected and patient received the correct portions as reflected on the menu. Verbal Counseling and re-training with cooks on preparing portions, Written Training with supervisors on daily monitoring of portioning for patients. **Date of Implementation**: 4/11/14 **Monitoring Process**: Daily data collection by supervisors and monthly data analysis by Clinical Nutrition Manager on portion accuracy with Semi-annual reporting to Quality Council. **Person Responsible**: R.D. Clinical Nutrition Manager **2. Double portion:** **Corrective Actions:** Policy for Double Portions was added to our current Policy on Special Patient Meals and Services. The policy includes serving double portions of meat, starch and vegetables. Procedure was added to daily menu spreadsheets. **Date of Implementation**: 6/20/2014 **Monitoring Process:** Random monitoring of double portions as part of Quarterly Tray Accuracy. **Person Responsible**: R.D. Clinical Nutrition Manager	5/19/2014 7/31/2014 4/11/2014 6/20/2014

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A 628	Continued From page 98 not include instructions on a Double Portions. Review of the policy titled Double Portions did not specify what food needed to be doubled per meal. It is unclear whether this tray was accurate as there was no formal checking of trays for accuracy except for those on "complicated diets." Van Nuys campus Dietary Staff (DS) 1 was observed not using scoops when dishing out patients' food. The assurance that the diet meets the need of the patients cannot be guaranteed when the correct portion size is not used in serving. There were several patient food trays observed with large amounts of food. Each of the trays had 2 large hash browns, two eggs, 2 slices of bagel, 2 sausages, a bowl of cream of wheat and a carton of 2 % milk. Staff 1 stated on March 27, 2014 at approximately 9:50a.m. that those patients had orders for double portions. She stated there was no policy on double portions and that patients are given just what the patients want. They provide them every item times two. She stated patients ..want double meats not salads... There was no policy provided on double portions. Staff 2 stated in an interview on March 27, 2014 at approximately 10:00 a.m. that keeping the menus, spreadsheets and policies and procedure was a challenge because former employees who were disciplined would remove them from the department as retaliation. Items served to the patients did not match what was on the "menu." On March 27, 2014	A 628	(Continued from page 98) **3. Tray accuracy:** **Corrective Actions:** To address the lack of formal checking of all patient food trays, the sample size of Tray Accuracy monitoring was increased to 10% to reduce inaccuracies through observation and training. .**Date of Implementation:** April 2014 **Monitoring Process:** Monitor 10% of patient trays on a quarterly basis for accuracy of patient trays against the tray ticket. Analyze data and report to Quality Council on a Semi-Annual Basis. **Person Responsible**: RD, Clinical Nutrition Manager **Van Nuys** **1) Portioning devices:** **Corrective Actions:** Portioning devices were purchased. Staff was in-serviced on using correct portioning devices to match the portions on the menu spreads. **2) Double portion:** **Corrective Actions**: A procedure was developed and implemented for double portions and staff was in-serviced. **3) Tray accuracy, portion sizes and food substitution:** **Corrective Actions**: The Food Service staff and Supervisor were trained to provide portion sizes to match the menu spread. Staff was in-serviced to consult Registered Dietitians for proper food substitution. Dietary staff was provided a routine substitution list on proper food substitution. Dietary staff was in-serviced on appropriate portion sizes, correct consistency, menu reading, menu substitutions procedures and following therapeutic diet requirements including double portions	4/30/2014

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A 628	Continued From page 99 according to the menu, bread pudding was to be offered for lunch. DS 5 was observed dishing out vanilla pudding. In an interview at approximately 10:30 a.m., DS 5 stated she had checked the refrigerator and there was no bread pudding and Director of Food Services A had asked her to substitute vanilla pudding for the bread pudding. She was observed using a #12 scoop (or approximately 3 ounces) to dish the vanilla pudding into containers. The usual portion size for food like vanilla pudding is% cup. The RD who was present during the observation could not validate the correct amount. Hospital policy titled "General Requirements for Food" dated 11/12 states "The Clinical Dietitian shall be responsible for substituting food so that the patient has adequate quality and quantity" The Clinical Dietitian was not consulted in the determination of substitutes being made.	A 628	(Continued from page 99) Menu books were provided to the dietary staff for reference to ensure accurate patient tray preparation. In addition a simplified "snap shot" of items to be used in the prep area was created and posted. Additional changes to these processes will be implemented and staff trained based on audit results. **Date of Implementation:** April 30, 2014 – June 5, 2014 Initial competency assessed by 7/31/14 **Monitoring Process:** Biannual return Demonstration/Comprehension competencies will be conducted on all food service staff at Van Nuys and maintained in employee files. Tray audits will be performed 3-5 times per week to ensure diet tray accuracy and compliance with prescribed menu. Results of audit activity will be reported to the hospital's Quality Council, MEC, and Governing Board on a quarterly basis. **Person Responsible:** RD, Director of Dietary Department and Food Services Supervisor	4/30/2014 7/31/2014
A 629	482.28(b)(1) THERAPEUTIC DIETS Therapeutic diets must be prescribed by the practitioner or practitioners responsible for the care of the patients. This STANDARD is not met as evidenced by: Based on food distribution observations, dietary and administrative staff interview and departmental document review, the facility failed to ensure that diets were ordered by the physician as evidenced by inaccurate interpretation of diet orders by dietary and nursing staff. Failure to ensure that physician diet orders are followed may result in the further compromising of patients' medical status. Findings:	A 629	**Corrective Actions:** Only diets ordered by physicians are to be transcribed. Dietitians have compared Diet orders as written by physicians are compared to those transcribed by others i.e. Computerized Physician Order Entry not used. Assessed current status of diet orders to identify potential opportunities for order to not reach food service as ordered by physicians. Errors included- transcription error or lack of deletion of previous diet order, verbal orders or other orders not authenticated by a physician or diets not sent as doctors ordered due to diet ticket errors in the food service department. Memos sent to physicians to use approved diet orders only to be entered in Electronic Medical Record by physicians. List of approved diet orders were streamlined to only include approved diet orders. Require the use of mandatory physician computer ordering to minimize errors. Nursing personnel completed training including procedures related to verbal order and order verification. Training provided to food service staff on properly full filling doctors' orders or the requirement to contact a registered dietitian to calculate order and obtain clarification from physicians for orders not written according to standard. Dietitian to document requests in medical record for diet clarifications or inform physicians of recommended diet orders. **Date of Implementation:** April 30, 2014 to September 10, 2014 **Monitoring Process:** Diet accuracy of manual orders is monitored by clinical dietitians. These items are monitored including, accuracy of manual diet list completion at Hollywood and Van Nuys and monitoring of diet clerk tray tickets against diet lists. . Results of audit activity will be reported to the hospital's Quality Council, MEC, and Governing Board on a semi-annual basis. **Person Responsible:** Clinical Dietitian, Clinical Manager or Food Service Director who is a Registered Dietitian	4/30/2014

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A 629	Continued From page 100 1. Patient 8 was admitted with diagnoses including diabetes mellitus (high blood sugar), hypertension (high blood pressure) and asthma. Review of admitting orders revealed that there was no order for diet. Electronic record review on March 27, 2014 revealed that an order was entered for a No Added Salt later than evening by one of the nurses. Registered Nurse (RN) 20 stated that she received an order but was not sure she faxed an authentication of the diet order to the physician was faxed as it is customary to do with medical orders. She stated that another nurse was helping her with the admission and that she assumed the other nurse faxed the diet order. There was no documented evidence that either nurse had called the physician to receive a diet order or authenticate a verbal order. Comments made by other unidentified nurses on the unit revealed that they use information on diet orders from previous admission to determine diet orders when physicians do not add diet orders. There was no telephone order authentication by the admitting physician either in the electronic or paper record. According to the Hospital policy titled 11telephone and verbal orders dated 07/2004, states Telephone orders are too be written and read back to physicians to clarify. 2. Patient 13 was admitted to the Van Nuys campus on March 25, 2014 with diagnosis including exacerbation of depression. Physicians' admission diet order dated March 25, 2014 was a no added salt diet. Review of Patient 13's meal tray ticket on March 27,2014 at 10:30 a.m., revealed that the diet	A 629	(Continued from page 100) **1.) Corrective Actions**: All nursing staff re-educated with self-study module to validate that physician orders have been noted, examined, and verified. Caregivers must use SBAR and provide the opportunity to use read-back techniques and medications orders received must be read back by the receiver. 24 hour order/chart check policy & procedure PAT.059 implemented that mandates documentation of chart review before 7am each day. **Date of Implementation:** 5/18/2014 **Monitoring Process**: Random audit of 30 charts will be done per nursing unit. **Person Responsible:** Nursing Leadership	

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A 629	Continued From page 101 delivered was a 2 grams sodium restriction. In an interview with Staff 1 she stated that on a daily basis she received a diet list from nursing staff. Review of the diet list dated March 27, 2014 noted that nursing staff indicated that Patient 13 was to receive a no added salt diet. A no added salt diet is typically a 4 gram sodium diet. Therefore, Patient 13 was served a more restrictive diet than his physician had ordered. In an interview on March 27, 2014 beginning at 11 a.m., with the Registered Dietitian (RD 1) she stated that it appeared that Staff 1 was transcribing the order from a no added salt to a 2 gram diet. In addition, RN 20 and RN 21 stated in concurrent interviews on March 27, 2014 at approximately 3:15 p.m. that when they receive orders for diabetic diet, they translate that as Non Concentrated Sweets Diet. A non-concentrated sweets diet is one in which desserts, and sugars are avoided. According to the American Diabetes Association, this diet incorrectly teaches patients that sugar intake is the cause of diabetes.	A 629	(continued from page 101) **Corrective Actions:** Non-concentrated sweets diet order is being eliminated from the list of approved diets in CPOE. Physicians who have a justified need for this particular diet order, can order it through other diet options. **Date of Implementation:** August 18, 2014, elimination of non-concentrated sweets, at the Culver City Campus, was put into effect. Elimination of the non-concentrated sweets diet will be put into effect at the Hollywood and Van Nuys Campuses on September 10, 2014. **Person Responsible:** RD, Food Service Director, Clinical Dietitian RD	8/18/2014 9/10/2014
A 630	482.28(b)(2) DIETS Nutritional needs must be met in accordance with recognized dietary practices and in accordance with orders of the practitioner or practitioners responsible for the care of the patients. This STANDARD is not met as evidenced by: Based on patient observations, nursing and dietary department interview and medical record and departmental policy review, the facility failed to ensure the physician diet orders were implemented as ordered for 3 of 7 patients, in a sample of 51, reviewed for clinical nutrition care as evidenced by 1) Patient 12's tube feeding was	A 630		

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A 630	Continued From page 102 not delivered per physicians orders; 2) Patient 40's diet was implemented with greater restrictions than the physicians' orde; 3) patients with calorie defined diabetic diets were not implemented as ordered; 4) Patient 11's nutritional intervention delayed for five days before implementation. The deficient practice had the potential for compromising patients' nutritional status. Findings: Hollywood campus 1. During meal service at approximately 12:15 p.m. on March 24, 2014, a tray for a patient on pureed diet was observed placed on the cart for. distribution to the floor. The plate of the unsampled patient contained three small plastic souffle cups. In each cup was pureed meat, pureed vegetable and mashed potatoes. The amounts served appeared smaller than would be expected for an adult. Measurement of the food revealed the meat and vegetables were each 2 oz. The mashed potato was 2/5 c or 3.2 ounces. The correct portion for purred meat should have been 3 ounces, 4 ounces for the vegetables and mashed potatoes based on the serving size of the patients on the regular diets. The consistency of the meat and vegetables in each of the cups was that of soup or liquefied pureed. The correct consistency of pureed food is that of mashed potatoes. Incorrect consistency could result in aspiration of food into the lungs resulting in aspiration pneumonia. Aspiration pneumonia is an inflammation of the lungs or bronchial tubes resulting from food, saliva, liquids or vomit breathed into the lungs.	A 630	**Hollywood & Van Nuys** **1.) Pureed food :** **Corrective Actions:** Food service staff was educated on proper preparation of pureed food using food thickener and portioning of pureed food items. Dietary staff was in-serviced on appropriate portion sizes, correct consistency, menu reading and following therapeutic diet requirements. Menu books were provided to the dietary staff for reference to ensure accurate patient tray preparation. In addition a simplified “snap shot” of items to be used in the prep area was created and posted. Additional changes to these processes will be implemented and staff trained based on audit results. **Date of Implementation:** May 19, 2014 and April 30, 2014 to June 5, 2015. Initial Competency will be completed 7/31/14. **Monitoring Process:** Biannual return Demonstration/Comprehension competencies will be conducted on all food service staff at Hollywood and maintained in employee files. Tray audits will be performed 3-5 times per week to ensure diet tray accuracy and compliance with prescribed menu. Results of audit activity will be reported to the hospital’s Quality Council, MEC, and Governing Board on a quarterly basis. **Person Responsible:** RD, Director of Dietary Department	5/19/2014 7/31/2014

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A 630	Continued From page 103 Culver City campus 2. Patient 12 was admitted with diagnosis including pneumonia (an infection in the lungs) and hypoxia (a low level of oxygen in tissues and blood). Electronic medical record review was conducted on March 26, 2014 beginning at 2 p.m. Admission diet order dated March 13, 2014 was a cardiac diet. A physicians' order dated March 24, 2014 was for tube feeding through a nasogastric tube (tube through the nose inserted in the stomach for feeding) with Diabetasource (tube feeding formula for diabetics) at a rate of 20 cc (cubic centiliters)/hour. A follow up order dated March 26, 2014 requested water via the NG tube, 150 cc (a metric unit of measure) every 6 hours. The tube feeding was ordered on March 24, 2014 at 3 p.m. An observation of the tube feeding was conducted on March 26, 2014 at 3:00 p.m. It was noted that the tube feeding pump was off. It was also noted that the feeding bag or the tubing was not dated and/or labeled; the volume in the bag at the time of hanging was 1,000 cc and that there was approximately 300 cc left. It was also noted that a new bag of Diabetasource was lying on the residents' bedside table. In a concurrent interview with Staff 3, she stated that the dietary department sent up tube feedings every day at lunch that included labels which were intended to be placed on the tube feeding when it was hung. In an interview with RN 17, she stated that she reset the pump as 12 p.m. (3 hours prior). She also stated that she cleared the pump at 12 p.m. and turned the pump off shortly before 3 p.m. to provide personal care and probably forgot to turn it back on.	A 630	(Continued from page 103) **Culver City** **Corrective Action:** Policy VAS.005 “Intravenous Therapy – Initiation and Management of Peripheral Intravenous Lines” and Policy PAT.057 “Enteral Nutrition Support” were used, along with the mandatory online self-study module, to re-educate nursing staff. All feeding bags, IV bags and all tubing must be labeled, dated, timed and initialed. Documentation of tube feeding will be accurate. **Date of Implementation:** 6/16/2014 **Monitoring Process:** Nursing Leadership from each department will monitor proper labeling of IV bags, feeding bags and all tubing using the newly created “IV Fluid P.I.” and “Feeding Formula P.I.” audit tools. Date will be collected on 30 random patients and then results will be reported to the Quality Council on a monthly basis. **Person Responsible:** Nursing Leadership in each unit.	06/16/2014

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A 630	Continued From page 104 A review of medical record document titled "Daily Assessment Inquiry" dated March 24, 2014 at 8 p.m. was the first time that the tube feeding was noted; however there was no documentation in the electronic medical record when the feeding was actually hung. It was also noted that the actual amount of feeding that was being delivered was not accurately recorded and/or the documentation noted the physician's order of 20 cc/hour. For example, on March 26, 2014 at 6 a.m. the amount of tube feeding delivered was recorded as 240 cc. Follow up documentation dated March 26, 2014 at 12 p.m., noted an entry of 240 cc. If the feeding was running per the physicians order the pump should have read either 360 cc (if the pump was not cleared at the 6 a.m. entry) or 120 cc for the 12 p.m. entry rather than the documented 200 cc. In an interview on March 24, 2014 at 3:15p.m., RN 17 was unable to explain the discrepancy. In a concurrent interview with Staff 3 she acknowledged that the feeding was not likely delivered per the physicians' order. A review of training dated 10/13 noted that Staff 4 completed a handout at the annual nursing skills fair that reminded staff to "always put a date and hang time on each tube feeding bag even if you do not get a pharmacy label ..." 3. During a review of physician ordered diets on March 26, 2014 at 9 a.m., it was noted that Patient 49 had a physician ordered 3 gram potassium diet. It was also noted that the physicians' diet was transcribed as a low potassium diet. In an interview on March 26, 2014 at 3:30p.m., with DS 2 she was asked to	A 630	(Continued from page 104) **3)Culver City** **Physician orders not implemented:** **Corrective Actions:** The diet pattern was calculated by the RD dietitian and implemented immediately. Food & Nutrition Services Diet office personnel were retrained on Diet Modifications for K diets and on the requirement to contact a dietitian for diets not found in the diet manual or for diet clarifications. **Date of Implementation:** 4/22/14 **Monitoring Process:** Diet Modification accuracy is monitored quarterly with a sample size of 30 menus per clerk. . Results of audit activity will be reported to the hospital's Quality Council, MEC, and Governing Board on a semi-annual basis. **Person Responsible:** R.D. Clinical Nutrition Manager	4/22/2014

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A 630	Continued From page 105 describe how this diet was implemented. She stated that she had not yet completed the tray cards for the ensuing day; however she would use the pre-printed menu for renal diets, which limited the potassium to 2 grams/day. She also stated that if the renal diet did not meet the physicians' specific parameters she would decrease the amount of protein in each of the meals to meet the parameters. The example she described was to decrease the noon meal to 1-ounce of protein and the dinner entree selection to 3 ounces. She also stated that once the meal was delivered she would not be able to recount what was actually delivered as there was no system to know what was delivered to patients after the fact. In a concurrent interview with Staff 4; she was asked if there was guidance for dietary staff to follow when referring specialized diets to a registered dietitian (RD) 1 for review. She replied that while there was no guidance this was one that should have been reviewed by an RD 1. Review of the hospitals diet manual on March 26, 2014 at 4 p.m., revealed that a renal diet would restrict protein, sodium and the potassium was limited to 2 grams, a more severe restriction than was ordered by the physician. Sources of potassium include meats, vegetables, and dairy (National Institute of Medicine), a 3 gram potassium diet would have included additional sources of potassium rather than restricting them. On March 28, 2014, the hospital presented a blank document titled "Diet Clerk Competency Test" which included guidance to contact the RD for modification of complicated diet orders. 4. Patient 11 was admitted on March 9, 2014, with diagnoses including congestive heart failure (a	A 630	(continued from page 105) **Culver City (page 104)** **4) RD recommendation:** **Corrective Actions:** RD recommendations to physicians are a current performance indicator. A letter has been drafted by Food & Nutrition and was sent by Medical Administration reinforcing the importance of the timely acknowledgement and/or ordering of dietitian recommendations. **Date of Implementation:** 6/16/2014	6/16/2014

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A 630	Continued From page 106 condition in which the heart's function as a pump is inadequate to deliver oxygen rich blood to the body), hypertension (high blood pressure), diabetes (a condition in which a person has high blood sugar) and chronic kidney disease (a gradual loss of kidney function). His physician ordered a 1500 to 1800 calorie diet on admission. After a nutritional assessment on March 12, 2014, the registered dietitian recommended a diet change to a 2000 calorie ADA cardiac renal diet. This recommendation was written on a bright colored pink paper placed in the physician's order section of the clinical record for physician acknowledgement and/ or approval of recommendation. The physician did not acknowledge/approve the recommendation until March 16, 2014, four days after the recommendation was made. The diet was not ordered until the next day. Nutrition intervention was delayed for about five days due to physician's delay in acknowledging the RD's recommendation. In addition, the physician ordered a fluid restriction of less than 1500 cc on admission. This order was not transcribed as part of the diet order and so the fluid restriction was not implemented as part of the order until three days later on March 12, 2014 when the RD noticed it while conducting the nutritional assessment. In between the three days that the fluid restriction was not implemented, Patient 11 was ordered Boost, a nutritional supplement three times a day with meals. He received this in addition to the 2000 cc of fluid which is part of his diet, an additional 720 cc from three boxes of Boost. Laboratory values on March 26, 2014 showed	A 630	(Continued from page 106) **Monitoring Process:** Continued tracking of % of dietitian recommended√ acknowledged or ordered for all recommendations made. Results of audit activity will be reported to the hospital's Quality Council, MEC, and Governing Board on a quarterly basis. **Person Responsible:** R.D. Clinical Nutrition Manager at Culver City **FINDING: PATIENT 11 *Dietary Orders*** **Corrective Actions:** An internal review of dietary processes identified handwritten dietary recommendations were placed into the patient's medical record and not reviewed in a timely manner. The following improvements have been implemented: • All physicians are required to input orders via the Computerized Physician Order Entry System (CPOE). • All dietary recommendations are required to be input into the electronic medical record (EMR). Input of a dietary recommendation into the EMR triggers a "flag" of a pending diet recommendation and prompts appropriate follow-up for a physician's order to finalize said dietary recommendation. • The Dietary Department will monitor all diet orders, executed as a result of a diet recommendation, to ensure all diet orders are appropriately fulfilled. Audit results will be reported to the hospital's Pharmacy and Therapeutics Committee, Quality Council, Medical Executive Committee, and Governing Board. **Date of Implementation** • Internal review of the dietary processes was conducted April through June 2014. • Mandatory input of dietary recommendations into the EMR completed July 22, 2014 for the Culver City campus and August 1, 2014 for the Van Nuys and Hollywood campuses. • Physicians mandated to input orders via CPOE by July 15, 2014 for the Hollywood and Van Nuys campuses and by August 18, 2014 for the Culver City campus. • Super-users have been hired and trained to support physician adoption and training. Physician CPOE training commenced June 25, 2014. **Monitoring Process:** • The Dietary Department will monitor all diet orders, executed as a result of a diet recommendation, to ensure diet orders are appropriately fulfilled. Audit results will be reported to the hospital's Pharmacy and Therapeutics Committee, Quality Council, Medical Executive Committee, and Governing Board. • Compliance will be gauged by reviewing the number of diet recommendations generated (denominator), and of those, the number of orders written and executed (numerator) • Targeted compliance is 90% • Monitoring activity will commence for a period not to exceed 4 months or until optimal compliance is achieved and sustained. • Random audits will be performed thereafter. • Results of the audits will be reported to the hospital's Pharmacy and Therapeutics Committee, Quality Council, Medical Executive Committee, and Governing Board. **Person Responsible:** Director of Dietary/Food Services or designee.	4/15/2014 7/22/2014 8/1/2014 7/15/2014 8/18/2014 6/25/2014

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A 630	Continued From page 107 that his kidneys were working well and cleaning out toxins in his body. His blood urea nitrogen (measurement of nitrogen in the blood that comes from waste product urea) was 65 (normal 7-20) and creatinine a byproduct of normal muscle contractions that is cleared by the kidneys) was 5.0 (Normal 0.6 -1.3) Clinical record review showed that Patient 11 was refusing dialysis (treatment that removes wastes in the blood done by healthy kidneys) which would have alleviated the fluid his body was retaining. The physician had ordered daily weights also as part of the admission orders but this was not done. Monitoring weight is one of the ways a physician could monitor how much fluid the body is retaining. This is of significance because Patient 11 suffered from both congestive heart failure and kidney failure, two conditions in which excessive fluid retention is detrimental. 5. During review of physician ordered diets on March 26, 2014 at 9 a.m., it was noted that the diets for patients with diabetes were not consistent with what was transcribed to the electronic diet entry order system. The hospital utilized consistent carbohydrate diets which utilize meal plans without specific calorie levels, rather incorporates consistent levels of carbohydrate from day to day at breakfast, lunch and dinner (American Diabetes Association, 1997); however the physician ordered diets depicted specific calorie levels. For example, if a physician ordered a 2000 calorie American Diabetes Association (ADA) diet it would get transcribed to a 1900-2200 carbohydrate consistent diet. Review of the hospital diet list dated March 28, 2014 for the	A 630	(continued from page 107) **Corrective Actions:** All nursing staff will be re-educated on proper I & O documentation, obtaining weights and documentation of weights. Super users will notify RNs of any discrepancies. RNs will correct discrepancies. SuperUsers are qualified clinical staff with extensive competencies in electronic clinical documentation. They are available on site 24 hrs. a day/ 7 days a week. **Date of Implementation**: 6-19-2014 with full implementation in 30 days **Monitoring Process**: Super Users will monitor and collect data on a minimum of 200 charts a month and outcomes will be reported up to the Quality Council on a monthly basis. Any level of non-compliance will be reported to the Nursing Director for immediate corrective action. **Person Responsible:** Clinical Education Coordinator/Informatics	6/19/2014

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A 630	Continued From page 108 medical/surgical unit (5 east) revealed that 11 of 11 diets were transcribed in this manner. It was also noted that the method of transcription was not consistent within the hospital. For example, the diet list dated March 26, 2014 noted that the physician ordered an 1800 calorie ADA diet (Patient 18) which was transcribed to a 1500-1800 calorie consistent carbohydrate diet. In contrast Patient 50, who was on the medical surgical unit had an 1800 ADA diet order which was transcribed to a diabetic diet/consistent carbohydrate. Additionally, Patient 43 had a 2500 calorie ADA diet which was transcribed to a 1900-2200 calorie diet. On March 26, 2014 beginning at 9:30a.m., the analysis of the hospitals non-select, standard carbohydrate consistent diet which was designed to provide 4-5 carbohydrates/meal (60-75 grams/meal) was reviewed. It was noted that for 6 of 21 meals the carbohydrate level did not meet the hospitals upper limit parameter, ranging from 82-95 grams/meal. It was also noted that only 10 of 21 meals fell within the documented parameters of 60-75 grams/meal. In an interview on March 26, 2014 at 4 p.m., with Staff 4, she stated that the hospital was attempting to eliminate physicians ordering diabetic diets, rather transition to the carbohydrate consistent terminology. She also stated that while there was discussion with medical staff, physicians continued to prefer to use the concept of calorie restriction. On March 28, 2014 at 9 a.m., Staff 4 the hospitals' pharmacy and therapeutics committee approved the translation of the diet orders by the department. Review of hospital document titled "	A 630	(continued from page 108) **b) Consistent Carbohydrate diet:** **Corrective Actions:** Consistent Carbohydrate diets have been modified to fit within the description in the diet manual with appropriate changes noted on the diet spreadsheet. **Date of Implementation**: 6/19/14	6/19/2014

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A 630	Continued From page 109 Medical Staff Bylaws" dated 12/4/13, Section 12.7.2 which described the duties related to the Pharmacy and Therapeutics (P&T) Committee noted that the purpose of the committee was to "Objectively review the clinical use of all drugs…" and to advise the Medical Executive Committee and Medical Staff on issues related to pharmacy services. There was no indication that the P&T was assigned the duty of reviewing nutrition practices that were not related to medication administration. On March 25, 2014 at 4 p.m., the hospital provided a screen shot of the available diet orders in the electronic medical record. It was noted that there were five different types of consistent carbohydrate diets: 1900-2200 calories (5-6 carbohydrates [CHO]/meal); 1500-1800 (4-5 CHO/meal); 1200-1400 (3-4 CHO/meal); 2300-2500 (6-7 CHO/meal) and a diabetic/consistent carbohydrate diet. Hospital policy titled "Diet Manual" dated 11/12 guided staff that the "diet order should be specified in terms of exact amount of restriction: 1500 calorie …" It also noted that if the physician "is unsure of the terminology necessary for desire diet order, he/she should consult the Clinical Diet Manual ..." It was noted that the policy did not reflect the practice within the department, as the physicians ordered diets in accordance with the policy. Review of the hospitals' diet manual under the section titled 11 "Dietary Management of Diabetes Mellitus" revealed that this section provided clinical practice recommendations; rather than the elements of a diet manual. Additionally it was noted that referring to the diet manual would not	A 630	(Continued from page 109) **c) Corrective Actions:** A separate document for Alta Hollywood Hospitals Medical Staff Bylaws was found which specifies the responsibilities to assess and make recommendations to the Medical Executive Committee regarding the nutritional products and services provided to the patients in the hospital. **d) Corrective Actions:** A diet manual addendum was added to include 5 different types of Consistent Carbohydrate diets. Diabetic/Consistent Carbohydrate diet was eliminated from the diet order list. **Date of Implementation:** 6/30/14 **e) Corrective Actions:** Dietitians reviewed the physicians' diet orders and requested clarifications from physician when orders were not written according to diet manual. Facility to enforce mandatory use of physician computer order entry which will restrict the possibility of ordering diets that are not present in the diet manual removing the potential for improper transcription or the need to interpret diet orders. Memo sent to physicians concerning the upcoming conversion to all computerized order entry and the diet types that will be present. Until conversion dietitians will monitor order transcription and make recommendations for diet order changes to currently accepted diets Interim plan to provide ADA diets as ordered by physicians until required use of Computerized Physician Order Entry (CPOE) is totally implemented. Diet Spread in the process of being modified to include ADA exchange diet patterns and complete nutritional analysis of these diets. **Date of Implementation:** 8/18/14 **f) Corrective Actions:** A diet manual addendum will be added for Van Nuys and Hollywood to include all required components for diets in the diet manual to ensure physicians can accurately order diets. A list of diets available within the CPOE will be created and distributed to the doctors to improve the ease of ordering. Diets not specifically on the list that are required for physician order will be available through an "other diet" entry system. **Date of Implementation: 9/10/14**	6/30/2014 8/18/2014

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	050135	Q. BUILDING **01 – SOUTHERN CALIFORNIA HOSPITAL AT HOLLYWOOD** R. WING _____	**04/01/2014**

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A 630	Continued From page 110 have provided physicians additional guidance for ordering diabetic diets as the document provided clinical practice recommendations rather than guidance for ordering diabetic diets within the hospital. Hospital documents showed that on March 28, 2014 at 9 a.m., the hospital provided education provided to nursing leadership on entering diets into the system. It guided nurses to "transcribe the physician's diet order correctly from the diets available in the system;" however, it would not be possible for nursing staff to follow this guideline as ordering calorie specific diets was not an option in the electronic medical record.	A 630	(Continued from page 110) **Monitoring Process:** The Manual of Clinical Nutrition Management (diet manual) is reviewed and approved annually by the medical staff and Registered Dietitians. Audit to monitor physicians ordering approved diets and accurate diet order transcriptions. Clinical nutrition team audits 10% of patients admitted on a weekly basis. Report finding of diet order errors after CPOE mandatory implemented to Quality Council, Med Exec and Governing Board as part of PI program. **Person Responsible:** R.D. Clinical Dietitian or Culver City Clinical Nutrition Manager	
A 631	482.28(b)(3) THERAPEUTIC DIET MANUAL A current therapeutic diet manual approved by the dietitian and medical staff must be readily available to all medical, nursing, and food service personnel. This STANDARD is not met as evidenced by: Based on departmental document review, the facility failed to ensure that the approved hospital diet manual was used as the basis of ordering diets when it used on the Culver City campus, a non-select diet for a low fiber diet. According to the diet manual, a low fiber diet would provide less fiber than its regular diet. Failure to offer diets with as approved by the medical staff may result in further compromising patients' medical status. Findings: 1. On March 26, 2014 beginning at 11 a.m., the hospitals diet manual and nutritional analysis was	A 631		

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A 631	Continued From page 111 reviewed. It was noted that in the diet manual, a low fiber diet was described as less than 15 grams of fiber/day. Review of the nutritional analysis of the low-fiber menu revealed that for 3 of 7 days the fiber content exceeded the diet manuals specifications ranging from 16.4-18.7 grams of fiber/day. Hospital failed to use the low fiber diet parameters approved by medical staff to develop the menu for patients on low fiber diets. 2. Review of the hospitals' diet manual under the section titled “Dietary Management of Diabetes Mellitus” revealed that this section provided clinical practice recommendations; rather than the elements of a diet manual. Diet manuals establish a common language based on hospital practices. A diet manual would reflect the purpose and principles of each diet, a meal pattern based on the hospitals menu, foods allowed and not allowed and the inadequacies of each diet. The facility's diet manual should mirror the diets ordered by physicians and the nutritional care provided by the facility. Hospital policy titled “Diet Manual” dated 11/12 guided staff that the “diet order should be specified in terms of exact amount of restriction: 1500 calorie ....” However, when these diets were ordered with specific caloric restrictions they were changed and interpreted as consistent carbohydrate levels (CCHO). The policy also noted that if the physician “is unsure of the terminology necessary for desire diet order, he/she should consult the Clinical Diet Manual ... “ It was noted that referring to the diet manual would not have provided physicians additional guidance for	A 631	(Continued from page 111) **Culver City** **1) Corrective Actions:** Low Fiber diet has been revised so that nutrition analysis is consistent with the Manual of Clinical Nutrition Management, diet manual used at Culver City. Diet spread sheets have been revised. **(see Addendum 55)** **Date of Implementation:** April 5, 2014 **Monitoring Process**: The Manual of Clinical Nutrition Management (diet manual) is reviewed and approved annually by the medical staff and Registered Dietitians. **Person Responsible:** R.D. Clinical Nutrition Manager. **2) Corrective Actions:** The Medical Nutrition Therapy for Diabetes Mellitus addendum to the Manual of Clinical Nutrition Management (Diet Manual) has been modified to reflect the missing components. Policies, Diet Manual and Electronic Medical Record System will be in sync with the requirement of computerized physician ordering in July 2014. The Diet Manual policy referred to is for Hollywood/Van Nuys. Culver City does not require that “diet orders should be specified in terms of exact amount of restriction” pertaining to 1500 calorie diets **(see Addendum 56)** **Date of Implementation:** 6/1/14 **Monitoring Process:** Monitoring of the accuracy of Diet orders in CPOE will be implemented in 8/2014 following implementation. **Person Responsible:** R.D. Clinical Nutrition Manager	4/5/2014 6/1/2014

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A 631	Continued From page 112 ordering diabetic diets as the document provided clinical practice recommendations rather than guidance for ordering diabetic diets within the hospital. The current standard of practice for the nutritional management of diabetes is the consistent carbohydrate meal plan with has the support of the American Diabetes Association. In an interview with Staff 4 on March 28, 2014 at approximately 10:45 a.m., she stated that the desire has been to have physician order the CCHO diets. If the hospital wanted to meet current standards of practice, its policies, diet manual and electronic medical record system were not in sync and did not reflect the requirements of a diet manual (cross reference A0630).	A 631		
A 700	482.41 PHYSICAL ENVIRONMENT The hospital must be constructed, arranged, and maintained to ensure the safety of the patient, and to provide facilities for diagnosis and treatment and for special hospital services appropriate to the needs of the community. This CONDITION is not met as evidenced by: Based on observation, review of facility documents and staff interview, the facility failed to meet the Condition of Participation in Physical Environment by failing to: 1. Develop and maintain the physical plant in a manner that assured the safety and well-being of patients (Refer A 701). 2. Ensure the safety of patients and staff when it	A 700	Item 1-6. Captured in A-701 Corrective Action Plans.	

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A 700	Continued From page 113 failed to ensure an adequate food supply to be implemented in a widespread disaster; and hand washing sink that did not have an adequate hot water supply. Failure to ensure maintenance of the physical environment may compromise the medical status of patients and the ability for staff to care for patients (Refer to A 701). 3. Ensure an effective water management plan and supplies to be implemented in a widespread disaster (Refer to A 703). 4. Properly store and dispose of trash by having overfilled and uncovered dumpster's creating conditions conducive to fly breeding and offensive odors (Refer to A 713). 5. Ensure the plumbing in food production areas were designed and maintained in a manner to prevent potential cross contamination of foods (Refer to A 722). 6. Maintain facilities that mitigate cross contamination may result in exposing patients to a foodborne illness (Refer to A 722). The cumulative effect of these systemic issues resulted in the facility's inability to ensure and provide a safe patient care environment.	A 700		
A 701	482.41(a) MAINTENANCE OF PHYSICAL A PLANT The condition of the physical plant and the overall hospital environment must be developed and maintained in such a manner that the safety and well-being of patients are assured.	A 701	**Van Nuys** **1) Corrective Actions** Patient room bathrooms, 101, 102, 103, 104, 105, 106, 107, 108, 109 and 110 grab bars were removed. Only the grab bar in room 110, an ADA accessible room, was replaced with an anti-ligature grab bar. Grab bars in other patient bathrooms will not be replaced. The exposed plumbing pipes in patient room bathrooms, 101- 110 will be covered with stainless steel flush valve vandal resistant covers and p-trap covers. The standard faucets in patient room bathrooms, 101- 110 were replaced with anti-ligature faucets. All accessible mortise hinges that could be used as anchors by patients will be replaced with anti-ligature continuous hinges. **Date of Implementation:** Patient room bathrooms, 101, 102, 103, 104, 105, 106, 107, 108, 109 and 110 grab bars were removed on 4/21/2014. Planned replacement of anti-ligature grab bars for room 110, an ADA accessible room, was completed on 8/16/2014. The exposed plumbing pipes in patient room bathrooms, 101- 110	4/21/2014 8/16/2014

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A 701	Continued From page 114 This STANDARD is not met as evidenced by: Based on observation and interview the acute psychiatric staffs, the facility failed to develop and maintain the physical plant in a manner that assured the safety and well-being of patients by not reducing opportunities for self-harm and eliminating as many risk factors as possible in the patient's environment including fixtures that could be used as anchor points to tie to that can hold a person's weight and other conditions that could be used as opportunities for self-harm. Additionally, the facility failed to ensure the safety of patients and staff when it failed to ensure an adequate food supply to be implemented in a widespread disaster; and hand washing sink that did not have an adequate hot water supply. Failure to ensure maintenance of the physical environment may compromise the medical status of patients and the ability for staff to care for patients. Findings: On March 24, 2014 between 10:05 a.m. and 3:20 p.m. the following conditions existed in the Van Nuys psychiatric campus. Station 1 (Van Nuys campus) There were fixtures throughout that could be used as anchor points to tie to that can hold a person's weight throughout the unit; including pendant sprinkler heads, grab bars, shower handles, soap dishes, exposed plumbing pipes (water supply to toilet and sink drain line), standard faucets, vents, mortise hinges and self-closing door arms. 1. Patient room bathrooms, including those in	A 701	(Continued from page 114) will be covered by stainless steel flush valve vandal resistant covers to be installed by September 26, 2014; P-trap covers will be installed by September 12, 2014. The standard faucets in patient room bathrooms, 101- 110 were replaced with anti-ligature faucets on August 19, 2014.All accessible mortise hinges that could be used as anchors by patients will be replaced with anti-ligature continuous hinges by September 26, 2014. **Monitoring Process:** Until patient bathrooms are resistant to ligature, continual round the clock rounding by mental health workers will be conducted to ensure patient safety. Once anti-ligature safety features are complete, engineering will monitor via weekly EOC rounds to ensure a safe environment is maintained. **Person Responsible:** Director of Engineering, ACNO **2) Corrective Actions:** The mechanical fan cover that was exposing the spinning blades of the exhaust fan in Room 101 was secured to the ceiling with new securing screws. A hospital-wide review and facility tour made to ensure all covers are secured for all exhaust fans. **(See Addendum 58)** **Date of Implementation:** 3/24/14 **Monitoring Process:** Monitoring of all exhaust fans scheduled through EOC rounds daily by nursing staff. **(see Addendum 57)** **Person Responsible:** ACNO & Director of Engineering **3) Corrective Actions:** The atmospheric ventilation cover was replaced in Room 101. A hospital-wide review and facility tour made to ensure all atmospheric covers are secure and will be monitored in the EOC rounds daily by nursing staff. **(see Addendum 59)** **Date of Implementation**: 3/24/14 **Monitoring Process:** The monitoring of all atmospheric covers will be monitored in the EOC rounds daily by nursing staff. **(see Addendum 57)** **Person Responsible:** ACNO & Director of Engineering **4) Corrective Actions:** Shower room 4 grab bar was removed. New Anti-Ligature grab bar was installed. The mortise hinges that could be used as anchors by patients will be replaced with anti-ligature continuous hinges. The self-closer arm was reversed to the outside. **Date of Implementation:** Shower room 4 grab bar was removed and replaced with a new anti-Ligature grab bar on April 15, 2014. The mortise hinges that could be used as anchors by patients will be replaced with anti-ligature continuous hinges by September 26, 2014.The self-closer arm was reversed to the outside on 8/16/2014. **Monitoring Process:** Until patient bathrooms are resistant to ligature, continual round the clock rounding by mental health workers will be conducted to ensure patient safety. Once anti-ligature safety features are complete, engineering will monitor via weekly EOC rounds to ensure a safe environment is maintained. **Person Responsible:** Director of Engineering, ACNO **5) Corrective Actions:** Shower room 5 grab bar was removed. New Anti-Ligature grab bar has been installed in shower room 5. The soap dish was removed. Liquid soap is provided upon request form nurses. The mortise hinges that could be used as anchors by patients will be replaced with anti-ligature continuous hinges. The self-closer arms have been reversed to the outside. **Date of Implementation:** New Anti-Ligature grab bar was installed in shower 5 on April 15, 2014. The soap dish was removed on March 30, 2014.The mortise hinges that could be used as anchors by patients was replaced with anti-ligature continuous hinges by September 26, 2014.The self-closer arms was reversed to outside on April 15, 2014.	8/16/2014 9/12/2014 9/26/2014 3/24/2014 3/24/2014 4/15/2014 8/16/2014 9/26/2014 3/30/2014 4/15/2014 9/26/2014

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A 701	Continued From page 115 rooms 101, 102, 103, 104, 105, 106, 107, 108, 109, and 110 had grab bars, exposed plumbing pipes, standard faucets and mortise hinges that could be used as anchors. 2. Room 101 had the mechanical fan *cover* moved one inch exposing the spinning blades of the exhaust fan. 3. Room 101 had the atmospheric ventilation cover missing, exposing the ventilation duct and a damper and its components. 4. Shower room 4 had a grab bar, mortise hinges and self-closer arm at the door that could be used as anchors. 5. Shower room 5 had a grab bar, shower handles, soap dish mortise hinges and self-closer arm at the door that could be used as anchors. During an interview at the same time as the observation, Staff 6 (director of facilities) stated, "We should have the type of (grab) bar that has the safety plate, they can tie something here and lay down on the floor." 6. The dining/activity room had pendent sprinkler heads at the ceiling, a standard sink faucet, and exposed sink drain pipe that could be used as anchors. 7. The bathroom of the dining/activity room had grab bars, exposed plumbing pipes, a standard faucet and mortise hinges that could be used as anchors. At the time of the observation a patient had come non-escorted out of the rest room. 8. The women's common bathroom had grab bars, exposed plumbing pipes, and a standard	A 701	(Continued from page 115) **Monitoring Process:** Until patient bathrooms are resistant to ligature, continual round the clock rounding by mental health workers will be conducted to ensure patient safety. Once anti-ligature safety features are complete, engineering will monitor via weekly EOC rounds to ensure a safe environment is maintained. **Person Responsible:** ACNO & Director of Engineering **6) Corrective Actions:** The dining/activity room pendent sprinkler heads have been changed to a Recessed Sprinkler head by Mid-Valley Automatic Fire System, Inc. Safety, anti-ligature faucets have replaced the standard faucets. P-trap covers have been ordered to cover exposed sink drain pipe in dining/activity room. **Date of Implementation:** The dining/activity room pendent sprinkler heads have been changed to Recessed Sprinkler heads by Mid-Valley Automatic Fire System, Inc. completed July 11, 2014. The replacement of standard faucets to safe, anti-ligature faucets was completed on August 19, 2014. Installation of p-trap covers will be completed by September 12, 2014. **Monitoring Process:** Until patient bathrooms are resistant to ligature, continual round the clock rounding by mental health workers will be conducted to ensure patient safety. Once anti-ligature safety features are complete, engineering will monitor via weekly EOC rounds to ensure a safe environment is maintained. **Person Responsible:** Director of Engineering & ACNO **7) Corrective Actions**: The grab bar in the bathroom located in the dining/activity room was removed and will not be replaced. The exposed plumbing pipes will be covered by stainless steel flush valve vandal resistant covers and P-trap covers. Safety, anti-ligature faucets have replaced the standard faucet. The mortise hinges that could be used as anchors by patients will be replaced with anti-ligature continuous hinges door hinges have been ordered to replace the standard hinges. **Date of Implementation:** The grab bar was removed on April 21, 2014 and will not be replaced. The exposed plumbing pipes will be covered by stainless steel flush valve vandal resistant covers to be installed by September 26, 2014; P-trap covers will be installed by September 12, 2014.Safety, anti-ligature faucets replaced the standard faucet on August 19, 2014. The mortise hinges that could be used as anchors by patients was replaced with anti-ligature continuous hinges by September 26, 2014. **Monitoring Process:** Until patient bathrooms are resistant to ligature, continual round the clock rounding by mental health workers will be conducted to ensure patient safety. Once anti-ligature safety features are complete, engineering will monitor via weekly EOC rounds to ensure a safe environment is maintained. **Person Responsible:** Director of Engineering & ACNO **8) Corrective Actions:** The grab bar in the women's common bathroom was removed and will not be replaced. The exposed plumbing pipes will be covered by stainless steel flush valve vandal resistant covers and P-trap covers. Safety, anti-ligature faucets have replaced the standard faucet. **Date of Implementation:** The grab bar was removed on April 21, 2014 and will not be replaced. The exposed plumbing pipes will be covered by stainless steel flush valve vandal resistant covers to be installed by September 26, 2014; P-trap covers will be installed by September 12, 2014. Safety, anti-ligature faucets replaced the standard faucet on August 19, 2014. **Monitoring Process:** Until patient bathrooms are resistant to ligature, continual round the clock rounding by mental health workers will be conducted to ensure patient safety. Once anti-ligature safety features are complete, engineering will monitor via weekly EOC rounds to ensure a safe environment is maintained. **Person Responsible:** Director of Engineering & ACNO	7/11/2014 8/19/2014 9/12/2014 8/19/2014 9/12/2014 9/26/2014 4/21/2014 8/19/2014 9/12/2014 9/26/2014

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A 701	Continued From page 116 faucet that could be used as anchors. During an interview, Staff *6* stated the patients are escorted to the bathroom and a staff member needs to unlock the bathroom, but the patient remains in the bathroom by themselves. 9. The men's common bathroom had grab bars, exposed plumbing pipes, and a standard faucet that could be used as anchors. 10. There were pendent type sprinkler heads throughout the corridor. 11. There was unimpeded access from Unit 1 into an interior stairwell connecting the first floor to the basement. There were hand rails and sprinkler pipes in the stairwell that could be used as anchors. There was also a fourteen foot drop from the top first floor landing rail to the bottom of the stairwell. During an interview at the same time as the observation, Staff 6 stated that on a weekend morning years ago they found a patient hanging around at the top stairwell landing and that when they took the patient to his room they found a sheet in the patients room. Outpatient (Van Nuys campus) 12. Common bathroom by group meeting room had a ceiling pendent sprinkler, grab bars, exposed plumbing pipes, standard faucets, mortise hinges and arm of a self-closing device at the door that could be used as anchors. The bathroom also had a standard porcelain water tank and cover with accessible flush mechanism parts within. 13. Common bathroom by the group meeting	A 701	(Continued from page 116) **9) Corrective Actions**: The grab bar in the men's common bathroom was removed and will not be replaced. The exposed plumbing pipes will be covered by stainless steel flush valve vandal resistant covers and P-trap covers. Safety, anti-ligature faucets have replaced the standard faucet. **Date of Implementation:** The grab bar was removed on April 21, 2014 and will not be replaced. The exposed plumbing pipes will be covered by stainless steel flush valve vandal resistant covers to be installed by September 26, 2014; P-trap covers will be installed by September 12, 2014. Safety, anti-ligature faucets replaced the standard faucet on August 19, 2014. **Monitoring Process:** Until patient bathrooms are resistant to ligature, continual round the clock rounding by mental health workers will be conducted to ensure patient safety. Once anti-ligature safety features are complete, engineering will monitor via weekly EOC rounds to ensure a safe environment is maintained. **Person Responsible:** Director of Engineering & ACNO **10) Corrective Actions:** All pendent type sprinkler heads located throughout all corridors have been removed and replaced with Recessed Sprinkler heads by Mid-Valley Automatic Fire System, Inc. **Date of Implementation:** The pendent type sprinkler heads throughout all corridors have been replaced with Recessed Sprinkler heads by Mid-Valley Automatic Fire System, Inc. Completed July 11, 2014. **Monitoring Process:** Engineering will monitor integrity of the recessed sprinkler heads via weekly EOC rounds. EOC rounds are planned to be ongoing to ensure a safe environment is maintained. Monitoring of fire sprinklers will also be part of the Annual Sprinkler Testing Evaluation. **Person Responsible:** Director of Engineering **11) Corrective Actions:** Access from Unit 1 into the interior stairwell, exposing handrails and pipes, leading to the basement was secured with the installation of a lock and alarm. Patients are unable to access the interior stairwell; only authorized personnel can access stairway. **Date of Implementation:** Access from Unit 1 into the interior stairwell, with exposed handrails and pipes, was secured with the installation of a lock and alarm on March 25, 2014. **Monitoring Process**: All doors & locks throughout the hospital are checked 3 times a day by security. **Person Responsible:** Director of Engineering **12) Corrective Actions:** The pendent type sprinkler heads have been replaced with Recessed Sprinkler heads by Mid-Valley Automatic Fire System, Inc. The grab bar in the common bathroom by the group meeting room was removed and will not be replaced. The exposed plumbing pipes will be covered by stainless steel flush valve vandal resistant covers and P-trap covers. Safety, anti-ligature faucet has replaced the standard faucet. The mortise hinges that could be used as anchors by patients will be replaced with anti-ligature continuous hinges. The self-closer arm was reversed to outside. The toilet will be removed and replaced with a commercial vandal resistant toilet. **Date of Implementation**: The pendent type sprinkler heads have been replaced with Recessed Sprinkler heads by Mid-Valley Automatic Fire System, Inc. Completed July 11, 2014. The grab bar was removed on April 21, 2014 and will not be replaced. The exposed plumbing pipes will be covered by stainless steel flush valve vandal resistant covers to be installed by September 26, 2014; P-trap covers will be installed by September 12, 2014. Safety, anti-ligature faucets replaced the standard faucet on August 19, 2014. All accessible mortise hinges that could be used as anchors by patients will be replaced with anti-ligature continuous hinges by September 26, 2014.The self-closer arms was reversed to outside on April 15, 2014. The toilet will be removed and replaced with a commercial vandal resistant toilet by September 26, 2014. **Monitoring Process:** Engineering will monitor integrity of the recessed sprinkler heads via weekly EOC rounds. EOC rounds are planned to be ongoing to ensure a safe environment is maintained. Monitoring of fire sprinklers will also be part of the Annual Sprinkler Testing Evaluation. Until patient bathrooms are resistant to ligature, continual round the clock rounding by mental health workers will be conducted to ensure patient safety.	4/21/2014 8/19/2014 9/12/2014 9/26/2014 7/11/2014 3/25/2014 4/15/2014 4/21/2014 7/11/2014 8/19/2014 9/12/2014 9/26/2014

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	050135	S. BUILDING **01 – SOUTHERN CALIFORNIA HOSPITAL AT HOLLYWOOD** T. WING _____	**04/01/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN CALIFORNIA HOSPITAL AT HOLLYWOOD	**6245 DE LONGPRE AVE HOLLYWOOD, CA 90028**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 701	Continued From page 117 room had a loose toilet. Closer observation revealed the anchor bolt was missing. 14. Common bathroom by the outpatient lounge had grab bars, exposed plumbing pipes, standard faucets and mortise hinges that could be used as anchors. Basement (Van Nuys campus) 15. There was an 8 inch by 5 inch dark brown water stain at the ceiling of the intake department. 16. There was a 10 inch by 10 inch dark brown water stain with a 4 inch by 4 inch black stain at its center at the ceiling of the medical records storage room. 17. There was an exposed plumbing (P-trap) that could be used as an anchor at the corridor near the medical records room. There was unimpeded access from Unit 1 to the basement by use of an interior stairwell or elevator. 18. There was an unlocked laundry room that had a pendent ceiling sprinkler and self-closing device arm at the door that could be used as anchors. There was unimpeded access from Unit 1 to the unlocked laundry in the basement by use of an interior stairwell or elevator. Exterior (Nan Nuys campus) 18. There was overgrown live vegetation and accumulation of dry vegetation conducive to the possible harborage of rodents and other pests at and next to Unit 2 patio. The vegetation was next	A 701	(Continued from page 117) Once anti-ligature safety features are complete, engineering will monitor via weekly EOC rounds to ensure a safe environment is maintained. **Person Responsible:** Director of Engineering & ACNO **13) Corrective Actions:** The common bathroom toilet by the group meeting room was secured with new screws on March 25, 2014. A hospital-wide review and facility tour made to ensure all toilets are secured and will be monitored in the EOC rounds weekly by IOP staff**.** **Date of Implementation:** Bathroom toilet was secured with new screws on March 25, 2014. 3/25/2014 **Monitoring Process:** Monitoring that all toilets are secured in the EOC rounds weekly by IOP Staff**.** **Person Responsible:** Director of IOP & Director of Engineering **14) Corrective Actions:** The grab bars located in the common bathroom by the outpatient lounge was removed and will not be replaced. The exposed plumbing pipes will be covered by stainless steel flush valve vandal resistant covers and P-trap covers. Safety, anti-ligature faucets have replaced the standard faucet. All accessible mortise hinges that could be used as anchors by patients will be replaced with anti-ligature continuous hinges. **Date of Implementation:** The grab bars located in the common bathroom by the outpatient lounge was removed on April 21, 2014 and will not be replaced. 4/21/2014 The exposed plumbing pipes will be covered by stainless steel flush valve vandal resistant covers to be installed by September 26, 2014; 9/12/2014 P-trap covers will be installed by September 12, 2014. 9/26/2014 Replacement of standard faucets to safe, anti-ligature faucets will be completed on September 30, 2014. 9/30/2014 All accessible mortise hinges that could be used as anchors by patients will be replaced with anti-ligature continuous hinges by September 26, 2014. **Monitoring Process:** Until patient bathrooms are resistant to ligature, continual round the clock rounding by mental health workers will be conducted to ensure patient safety. Once anti-ligature safety features are complete, engineering will monitor via weekly EOC rounds to ensure a safe environment is maintained. **Person Responsible:** Director of Engineering & ACNO **15) Corrective Actions:** The 8 inch by 5 inch dark brown water stain on the ceiling of the intake department was replace and re-tape the A/C lines with rubber tubes on March 27, 2014. A hospital-wide review and facility tour made to ensure all ceilings are clear of stains and will be monitored in the EOC rounds monthly. 3/27/2014 **Date of Implementation:** 3/27/14 **Monitoring Process:** All ceilings in intake departments are to be monitored for any stains in the EOC rounds. **Person Responsible:** Director of Engineering **16) Corrective Actions:** The 10 inch by 10 inch dark brown water stain with a 4 inch by 4 inch black stain at its center of the ceiling tile in medical records storage room was tile replaced on March 27, 2014. **See Addendum 71, 71a)** A hospital-wide review and facility tour made to ensure all ceilings are clear of stains and will be monitored in the EOC rounds monthly. **Date of Implementation:** 3/27/14 3/27/2014 **Monitoring Process:** All ceilings in medical records are to be monitored for any stains in the EOC rounds monthly. **Person Responsible:** Director of Engineering **17) Corrective Actions:** The exposed plumbing (p-trap) that could be used as an anchor at the corridor near the medical records room was removed. The access from Unit 1 to the basement by the use of the interior stairwell door was replaced with a locked handle to ensure only authorized personnel can access stairways. No impact on egress. **Date of Implementation:** In process, expected implementation date July 1, 2014. **Monitoring Process:** All doors & locks throughout the hospital are checked 3 times a day by security. **Person Responsible:** Director of Engineering **18) Corrective Actions:** The laundry room door is now locked and only authorized personnel have access. The access from Unit 1 to the basement by the use of the interior stairwell door was replaced with a locked handle to ensure only authorized personnel can access stairways	

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A 701	Continued From page 118 to, over, and on top of the smoking area canopy, and next to building structure. The vegetation (avocado tree) also created a food source, shelter and natural bridge onto the facility roof for possible rodents. On March 25, 2014 between the hours of 8:30 a.m. and 11:00 a.m. the following conditions existed in the Van Nuys psychiatric facility. Station 2 (Van Nuys campus) There were fixtures throughout that could be used as anchor points to tie to that can hold a person's weight throughout the unit; including pendant sprinkler heads, grab bars, shower handles, soap dishes, exposed plumbing pipes (water supply to toilet, sink drain line and condensation line), standard faucets, vents, mortise hinges and self-closing door arms. 20. Patient Room bathrooms, including those in Rooms 203, 205, 207, 209, 210, 211, 212, 213, 214,215,216,217,218,219,220,222,226, had fixtures that could be used as anchors including grab bars, exposed plumbing pipes, standard faucets and mortise hinges. 21. Patient Room bathrooms, including those in Rooms 203, 205, 207, 209, 210, 211, 212, 213, 214,215,216,217,218,219,220,222,226,had locksets on the bathroom doors that were lockable from the inside and required an emergency key to unlock from the outside. During a interviews of two registered nurses (RN) at Unit 2 nurses Station, RN 23 stated we don't have the pin (emergency key) and RN 24 stated I	A 701	(Continued from page 118) **Date of Implementation:** 3/14/2014 **Monitoring Process:** All doors & locks throughout the hospital are checked 3 times a day by security. **Person Responsible**: Director of Engineering **18) Corrective Actions:** The overgrown live vegetation and accumulation of dry vegetation next to Unit 2 patio was cleaned up and trimmed by gardener in March 27, 2014. It will be monitored and maintained by the gardener during routine weekly service as well as during EOC rounds monthly. **Date of Implementation:** 3/27/2014 **Monitoring Process:** The live and dry vegetation will be monitored and maintained by the gardener during routine weekly service as well as during EOC rounds monthly. **Person Responsible:** Director of Engineering **20) Corrective Actions:** Patient room bathrooms, 203, 205, 207, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 222, and 226 grab bars were removed. Only the grab bar in room 226, an ADA accessible room, was replaced with an anti-ligature grab bar. Grab bars in other patient bathrooms will not be replaced. The exposed plumbing pipes in patient room bathrooms, 203, 205, 207, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 222, and 226 will be covered with stainless steel flush valve vandal resistant covers and p-trap covers. The standard faucets in patient room bathrooms, 203, 205, 207, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 222, and 226 were replaced with anti-ligature faucets. All accessible mortise hinges that could be used as anchors by patients will be replaced with anti-ligature continuous hinges. **Date of Implementation:** Patient room bathrooms, 203, 205, 207, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 222, and 226 grab bars were removed on 4/21/2014. Planned replacement of anti-ligature grab bar for room 226, an ADA accessible room, was completed on 8/16/2014. The exposed plumbing pipes in patient room bathrooms, 203, 205, 207, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 222, and 226 will be covered by stainless steel flush valve vandal resistant covers to be installed by September 26, 2014; P-trap covers will be installed by September 12, 2014. The standard faucets in patient room bathrooms, 203, 205, 207, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 222, and 226 were replaced with anti-ligature faucets on August 19, 2014. All accessible mortise hinges that could be used as anchors by patients will be replaced with anti-ligature continuous hinges by September 26, 2014. **Monitoring Process**: Until patient bathrooms are resistant to ligature, continual round the clock rounding by mental health workers will be conducted to ensure patient safety. Once anti-ligature safety features are complete, engineering will monitor via weekly EOC rounds to ensure a safe environment is maintained. **Person Responsible:** Director of Engineering **21)Corrective Actions:** New Push and Pull latch (GYLNN_ Johnson) door handles will be installed for patient bathrooms 203, 205, 207, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 222, and 226. **Date of Implementation:** New Push and Pull latch (GYLNN_ Johnson) door handles will be installed for patient bathrooms 203, 205, 207, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 222, and 226 by September 14, 2014. **Monitoring Process:** Engineering will monitor via weekly EOC rounds to ensure proper operation of door handles. **Person Responsible:** Director of Engineering	3/14/2014 3/27/2014 8/16/2014 8/19/2014 9/26/2014 9/14/2014

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A 701	Continued From page 119 don't know where the pin is. 22. Retention clips were missing from the anti-ligature type ceiling sprinkler heads in Rooms 203,207 209,211,213,222,226 and in the medication room. The missing retaining clips caused the escutcheons to drop one inch from the ceiling exposing the sprinkler pipes that could be used as anchors. The anti-ligature type ceiling sprinkler head in Room 211 had expanding foam between the top of the escutcheon and the ceiling. During an interview the Director of Facilities stated "that's the wrong way to fix it, should have a ring (retention clip)". 23. Room 211 had a loose sink with dislodged caulking and a half inch space between the sink and the wall. 24. Room 213 had a loose toilet. 25. Room 215 had a loose toilet and a 4 foot by 2 foot area of corroded and water damaged ceiling above the doorway. 26. Room 216 had the door handle rosette pulled away from the bathroom side of the bathroom door creating a space between the rosette and the door that could be used as an anchor. 27. Room 205 had a loose exhaust fan cover with a half in gap between the cover and the ceiling. 28. Room 222 had a missing handle at the bathroom sink faucet exposing the valve stem and had a missing anchor bolt cap at the toilet. 29. The shaving room had standard faucet that could be used as an anchor.	A 701	(Continued from page 119) **22) Corrective Actions:** The retention clips missing from the anti-ligature type sprinkler in room 203, 207, 209, 211, 213, 222, 226, and medication room were replaced on April 20, 2014 by Engineering. A hospital-wide review and facility tour of all sprinklers in patient rooms and will be monitored during routine cleaning of sprinkler heads. In room 211 the anti-ligature type ceiling that had expanded foam between the top of the escutcheon and the ceiling was cleaned on March 27, 2014 by Engineering. **Date of Implementation:** 4/20/14 **Monitoring Process:** All sprinklers in patient rooms and will be monitored during routine cleaning of sprinkler heads. **Person Responsible:** Director of Engineering **23) Corrective Actions:** The sink in room 211 was removed and re-installed on the wall, secured, patched and sealed with white caulking by engineering on March 24, 2014. A hospital-wide review and facility tour made to ensure all sinks are secured and will be monitored in the EOC rounds daily by nursing staff. **Date of Implementation**: 3/24/14 **Monitoring Process:** All patient sinks will be monitored in the EOC rounds daily by nursing staff**.** **Person Responsible:** ACNO & Director of Engineering **24) Corrective Actions:** The toilet in room 213 secured with new screws on March 27, 2014. A hospital-wide review and facility tour made to ensure all toilets are secured and will be monitored in the EOC rounds daily by nursing staff. **Date of Implementation:** 3/24/14 **Monitoring Process**: All patient toilets are secured and will be monitored in the EOC rounds daily by nursing staff**.** **Person Responsible:** ACNO & Director of Engineering **25) Corrective Actions**: The toilet in room 213 secured with new screws on March 24, 2014 by Engineering. A hospital-wide review and facility tour made to ensure all toilets are secured and will be monitored in the EOC rounds daily by nursing staff. The 4 foot by 2 foot area of corroded and water damaged ceiling above the doorway was repaired on March 28, 2014. A hospital-wide review and facility tour made to ensure all toilets are secured and will be monitored in the EOC rounds daily by nursing staff. **Date of Implementation:** 3/24/14 **Monitoring Process:** All patient toilets will be monitored in the EOC rounds daily by nursing staff. All ceilings in patient rooms are to be monitored for any stains in the EOC rounds by nursing staff**.** **Person Responsible:** ACNO & Director of Engineering **26) Corrective Actions**: The door handle rosette from the bathroom side in room 216 that created a space between the rosette and door was repaired and the lock was replaced on March 28, 2014. **Date of Implementation:** 3/28/14 **Monitoring Process:** All patient doors to be monitored in the EOC rounds daily by nursing. **Person Responsible:** ACNO & Director of Engineering **27) Corrective Actions:** The loose exhaust fan cover gap between the cover and the ceiling in Room 205 was replaced and that corrected the problem. A hospital-wide review and facility tour made to ensure all fan covers are secured and will be monitored in the EOC rounds daily by nursing staff. **Date of Implementation:** 3/24/14 **Monitoring Process:** All fan covers are secured and will be monitored in the EOC rounds daily by nursing. **Person Responsible:** ACNO & Director of Engineering **28) Corrective Actions:** The missing handle on the bathroom room 222 exposing the valve stem and sink were replaced on March 25, 2014 by maintenance. The anchor bold cap was replaced on the toilet in room 222 on March 25, 2014. A hospital-wide review and facility tour made to ensure all toilet caps are secured on all toilets and will be monitored in the EOC rounds daily by nursing staff. **Date of Implementation:** 3/25/14 **Monitoring Process:** All patient room doors and toilets will be monitored through the EOC rounds daily by nursing**.** **Person Responsible:** ACNO & Director of Engineering	4/20/2014 3/24/14 3/24/2014 3/24/2014 3/28/2014 3/24/2014 3/25/2014

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A 701	Continued From page 120 30. The observation room had a metal bed frame with a painted plywood board in it used as a mattress support. The plywood board could be removed from the bedframe without the need of tools which would leave the metal frame that could be used as an anchor. Also plywood is an absorbent material that is not easily cleaned and disinfected. 31. Shower Rooms 1, 2 and 3 had a grab bars that could be used as an anchors. 32. The hose for use in Shower Room 2 could not be found. Shower room 2 had a quick connect bib at the shower stall. During an interview, Staff 6 (director of facilities) stated the bib was used to connect a hose that is used by nursing in the shower when a patient is very dirty. Staff 6 stated that he did not know where the hose was but would ask the nursing staff. By the end of the survey the Staff 6 stated that the nursing staff did not know where the hose was. The shower hose could be used to tie onto an anchor point. 33. There were pendent type sprinkler heads throughout the corridor and in the recreation room. 34. There was an accumulation of dirt on the agitator and tub of the laundry room washing machine. Culver City Campus 6th floor Pavilion There were anchor points within the patient's	A 701	(Continued from page 120) **29) Corrective Actions:** The standard faucet in the shaving room was replaced with an anti-ligature faucet. **Date of Implementation:** The standard faucet in the shaving room was replaced with an anti-ligature faucet on August 19, 2014. **Monitoring Process:** Until patient bathrooms are resistant to ligature, continual round the clock rounding by mental health workers will be conducted to ensure patient safety. Once anti-ligature safety features are complete, engineering will monitor via weekly EOC rounds to ensure a safe environment is maintained. **Person Responsible:** Director of Engineering & ACNO **30) Corrective Actions**: The observation room metal bed frame was replaced with plastic bed on April 21, 2014. The plastic bed is cleaned and disinfected daily. **Date of Implementation:** 4/21/14 **Monitoring Process:** Cleanliness will be monitored during routine cleaning of beds done daily by nursing staff and EVS. **Person Responsible:** ACNO & Director of Engineering **31) Corrective Actions:** The grab bars from shower room numbers 1, 2 and 3 were removed and replaced with anti-ligature grab bars. **Date of Implementation**: The grab bars from shower room numbers 1, 2 and 3 were removed and replaced with anti-ligature grab bars on March 30, 2014. **Monitoring Process:** Engineering will monitor via weekly EOC rounds to ensure a safe environment is maintained. **Person Responsible:** Director of Engineering & ACNO **32) Corrective Actions**: The hose from shower room 2 was located in the engineering shop awaiting repair. The shower hose will be kept and locked in the nursing office when not in use. The nurse will check the hose out for use. No hose will be left in the shower room unattended. An in-service will be provided to staff to reiterate proper safety precautions. **Date of Implementation:** The replacement hose will arrive August 21, 2014. The process of checking the hose out for use will be implemented on August 21, 2014. An in-service will be scheduled on August 21, 2014. **Monitoring Process:** A sign-out sheet will be used to monitor the hose usage and a "check for loose equipment" item will be added to the daily nursing checklists used for monitoring patient care areas. **Person Responsible:** ACNO, Nursing Supervisor and Charge Nurse **33) Corrective Actions** All pendent type sprinkler heads located throughout all corridors and the recreation room have been removed and replaced with Recessed Sprinkler heads by Mid-Valley Automatic Fire System, Inc. **Date of Implementation:** All pendent type sprinkler heads located throughout all corridors and the recreation room have been removed and replaced with Recessed Sprinkler heads by Mid-Valley Automatic Fire System, Inc. completed July 11, 2014. **Monitoring Process:** Engineering will monitor integrity of the recessed sprinkler heads via weekly EOC rounds. EOC rounds are planned to be ongoing to ensure a safe environment is maintained. Monitoring of fire sprinklers will also be part of the Annual Sprinkler Testing Evaluation. **Person Responsible:** Director of Engineering **34) Corrective Actions:** The accumulation of dirt on the agitator and tub of the laundry room washing machine was cleaned and disinfected on 3/24/14 by EVS. New washing machine delivered 6/19/14. Routine daily cleanliness to be monitored by mental health workers and EVS. **Date of Implementation:** 6/19/14 New washing machine delivered **Monitoring Process:** Routine daily cleaning by mental health worker and EVS. **Person Responsible:** ACNO & Director of Engineering	8/19/2014 4/21/2014 3/30/2014 8/21/2014 7/11/2014 6/19/2014

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A 701	Continued From page 121 environment and areas accessible to the patient that could be used to tie to that could hold a person's weight, including mortise hinges & standard faucets throughout. 6th floor Unit A Psychiatric On March 26, 2014 between the time of 10:00 a.m. and 11:15 a.m. the following conditions existed in 6th floor Psychiatric Unit A. 35. Room 602 had burn (arching) marks at the electrical receptacle by the sink, there was damaged plaster the length of one foot at the corner by the bathroom, and there was blistering at the wall along the wall coving by the sink. 36. Room 604 had the door of the night stand hanging loose, and there was an accumulation of dust on the ceiling curtain rails. 37. Room 605 had a 4 inch by 4 inch area of water damage at the bathroom ceiling that included blistering of the paint. 38. Room 606 water damage around the window and at the ceiling that included blistering of the paint, had a broken soap dispenser, and had a loose air conditioning control that was pulled away from the wall by bed C. 39. Room 607 had an accumulation of dust below the air supply, above and on the side of the bathroom door, above the wall mounted light fixture, and had blistering at the corner of a wall by bed B. 40. Room 608 a 2 foot by 4 foot area of water damage at the ceiling above bed B and 2 feet	A 701	(Continued from page 121) **CULVER CITY CAMPUS (6th Floor Pavilion – Unit A)** **35) Corrective Actions:** The electrical receptacle by the sink in Room 602 in the Psych unit was replaced by Engineering on April 4, 2014. The damaged wall was repaired also on April 4, 2014. **Date of Implementation:** Electrical receptacle replaced on April 4, 2014. **Monitoring Process:** Engineering to conduct daily rounding for routine maintenance repairs commencing in June 2014 in clinical areas including psych. **Person Responsible:** Director of Engineering **36) Corrective Actions:** The night stand was replaced with a new night stand by Engineering. Upon review of P&P, staff was in-serviced and high dusting was performed on the ceiling curtain rails. **Date of Implementation:** The night stand was replaced on June 19, 2014. High dusting was performed on March 26, 2014, when the room became available. **Monitoring Process:** Engineering to conduct daily rounding for routine maintenance repairs commencing in June 2014. **Person Responsible:** Director of Engineering & Director of EVS. **37) Corrective Actions:** The water damage at the bathroom ceiling, including blistering of paint, was repaired by Engineering on April 4, 2014. **Date of Implementation:** The water damage at the bathroom ceiling, including blistering of paint, was repaired on April 4, 2014. **Monitoring Process:** Engineering to conduct daily rounding for routine maintenance repairs commencing in June 2014 in clinical areas including psych. **Person Responsible:** Director of Engineering **38) Corrective Actions:** The water damage around the window and the AC control switch in room 606 were repaired by Engineering on April 4, 2014. The hand soap dispenser will be replaced in June 2014. **Date of Implementation:** The water damage around the window and the AC control switch in room 606 were repaired by on April 4, 2014. The hand soap dispenser will be replaced in June 2014. **Monitoring Process:** Engineering to conduct daily rounding for routine maintenance repairs commencing in June 2014 in clinical areas including psych. **Person Responsible:** Director of Engineering. **39) Corrective Actions:** The water damage along wall near window was repaired by Engineering on April 4, 2014. Dust accumulation in patient rooms was addressed by EVS. Daily rounding is conducted to monitor cleanliness. Deep cleaning is done in patient rooms in the Psych Unit bimonthly. **Date of Implementation:** The water damage along wall near window was repaired on April 4, 2014. Dust accumulation in patient rooms was addressed by EVS immediately on March 26, 2014. **Monitoring Process:** Engineering to conduct daily rounding for routine maintenance repairs commencing in June 2014 in clinical areas including psych. Daily rounding is conducted by EVS to monitor cleanliness. Deep cleaning is done in patient rooms in the Psych Unit bimonthly. **Person Responsible:** Director of Engineering & Director of EVS **40) Corrective Actions:** The water damage at the ceiling area Room 608 above bed B and at the area 2 feet along the wall by window of bed B was repaired by Engineering on April 4, 2014. **Date of Implementation**: The water damage at the ceiling area above bed B and at the area 2 feet along the wall by window of bed B was repaired on April 4, 2014. **Monitoring Process:** Engineering to conduct daily rounding for routine maintenance repairs commencing in June 2014 in clinical areas including psych. **Person Responsible:** Director of Engineering.	4/4/2014 3/26/2014 6/19/2014 4/4/2014 4/4/2014 6/30/2014 3/26/2014 4/4/2014 4/4/2014

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SOUTHERN CALIFORNIA HOSPITAL AT HOLLYWOOD	**6245 DE LONGPRE AVE HOLLYWOOD, CA 90028**

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A 701	Continued From page 122 along the wall by window of bed B. 41. Room 609 had an exposed drain pipe (P-trap) under the sink that could be used as an anchor, and the wall was cracked near the bottom edge of the window by bed B. 42. Shower room 1 had a make-shift safety grab bar. The grab bar had two 2 inch by 1/4 inch spaces between the bar & plate that could be used to tie to. The shower room also had a blistered wall and a missing wall tile. 43. Shower Room 4 had a shower head with a 5 foot hose in it. During an interview at the same time as the observation Staff S (director of the psychiatric unit) stated the hand shower was suppose to remain in the shower because patients can only come in with staff and staff remain during the shower. Review of the hospital's policy titled Standards of Care (Number BHU.064) with an effective date of July 1998 indicated the handheld shower is available for patients who need assistance, the showerheads are held in the medication room on the open unit and are monitored by means of a sign in/out sheet. Staff S was asked to provide a copy of the sign in/out sheet for that included the hand held shower sign out for March 26, 2014. By the end of the survey a copy of or any evidence of the sign in/out sheet was not provided. 44. Shower Room 5 had an accumulation of mold on two of the walls.	A 701	(Continued from page 122) **41) Corrective Actions:** The exposed drain pipe will be covered with a p trap cover. The crack on the wall was repaired by Engineering. **Date of Implementation:** The exposed drain pipe will be covered with a p trap cover by September 19, 2014. The crack on the wall was repaired on April 4, 2014. **Monitoring Process:** Until patient bathrooms are resistant to ligature, continual round the clock rounding by mental health workers will be conducted at 30-minute intervals to ensure patient safety. Criteria to monitor that integrity of p-trap covers are in place will be added to the Behavioral Safety Rounds sheets, and will be surveyed on a weekly basis. be added to the Behavioral Safety Rounds sheets, and will be surveyed on a weekly basis. Engineering to conduct weekly rounding for routine maintenance repairs in the Psych Unit. **Person Responsible:** Director of Engineering, Director of Behavioral Health **42) Corrective Actions:** Hang-proof grab bars will be purchased and installed in Shower Room #1 and wall damage will be repaired by Engineering scheduled for completion in June 2014. **Date of Implementation:** Hang-proof grab bars will be purchased and installed in Shower Room #1 and wall damage will be repaired in June 2014 or immediately upon receiving. **Monitoring Process:** Engineering to conduct daily rounding for routine maintenance repairs commencing in June 2014 in clinical areas including psych. **Person Responsible:** Director of Engineering. **43) Corrective Actions:** The removable shower head has been taken out and kept in the Nurse's Station and is only re-installed by staff when or as needed. Re-educate of BHU nursing staff regarding monitoring the location (charge nurse office) and use of the hand held showerhead and the required signed in and out and must be visually monitored at all times to ensure patient safety. **Date of Implementation:** Completion of staff education 4/30/2014. **Monitoring Process:** The sign out /in sheet will be monitored by the charge nurse. The showers are monitored every shift by RN rounds. **Person Responsible:** BHU Nursing Leadership on BHU & Director of Engineering. **44) Corrective Actions**: Mold along back wall had been removed and water damage had been repaired in shower room #5 by Engineering on March 31, 2014. **Date of Implementation:** Mold along back wall had been removed and water damage had been repaired in shower room #5 on March 31, 2014. **Monitoring Process:** Engineering to conduct daily rounding for routine maintenance repairs commencing in June 2014 in clinical areas including psych. Person Responsible: Director of Engineering.	4/4/2014 9/19/2014 6/30/2014 4/30/2014 3/31/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	
	050135	S. BUILDING **01 – SOUTHERN CALIFORNIA HOSPITAL AT HOLLYWOOD** T. WING _____	

NAME OF PROVIDER OR SUPPLIER	
SOUTHERN CALIFORNIA HOSPITAL AT HOLLYWOOD	

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A 701	Continued From page 123 45. There was a damaged phone cubicle exposing two 2 inch by 1 inch spaces between the metal frame & the metal shelve of the cubicle that could be used as an anchor. 46. There were three loose hand rails at corridor under pay phone by supply room, by secretary office, and by the laundry room. 47. There was a chair with torn upholstery exposing the padding underneath at the pay phone area. 48. There was a broken light diffuser at station kitchen. 49. There was a water damaged ceiling tile at the corridor of the doctors consultation area. 50. There was a sign of water damage at the ceiling of the 6th floor southwest stairway landing. 6th floor Unit B Psychiatric On March 26, 2014 between the time of 11:15 a.m. and 12:12 p.m. the following conditions existed in 6th floor Psychiatric Unit B. 51. Room 622 had a urine stained wall next to toilet, and burn (arching) marks at the electrical receptacle next to the sink. 52. Room 625 had an accumulation of dust at the ceiling light fixture. 53. Room 624 had a small flying insect in it.	A 701	(Continued from page 123) **45) Corrective Actions:** The phone booth shelf on Pavilion 6 was removed by Engineering on April 7, 2014. **Date of Implementation:** The phone booth shelf on Pavilion 6 was removed on April 7, 2014. **Monitoring Process:** Engineering to conduct daily rounding for routine maintenance repairs commencing in June 2014 in clinical areas including psych. **Person Responsible**: Director of Engineering. **46) Corrective Actions:** The hand rails were re-secured at corridor by Engineering on April 4, 2014. **Date of Implementation:** The hand rails were re-secured at corridor on April 4, 2014. **Monitoring Process:** Engineering to conduct daily rounding for routine maintenance repairs commencing in June 2014 in clinical areas including psych. **Person Responsible:** Director of Engineering. **47) Corrective Actions:** The torn chair was removed by Engineering immediately on March 26, 2014. **Date of Implementation:** The torn chair was removed immediately on March 26, 2014. **Monitoring Process:** Engineering to conduct daily rounding for routine maintenance repairs commencing in June 2014 in clinical areas including psych. **Person Responsible:** Director of Engineering. **48) Corrective Actions:** The broken light diffuser at the station kitchen was replaced on June 18, 2014. **Date of Implementation:** The broken light diffuser at the station kitchen will be replaced in June 2014. **Monitoring Process:** Engineering to conduct daily rounding for routine maintenance repairs commencing in June 2014 in clinical areas including psych. **Person Responsible:** Director of Engineering. **49) Corrective Actions:** The ceiling tile at the corridor of the doctor's consultation area was replaced by Engineering on April 4, 2014. **Date of Implementation:** The ceiling tile at the corridor of the doctor's consultation area was replaced on April 4, 2014. **Monitoring Process:** Engineering to conduct daily rounding for routine maintenance repairs commencing in June 2014 in clinical areas including psych. **Person Responsible:** Director of Engineering. **50) Corrective Actions:** The sign of water damage at the ceiling of the southwest stairway landing was investigated by the Director of Engineering. Minor repairs were conducted on June 18, 2014 although no leaks were noted or identified. **Date of Implementation:** Minor repairs were conducted on June 18, 2014 **Monitoring Process:** Engineering to conduct daily rounding for routine maintenance repairs commencing in June 2014 in clinical areas including psych. **Person Responsible:** Director of Engineering **51). Corrective Actions:** Urine stain on the wall in room 622 was cleaned by EVS then repainted. The electrical receptacle next to the sink was replaced by Engineering on April 15, 2014. **Date of Implementation:** April 15, 2014 **Monitoring Process:** Daily rounding is conducted by EVS to monitor cleanliness. Engineering to conduct daily rounding for routine maintenance repairs commencing in June 2014. **Person Responsible**: Director of EVS and Director of Engineering **52). Corrective Actions:** Dust accumulation was addressed immediately by EVS. Daily rounding is conducted to monitor cleanliness. Deep cleaning is done in Psych Unit patient rooms bimonthly. **Date of Implementation:** March 26, 2014 **Monitoring Process:** Daily rounding is conducted by EVS to monitor for cleanliness. **Person Responsible:** Director of EVS	4/7/2014 4/4/2014 3/26/2014 6/30/2014 4/4/2014 6/18/2014 4/15/2014 3/26/2014

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	050135	S. BUILDING **01 – SOUTHERN CALIFORNIA HOSPITAL AT HOLLYWOOD** T. WING _____	**04/01/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN CALIFORNIA HOSPITAL AT HOLLYWOOD	**6245 DE LONGPRE AVE HOLLYWOOD, CA 90028**

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A 701	Continued From page 124 54. Room 627 had exposed plumbing pipe (P-trap) under the sink that could be used as an anchor, a blistered water damaged wall under the sink, and laminate pulled away from the base of the closet. 55. Room 628 had burn (arching) marks and a metal bolt in the ground slot of the electrical receptacle next to the sink, had a plastic tube in the ground slot of an emergency power receptacle and the tooth of a comb in another slot of the same receptacle, and was missing soap dispenser. 56. Room 629 had a strong urine odor and urine on the floor in the bathroom, and had wall caving pulled away from the wall next to the bathroom. 57. The men's common bathroom by day room had a standard faucet and an exposed plumbing pipe (P-trap) under the sink that could be used as an anchor. The bathroom also had strong urine odor. 58. The day room had an accumulation of dust around the air supply registers and at 8 foot by 3 foot ceiling areas on both sides of the room. There was also 2 inch by inch area of damage at the wall by the entrance to the room. 59. There were two loose hand rails at the wall by the water fountain and by the phone near the day room. 60. There a piece of broken wall caving with a sharp edge at the corridor between Rooms 622 and 623. 6th floor Unit C	A 701	(Continued from page 124) **53). Corrective Actions:** Steritech, a Pest control company, came on April 7 & 11, 2014 to address small flying insects in room 624. The pest control company also did visual inspection of the whole unit. **Date of Implementation:** April 7 (inspection) and April 11 (work performed) — 4/7/2014 **Monitoring Process:** Daily rounding is conducted by EVS to monitor cleanliness. **Person Responsible:** Director of EVS **54). Corrective Actions:** The water damage in room 627 will be repaired by Engineering in June 2014. The p-trap cover (under sink enclosure) will be purchased and installed in June 2014 or immediately upon receiving them. — 6/30/2014 **Date of Implementation**: June 2014 **Monitoring Process:** Engineering to conduct daily rounding for routine maintenance repairs commencing in June 2014. **Person Responsible:** Director of Engineering **55). Corrective Actions:** The electrical receptacle next to the sink in room 628 was replaced by Engineering on April 15, 2014. The hand soap dispenser was replaced by Engineering on June 18, 2014. **Date of Implementation:** April 15 and June 18, 2014, respectively — 4/15/2014 **Monitoring Process**: Engineering to conduct daily rounding for routine maintenance repairs commencing in June 2014. — 6/18/2014 **Person Responsible**: Director of Engineering **56). Corrective Actions:** Deep cleaning was performed in Room 629 to address the strong urine odor. The wall coving was replaced on April 7, 2014. **Date of Implementation**: April 7, 2014 — 4/7/2014 **Monitoring Process:** Daily rounding is conducted by EVS to monitor cleanliness. Engineering to conduct daily rounding for routine maintenance repairs commencing in June 2014. **Person Responsible:** Director of EVS and Director of Engineering **57). Corrective Actions:** Ligature-proof faucets and p-trap cover will be purchased and installed in June 2014 or immediately upon receiving them. Deep cleaning was performed in the men's common bathroom by EVS to address the strong urine odor. **Date of Implementation:** June 2014 or immediately upon receiving parts. — 6/30/2014 **Monitoring Process:** Daily rounding is conducted by EVS to monitor cleanliness. Engineering to conduct daily rounding for routine maintenance repairs commencing in June 2014. **Person Responsible:** Director of EVS and Director of Engineering **58). Corrective Actions:** The wall damage at the entrance in the day room was repaired by Engineering. Upon review of P&P, staff was in-serviced and high dusting was performed in the day room around the air supply registers and ceiling area. **Date of Implementation:** The wall damage was repaired on April 30, 2014. High dusting was performed on March 26, 2014, when the room became available. — 3/26/2014 **Monitoring Process:** Engineering to conduct daily rounding for routine maintenance repairs commencing in June 2014. Daily rounding is conducted by EVS in the Psych Unit. Deep cleaning is done in the Psych Unit bimonthly. A dusting calendar is kept to ensure every patient room is dusted, starting in the Psych Unit then house-wide. In addition, EOC Rounding is conducted routinely, covering patient care areas, twice a year and as needed. **Person Responsible**: Director of Engineering & Director of EVS **59). Corrective Actions:** The loose hand rails at the wall by the water fountain and phone were repaired by Engineering on April 4, 2014. **Date of Implementation**: April 4, 2014 — 4/4/2014 **Monitoring Process:** Engineering to conduct daily rounding for routine maintenance repairs commencing in June 2014. **Person Responsible:** Director of Engineering **60). Corrective Actions:** The broken wall coving at the corridor between rooms 622 and 623 will be repaired in June 2014. — 6/30/2014 **Date of Implementation:** June 2014 **Monitoring Process:** Engineering to conduct daily rounding for routine maintenance repairs commencing in June 2014.	

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A 701	Continued From page 125 On March 26, 2014 between the time of 12:12 p.m. and 12:40 p.m. the following conditions existed in 6th floor psychiatric unit C. 61. Room 630 had a standard faucet that could be used as an anchor, and there was a piece of wall caving missing from behind the bed. During an interview at the same time of the observation the director of engineering stated that all the rooms had standard faucets. 62. Room 631 had burn (arching) marks at the electrical receptacle next to the sink, and there were pieces of porcelain missing from the sink. 63. Room 632 had worn flooring exposing the sub-flooring. 64. Room 634 had had a standard faucet and exposed plumbing (P-trap) that could be used as an anchor, and had a strong urine odor. 65. Room 635 had had a standard faucet and exposed plumbing (P-trap) that could be used as an anchor. 66. Room 636 (seclusion room) had an accumulation of dirt around foot of the bed. 67. Room 639 had had a standard faucet and exposed plumbing (P-trap) that could be used as an anchor, and had a strong urine odor. 68. The recreation room had a standard faucet and exposed plumbing (P-trap) that could be used as an anchor, and had an accumulation of dust at the wall mounted light fixture.	A 701	(Continued from page 125) **Person Responsible**: Director of Engineering **CULVER CITY CAMPUS (6th Floor Pavilion – Unit C)** **61). Corrective Actions:** The ligature-proof faucet will be purchased and installed in June 2014 or immediately upon arrival. The wall coving in room 630 was replaced by Engineering on June 18, 2014. **Date of Implementation:** June 18, 2014 **Monitoring Process:** Engineering to conduct daily rounding for routine maintenance repairs commencing in June 2014. **Person Responsible:** Director of Engineering **62). Corrective Actions:** In room 631, the electrical receptacle was replaced on April 14, 2014 and porcelain sink was replaced by Engineering on June 18 2014. **Date of Implementation:** April 14, 2014 and June 18, 2014 **Monitoring Process:** Engineering to conduct daily rounding for routine maintenance repairs commencing in June 2014. **Person Responsible**: Director of Engineering **63). Corrective Actions:** The flooring in room 632 will be repaired by Engineering in June 2014. **Date of Implementation:** June 2014 **Monitoring Process**: Engineering to conduct daily rounding for routine maintenance repairs commencing in June 2014. **Person Responsible**: Director of Engineering **64). Corrective Actions**: The standard faucet in the patient bathroom will be replaced with anti-ligature faucet. The exposed drain pipe will be covered with a p trap covers. Room cleaning was performed in Room 634 immediately on March 26, 2014 by EVS to address the strong urine odor. **Date of Implementation:** The standard faucet in the patient bathroom will be replaced with anti-ligature faucet by September 19, 2014. The exposed drain pipe will be covered with a p trap cover by September 19, 2014. Deep cleaning was performed on March 26, 2014. **Monitoring Process:** Until patient bathrooms are resistant to ligature, continual round the clock rounding by mental health workers will be conducted at 30-minute intervals to ensure patient safety. Criteria to monitor that integrity of anti-ligature faucets and p-trap covers are in place will be added to the Behavioral Safety Rounds sheets, and will be surveyed on a weekly basis. EVS to conduct daily routine at high-touched areas and restrooms. EVS also conducts discharge cleaning by performing daily cleaning routine and thorough cleaning of beds and mattresses, including high dusting. **Person Responsible**: Director of EVS, Director of Behavioral Health, Director of Engineering **65). Corrective Actions:** The standard faucet in the patient bathroom will be replaced with anti-ligature faucet. The exposed drain pipe will be covered with a p trap cover. **Date of Implementation:** The standard faucet in the patient bathroom will be replaced with anti-ligature faucet by September 19, 2014. The exposed drain pipe will be covered with a p trap cover by September 19, 2014. **Monitoring Process:** Engineering to conduct weekly rounding. Until patient bathrooms are resistant to ligature, continual round the clock rounding by mental health workers will be conducted at 30-minute intervals to ensure patient safety. Criteria to monitor that integrity of anti-ligature faucets and p-trap covers are in place will be added to the Behavioral Safety Rounds sheets, and will be surveyed on a weekly basis. **Person Responsible:** Director of Engineering, Director of Behavioral Health **66). Corrective Actions:** EVS addressed the dirt accumulation in room 636 on March 29, 2014. Daily rounding is conducted to monitor cleanliness. Deep cleaning is done in patient rooms in the Psych Unit bimonthly. **Date of Implementation:** March 29, 2014 **Monitoring Process:** Daily rounding is conducted by EVS to monitor cleanliness. **Person Responsible**: Director of EVS **67). Corrective Actions:** The standard faucet in the patient bathroom will be replaced with anti-ligature faucet. The exposed drain pipe will be covered with a p trap cover. Deep cleaning was performed in Room 639 immediately on March 26, 2014 by EVS to address the strong urine odor. **Date of Implementation** The standard faucet in the patient bathroom will be replaced with anti-ligature faucet by September 19, 2014. The exposed drain pipe will be covered with a p trap cover by September 19, 2014. Deep cleaning was performed on March 26, 2014. **Monitoring Process:** Until patient bathrooms are resistant to ligature, continual round the clock rounding by mental health workers will be conducted at 30-minute intervals to ensure patient safety. Criteria to monitor that integrity of anti-ligature faucets and p-trap covers are in place will be added to the Behavioral Safety Rounds sheets, and will be surveyed on a weekly basis.	6/18/2014 4/14/2014 6/18/2014 6/30/2014 3/26/2014 9/19/2014 9/19/2014 3/29/2014 3/26/2014 9/19/2014

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A 701	Continued From page 126 69. The light missing in the patient food refrigerator at the nurses station. 6th floor Unit D 70. On March 26, 2014 between the times of 12:40 p.m. and 2:25 p.m. the following conditions existed in 6th floor psychiatric unit D. 71. Room 612 had a water damaged blistered wall under the sink, and had a small flying insect in the room. 72. Room 614 had had a standard faucet and exposed plumbing (P-trap) that could be used as an anchor. 73. Room 615 had had a standard faucet that could be used as an anchor, and had a small flying insect the room. 74. Room 616 had had a standard faucet and exposed plumbing (P-trap) that could be used as an anchor. There was also missing wall caving by the bathroom. 75. Room 617 had a standard faucet and exposed plumbing (P-trap) that could be used as an anchor, and a also had a broken soap dispenser. 76. Room 619 had a standard faucet and exposed plumbing (P-trap) that could be used as an anchor, and also had two drawers missing from a night stand. 77. Room 620 had a standard faucet and	A 701	(Continued from page 126) EVS to conduct daily routine at high-touched areas and restrooms. EVS also conducts discharge cleaning by performing daily cleaning routine and thorough cleaning of beds and mattresses, including high dusting. **Person Responsible:** Director of EVS, Director of Behavioral Health, Director of Engineering **68). Corrective Actions:** The standard faucet in the bathroom will be replaced with anti-ligature faucet. The exposed drain pipe will be covered with a p trap cover. Deep cleaning was performed by EVS in the recreation room to remove dust. **Date of Implementation:** The standard faucet in the patient bathroom will be replaced with anti-ligature faucet by September 19, 2014. The exposed drain pipe will be covered with a p trap cover by September 19, 2014. Deep cleaning was performed on March 26, 2014. **Monitoring Process:** Engineering to conduct weekly rounding for routine maintenance repairs in the Psych Unit. Until patient bathrooms are resistant to ligature, continual round the clock rounding by mental health workers will be conducted at 30-minute intervals to ensure patient safety. Criteria to monitor that integrity of anti-ligature faucets and p-trap covers are in place will be added to the Behavioral Safety Rounds sheets, and will be surveyed on a weekly basis. Daily rounding is conducted by EVS in the Psych Unit. Deep cleaning is done in patient rooms in the Psych Unit bimonthly. In addition, EOC Rounding is conducted weekly covering patient areas twice a year. **Person Responsible**: Director of EVS, Director of Behavioral Health, Director of Engineering **69). Corrective Actions:** The light bulb in the patient food refrigerator at the nurse's station was replaced by Engineering on April 10, 2014. **Date of Implementation:** April 10, 2014 **Monitoring Process:** Engineering to conduct daily rounding for routine maintenance repairs commencing in June 2014. **Person Responsible:** Director of Engineering **CULVER CITY CAMPUS (6th Floor Pavilion – Unit D** **71). Corrective Actions:** Steritech, pest control, came on April 7 and 11, 2014 to address small flying insects in room 612. The pest control company also did visual inspection of entire unit. Water damage will be repaired in June 2014 by Engineering. Infection Control was notified of the insects in room 612. (A copy of the service report is attached) **Date of Implementation:** April 11, 2014 (pest control) / June 2014 (water damage) **Monitoring Process:** Engineering to conduct daily rounding for routine maintenance repairs commencing in June 2014. Daily rounding is conducted by EVS to monitor cleanliness. **Person Responsible:** Director of EVS and Director of Engineering **72). Corrective Actions:** The standard faucet in the patient bathroom was replaced with anti-ligature faucet. The exposed drain pipe will be covered with a p trap cover. **Date of Implementation:** The standard faucet in the patient bathroom was replaced with anti-ligature faucet on August 19, 2014. The exposed drain pipe will be covered with a p trap cover by September 19, 2014. **Monitoring Process**: Until patient bathrooms are resistant to ligature, continual round the clock rounding by mental health workers will be conducted at 30-minute intervals to ensure patient safety. Criteria to monitor that integrity of anti-ligature faucets and p-trap covers are in place will be added to the Behavioral Safety Rounds sheets, and will be surveyed on a weekly basis. **Person Responsible:** Director of Engineering, Director of Behavioral Health **73). Corrective Actions:** The standard faucet in the patient bathroom was replaced with anti-ligature faucet. Source of insects, e.g. food tray, was removed from the room by Nursing staff. Steritech, pest control, came on April 7 and 11, 2014 and got rid of small flying insects in room 615. The pest control company also did visual inspection of the entire unit. **Date of Implementation:** The standard faucet in the patient bathroom was replaced with anti-ligature faucet on August 19, 2014. Steritech completed work on April 11, 2014 (pest control). **Monitoring Process:** Until patient bathrooms are resistant to ligature, continual round the clock rounding by mental health workers will be conducted at 30-minute intervals to ensure patient safety. Criteria to monitor that integrity of anti-ligature faucets and p-trap covers are in place will be added to the Behavioral Safety Rounds sheets, and will be surveyed on a weekly basis. Food trays are brought by staff inside the rooms of Geropsych patients and any patient who is unable to get out of bed. Leftover food is removed by staff immediately after meal time. All the other patients are allowed to dine only in the activity/dining room. Pest control provider comes monthly for routine service at high-risk areas for insects/pests and is on call to areas requiring their service. **Person Responsible:** Director of EVS and Director of Engineering	3/26/2014 9/19/2014 4/10/2014 4/11/2014 6/30/2014 8/19/2014 9/19/2014 4/7/2014 8/19/2014

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A 701	Continued From page 127 exposed plumbing (P-trap) that could be used as an anchor, and also had a broken soap dispenser 78. Room 621 had a standard faucet and exposed plumbing (P-trap) that could be used as an anchor, and also had wall caving that was pulled away from the wall. 79. There were water stains at the ceiling tile of the corridor by Room 610. 80. There was an electric insence burner stuck to the floor between a file cabinet and a wall cabinet in the utility review office. Detox Unit 6th Floor Tower 81. On March 26, 2014 between 3:20 p.m. and 3:35a.m. the following conditions existed in the Detox unit. 82. There were braided nurse call cords that could not be easily cleaned throughout the unit including dirty call bell cords in Rooms 679, 680, and 681. 83. Room 679 had a loose flange at a grab bar. 84. Room 680 was missing a grab bar next to toilet. There were three % inch holes in the bathroom wall where the grab bar use to be. 85. At the east stairway there was plaster missing at the wall around a wet stand by pipe. 4th floor Pavilion	A 701	(Continued from page 127) **74). Corrective Actions:** Safety, anti-ligature faucets and p-trap covers have been ordered to replace all standard faucets and cover exposed plumbing, respectively. The missing wall coving was replaced. **Date of Implementation:** The replacement of standard faucets to safe, anti-ligature faucets is expected to be completed by November 28, 2014 and installation of p-trap covers is expected to be completed by October 31, 2014.The missing wall coving was replaced on June 30, 2014. **Monitoring Process:** Engineering to conduct daily rounding for routine maintenance repairs commencing in June 2014. **Person Responsible:** Director of Engineering **75). Corrective Actions**: The standard faucet in the patient bathroom was replaced with anti-ligature faucet. The exposed drain pipe will be covered with a p trap cover. The hand soap dispenser was replaced by Engineering. **Date of Implementation:** The standard faucet in the patient bathroom was replaced with anti-ligature faucet on August 19, 2014. The exposed drain pipe will be covered with a p trap cover by September 19, 2014. The hand soap dispenser was replaced on June 18, 2014. **Monitoring Process:** Until patient bathrooms are resistant to ligature, continual round the clock rounding by mental health workers will be conducted at 30-minute intervals to ensure patient safety. Criteria to monitor that integrity of anti-ligature faucets and p-trap covers are in place will be added to the Behavioral Safety Rounds sheets, and will be surveyed on a weekly basis. Daily rounding is conducted by EVS in the Psych Unit. Deep cleaning is done in patient rooms in the Psych Unit bimonthly. In addition, EOC Rounding is conducted weekly covering patient areas twice a year. **Person Responsible:** Director of Engineering, Director of Behavioral Health, Director of EVS. **76). Corrective Actions:** The standard faucet in the patient bathroom was replaced with anti-ligature faucet. The exposed drain pipe will be covered with a p trap cover. The night stand was replaced with a new night stand by Engineering. **Date of Implementation:** The standard faucet in the patient bathroom was replaced with anti-ligature faucet on August 19, 2014. The exposed drain pipe will be covered with a p trap cover by September 19, 2014. The night stand was replaced on June 18, 2014. **Monitoring Process**: Until patient bathrooms are resistant to ligature, continual round the clock rounding by mental health workers will be conducted at 30-minute intervals to ensure patient safety. Criteria to monitor that integrity of anti-ligature faucets and p-trap covers are in place will be added to the Behavioral Safety Rounds sheets, and will be surveyed on a weekly basis. **Person Responsible**: Director of Engineering, Director of Behavioral Health **77). Corrective Actions:** The standard faucet in the patient bathroom will be replaced with anti-ligature faucet. The exposed drain pipe will be covered with a p trap cover. The broken soap dispenser was replaced with a new soap dispenser by Engineering. **Date of Implementation:** The standard faucet in the patient bathroom will be replaced with anti-ligature faucet by September 19, 2014. The exposed drain pipe will be covered with a p trap cover by September 19, 2014. The broken soap dispenser was replaced on June 18, 2014. **Monitoring Process:** Until patient bathrooms are resistant to ligature, continual round the clock rounding by mental health workers will be conducted at 30-minute intervals to ensure patient safety. Criteria to monitor that integrity of anti-ligature faucets and p-trap covers are in place will be added to the Behavioral Safety Rounds sheets, and will be surveyed on a weekly basis. **Person Responsible:** Director of Engineering, Director of Behavioral Health **78). Corrective Actions:** The standard faucet in the patient bathroom will be replaced with anti-ligature faucet. The exposed drain pipe will be covered with a p trap cover. The wall coving was repaired by Engineering. **Date of Implementation:** The standard faucet in the patient bathroom will be replaced with anti-ligature faucet by September 19, 2014. Exposed drain pipe will be covered with a p trap cover by September 19, 2014. The wall coving was repaired on June 21, 2014 by Engineering. **Monitoring Process:** Engineering to conduct weekly rounding for routine maintenance repairs in the Psych Unit. Until patient bathrooms are resistant to ligature, continual round the clock rounding by mental health workers will be conducted at 30-minute intervals to ensure patient safety. Criteria to monitor that integrity of anti-ligature faucets and p-trap covers are in place will be added to the Behavioral Safety Rounds sheets, and will be surveyed on a weekly basis. Daily rounding is conducted by EVS in the Psych Unit. Deep cleaning is done in patient rooms in the Psych Unit bimonthly. In addition, EOC Rounding is conducted weekly covering patient areas twice a year. **Person Responsible:** Director of Engineering	6/30/2014 10/31/2014 11/28/2014 6/18/2014 8/19/2014 9/19/2014 6/18/2014 8/19/2014 9/19/2014 6/18/2014 8/19/2014 9/19/2014 6/21/2014 9/19/2014 6/18/2014

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A 701	Continued From page 128 4th floor Rehabilitation Unit On March 28, 2014 between 9:30a.m. and 10:45 a.m. the following conditions existed in 4th floor rehabilitation unit. 86. Room 401 had a sharps container that was filled above the fill line. 87. Room 406 had a broken & loose soap dispenser next to the sink. 88. Room 409 had a dirty braided nurse call cord next to the shower. 89. Room 423 had a broken diffuser at the wall mounted light fixture by the door. 90. In the physical therapy room there four oxygen cylinders with gauges on them. The needles of the gauges of three of the oxygen cylinders were in the red area that indicated "0". During an interview at the same time as the observation, Registered Nurse (RN) 25 (charge nurse) stated the cylinders were for patient emergency use. 91. The common tub room had a torn shower curtain missing a 2 ft by 3 ft piece of the curtain. 92. In the clean supply room, there was a clean supplies cart that was not covered and a clean supplies cabinet with the doors fully open. During the observation a nurse walked in to the supply room obtained supplies and left without covering the cart or closing the cabinet doors. Supplies in the cart included tape, gauze, mouth swabs and Band-Aid.	A 701	(Continued from page 128) **79). Corrective Actions:** The ceiling tile within the corridor outside of Room 610 was replaced June 18, 2014 by Engineering. **Date of Implementation:** June 18, 2014 **Monitoring Process**: Engineering to conduct daily rounding for routine maintenance repairs commencing in June 2014. **Person Responsible:** Director of Engineering **80). Corrective Actions:** The electric incense burner was removed and staff was in-serviced on June 18, 2014. The sign-in sheet is attached herewith. **Date of Implementation:** June 18, 2014 **Monitoring Process:** Monitoring during Engineering daily rounding. **Person Responsible:** Director of Engineering **CULVER CITY CAMPUS (Tower 6 – Detox Unit)** **82) Corrective Actions:** A All braided nurse call cords in the Detox Unit were replaced with cleanable plastic cords by Engineering. **Date of Implementation:** All braided nurse call cords were replaced on April 22, 2014. **Monitoring Process:** Nurse call cords have been replaced with cleanable plastic cords house-wide. Criteria to monitor that the integrity of the cleanable, plastic cords are in place, will be added to the EOC Rounds sheets, and will be surveyed on a semi-annual basis. **Person Responsible**: Director of Engineering **83) Corrective Actions**: The loose flange of the grab bar in room 679 was re-secured by tightening the screws. **Date of Implementation:** The loose flange of the grab bar in room 679 was secured on June 18, 2014. **Monitoring Process:** Engineering to conduct weekly rounding for routine maintenance repairs in the Psych Unit. **Person Responsible:** Director of Engineering **84) Corrective Actions:** The grab bar in room 680 was re-installed thereby covering holes on April 22, 2014 by Engineering. **Date of Implementation:** The grab bar in room 680 was re-installed thereby covering holes on April 22, 2014. **Monitoring Process:** Engineering to conduct daily rounding for routine maintenance repairs commencing in June 2014 in clinical areas. **Person Responsible:** Director of Engineering **85) Corrective Actions**: The wall in East Stairway will be patched and repainted in June 2014 by Engineering. **Date of Implementation:** The wall in East Stairway will be patched and repainted in June 2014. **Monitoring Process:** Engineering to conduct daily rounding for routine maintenance repairs commencing in June 2014 in clinical areas. **Person Responsible:** Director of Engineering **CULVER CITY CAMPUS (Pavilion 4 Rehabilitation Unit)** **86) Corrective Actions:** The sharps container in room 401 was removed and replaced on March 28, 2014 by EVS. EVS supervisor will in service staff to monitor sharps daily. **Date of Implementation:** The sharps container in room 401 was removed and replaced on March 28, 2014. **Monitoring Process:** Daily rounding is conducted by EVS to monitor cleanliness, including sharps container fill lines. **Person Responsible:** Director of EVS **87) Corrective Actions:** The hand soap dispenser in room 406 was replaced on April 4, 2014 by Engineering. **Date of Implementation:** The hand soap dispenser in room 406 was replaced on April 4, 2014. **Monitoring Process:** Engineering to conduct daily rounding for routine maintenance repairs commencing in June 2014 in clinical areas. **Person Responsible**: Director of Engineering **88) Corrective Actions:** The nurse call pull cords have been replaced hospital-wide, including room 409, on April 2014 by Engineering. **Date of Implementation:** The nurse call pull cords have been replaced hospital-wide, including room 409, on April 4, 2014. **Monitoring Process:** Engineering to conduct daily rounding for routine maintenance repairs commencing in June 2014 in clinical areas. **Person Responsible:** Director of Engineering **89) Corrective Actions**: The light diffuser in room 423 was replaced by Engineering. **Date of Implementation:** April 3, 2014. **Monitoring Process:** Engineering to conduct daily rounding for routine maintenance repairs commencing in June 2014 in clinical areas. **Person Responsible:** Director of Engineering	6/18/2014 6/18/2014 4/22/2014 6/18/2014 4/22/2014 6/30/2014 3/28/2014 4/4/2014 4/4/2014 4/3/2014

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A 701	Continued From page 129 During an interview at the same time as the observation, AN 25 stated the cart was supposed to be covered and the cabinet doors were suppose to be closed. 93. The ice storage of ice machine in unit kitchen had a direct drain instead of an indirect drain (air gap). 94. At the construction separation between the back of the 4th floor and the rehabilitation unit at the front of the 4th floor, the plastic barrier in front of a gypsum board barrier was loose and separating from the drop down ceiling. Closer observation revealed there were also eight unsealed penetrations through the gypsum board barrier at the separation. During an interview Staff 5 (director of engineering) stated that besides being a dust barrier the gypsum board barrier is also suppose to be a fire barrier. 3rd floor Pavilion 3rd floor SICU On March 28, 2014 between the times of 10:45 a.m. and 11:20 a.m. the following conditions existed in 3rd floor SICU (surgical intensive care unit). 95. Room 332A had adhesive paper peeling off of the head wall mounted light fixture. 96. Room 332D had a towel taped onto a camera in the room. Further observation revealed that at the nurses station monitor the patients in the rest	A 701	(Continued from page 129) **90) Corrective Actions:** The oxygen tanks were immediately exchanged for full tanks. Charge nurses educated on use of Environment of Care Log to be completed every shift. This put in place to prevent oxygen tanks from being left empty in the Physical Therapy Room. Initial education completed to charge nurses on 6/19/2014 at 12:00pm. Education will be ongoing to ensure that all charge nurses will be aware. EOC charge nurse log will be kept on unit in separate binder at all times. **Date of Implementation:** 6/19/2014 **Monitoring Process:** Logs to reviewed weekly by Unit Director **Person Responsible:** Nursing Director **91) Corrective Actions:** The shower curtain in the common tub room was replaced by EVS. **Date of Implementation**: March 28, 2014. **Monitoring Process:** Daily rounding is conducted by EVS to monitor for cleanliness. **Person Responsible:** Director of EVS **92) Corrective Actions:** Linen cart cover was present but was not pulled down to provide coverage for the linen. The cover was pulled down and secured. Nursing education developed regarding ensuring cart covers are used and/or cabinet doors closed. **Date of Implementation**: Education started on June 19, 2014 with full implementation in 30 days. **Monitoring Process:** Infection Control Rounds **Person Responsible**: Nursing Director & Infection Control. **93) Corrective Actions**: Drain was redirected to an indirect drain line to provide air gap. **Date of Implementation:** Repairs will be completed by June 30, 2014. **Monitoring Process:** Engineering to conduct quarterly rounding, during performance of the Ice Machine Preventive Maintenance, to ensure integrity of the indirect drain line (air gap) is in place. **Person Responsible:** Director of Engineering **94) Corrective Actions:** Penetrations were sealed around pipes and joints using fire caulk, 3M-CP 25WB+, on the gypsum board barrier (dust barrier), at the construction separation between back of 4th floor and the Rehabilitation Unit on March 29, 2014 by Engineering. Below protocol will be complied: a) Contractors must train their employees in ILSM and provide documentation to the Director of Plant Operations/Safety Officer that this training has been accomplished. Documentation should include the subject matter covered, names of employees receiving the training, and the date the training was provided. In turn, the Director of Plant Operations will provide this documentation to the Chair of EOC. **Date of Implementation:** Penetrations were caulked on March 29, 2014. Protocol will be on going. **Monitoring Process:** During pre-construction meetings, the Director of Engineering will discuss the ILSM with the Contractor. Contractor is to sign on the copy of the ILSM for acknowledgment and agreement in compliance of fire penetrations **Person Responsible:** Director of Engineering **CULVER CITY CAMPUS (Pavilion 3 SICU)** **95).Corrective Actions:** The wall mounted light fixture in room 332A will be repaired in June 2014 by Engineering. **Date of Implementation:** June 2014 **Monitoring Process:** Engineering to conduct daily rounding for routine maintenance repairs commencing in June 2014. **Person Responsible:** Director of Engineering **96. Corrective Action:** Cameras placed on Charge RN daily environmental rounds to ensure their integrity. **Date of Implementation:** June 20, 2014 **Monitoring Process:** Charge RN Environmental Rounds Record**.** Data to be reviewed and aggregated by Nursing Director with report to Quality Dept. **Person Responsible:** Director of Engineering	6/19/2014 3/28/2014 6/19/2014 6/30/2014 3/29/2014 6/30/2014 6/20/2014

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A 701	Continued From page 130 of the unit's rooms could be observed by the cameras except for Room 333D which had the view obstructed by the towel. During an interview, RN 26 (charge nurse) stated the the purpose of the cameras was to observe the patients for patient safety, she further stated that the patient did not request the towel to be placed over the camera and that she did not know why the towel was taped onto the camera or who taped onto the camera. 97. In Room 332G, there was a loose front panel of head wall mounted light fixture. 98. In the clean supply room, there was a clean supplies cart that was not covered and a clean supplies cabinet with the doors fully open. Supplies in the cart included suction tubing, yankawers, cath plugs, trach holders, suction cather kits, ball and trach care suction systems, tongue depressors and swab sticks. 3rd floor CCU On March 28, 2014 between the time of 11:20 a.m. and 11:50 a.m., the following conditions existed in 3rd floor CCU (critical care unit). 99. There was an accumulation of dust and a gray substance at ceiling of Rooms 333A, 333D, and 333E. 100. Room 333 F/G had six 1/2 inch diameter holes through the wall. 101. During an interview at the time of the observation, Staff 5 stated the holes were from a	A 701	(Continued from page 130) **97. Corrective Actions:** The wall mounted light fixture in room 332G will be repaired in June 2014 by Engineering. **Date of Implementation:** June 2014 **Monitoring Process:** Engineering to conduct daily rounding for routine maintenance repairs commencing in June 2014. **Person Responsible:** Director of Engineering	6/30/2014
			98. Corrective Actions: Linen cart cover was present but was not pulled down to provide coverage for the linen. The cover was pulled down and secured. Nursing education developed regarding ensuring cart covers are used and/or cabinet doors closed. **Date of Implementation**: Education started on June 19, 2014 with full implementation in 30 days. **Monitoring Process:** Infection Control Rounds **Person Responsible:** Nursing Director & Infection Control.	6/19/2014
			CULVER CITY CAMPUS (Pavilion 3 CCU) **99) Corrective Actions:** Upon review of P&P, staff was in-serviced and high dusting was performed in room nos. 333A, 333D and 333E by EVS. **Date of Implementation:** Dust in rooms 333A, 333D and 333E was removed on March 28, 2014, when the rooms became available. **Monitoring Process:** A dusting calendar is kept by EVS to ensure every patient room is dusted, commencing in the Psych unit and then house-wide. In addition, EOC Rounding is conducted routinely, covering patient areas, twice a year and as needed. **Person Responsible:** Director of Engineering	3/28/2014
			100-101) Corrective Actions: Holes on wall were patched and painted in room 333, beds F&G, on April 7, 2014 by Engineering. **Date of Implementation:** Holes in the wall were patched and painted in room 333, beds F&G, on April 7, 2014. **Monitoring Process:** Engineering to conduct daily rounding for routine maintenance repairs commencing in June 2014 in clinical areas. **Person Responsible:** Director of Engineering	4/7/2014

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A 701	Continued From page 131 sharps container that use to be mounted on the wall and that the holes need to be sealed. 102. The patient rooms safety monitor was off at the at the nurses. 103. There was a missing cover plate at communication line at corridor wall between Rooms 3338 and 333C. 3rd floor ACU On March 28, 2014, between the time of 11:50 a.m. and 12:10 p.m,. the following conditions existed in 3rd floor ACU (ambulatory care unit). 104. There was no thermometer in the patient food refrigerator holding 8 cold cut sandwiches. 105. The X-Ray room had a two inch diameter hole in wall, and was missing wall caving. 106. There was a one foot crack at floor of common bathroom next to the waiting room. 3rd floor SOU On March 28, 2014 between the time of 12:10 p.m. and 2:00 p.m., the following conditions existed in 3rd floor SOU (step down unit). 107. Room 312 had a missing light shield at wall mounted light fixture exposing four fluorescent glass tubes, and had four 1/2 inch holes through the head wall exposing the wall cavity and particle board around the holes. 108. Room 314A had a loose nurse call at the	A 701	(Continued from page 131) **102) Corrective Actions:** Re-educate RN's and Monitor Techs to keep safety monitor alarms on. Revised Patient Rhythm Documentation Form to include Alarm monitoring. **Date of Implementation:** Revised form will be implemented June 20, 2014. **Monitoring Process:** Registered Nurses (RN's) and Monitor Techs (MT's) will monitor for alarms and document on Patient Rhythm/Alarm Documentation Form. Nursing Director will monitor form for 100% compliance and report compliance to the Quality Department. Non-compliance will be addressed with progressive discipline; will monitor for 30 days. **Person Responsible**: Director of Nursing and/or Designee. **103) Corrective Actions:** The cover plate in rooms 333B and 333B will be replaced in June 2014 by Engineering. Date of Implementation: The cover plate in rooms 333B and 333B will be replaced in June 2014. **Date of Implementation**: The cover plate in rooms 333B and 333B will be replaced in June 2014. **Monitoring Process:** Engineering to conduct daily rounding for routine maintenance repairs commencing in June 2014 in clinical areas. **Person Responsible:** Director of Engineering **CULVER CITY CAMPUS (Pavilion 3 ACU)** **104) Corrective Actions:** A thermometer was placed in the patient food refrigerator holding sandwiches on June 18, 2014 by Dietary. A log to ensure thermometers are checked daily has been created and is attached herewith. **Date of Implementation**: A thermometer was placed in the patient food refrigerator on June 18, 2014 by Dietary **Monitoring Process**: Dietary will conduct daily monitoring to ensure all patient food refrigerators have thermometers. **Person Responsible:** Director of Food Services. **105) Corrective Actions:** The hole in the wall and the missing wall coving in the x-ray room will be addressed in June 2014 by Engineering. **Date of Implementation**: The hole in the wall and the missing wall coving in the x-ray room will be addressed in June 2014. **Monitoring Process**: Engineering to conduct daily rounding for routine maintenance repairs commencing in June 2014 in clinical areas. **Person Responsible:** Director of Engineering. **106) Corrective Actions**: The crack on the bathroom floor next to Pavilion 4 waiting room was repaired on April 10, 2014 by Engineering. **Date of Implementation:** The crack on the bathroom floor next to Pavilion 4 waiting room was repaired on April 10, 2014. **Monitoring Process:** Engineering to conduct daily rounding for routine maintenance repairs commencing in June 2014 in clinical areas **Person Responsible:** Director of Engineering. **CULVER CITY CAMPUS (Pavilion 3 SDU)** **107). Corrective Actions:** The light shield at light fixture in room 312 was replaced and the holes in the wall were patched and painted on April 11, 2014 by Engineering. **Date of Implementation**: April 11, 2014 **Monitoring Process:** Engineering to conduct daily rounding for routine maintenance repairs commencing in June 2014. **Person Responsible:** Director of Engineering **108). Corrective Actions**: The nurse call was re-secured to the wall in room 314A in March 2014 by Engineering. **Date of Implementation:** March 2014 **Monitoring Process:** Engineering to conduct daily rounding for routine maintenance repairs commencing in June 2014. **Person Responsible:** Director of Engineering	6/20/2014 6/30/2014 6/18/2014 6/30/2014 4/10/2014 4/11/2014 3/30/2014

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A 701	Continued From page 132 head wall. 109. Room 318 had a three inch by one inch hole at the wall behind the door, and a loose nurse call bell light outside of the room. 110. There was a worn cover with tears and flaking pieces covering the clean linen cart in the corridor. 111. There was missing laminate at corners of nurses station exposing the wood beneath. 112. The common shower/tub room next to SOU had one foot by six inch area of damage at a wall, and three inch by two inch area of damage at a corner of the wall. 2nd floor Pavilion 113. There were braided nurse call cords throughout the southwest and southeast telemetry units. 114. The handrail across from room 244 had a broken corner with two inch wide sharp corner where a piece of the rail was missing. 2nd floor Southwest Telemetry On March 28, 2014 between 2:00 p.m. and 2:20 p.m. the following conditions existed in 2nd floor Telemetry Southwest Unit. 115. Room 203 had peeling paint at the shower stall. 116. Room 204 had a 1/2 inch diameter hole	A 701	(Continued from page 132) **109). Corrective Actions:** The nurse call bell light was re-secured to the wall in room 318 in March 2014 by Engineering. The holes were patched and painted on April 11, 2014 by Engineering. **Date of Implementation:** March 2014 and April 11, 2014, respectively **Monitoring Process**: Engineering to conduct daily rounding for routine maintenance repairs commencing in June 2014. **Person Responsible**: Director of Engineering **110) Corrective Actions**: A representative from Medline came on June 19, 2014 to assess replacement of worn and missing clean linen cart covers. An order has been placed for cart covers and ETA is July 3, 2014. **Date of Implementation:** July 3, 2014 **Monitoring Process**: Daily rounding is conducted by EVS to monitor cleanliness and ensure linen carts are covered at all times. Deficiencies will be addressed immediately. **Person Responsible**: Director of EVS **111). Corrective Actions:** The exposed wood at the corner of the nurse's station was covered using new laminate sheet. **Date of Implementation:** Repairs will be completed on August 19, 2014. **Monitoring Process:** Engineering to conduct quarterly rounding to monitor work stations to ensure they are in good and safe working condition i.e., free of wood exposure or chipped surface. **Person Responsible**: Director of Engineering **112). Corrective Actions**: Wall damage in shower/tub room next to SDU was repaired on April 9, 2014 by Engineering. **Date of Implementation**: April 9, 2014 **Monitoring Process:** Engineering to conduct daily rounding for routine maintenance repairs commencing in June 2014. **Person Responsible:** Director of Engineering **CULVER CITY CAMPUS (2nd Floor Pavilion/2nd Floor Southwest Telemetry/2nd Floor Southeast Telemetry)** **113). Corrective Actions:** All nurse call pull cords have been replaced in April 2014 hospital-wide by Engineering. **(See Addendum 96)** **Date of Implementation:** April 2014 **Monitoring Process:** Engineering to conduct daily rounding for routine maintenance repairs commencing in June 2014. **Person Responsible:** Director of Engineering **114). Corrective Actions:** The handrail across from room 244 will be repaired in June 2014 by Engineering. **Date of Implementation:** June 2014 **Monitoring Process:** Engineering to conduct daily rounding for routine maintenance repairs commencing in June 2014. **Person Responsible**: Director of Engineering **115). Corrective Actions:** The shower stall in room 203 was repainted on May 5, 2014 by Engineering. **Date of Implementation**: May 5, 2014 **Monitoring Process:** Engineering to conduct daily rounding for routine maintenance repairs commencing in June 2014. **Person Responsible:** Director of Engineering **116). Corrective Actions:** The hole through the bathroom door in room 204 was patched and painted on April 10, 2014 by Engineering. **Date of Implementation:** April 10, 2014 **Monitoring Process:** Engineering to conduct daily rounding for routine maintenance repairs commencing in	3/30/2014 4/11/2014 7/3/2014 8/19/2014 4/9/2014 4/30/2014 6/30/2014 5/5/2014 4/10/2014

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A 701	Continued From page 133 through the bathroom door. 117. Room 207 had eight *V4* inch holes at a bathroom wall. Closer observation revealed the toilet paper dispenser was missing and the toilet paper roll was sitting on the bathroom sink counter. 118. Missing cover at two clean supply carts in supply room. 119. In the supply room there were two clean supplies carts that were not covered. During an interview at the same time as the observation, AN 27 (charge nurse) stated that the carts were clean supplies carts and should have been covered, that they were covered before and did not know why they were no longer covered. 2nd floor Southeast Telemetry On March 28, 2014, between the time of 2:23 p.m. and 2:45 p.m., the following conditions existed in 2nd floor Telemetry Southeast Unit. 120. Room 211 had a night stand table with a broken drawer. 121. Room 214 had a grab bar that was off the shower stall wall and laying against bottom of the stall wall. 121. Room 218 was missing the towel bar from the bathroom, and there was also damaged at the corner of a wall. 123. Room 220 had a water leak at the nut of the sink drain pipe (P-trap), and had a loose lockset	A 701	(Continued from page 133) **117) Corrective Actions:** holes at a bathroom wall in room 207 will be patched and painted and the toilet paper dispenser will be installed in June 2014 by Engineering. **Date of Implementation**: June 2014 **Monitoring Process:** Engineering to conduct daily rounding for routine maintenance repairs commencing in June 2014. **Person Responsible**: Director of Engineering **118) Corrective Actions:** A representative from Medline came on June 19, 2014 to assess replacement of worn and missing clean supply cart covers. An order has been placed for cart covers and ETA is July 3, 2014. **Date of Implementation:** July 3, 2014 **Monitoring Process:** Nursing will be in-serviced to ensure that clean supply carts are covered at all times. Daily rounding is conducted by Nursing and EVS to monitor cleanliness and ensure clean supply carts are covered at all times. Deficiencies will be addressed immediately. **Person Responsible:** Nursing Personnel, Charge Nurses and Nursing Directors on each unit. **119). Corrective Actions:** Nursing education developed, ensuring cart covers are used and cabinet doors closed. **Date of Implementation:** Education started on June 19, 2014 with full implementation in 30 days. **Monitoring Process:** Infection Control Rounds **Person Responsible:** Nursing Director & Infection Control. **120). Corrective Actions:** The night stand table in room 211 will be replaced in June 2014 by Engineering. **Date of Implementation:** June 2014 **Monitoring Process:** Engineering to conduct daily rounding for routine maintenance repairs commencing in June 2014. **Person Responsible**: Director of Engineering **121). Corrective Actions:** The grab bar in the shower stall in room 214 was remounted on April 29, 2014 by Engineering. **Date of Implementation**: April 29, 2014 **Monitoring Process:** Engineering to conduct daily rounding for routine maintenance repairs commencing in June 2014. **Person Responsible:** Director of Engineering **121). Corrective Actions:** The missing towel bar from the bathroom was replaced on April 22, 2014 and the wall damage was repaired on April 10, 2014 by Engineering. **Date of Implementation**: April 22 and April 10 accordingly **Monitoring Process:** Engineering to conduct daily rounding for routine maintenance repairs commencing in June 2014. **Person Responsible:** Director of Engineering **123). Corrective Actions**: The water leak in room 220 was repaired on April 22, 2014 and the lockset as re-secured on April 10, 2014 by Engineering. **Date of Implementation:** April 22 and April 10, 2014 accordingly **Monitoring Process:** Engineering to conduct daily rounding for routine maintenance repairs commencing in June 2014. **Person Responsible:** Director of Engineering	6/30/2014 7/3/2014 6/19/2014 6/30/2014 4/29/2014 4/10/2014 4/22/2014 4/10/2014 4/22/2014

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	050135	U. BUILDING **01 – SOUTHERN CALIFORNIA HOSPITAL AT HOLLYWOOD** V. WING	**04/01/2014**

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A 701	Continued From page 134 handle at the bathroom door. 124. Room 221 had a missing grab bar at shower stall wall, and a three foot crack at shower stall wall. 1st floor Pavilion On March 31, 2014 between the time of 9:04a.m. and 10:20 a.m., the following conditions existed on 1st floor Pavilion. 125. The main laboratory had a missing light shield at a light fixture above the center work station where immunoassay procedures are done. 126. The pharmacy storage room was missing a light diffuser shield exposing four glass fluorescent tubes at at one of three ceiling lights over a rack of clean supplies. 127. The pharmacy had a pharmacy waste incineration container that was filled above the fill line and beginning to overflow out from the top of the container. There was also a missing cover plate at a wall exposing a three inch by two inch hole in the wall. 128. On March 25, 2014, the following conditions were observed in the the Hollywood campus: 4th Floor a. The toilet base was dirty and caulking; the sealant was in disrepair at the Nurse Station.	A 701	(Continued from page 134) **124). Corrective Actions:** The grab bar at the shower stall wall and the crack on the wall will be repaired in June 2014 by Engineering. **Date of Implementation**: June 2014 **Monitoring Process**: Engineering to conduct daily rounding for routine maintenance repairs commencing in June 2014. **Person Responsible:** Director of Engineering **CULVER CITY CAMPUS (Pavilion 1)** **125). Corrective Actions:** The missing light shield in the main laboratory above the center work station was replaced on April 11, 2014 by Engineering. **Date of Implementation:** April 11, 2014 **Monitoring Process:** Engineering to conduct daily rounding for routine maintenance repairs commencing in June 2014. **Person Responsible:** Director of Engineering **126). Corrective Actions:** The missing light diffuser shield in the Pharmacy storage room will be replaced in June 2014 by Engineering. **(see Addendum 98)** **Date of Implementation**: June 2014 **Monitoring Process:** Engineering to conduct daily rounding for routine maintenance repairs commencing in June 2014. **Person Responsible:** Director of Engineering **127). Corrective Actions:** The pharmacy waste incinerator container was replaced by EVS. The missing cover plate at a wall will be replaced in June 2014 by Engineering. **Date of Implementation**: Incinerator replaced on March 31, 2014 **Monitoring Process**: Daily rounding is conducted by EVS to monitor cleanliness. **Person Responsible:** Director of EVS **HOLLYWOOD** **Fourth Floor: 128 a-d** **128a). Corrective Actions:** Remove, clean and reset the toilet bowl and reseal with white caulking at the base. **Date of Implementation:** April 2, 2014 cleaning and repairs completed. **Monitoring Process:** Inspection of the toilet rooms will be performed quarterly. **Person Responsible:** Chief Engineer	6/30/2014 4/11/2014 6/30/2014 3/31/2014 4/2/2014

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A 701	Continued From page 135 b. There was leaking water/intrusion in the base cabinet of the Urgent Care base cabinet. c. The plumbing faucet was covered in calcium deposits in the Medication Room and the nurse station shower head. d. The shower/bathroom was in disrepair and the floor nurse station restroom shower enclosure had missing wall tiles. 3rd Floor a. Handwash sink had an unsealed hole measuring 3 inches (in) by 4 in. b. In the Nurse Station, the rest room had unclean shower base, missing shower door handle, missing threshold hardware, and missing facing in the dictation area. c. In Room 316, the wallpaper was torn and damage behind bed 3. d. Room 307, an over the bed table was damaged at a corner and revealed uncleanable particle board. e. In Room 308, the patient had no privacy curtain and a staff stated' 11She is the only one in the room!n 5th Floor a. The toilet base was dirty and caulking; the sealant was in disrepair in Room 507 and Room 508. b. The handwash sink faucets had aerators located in the following areas: respiratory,	A 701	(Continued from page 135) **128 b). Corrective Actions:** Replace defective angle stop to in the base cabinet of the Urgent Care cabinet base. **Date of Implementation**: April 7, 2014 angle stop replaced by Engineering and no more leaks noted. **Monitoring Process:** Continue to monitor sinks for water leaks during EOC rounds. **Responsible Person**: Chief Engineer **128 c). Corrective Actions:** Clean the calcium deposits on the plumbing faucet in the Medication Room and replace the shower head in the Nurse Station shower. **Date of Implementation:** April 5, 2014 faucet cleaned and shower head replaced. **Monitoring Process:** Continue to monitor sink faucets and shower heads for leaks during EOC rounds. **Responsible Person:** Chief Engineer **128 d) Corrective Actions:** Replace and re-caulk the missing wall tiles in the floor nurse station restroom shower enclosure. **Date of Implementation:** June 18, 2014 repairs completed. **Monitoring Process:** Continue to monitor shower/bathroom tiles during EOC rounds. **Responsible Person:** Maintenance Engineer **Third Floor: a-e** **128 a). Corrective Actions:** Seal the Hand wash sink hole (3 in. by 4 in) with 3M fire caulk. **Date of Implementation:** April 10, 2014 repairs completed. **Monitoring Process:** Quarterly Hospital-wide checks for penetrations will be performed. **Department Responsible:** Chief Engineer **128 b. Corrective Actions:** Clean shower base, replace the shower arm and shower head and shower door handle at the Nurse Station Lounge including the missing facing in the dictation area. **Date of Implementation:** June 20, 2014 cleaning and repairs completed. **Monitoring Process:** Continue to monitor during EOC rounds. **Department Responsible:** Chief Engineer **128 c). Corrective Actions:** Repair the torn and damaged wallpaper in ICU Room 316. **Date of Implementation:** June 16, 2014 repairs completed. **Monitoring Process:** Continue to monitor during EOC rounds. **Department Responsible:** Chief Engineer **128 d). Corrective Actions:** Remove and replace damaged over the bed table in room 307. **Date of Implementation**: March 25, 2014 replaced immediately. **Monitoring Process:** Continue to monitor during EOC rounds. **Department Responsible:** Chief Engineer **128 e) Corrective Actions:** Install a patient privacy curtain in Room 308. **Date of Implementation:** March 31, 2014 installation of curtain completed. **Monitoring Process;** Privacy curtains checks will continue to be performed during EVS Daily Rounds. **Department Responsible:** Environmental Services Lead Person **Fifth Floor: a-f** **128 a. Corrective Actions:** Clean toilet bases and reseal with new caulking in Rooms 507 and 508. **Date of Implementation:** March 31, 2014 cleaning and repairs completed. **Monitoring Process:** Continue to monitor during EOC rounds. **Department Responsible:** Engineering/Infection Control/EVS **128 b). Corrective Actions**: Remove all faucet aerators in Respiratory, Medical Supply floor, Basement sink, Recovery Room and Pharmacy hand wash sink. **Date of Implementation:** March 27, 2014 faucet aerators removed. **Monitoring Process;** Continue to monitor thru EOC rounds every six months. **Department Responsible:** Chief Engineer	4/7/2014 4/5/2014 6/18/2014 4/10/2014 6/20/2014 6/16/2014 3/25/2014 3/31/2014 3/27/2014

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A 701	Continued From page 136 medical supply floor, a basement sink, recovery area, and pharmacy handwash sink. c. There was ceiling damage and hole in the boiler room (3 in by 4 in hole). d. There was trash stored in the patient sleeping room 509. e. The ice maker had a direct connection to sewer system. f. In the Medical Supply room, the threshold floor was missing in the shower room and in the janitor room. 6th Floor a. There was missing threshold hardware in the IV (intravenous) Stockroom and one stained ceiling tile. b. The handwash sink faucets had aerators in the respiratory room. c. There were 4 suction containers that were rusted. d. In the Operating Room, the X-ray viewing frame was dirty/marred and the anesthesia cart had discolored white tape on the contact surface. e. The 6th floor pharmacy under the hood and the floor finish pieced together with open and dirty seams. f. The wall finish was damaged on the respiratory room. g. The 6th floor water heater room with a fifteen	A 701	(Continued from page 136) **128 c). Corrective Actions:** Repair the ceiling damage and hole in the boiler room. **Date of Implementation**: April 2, 2014 repair completed **Monitoring Process;** Monthly inspection rounds to be performed for penetrations, ceiling or wall damages. **Department Responsible**: Chief Engineer **128 d). Corrective Actions:** Remove all trash stored in the patient sleeping Room 509. **Date of Implementation:** March 25, 2014 trash immediately removed. **Monitoring Process;** Continue to monitor during EOC rounds. **Department Responsible:** Chief Engineer **128 e). Corrective Actions**: Adjusted Ice maker drain pipe tip/end to maintain (1) one inch clearance from sewer system/line. **Date of Implementation:** April 1, 2014 completed. **Monitoring Process;** Semi-annual inspection during EOC rounds. **Department Responsible:** Chief Engineer **128 f). Corrective Actions:** Reinstall missing threshold floors in the Medical Supply room, Shower Room and Janitors Rooms. **Date of Implementation:** June 16, 2014 started and will be completed June 20, 2014. **Monitoring Process;** Continue to monitor during EOC rounds. **Department Responsible:** Chief Engineer **Sixth Floor: a-i** **128 a). Corrective Actions:** Replace the missing threshold hardware in the IV Stockroom and replace the stained ceiling tile. **Date of Implementation:** April 15, 2014 repairs completed. **Monitoring Process;** Continue to monitor during the EOC rounds. **Department Responsible:** Chief Engineer **128 b). Corrective Actions:** Remove the aerators in the sink faucet located in Respiratory room. **Date of Implementation:** March 25, 2014 faucet aerator removed. **Monitoring Process:** Continue to monitor during the EOC rounds on a semi-annual inspection. **Department Responsible**: Chief Engineer **128 c). Corrective Actions:** Remove from service the 4 suction containers that were rusted and replaced with 4 new suction containers. **Date of Implementation:** April 23, 2014 completed. **Monitoring Process;** Continue to monitor during the EOC rounds. **Department Responsible:** EOC committee **128 d). Corrective Actions:** Replace the dirty/marred X-ray viewing frame and remove the discolored white tape on the contact surface of the anesthesia cart in the Operating Room. **Date of Implementation**: April 23, 2014 repairs completed **Monitoring Process;** Continue to monitor in the EOC rounds. **Department Responsible:** EOC Committee /Surgery Staff **128 e). Corrective Actions:** Remove and replace defective floor finish and clean the seams at the foot of Pharmacy hood. **Date of Implementation:** April 23, 2014 completed. **Monitoring Process;** Continue to monitor during EOC rounds. **Department Responsible:** Chief Engineer **128 f). Corrective Actions:** Remove the damaged wall finish and paint the walls in Respiratory. **Date of Implementation:** April 24, 2014 repairs completed. **Monitoring Process:** Continue to monitor during the EOC rounds. **Department Responsible:** Chief Engineer/Infection Control **128 g). Corrective Actions:** Anchor the copper pipe on the wall with metal clips in the hot water storage room of the 6th Floor.	4/2/2014 3/25/20144 6/16/2014 4/15/2014 3/25/2014 4/23/2014 4/23/2014 4/24/2014

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A 701	Continued From page 137 feet line without support brackets and held up at the ceiling with a mop stick. h. In the Medical File Room, there was one small two drawer file cabinet with missing facing exposing unfinish wood and dirty. i. In the Urgent Care Room, the door was not labeled and there was water intrusion under the handwash sink and inside the base cabinet. Basement a. There was an unfinished wall/plaster in the contaminate room ceiling puffy and damaged 3 in. by 6 in. b. In the X-ray room, the toilet base needed to be serviced/caulk. c. In the Pre-Op room, the floor finish had an one inch adhesive strip which was not cleanable. d. In Operating Room 3, two cabinets had missing facing and a section of the floor had left over adhesive/uncleanable. Culver City campus a. In the emergency room entryway rug runner, in the 1st floor Nurse Station, the floor was very dirty and the carpet was stained; In the 1st floor Transportation Dispatch Office, the rug and base flooring was elevated about 3/4 inch above the adjoining room and the threshold had no hardware. In the 1st floor X-ray room #3, the handwash sink counter top had missing facing and there was no handwash soap available; In the Nuclear Medicine disposal area, the entry door to the area was not labeled and the disposal	A 701	(Continued from page 137) **Date of Implementation:** April 23, 2014 completed. **Monitoring Process:** Continue to monitor by Engineers during rounds. **Department Responsible:** Engineering **128 h). Corrective Actions:** Clean and laminate the two drawer file cabinet in the Medical File Room. **Date of Implementation:** April 19, 2014 cleaning and repair completed. **Monitoring Process;** Continue to monitor during EOC rounds. **Department Responsible:** Chief Engineer **128 i). Corrective Actions:** Install label on the door and replace the angle stop in Urgent care under the sink cabinet. **Date of Implementation:** April 7, 2014 Installed door label and replaced angle stop and no leak noted. **Monitoring Process**: Continue to monitor sinks during the EOC rounds for leaks. **Person Responsible:** Chief Engineer **Basement: a-d** **128 a). Corrective Actions**: Repair and paint the puffy and damaged (3 in x 6 in) area on the ceiling in the contaminate room. **Date of Implementation:** April 9, 2014 started and completed on April 11, 2014. **Monitoring Process:** Continue to monitor during the EOC rounds. **Responsible Person:** Chief Engineer **128 b). Corrective Actions:** Re-caulk the toilet base in the X-ray room with polyurethane high performance sealer. **Date of Implementation:** April 9, 2014 repair completed. **Monitoring Process:** Continue to monitor during the EOC rounds. **Responsible Person**: Chief Engineer **128 c). Corrective Actions:** Remove the one inch adhesive strip on the floor in the Pre-op room. **Date of Implementation:** April 9, 2014 date completed. **Monitoring Process:** Continue to monitor during the EOC rounds**.** **Department Responsible:** Chief Engineer **128 d). Corrective Actions:** Repair the two cabinets in Operating Room 3 and remove the leftover adhesive from the floor. **Date of Implementation**: April 22, 2014 date completed. **Monitoring Process:** Continue to monitor during the EOC rounds. **Responsible Person:** Chief Engineer **CULVER CITY** **a). Corrective Actions:** The entryway rug runner was removed and the floor stripped and waxed by EVS. **Date of Implementation**: April 2014. **Monitoring Process:** Daily rounding is conducted by EVS to monitor cleanliness. **Person Responsible:** Director of EVS **Corrective Actions:** The transportation dispatch office flooring will be replaced in June 2014 by Starfloors, a flooring vendor. **Date of Implementation**: June 2014. **Monitoring Process:** Engineering to conduct daily rounding for routine maintenance repairs commencing in June 2014. **Person Responsible:** Director of Engineering & Director of EVS **Corrective Actions:** The sink countertop in x-ray room #3 will be replaced with Formica and hand soap dispenser will be installed by Engineering. **Date of Implementation:** June 2014 **Monitoring Process:** Engineering to conduct daily rounding for routine maintenance repairs commencing in June 2014. **Person Responsible:** Director of Engineering	4/23/2014 4/19/2014 4/7/2014 4/9/2014 4/9/2014 4/9/2014 4/22/2014 4/30/2014 6/30/2014 6/30/2014

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A 701	Continued From page 138 containers were not maintained; In the Radioactive Laboratory area, the dark room floor sink was very dirty and the floor tile was very dirty, separating, and lifting; In the Nuclear Medicine Imaging, the bathroom floor tiles was lifting. b. In the 1st floor emergency employee lounge, there were twenty plus American Cockroaches desiccate and stuck to 3-glue boards located underneath the employee lounge kitchenette base cabinet. c. In the Radioactive Laboratory, the exam table had missing screw and on screw missing, there was a sleeve to protect patients from the exposed screws. d. In the Emergency Room/ISO, the toilet base needs recaulking at the toilet base. e. In the Emergency Room, the patient bathroom had cracked doorjam; In the 2nd floor staff bathroom, the soap dispenser was relocated and wall not repaired; In the 2nd floor, the Janitor Closet had wall caving separating from the wall; In the 2nd floor kitchenette, the floor tiles was lifting. Basement a. In the dumb waiter, the storage area was unsanitary and dirty. b. In the Central Supply Room, the 5-shelf rack was dirty with dust and dirt, eyewash sink counter top damaged, rusty paper dispenser located over the sink; the sink's caving detached from the sides/wall; the door panel detached.	A 701	(Continued from page 138) **Corrective Actions:** Missing door signs, including the door in Nuclear Medicine, will be addressed by Sign Centrix, who is currently providing a master plan for all interior signage upgrades. Nuclear Medicine created a weekly log and scheduled weekly disposal of radioactive contaminated trash with EVS. (A copy of the log is as attached.) **Date of Implementation:** Weekly monitoring commenced on June17, 2014 **Monitoring Process:** Weekly disposal of radioactive contaminated trash. **Person Responsible**: Director of Engineering & Director of EVS **Corrective Actions:** The flooring in Radioactive Lab area dark room, Nuclear Medicine Imaging bathroom will be addressed by Starfloors, a flooring vendor, in June 2014. **Date of Implementation**: June 2014. **Monitoring Process:** Engineering to conduct daily rounding for routine maintenance repairs commencing in June 2014. Daily rounding is conducted by EVS to monitor cleanliness. **Person Responsible:** Director of Engineering & Director of EVS **b) Corrective Actions:** Dead bugs were removed and the cabinet cleaned on March 25, 2014 while EVS staff is tasked to monitor cabinets in the ER Employee Lounge weekly. **Date of Implementation**: March 25, 2014 **Monitoring Process:** Daily rounding is conducted by EVS to monitor cleanliness. **Person Responsible:** Director of EVS **c) Corrective Actions:** The missing screws have been replaced on table of the gamma camera (exam table in the Radioactive Lab) by Bio Med. **Date of Implementation:** June 16, 2014 **Monitoring Process:** Engineering to conduct daily rounding for routine maintenance repairs commencing in June 2014. **Person Responsible:** Director of Engineering **d) Corrective Actions:** The toilet base in the restroom inside the Isolation Room in the ER was cleaned and recaulked by Engineering. **Date of Implementation:** April 11, 2014 Monitoring Process: Engineering to conduct daily rounding for routine maintenance repairs commencing in June 2014. Person Responsible: Director of Engineering **e) Corrective Actions:** The cracked door jam in the patient bathroom in the Emergency Room will be repaired by Engineering. **Date of Implementation:** June 2014 **Corrective Actions:** The holes on wall in staff bathroom in Pavilion 2 will be patched and repainted by Engineering. **Date of Implementation**: June 2014 **Corrective Actions:** The wall coving in the Janitor Closet was repaired by Engineering. **Date of Implementation**: April 3, 2014 **Corrective Actions:** The floor tiles on the 2nd floor kitchenette will be repaired by Engineering. **Date of Implementation**: June 2014 **Monitoring Process:** Engineering to conduct daily rounding for routine maintenance repairs commencing in June 2014. **Person Responsible:** Director of Engineering **BASEMENT** **a).Corrective Actions:** EVS is scheduled to clean the dumb waiter and will monitor and log weekly. **Date of Implementation**: June 2014 **Monitoring Process**: Daily rounding is conducted by EVS to monitor cleanliness. **Person Responsible**: Director of EVS **b). Corrective Actions:** EVS dusted off the shelf rack in Central Supply on June 17, 2014 and will continue to monitor and log dustings bi-weekly. **Corrective Actions:** The eyewash sink will be repaired in June 2014. **Corrective Actions:** The rusty paper dispenser will be replaced in June 2014 **Corrective Actions:** The door panel will be repaired in June 2014. **Date of Implementation:** Repairs and replacements to be completed by the end of June 2014.	6/17/2014 6/30/2014 3/25/2014 6/16/2014 4/11/2014 6/30/2014 6/30/2014 4/3/2014 6/30/2014 6/17/2014 6/30/2014

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A 701	Continued From page 139 c. In the Operating Room area, the floor finish/buckling with open floor seams; the dirty floor finish and caving were discolored and not clean; the corridor metal wall strip had exposed screw holes. d. In the Recovery area, the Nurse Station had damaged counter top with the facing detached or missing; handwash sink had an aerator; soap dispenser was dirty and blacken. e. In the Microbiology Room, the floor finish was removed; air hood with worn down finish and rusted. Van Nuys campus 129. On March 24, 2014, at 10:30 a.m., during an initial tour of locked unit 2 , the housekeeping staff was spraying air freshener in the hallways and walked toward the utility cart. The housekeeping staff opened the cabinet and placed the air fresher can inside. During a concurrent interview, when asked about the utility cart should be closed. She stated, "Yes, the utility cart is in use it should be locked at all times." She reached in the drawer and got the	A 701	(Continued from page 139) **Monitoring Process:** Engineering to conduct daily rounding for routine maintenance repairs commencing in June 2014. Daily rounding is conducted by EVS to monitor cleanliness. **Person Responsible:** Director of Engineering & Director of EVS **c).Corrective Actions:** Operating Room • Minor repairs for heat welding seams have been made to the OR flooring while proposals are being obtained to replace the entire OR flooring. • The holes on the corridor metal wall strip were patched with Epoxy on April 7, 2014 by Engineering. **Date of Implementation**: April 7, 2014 **Monitoring Process:** Engineering to conduct daily rounding for routine maintenance repairs commencing in June 2014. **Person Responsible:** Director of Engineering **d).Corrective Actions & Date of Implementation**: Recovery Area • The damaged counter top in the Nurse Station will be assessed and repaired by Engineering. • The aerator in the Recovery Area hand wash sink was removed immediately on March 25, 2014. In addition, all aerators have been removed hospital-wide on April 4, 2014 by Engineering. • The soap dispenser was replaced on April 3, 2014 by Engineering. **Date of Implementation:** June 2014 for the countertop. **Monitoring Process:** Engineering to conduct daily rounding for routine maintenance repairs commencing in June 2014. **Person Responsible**: Director of Engineering **e).Corrective Actions:** Microbiology Room • New flooring will be installed in Microbiology Room in July 2014. • The rusted portion of the air hood in Microbiology was refinished on April 11, 2014 by Engineering. **Date of Implementation:** July 2014 for the flooring. **Monitoring Process:** Engineering to conduct daily rounding for routine maintenance repairs commencing in June 2014. **Person Responsible:** Director of Engineering **VAN NUYS** **129). Corrective Actions:** All utility carts in use should be locked at all times, except when removing or replacing cleaning items per policy item number 4.2.20. **Date of Implementation:** 3/24/14 **Monitoring Process:** JIT Training provided to EVS on March 25, 2014 for proper locking of utility carts. **Person Responsible:** Director of Engineering	4/7/2014 3/25/2014 4/3/2014 4/4/2014 4/11/2014 7/30/2014 3/24/2014

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	050135	W. BUILDING **01 – SOUTHERN CALIFORNIA HOSPITAL AT HOLLYWOOD** X. WING _____	**04/01/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN CALIFORNIA HOSPITAL AT HOLLYWOOD	**6245 DE LONGPRE AVE HOLLYWOOD, CA 90028**

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A 701	Continued From page 140 keys to lock the utility cart. According to the facility's policy titled, All Cleaning Supply dated EVS 2011, when the utility cart was in use on the units it should be locked at all times, except when removing or replacing cleaning items. 130. On March 24,2014, at 11:10 a.m., in the patio area of the locked unit, there was an umbrella base turned upside down. There was no umbrella. The inside where the umbrella pole holder had cigarette butts. The patio area of open unit 1 had cigarette butts in the flower beds and smelled of cigarettes. During a concurrent interview with Staff I, she stated the facility was "2 weeks nonsmoking facility... She further stated the patients were informed they were to smoke off the facility grounds. Hollywood campus 131. Staff 2 was interviewed on March 24, 2014 at approximately 3:05 p.m. on the emergency food and water for Hollywood campus. He did not present a plan but stated that there was some food including pasta on hand. The dry storage room where the food would have been stored had just received a delivery of food that completely blocked access to the room. No other supporting information about adequacy of food and water for use during emergency was provided during the survey. Van Nuys campus 132. On March 27,2014 beginning at 10:10 a.m., the hospitals' disaster meal plan was reviewed	A 701	(Continued from page 140) **130). Corrective Actions:** The umbrella base in the patio area of the locked unit was cleaned and removed. (See attached). The inside of the holder is now free of cigarette butts. The patio area of Unit 1 flower beds is free of cigarette butts. Routine monitoring through daily rounds for monitoring patio area by EVS. **Date of Implementation:** 3/24/14 **Monitoring Process:** Routine monitoring through daily rounds for monitoring patio area by EVS. **Person Responsible:** Director of Engineering **HOLLYWOOD** **131) Corrective Actions:** The Disaster menu and supplies for patients were adjusted to meet the needs of the facility. Disaster food and supplies for patients have been received. A disaster plan for staff is in process of being developed and food products will be ordered accordingly. Once the plan is finalized, staff will be trained on its use. **Date of Implementation:** July 31, 2014 Written plan completion, staff training and monthly inventory of disaster supplies will be completed by September 10, 2014 Weekly inventory of all food products to ensure adequate availability will take place starting September 10, 2014 **Monitoring process:** Weekly inventory to ensure adequate menu supplies are on hand. Monthly inventory for adequate emergency supplies will be compared to the "Disaster Inventory Sheet". Results of disaster supply monitoring activity will be reported to the hospital's EOC Committee. **Person Responsible:** RD, Director of Dietary Department **Corrective Action:** Just in time training provided to the delivery drivers and dietary staff regarding clearance of EXIT doors at all times **Date of Implementation:** June 19, 2014 **Monitoring process:** Monitoring will be managed through EOC rounds and daily operational rounds **Person Responsible:** Dietary staff, Safety officer **VAN NUYS** **132) Corrective Actions:** The Disaster freeze dried food menu and supplies for patients were adjusted to meet the needs of the facility. Disaster food and supplies for patients have been received. A disaster plan for staff is in process of being developed and food products will be ordered accordingly. Once the plan is finalized, staff will be trained on its use.	3/24/2014 7/31/2014 9/10/2014 6/19/2014

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A 701	Continued From page 141 with Staff 2. She stated that the hospital was preparing to serve 160 patients and staff for a period of 5-7 days. Concurrent review of the hospital document titled "Disaster Plan" dated 11/12 revealed that the menu was limited to 3 days, despite the hospitals' intent to be self-sufficient for 5-7 days. It was also noted that the food supply was inadequate, with insufficient quantity for some items for 1 meal. As an example the plan called for a tuna sandwich for 2 required 360 servings. It was also noted that the plan was to serve milk; however the hospital did not have any powdered milk and the current milk on hand would also be less than a 1-day supply. Similarly there were either inadequate or non-existent supplies of ravioli, soup, chicken or chili. Staff 1 acknowledged that the supply was not adequate. It was also noted that the menu/food supply consisted of items such as hot cereal, soups, and Sloppy Joes that required cooking. In an interview with the Facilities Director on March 27, 2014 at 10:30 a.m., he stated that he had a large barbeque in the basement that could be utilized. While the hospital had a barbeque, the fuel supply was limited to two 5-gallon tanks of propane. He stated he did not know how long these tanks would last and acknowledged that the use of the barbeque would not likely be practical in a mass disaster due to the unavailability of fuel. 133. During an initial kitchen tour on March 27, 2014 beginning at 8:20a.m., it was noted that the water at the employee hand washing sink was tepid. On March 27, 2014 at 9 a.m., Staff 2 was asked to take the water temperature. It was noted to be 70°F. It would be the standard of practice to ensure that the water temperature of	A 701	(Continued from page 141) **Date of Implementation:** July 31, 2014 Written plan completion, staff training and monthly inventory of disaster supplies will be completed by September 10, 2014 Weekly inventory of all food products to ensure adequate availability will take place starting September 10, 2014 **Monitoring Process:** Weekly inventory to ensure adequate menu supplies are on hand and no non pasteurized eggs are present. Monthly inventory for adequate emergency supplies will be compared to the "Disaster Inventory Sheet". Results of disaster supply monitoring activity will be reported to the hospital's EOC Committee. **Person Responsible:** RD, Director of Dietary Department **133) Corrective Action:** Kitchen sink has been fixed and calibrated **Date of Implementation:** March 26, 2014 **Monitoring Process**: Per dietary staff report **Person Responsible:** RD, Director of Dietary Department and Food Services Supervisor	7/31/2014 9/10/2014 3/26/2014

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			(Continued from page 142)	
A 701	Continued From page 142 the hand washing sink was a minimum of 100°F through the use of a hot water mixing valve (USDA Food Code 2013). In a concurrent interview with Foodservices Director 1 he stated he was unaware of the water temperature requirement.	A 701		
A 703	482.41 (a)(2) EMERGENCY GAS AND WATER There must be facilities for emergency gas and water supply. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to have documented evidence of a system to provide emergency water and failed to ensure an effective water management plan and supplies to be implemented in a widespread disaster as evidenced by a plan that did not effectively meet the hydration and personal care needs of patients and staff.. This deficient practice had the potential to result in inadequate supply of drinking water and water for other purposes to all patients and staff during a disaster affecting the hospital and effectively meet the hydration and personal care needs of patients. Finding: Van Nuys Campus 1. On March 24, 2014 between 2:45p.m. and 3:15p.m., accompanied by Staff 6 (Director of Facilities), a review of the facility's safety and disaster manual revealed there was no written plan to provide emergency water as needed to provide care to inpatients and other persons who may come to the hospital in need of care.	A 703	**VAN NUYS** **1). Corrective Action:** Water needs for each campus have been calculated and the water is securely stored at each facility in the levels calculated. A system wide policy, EMP.018 Loss of Water Policy and Procedure has been revised to include each hospitals calculated needs, location of the water, prioritized use of water and indicates arrangements made for the provision of emergency sources of water and security for emergency water stored on hospital grounds. The policy is anticipated to be approved by appropriate committees in September 2014. **Date of Implementation:** August 1, 2014 **Monitoring:** Monthly inventory of disaster water supplies with physical inspection of condition of water being stored. Results of audit activity will be reported to the hospital's Quality Council, MEC, and Governing Board on a quarterly basis. **Person Responsible:** Director of Facilities, each campus.	8/1/2014

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A 703	Continued From page 143 A policy titled, Dietary Responsibilities (Number D-021) dated effective November of 2001 indicated that in the event of water failure, potable water shall be obtained by engineering on a priority needs basis. The policy did not determine the hospital's emergency needs for water, calculations to determine the amount of water needed, location of the water, prioritize the use of the water, indicate if arrangements were made with the local utility company and others for the provision of emergency sources of water, nor indicated how to protect the emergency water. During an interview at the same time as the review, Staff 6 stated that there was no emergency water plan but that he thought the facility was going implement something with a bottled water vendor. On March 26, 2014, the facility provided the evaluator with a policy titled Loss of Water Policy and Procedure (Number EMP.018). The cover page of the policy had no effective date and had no date or other indication that it had been reviewed by the EOC committee, Quality council, medical executive committee, and governing board. Culver City Campus 2. On March 31, 2014, between 10:30 a.m. and 10:54 a.m., there were boxes of emergency drinking water stored in an exterior gated area at the Legion building. The boxes contained six one	A 703	(Continued from page 143) **CULVER CITY** **2).Corrective Actions:** Damaged boxes were disposed of, the bottled water inside the damaged boxes was restacked in clean boxes and the collapsing boxes were re-stacked. The disaster water supply stored in an exterior gated area at the Legion Building will all be replaced in July 2014 prior to its expiration date on July 31, 2014. • The Loss of Water Policy and Procedure went to the Combined EOC Committee meeting in April but was revised to include SCH at Hollywood and SCH at Van Nuys. The policy will be presented to the combined EOC Committee meeting in July and to the executive committees (Quality Council, MEC and the Governing Board) thereafter.	

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A 703	Continued From page 144 gallon bottles of water each and were stack on top of each other. Four of the boxes at the bottom of one side of the stacks had signs of water leakage (wet boxes). At the other side of the stacks six of the boxes at the top of the stacks were collapsing onto the fencing and two of the boxes were crushed at the bottom of the collapsing stack. Between 2:14 p.m. and 3:30 p.m. accompanied by Staff 5 the hospital provided a policy titled Loss of Water Policy and Procedure (Number EMP.018) as documented evidence of a system to provide emergency water. The cover page of the policy had no effective date and had no date or other indication that it had been reviewed by the EOC committee, quality council, medical executive committee, and governing board. The hospital also provided a policy titled, Failure of water supply (Number FSN-007) dated effective July of 2009 indicated that in the event of water failure to obtain water from Water Disaster stores through the disaster command center, to contact the bottle water providers, military organizations or Red Cross to have water trucked in. The policy did not determine the hospital's emergency needs for water, calculations to determine the amount of water needed, location of potable and non-potable water on site, prioritize the use of the water, indicate if arrangements were made with the local utility company and others for the provision of emergency sources of water, nor indicated how to protect the emergency water.	A 703	(Continued from page 144) • The same Loss of Water Policy and Procedure addresses calculations to determine the amount of water needed, location of potable and non-potable water on site, prioritization of the use of water and the hospital has MOUs with on file with appropriate vendors to receive additional emergency water sources. **Date of Implementation:** June 19, 2014. **Monitoring Process:** The Groundskeeper will conduct a visual inspection of the disaster water supply on a weekly basis while performing routine grounds keeping tasks in the area. **Person Responsible:** Director of Engineering	6/19/2014

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A 703	Continued From page 145 During an interview at the same time as the review, Staff 5 stated that the disaster coordinator not available and that the Loss of Water Policy and Procedure (Number EMP.018) is scheduled to go through committee in April. 3. On March 27, 2014 beginning at 10:30 a.m., an evaluation of the hospital disaster water storage was reviewed with the Facility Director (FD), Staff 6. It was noted that the hospital plan was to provide .5 gallons/person/day of potable water with an additional .5 gallons for non-potable water. It was also noted that in the basement the hospital was storing 240 gallons of bottled water. Staff 6 also stated that additional water would be obtained from the facility water heaters. Concurrent observation of the water heaters revealed that there was a discharge valve at the bottom of the water heater that was approximately 3 inches off the ground. Staff 6 director stated that he would use a garden hose to get the water out of the tank. He also stated the hospital did not have a hose specifically intended for the use of transferring potable water. Review on March 28, 2014 at 1 p.m., of an undated draft policy presented by the hospital titled 11 Loss of Water Policy and Procedure revealed that the hospital planned on using the boiler room water as a non-potable source of water, rather than a potable source which would limit the potable source to 240 gallons. It was also noted that the plan did not include any potable water required to implement the disaster menu or direct patient care needs. Additional review of the plan revealed that the hospital utilized a reference document developed by the Centers of Disease Control and the American Water Works Association (2012) that	A 703		

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A 703	Continued From page 146 was specific to water supply planning for health care facilities. Review of the reference document revealed that the amount of water, .5 gallon/person/day, was specific to healthy individuals. The referenced document suggested that individual needs vary, depending on age, physical condition, activity level, diet, climate and that ill people need more water. While the hospital utilized healthcare associated references there was no indication that a comprehensive evaluation of the anticipated water needs based on the hospital's population was conducted. In a concurrent interview with Staff 5 he stated that the presented plan was a draft copy and was not fully reviewed.	A 703		
A 713	482.41(b)(6) DISPOSAL OF TRASH The hospital must have procedures for the proper routine storage and prompt disposal of trash. This STANDARD is not met as evidenced by: Based on observation, the facility failed to properly store and dispose of trash by having overfilled and uncovered dumpsters creating conditions conducive to fly breeding and offensive odors. Finding: On March 24, 2014 at 11:55 a.m. two of four dumpsters were overfilled with trash. One of the dumpsters had its lids propped open by the overfilled trash. The second dumpster had its lids left fully open behind the dumpster. The two remaining dumpsters were less than half full.	A 713	**CULVER CITY: Corrective Actions:** EVS will monitor the dumpsters in the back alley of the Pavilion Building every 2 hours starting from 7:00 a.m. to 10:00 p.m. to ensure that dumpsters are not overflowing with trash and the lids remain closed. **Date of Implementation:** EVS will commence monitoring log on June 19, 2014. **Monitoring Process:** Monitor log. **(See Addendum 131).** **Person Responsible:** Director of EVS **Corrective Actions:** There is a clear hose placed next to water storage used to transfer potable water on March 28, 2014. **Date of Implementation:** 3/28/14 **Monitoring Process:** EOC rounds done semi-annually. **Person Responsible:** Director of Engineering . **VAN NUYS : Corrective Actions:** On March 24, 2014, the two of four dumpsters that were propped open were emptied to the other less than full dumpsters and all lids were closed**. (see Addendum 131, 132, 132a, 132b, 132c)** JIT In-service for all staff on P&P. EVS to monitor daily when dumping trash. **Date of Implementation:** March 24, 2014 **Monitoring Process**: EVS & Dietary staff to will be monitoring daily. **Person Responsible:** Dietary Supervisor & Director of EVS	6/19/2014 3/28/2014 3/24/2014
A 722	482.41(c) FACILITIES The hospital must maintain adequate facilities for	A 722		

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A 722	Continued From page 147 its services. This STANDARD is not met as evidenced by: Based on kitchen observations and dietary staff interview, the facility failed to ensure the plumbing in food production areas were designed and maintained in a manner to prevent potential cross contamination of foods. Failure to maintain facilities that mitigate cross contamination may result in exposing patients to a foodborne illness. Findings: Culver City campus 1. During kitchen tour on March 25, 2014 beginning at 2:45 p.m., at the Culver City campus it was noted that there were three sinks that were directly plumbed into the waste water system. In a concurrent interview with Staff 3 (Food services Director) she confirmed that each of the sinks was utilized for food production activities. In an observation on March 27, 2014 at 8:20am, at the Van Nuys campus it was also noted that the food production sink was directly plumbed into the waste water system. In a concurrent interview with she confirmed that the identified sink was utilized for food production activities. The standard of practice would be to ensure that plumbing was installed in a manner to ensure the presence of an air gap between the water supply inlet and the flood level rim of the plumbing fixture, equipment, or nonfood equipment and shall be at least twice the diameter of the water supply inlet and may not be less than 1 inch (USDA Food Code 2013). Van Nuys campus 2. During initial kitchen tour on March 27, 2014	A 722	**Culver City** **1). Corrective Actions:** Drains to each of the three sinks in the kitchen were re-plumbed to ensure the presence of air gap between water supply inlet and the flood level rim of the plumbing fixture in June 2014 by Engineering. **(see Addendum 133, 133a)** **Date of Implementation:** The re-plumbing was completed in June 2014. **Monitoring Process:** This is a one -time repair to resolve the issue. **Person Responsible**: Director of Facilities & Director of Food & Nutrition **Van Nuys** **2). Corrective Actions:** On March 27, the racks and refrigerator in the dry storage area were cleaned and found that there was rust. 10 racks were replaced. **Date of Implementation:** Completion of rack replacement by September 10, 2014. **Monitoring Process:** Replacements monitored for any repairs / replacements during EOC Rounds. **Person Responsible:** Dietary Supervisor	6//2014 9/10/2014

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A 722	Continued From page 148 beginning at 8 a.m., it was noted that the racks of the refrigerator located adjacent to the food production sink and the refrigerator in the dry storage area were covered in a brown colored matter, resembling rust, which was able to be removed with a paper towel. It would be the standard of practice to ensure that nonfood-contact surfaces of equipment are kept free of an accumulation of dust, dirt, food residue, and other debris (Food Code, 2013).	A 722		
A 724	482.41(c)(2) FACILITIES, SUPPLIES, EQUIPMENT MAINTENANCE This STANDARD is not met as evidenced by: Based on observation, review of hospital and staff interviews, the facility failed to maintain the food service equipment to ensure acceptable level of safety and quality. The dish machine, plate warmers, five refrigerators and freezer were not properly maintained. These failures had the potential food safety concern for patients and safety (fall risk) concerns for employees when its equipment were not in good working order, had the potential to result in unclean and unsanitized utensils, to result in cross contamination and growth of microorganisms that could cause food borne illness, and the build-up of ice on the floor from the outside freezer was a potential fall for the hospital employees. Finding: 1. During meal service on March 24, 2014, Dietary Staff (OS) 4 was observed serving all the	A 724	**1) Corrective Actions:** Plate warmer will be sent for further inspection and repair. Staff will be in-serviced on initiating work order process for broken equipment and will educate on policy UTM.015 Preventive maintenance. Will create a list of all kitchen items/equipment to include if internal or external service performance required and will include instructions on notification of broken equipment **Date of Implementation:** Target date of completion for plate warmer inspection/repair June 27, 2014. Target date of completion for education July 1, 2014; target date of completion for inventory list August 1, 2014 **Monitoring Process:** Will be managed through daily operations and to include in EOC rounds **Person Responsible:** RD, Director of Dietary Department and Food Services Supervisor, dietary staff and ENG **2). Corrective Actions:** Dishwashing machine has been repaired and in working condition. Staff will be in-serviced on initiating work order process for broken equipment and will educate on policy UTM.015 Preventive maintenance . Will create a list of all kitchen items/equipment to include if internal or external service performance required and will include instructions on notification of broken equipment **Date of Implementation:** Repair completed March 27, 2014; Target date of completion for education July 1, 2014; target date of completion for inventory list August 1, 2014 **Monitoring Process:** Will be managed through daily operations and to include in EOC rounds **Person Responsible:** RD, Director of Dietary Department and Food Services Supervisor	6/27/2014 3/27/2014

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	050135	Y. BUILDING **01 – SOUTHERN CALIFORNIA HOSPITAL AT HOLLYWOOD** Z. WING	**04/01/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN CALIFORNIA HOSPITAL AT HOLLYWOOD	**6245 DE LONGPRE AVE HOLLYWOOD, CA 90028**

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A 724	Continued From page 149 patients with disposable plastic plates. In an interview at approximately 11:45 a.m., OS 4 stated that he had to use the disposable plates because the plate warmer was broken. He further stated the disposable plates were better than using unheated plates, because the plates were cold and would cause the hot foods to become cold and unpalatable. 2. At approximately 3:30 p.m. on March 24, 2014, it was determined that the water temperature of the high temperature was not hot enough to properly sanitize dishes and other cooking utensils. The water temperature was 119.5 degrees F. The required minimum temperature for a high temperature is of 180 degrees F. There was a discrepancy between OS 3 and Staff 10 (Chief Engineer) on when hospital staff became aware that the temperature of the machine was not adequate and should not be used to dish washing. Staff 10 stated at approximately 3:35 p.m. that a part in the machine needed to be replaced and that he had informed DS 3. Inside the dish room there were cooking utensils, pots and pans that had been washed in machine. Improper water temperatures could result in unclean and unsanitized utensils. 3. At approximately 3:40p.m. on March 24, 2014, the preventive maintenance for the ice machine was reviewed. It was noted there was a buildup of black particles on both sides of the ice shield (a plastic cover over the ice production area). In an interview with Staff 10 he stated that the machine interior should be cleaned every two months. There was no documented evidence that this was done. 4. Over twelve Patient trays on the van Nuys	A 724	(Continued from page 149) **3). Corrective Actions**: Will provide staff education to include review of policy Infection Control FNS.042; Cleaning, sanitizing of ice machine will be performed twice yearly and will be documented on log sheet attached to unit. **Date of Implementation:** Target date of implementation for education July 1, 2014; target date for cleaning and sanitizing July 31, 2014 **Monitoring Process:** Monitoring will be managed through weekly and monthly cleaning logs **Person Responsible:** RD, Director and Food Services supervisors **4) Corrective Actions:** Will purchase additional trays to ensure patient and staff safety; Will provide education to staff on work order process for broken equipment and reporting process to supervisor **Date of Implementation:** Target date of completion in 30 days July 15, 2014 **Monitoring Process:** Monitoring process will be managed through daily operations by dietary staff and to include in EOC rounds **Person Responsible:** RD, Director of Dietary Department and Food Services Supervisor, dietary staff **Culver City** **4) Corrective Actions**: Twice yearly cleaning/sanitizing of internal components to be performed by outside vendor (Redline Air) **(see Addendum 134, 134a)** **Date of Implementation:** Serviced June 2014; to re-occur every six months. **Monitoring Process:** Cleaning/sanitizing of ice machine (twice yearly) is documented on log sheet attached to unit. **Person Responsible:** Director of Facilities & Director of Food & Nutrition **5) Corrective Actions:** Capital Expenditure Request (CER) has been approved for two roll-in coolers to replace "out of order" units. **Date of Implementation**: units to arrive and be installed July 2014	7/1/2014 7/15/2014 6/30/2014 7/30/2014

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A 724	Continued From page 150 Campus had chipped, broken jagged edges exposing a metal interior. The state of the trays presented a risk of cuts to patients. Staff 1 stated that they had recently purchased 36 trays. She provided no other information on when the other trays will be replaced. On March 25, 2014 beginning at 3 p.m., at the Culver City campus the preventive maintenance of the ice machine was reviewed. In a concurrent interview with Staff 5 he described he process. He stated that a) the hospital installed an automatic cleaning system for the unit; b) that with the installation of this unit required no additional maintenance and c) that the hospital contracted with a vendor to complete manufacturers' required maintenance. The bottle of chemical in the unit was labeled as an ice machine cleaner. In an interview on March 26, 2014 beginning at 9:35a.m., with REP 1 from the contracted vendor described how the automatic cleaning system worked. He described a process whereby the chemical would circulate through the ice producing mechanism two times/month. He also stated that the ice machine cleaner was the only chemical circulated. Posted on the interior panel of the ice machine was manufacturers' guidance for both a cleaning and sanitizing process. There was no evidence that the ice machines were sanitized This could result in cross contamination and growth of microorganisms that could cause food borne illness. 5. During the initial tour of the kitchen on the Culver City campus on March 25, 2014 at approximately 10:30 a.m., approximately five built-in refrigerators and/or freezers was labeled	A 724	(Continued from page 150) **Monitoring Process:** Routine inspection for "out of order" equipment included on quarterly safety audit. ("All equipment and tools in good working order"). **Person Responsible:** Joseph Pipes (Foodservice), Juanita Jones (Materials Mgmt) **6) Corrective Actions:** Work order (#209410) placed to provide insulation to close "gap" between freezer pipe and wall. **Date of Implementation**: date of service or installation of new unit, expected to be completed by the end of July 2014. **Monitoring Process:** Routine inspection for ice build-up in freezer included on quarterly safety audit. **(see Addendum 135)** **Person Responsible:** Ray La fond (Facilities), Joseph Pipes (Food & Nutrition)	7/30/2014

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A 724	Continued From page 151 as “out of order.” It was not clear how long these equipment had broken down and not repaired or replaced. There were several smaller mobile refrigerators around the kitchen resulting in a cluttered, cramped space. Dietary employees were often overheard warning other employees "I’ m behind you." Staff 2 who was present during the tour stated that the equipment have been broken for a while and was not sure how long. She further stated that it was part of the capital expenditure that had been presented to the hospital administration. Staff 11 who was present during the tour acknowledged that it was part of the capital expenditure for this fiscal year. The outside freezer had a build-up of ice on the floor a result of water drips from the condenser. There was a stainless steel pan also observed under the condenser. Dietary Staff 10 stated the pan had been placed under the condenser to "catch the drips... The ice build-up on the floor is a fall risk for the hospital employees. While in the freezer, sunlight was observed through the freezer wall from around the pipes. Inspection of the pipe on the outside revealed a gap around the pipe that fed into the freezer. The gap could have contributed to the condensation and water drips experienced in the freezer as it introduced warm outside temperature into the freezer. The gap could also allow the introduction of other substances and contaminants into the freezer. Review of the work orders from Dietary from the previous six months was done. It did not include request for the built in refrigerators and freezer.	A 724		

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A 724	Continued From page 152 There was an order on 11/13/2013 for water leaking under fan inside walk-in freezer. It showed it was completed on the same day. AA provided a copy of the approval of two refrigerators. Closer review showed that the approvals did not include copies original signatures but copies of signatures cut out and taped on the signature lines. It is not clear whether these equipment were indeed approved for replacement. The hospital failed to ensure that its equipment were in good working order. These failures related in food safety concern for patients and safety (fall risk) concerns for employees.	A 724		
A 747	482.421NFECTION CONTROL The hospital must provide a sanitary environment to avoid sources and transmission of infections and communicable diseases. There must be an active program for the prevention, control, and investigation of infections and communicable diseases. This CONDITION is not met as evidenced by: Based on observation, review of facility documents and staff interview, the facility failed to meet the Condition of Participation in Infection Control by failing to: 1. Ensure the single use ampule/vial was used for one patient. This deficient practice had the potential for transmission of bloodborne viruses (Culver City) (Refer to A748). 2. Reprocess the endoscopes in the reprocessing area which minimize the opportunity	A 747	**Culver City** **1).Corrective Actions:** Director of Infection Prevention and Control will receive & review anesthesia log audits weekly from Pharmacy for appropriate use on single use vial and report monthly to Quality Council. Targeted compliance is 100%. Aggregated data will be reported to Infection Control Committee on a quarterly basis. **Monitoring Process:** Pharmacy/Surgery **Date of Implementation:** June 18, 2014 **Person Responsible:** Director of Infection Prevention and Control, Director of Pharmacy, Director of Peri-Operative Services **Hollywood** **2).Corrective Actions:** OR team re-educated to Policy SGI.006 Cleaning and Disinfection of Endoscopes to ensure policy compliance with procedure to re-process scopes only in the designated re-processing room and not in the procedure room. Policy reviewed for compliance to SGNA Society for Gastrointestinal Nurses and Associates guidelines **(see Addendum 136, 136a, 136b, 136c, 136d)**. Completing competencies on ORT's on proper steps for cleaning/reprocessing of endoscopes in the proper locations target date for completion by July 31, 2014. **Date of Implementation:** Education provided 6-19-2014; target date of completion for competency tool 7-31-2014 **Monitoring Process**: Monitoring will be 100 % audit of all scope procedures until 100% compliance goal achieved consistently. Data will be reported monthly to PI, Quality and MEC **Person Responsible:** OR team, Infection Control	6/18/2014 6/19/2014

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A 747	Continued From page 153 for cross-contamination (Refer to A 749). 3. Change gloves and wash hands after removal of gloves which minimize the opportunity for cross contamination (Refer to A 749). 4. Develop a written policy and procedure for managing bed bugs to ensure an effective system was identified and developing practices and procedures were followed to prevent the spread of bed bugs. This deficient practice of not ensuring the infection prevention and control strategies for the bed bugs were implemented placed the patients, staff, and visitors at risk for infection and re-infestation (Refer to A 749). 5. Develop an effective systems for identifying, reporting and controlling infections when it failed to ensure safe food handling practices in the dietetic service areas on all three campuses and develop a policy to ensure tube feeding was handled in an effective manner to prevent growth of microorganisms. These failures are evidenced by: a. lack of system to ensure that meats and other leftover food items were monitored and cooled to prevent the growth of microorganisms that could result in food borne illness; b. lack of effective cleaning and sanitation of ice machines at the Hollywood, Culver City and Van Nuys campuses; c. lack of effective sanitation of soda syrup line connectors; d. lack of monitoring system for a cool down of potentially hazardous foods; e. lack of hand washing after handling soiled dishes; f. lack of an effective system to ensure food safety during thawing process of raw meat and	A 747	(Continued from page 153) **Culver City** **3).Corrective Actions**: All nursing staff re-educated starting 06/18/2014 on the hospital's policy titled Hand Hygiene with a focus on the expectation that hand hygiene must be practiced to decontaminate hands when moving from dirty to clean tasks and before donning and after removing gloves. Hand hygiene includes washing hands with soap and water &/or applying alcohol-hand rub. **Date of Implementation:** June 18, 2014 **Monitoring Process:** Director of Infection Control will conduct 30 random observations monthly among nursing staff to observe appropriate hand hygiene practices when moving from dirty to clean sites. Any episodes of non-compliance will immediately be corrected and nurses re-educated on the hand hygiene policy. Data will be aggregated monthly and reported quarterly to the Infection Control Committee and Quality Council. **Person Responsible:** Director of Infection Prevention and Control, Director of Nursing **Hollywood** **3).Corrective Actions**: In-services were conducted on hand hygiene practices and glove use for nursing staff. Hand hygiene audits are on-going. Hand Hygiene task force was initiated to discuss results and to work on ways to improve hand hygiene compliance. **[see Addendum 139, 141, 141a, 141b, 141c, 141d, 141e, 141f, 14 g, 141h]** **Date of Implementation:** 4/10/14; 4/30/14 **Monitoring Process:** On-going hand hygiene audits reported monthly to Hand Hygiene Task force and to Quality committee. **Person Responsible:** Infection Control Coordinator of Hollywood Campus **4).Corrective Actions:** A written policy and procedure **(see Addendum 144)** titled Control and Prevention of Bed Bug Infestation for managing bed bugs was developed and approved by Director of Infection Control on June 16, 2014 and has been sent to the Medical Executive Committee for approval (meeting taking place July 15, 2014). Re-education of all nursing staff will commence June 16th with a targeted and date of 31 days thereafter. **Date of Implementation:** June 18, 2014 **Monitoring Process:** EVS will determine a schedule for the routine assessment of bed bugs by the Pest Control Agency and report any findings to Director of Infection Prevention and Control for tracking and trending. Findings will be reported to Quality Council monthly and to the Infection Control Committee and Environment of Care Committee quarterly. **Person Responsible:** Director of Infection Prevention and Control, Director of Nursing	6/18/2014 4/10/2014 6/18/2014

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A 747	Continued From page 154 the use of wiping cloths to dry food production equipment; g. lack of removal of aprons prior to throwing out the garbage; h. lack of washing and sanitizing dishes manually when the dish machine temperatures would not properly clean and sanitize dishes and develop policies to ensure that hang-times on tube feeding systems are monitored to prevent growth of microorganisms. Failure to ensure operational processes that support safe food handling practices may result in exposure of patients to bacteria associated with foodborne illness. Foodborne illness may result in further compromising patients' medical status and in severe instances may result in death (Refer to A 749). The cumulative effect of these systemic issues resulted in the facility's inability to ensure and provide a safe patient care environment.	A 747	(Continued from page 154) **All Three Campuses** **5a-h). Corrective Actions:** Dietary department instituted several new logs, including cool-down process for foods and audit of enteral feeding bags.**(see Addendum 46, 46a)** Thawing process was revised and staff was in-serviced **(see Addendum 140, 140a)**. Ice machine cleaning was initiated and log was created by dietary. In addition, dietary conducted in-services on proper apron use and sanitizing of work areas. In-service on manual washing and sanitizing of dishes will be conducted by dietary. Infection Control to in-service dietary staff on hand hygiene and general infection control. Infection control reviewed these in-services, logs and processes and will conduct audits on the log sheets during bimonthly dietary infection control rounds for a minimum of 3 months. Dietary supervisor will notify infection control coordinator of any equipment malfunction or needed repairs so that the Infection Control Coordinator will monitor any necessary interventions until repairs are made and assure adherence to proper infection control practices. In addition, dietary conducted in-services on proper apron use and sanitizing of work areas. [see tag A 619 for dietary supporting documents; attached is Infection Control Rounding sheet **(see Addendum 91)**, and IC dietary policy **(see Addendum 137, 137a)** addressing hand hygiene and enteral feeding, among other things] **Date of Implementation**: 7/1/14 **Monitoring Process:** Infection Control bimonthly rounding and review of logs. **Person Responsible:** Infection Control Coordinator; Dietary Supervisor; Lead Dietician A 747 Continued on page 155a.	7/1/2014
A 748	482.42(a) INFECTION CONTROL OFFICER(S) A person or persons must be designated as infection control officer or officers to develop and implement policies governing control of infections and communicable diseases. This STANDARD is not met as evidenced by: Based on observations, interviews and record review, the facility failed to implement its policy and procedures for the use of a single dose ampule/vial in the facility's Culver City campus by failing to ensure the single use ampule/vial was used for one patient. This deficient practice had	A 748	**Culver City** **Corrective Actions:** Director of Infection Prevention and Control will receive anesthesia log audits weekly from Pharmacy and report monthly to Quality Council. Targeted compliance is 100%. Aggregated data will be reported to Infection Control Committee on a quarterly basis. **Date of Implementation:** June 18, 2014 **Monitoring Process:** Pharmacy/Surgery **Person Responsible:** Director of Infection Prevention and Control, Director of Pharmacy, Director of Peri-Operative Services	6/18/2014

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A 748	Continue From page 155 the potential for transmission of bloodborne viruses. Findings: On March 24, 2014 at 11:29 a.m., a review of the Anesthesia Controlled Drug Record indicated that entries were done in a manual, paper-based process. The Anesthesia Controlled Drug Record, dated ..March 18, 19, and 21, 2014," indicated that a Fentanyl250 mg per 5 milliliter (ml) ampule was used for two different patients, that half of the content was used for Patient 3, marked as "0.5" and half the content was used for Patient 2, marked as "0.5." The inventory count indicated the beginning count of 10 ampules and the ending balance of 9 ampules. The Anesthesia Record dated March 19, 2014 for Patient 3 showed that the Anesthesiologist administered Fentanyl 100 micrograms (meg) at approximately 10:15 a.m. and 25 meg at approximately 11:15 a.m., total125 meg. The Anesthesia Record dated March 19, 2014 for Patient 2 showed that the same Anesthesiologist administered Fentanyl 50 meg at approximately 11:45 a.m. and 75 meg at approximately 12:15 p.m., total125 meg. The manufacturer's package insert indicated "Fentanyl Citrate Injection ...is preservative-free and available as ...5 ml Single Dose ampules. On March 28, 2014 at 11:20 a.m., during an interview, when the surveyor showed the Anesthesia Controlled Drug Record and the use of the single dose ampule on two different patients to the director of infection prevention and	A 748	**Culver City** **Corrective Action:** Policy revised to be clear on the use of single dose vials. Policy will be sent to medical staff. **Date of Implementation:** July 1, 2014 **Monitoring Process:** DOP or designee will review anesthesia cart sheets, and will check that the SDVs are being used one time only. Any violations will be reported to the Quality Counsel. **Person Responsible:** VP of Pharmacy or designee	7/1/2014

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A 748	Continued From page 156 control, she responded " What does this have to do with me? " On March 28, 2014 at 11:25 a.m., during an interview, Staff P stated the single use ampule is not to be used for more than one patient. On March 28, 2014 at 12:45 p.m., a review of the facility policy and procedure titled "Medication, Care and Handling," Number: SAN.019, dated "11/2012," indicated "... Each patient is medicated with either single dose or multiple dose vials. The remainder of each of the multi-dose vial is discarded after each patient. " When the surveyor asked Rx 1 to clarify this policy, she stated the policy should read "The remainder of each of the single dose vial is discarded after each patient." A review of the policy and procedure titled "Handling of Multidose/Single Dose Vials and IV Compounding (Low Risk Condition) Outside Laminar Flow Hood," Number: PHA.090, dated " 10/2012 " indicated "…Single Dose vials / ampoules should be discarded soon after opening and not stored ... Opened single dose ampules shall not be stored for any time period According to Centers for Disease Control and Prevention on Injection Safety, single dose vial should be used for a single patient and single case/procedure/injection. There have been multiple outbreaks resulting from healthcare personnel using single dose or single use vials for multiple patients. The safest practice was to enter a single dose vial once to prevent inadvertent contamination and vial and infection of transmission.	A 748		

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A 749	482.42(a)(1) INFECTION CONTROL PROGRAM The infection control officer or officers must develop a system for identifying, reporting, investigating, and controlling infections and communicable diseases of patients and personnel. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure a system was developed for controlling infections and communicable disease for 4 of 52 Sampled patients (Patient 14, 15, 23, and 25) and 7 randomly selected patients (Patients 53, 54, 55, 56, 57, 58, and 59) by failing to: 1. Reprocess the endoscopes in the reprocessing area which minimize the opportunity for cross-contamination. 2. Apply alcohol-based hand rub for decontaminating hands when moving from a contaminated-body site to a clean-body site and before donning and after removing gloves. This deficient practice had the potential to transmission of infectious agents to the patients. 3. Label the peripheral intravenous (IV) sites with the date, gauge of needle and initials and label the IV tubing with a date. This deficient practice had the potential for not monitoring when the IV sites needed to be changed to ensure patient safety of intravenous therapy. 4. Ensure that in a closed system enteral feeding bottle should be dated, timed and initialed when the formula bottle is spiked. This deficient	A 749	**Hollywood** **1) Corrective Actions:** OR team re-educated to Policy SGI.006 Cleaning and Disinfection of Endoscopes to ensure policy compliance with procedure to re-process scopes only in the designated re-processing room and not in the procedure room. Policy reviewed for compliance to SGNA Society for Gastrointestinal Nurses and Associates guidelines **(see Addendum 136, 136a, 136b, 136c, 136d)**. Completing competencies on ORT's on proper steps for cleaning/reprocessing of endoscopes in the proper locations target date for completion by July 31, 2014. **Date of Implementation**: Education provided 6-19-2014; target date of completion for competency tool July 31, 2014 **Monitoring Process:** Monitoring will be managed by 100 % audit of all scope procedures until 100% goal achieved. Data will be reported monthly to PI, Quality and MEC **Person Responsible:** OR team, Infection Control **2)Corrective Actions:** **(HOLLYWOOD):** Hand hygiene and PPE usage in-services were conducted for nursing staff. Hand Hygiene task force was initiated to discuss results and to work on ways to improve hand hygiene compliance. **(See Addendum 141, 141a, 141b, 141c, 141d, 141e, 141f, 14 g, 141h).** **Date of Implementation:**4/10/14; 4/30/14 **Monitoring Process:** Hand Hygiene audits with results reported to Hand Hygiene Task Force and Quality Committee **Person Responsible:** Infection Control Coordinator **2).Corrective Actions:** **(CULVER CITY):** Director of Infection Prevention and Control has implemented a monthly plan to conduct 30 random observations among nurses to ensure appropriate hand hygiene practice when moving between dirty to clean tasks and/or body sites. **Date of Implementation:** June 18, 2014 **Monitoring Process:** Director of Infection Control will conduct 30 random observations monthly among nursing staff to observe appropriate hand hygiene practices when moving from dirty to clean tasks and/or body sites.	6/19/2014 4/10/2014 6/18/2014

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A 749	Continued From page 158 practice had the potential to not being able to determine when the feeding bottle was hang and had the potential for growth of microorganisms. 5. Develop a written policy and procedure for managing bed bugs to ensure an effective system was identified and developing practices and procedures were followed to prevent the spread of bed bugs. This deficient practice of not ensuring the infection prevention and control strategies for the bed bugs were implemented placed the patients, staff, and visitors at risk for infection and re-infestation. 6. Develop an effective systems for identifying, reporting and controlling infections when it failed to ensure safe food handling practices in the dietetic service areas on all three campuses and develop a policy to ensure tube feeding was handled in an effective manner to prevent growth of microorganisms. These failures are evidenced by: a. lack of system to ensure that meats and other leftover food items were monitored and cooled to prevent the growth of microorganisms that could result in food borne illness; b. lack of effective cleaning and sanitation of ice machines at the Hollywood, Culver City and Van Nuys campuses; c. lack of effective sanitation of soda syrup line connectors; d. lack of monitoring system for a cool down of potentially hazardous foods; e. lack of hand washing after handling soiled dishes; f. lack of an effective system to ensure food safety during thawing process of raw meat and the use of wiping cloths to dry food production equipment;	A 749	(Continued from page 158) Any episodes of non-compliance will immediately be corrected and nurses re-educated on the hand hygiene policy using just-in-time training. Data will be aggregated and reported monthly to Quality Council and quarterly to the Infection Control Committee. **Person Responsible:** Director of Infection Prevention and Control, Director of Nursing **3) Corrective Actions:** Education provided include review of policy and procedure on Intravenous Therapy-Initiation and Management of Peripheral Intravenous Lines, label IV sites with date, gauge of needles and initials, IV tubing changes, accurate and complete documentation **(See Addendum 142).** policy VAS.005) **Date of Implementation:** May 1, 2014 **Monitoring Process:** Daily rounds by Nurse Leadership on each department on all patients with IV, weekly audit will be performed by Infection control/Nurse Educator, data will be reported monthly to PI and Quality until 95 % goal has been achieved. **Person Responsible:** Nursing Leadership in each department and infection control practitioner, nursing staff **4) Corrective Actions:** Nursing in-service conducted on proper hanging of feeding bottle. Dietician to do daily audits on enteral feeding bottles in use. **(See 143)**. **Date of Implementation**: 6/2014 **Monitoring Process:** Dietician to audit feeding bags monthly. **Person Responsible:** Dietician **5) Corrective Actions**: **(CULVER CITY):** A written policy and procedure titled Control and Prevention of Bed Bug Infestation **(see Addendum 144)** for managing bed bugs was developed and approved by Director of Infection Control on June 16, 2014 and has been sent to the Medical Executive Committee for approval (meeting taking place July 15, 2014). Re-education of all nursing staff will commence June 16th with a targeted and date of 31 days thereafter.	5/1/2014 6/30/2014

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A 749	Continued From page 159 g. lack of removal of aprons prior to throwing out the garbage; h. lack of washing and sanitizing dishes manually when the dish machine temperatures would not properly clean and sanitize dishes and develop policies to ensure that hang-times on tube feeding systems are monitored to prevent growth of microorganisms. Failure to ensure operational processes that support safe food handling practices may result in exposure of patients to bacteria associated with foodborne illness. Foodborne illness may result in further compromising patients• medical status and in severe instances may result in death. Findings: 1. During the initial tour with Registered Nurse (RN) 7 in the operating rooms of the Hollywood campus on March 24, 2014 between 9:58a.m. and 11 a.m., AN 7 stated all endoscopes had been reprocessed in Operating Room (OR) #3 (GI) room. According to RN 7, those endoscopes then were transported to a room for high-level disinfection. According to APIC, Chapter 47-Endoscopy, "PREVENTION AND CONTROL OF INFECTIONS ASSOCIATED WITH ENDOSCOPY," in the Reprocessing Area or Room, reprocessing of contaminated equipment should be performed in a separate area or room, not in the endoscopy procedure room. The area must have adequate space for reprocessing, appropriate airflow and ventilation for the selection and method of disinfection/sterilization, appropriate work flow pattern (movement from dirty to clean minimizing the opportunity for	A 749	(Continued from page 159) **Date of Implementation:** June 18, 2014 **Monitoring Process:** EVS will determine a schedule for the routine assessment of bed bugs by the Pest Control Agency and report any findings to Director of Infection Prevention and Control for tracking and trending. Findings will be reported to Quality Council monthly and to the Infection Control Committee and Environment of Care Committee quarterly. **Person Responsible:** Director of Infection Prevention and Control, Director of Nursing **5). Culver City. Corrective Actions**: Infection Control in-service with Pharmacy staff regarding transportation and handling of Pharmacy items such as cassettes and contamination. **Monitoring Process:** Director of Pharmacy will randomly monitor Pharmacy Techs as they are doing their rounds on the floor. Any violations will be reported to the VP of Pharmacy. **Implementation Date:** 7/1/2014 **Person Responsible:** Director of Pharmacy. **a, c, d, e&f – Hollywood ; b- Culver City, Hollywood, Van Nuys** **Corrective Actions:** Created Policy on "Cool off log" and dietary staff in-serviced for the process; Policy created for Cool off method, staff in-serviced **(see Addendum 46, 46a)** . **Date of Implementation:** Education started April 23, 2014 and April 28, 2014; Policy created and will send for approval June 20, 2014 target approval date August 31, 2014 **Monitoring Process:** Will be managed through Staff competency Validation "Return Demonstration/Comprehension" will be done on a biannual basis and will be maintained in employee file. **Person Responsible:** RD, Director of Dietary Department and Food Services Supervisor **(e) Corrective Actions:** Will educate staff on proper hand hygiene practice, review of policy FNS.042 and will include in staff competency validation twice yearly **(see Addendum 145)**.	6/18/2014 7/1/2014 4/23/2014

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A 749	Continued From page 160 cross-contamination), and appropriate storage facilities. 2. During the initial tour with RN 1 in the mixed unit for DOU (Definitive Observation Unit) & Medical/surgical patients of the Hollywood campus on March 24, 2014 between 11:15 a.m. and 11:45 a.m., Patient 25 was observed resting on the bed with a sign of "Contact Isolation" posted by the door. According to RN 2, Patient 25 was placed in the room for Methicillin Resistant Staphyloccocus Aereus (MRSA) contact isolation. Licensed Vocational Nurse (LVN) 2 was standing by the patient's right side-rails without any PPE (Personal Protection equipment) including mask, gown and gloves. During the concurrent interview with LVN 2 on March 24, 2014 at 11:35 a.m., he stated he was not required to wear any PPE because he did not touch the patient. An interview with Staff E was conducted on March 2414 at 12:20 p.m. Staff E stated the staff should wear PPE if they anticipated to contact the patient or patient's environment. According to the facility's policy for "Contact Precautions": (Number INF.065) dated 11/2012: 4.2 PROCEDURE 4.1.26 GLOVES: 4.1.27 Wear gloves when hands will be in contact with body fluids (blood, urine, feces, wound drainage, oral secretions, sputum, vomitus, amniotic fluid, mucous membranes or non-intact skin of ALL patients.---. 4.1.28 MASK/GOGGLES: 4.1.31 Gowns are required when entering the room, when having contact with the environment,	A 749	(Continued from page 160) **Date of Implementation:** Will begin July 15-31, 2014 **Monitoring Process:** Will be managed through Staff competency Validation "Return Demonstration/Comprehension" will be done on a biannual basis and will be maintained in employee file. **Person Responsible:** RD, Director of Dietary Department and Food Services Supervisor **(f) Corrective Actions:** Staff education include review of policy Defrosting Meat FNS.010 and a new process "meat pull sheet" has been created and dietary staff have been trained on how to properly defrost meat (see attachment sign in sheet, log, pull sheet sample and policy) **Date of Implementation**: 4/23/2014; Staff validation competency will begin July 15-31, 2014 **Monitoring Process:** Will be managed through Staff Validation Competency "Return Demonstration/Comprehension log" will be done twice yearly and will be maintained in employee file **Responsible person:** RD, Director Dietary Department and Food Services Supervisor **Hollywood** **11). Corrective Actions:** "Cool off log" created and dietary staff in-serviced for the process; Policy created for Cool off method, staff in-serviced **(See Addendum 46, 46a).** **Date of Implementation:** Education started April 23, 2014 and April 28, 2014; Policy created and will send for approval June 20, 2014 target approval date August 31, 2014 **Monitoring Process:** "Return Demonstration/Comprehension" done on at least biannual basis and maintained in employee file. **Person Responsible:** RD, Director of Dietary Department and Food Services Supervisor **12) .Corrective Actions**: Water temp for dishwashing: Dishwasher has been fixed **(See Addendum 146)**. **Date of Implementation:** March 2014 **Monitoring Process:** Dish washer temperature check log implemented and water temperatures will be checked daily and reported. Aggregated data will be provided to the Quality Council.	7/15/2014 4/23/2014 4/23/2014 3/30/2014

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A 749	Continued From page 161 and/or when having contact with the patient. " Culver City campus 2. On March 25,2014 at 10 a.m., a wound treatment observation for Patient 14 was conducted. Registered Nurse (RN) 11 was wearing gloves and removed the soiled dressing on the left knee and disposed the soiled dressing in the plastic bag. With the same gloves, RN 11 applied wound cleanser to the open wound and wiped with a gauze. RN 11 applied a xerofoam dressing, covered the wound with dry dressing and wrapped with Kerlix. The RN then took off the gloves and applied hand sanitizer. RN 11 donned a new pair of gloves and removed the soiled dressing on the patient's mid-back wound and discarded the dressing in the plastic bag. With same gloves, RN 11 prepared the xerofoam dressing and started to cleanse the wound with wound cleanser. RN 11 applied the xerofoam dressing on the wound and cover it with optifoam dressing. RN 11 then gathered her residual supplies such as the xerofoam, gauzes and placed them back in the plastic basin container by the bedside table. During a concurrent interview, RN 11 stated hand hygiene/change of glove is performed when moving from dirty task to clean task such as removing soiled dressing, cleaning the wound then to applying new dressing. According to the facility's policy and procedure on Hand Hygiene dated November 2012, apply alcohol-based hand rub for decontaminating hands if moving from a contaminated-body site to a clean-body site and before donning and after removing gloves. Hand Hygiene included	A 749	(Continued from page 161) **Person Responsible:** RD, Director of Dietary Department and Food Services Supervisor **13) Corrective Actions:** Blender Storage/ Cleanliness; Review of policy # FNS.042 and educated staff. **(See Addendum 147)**. Implementation of a daily cleaning schedule. **(see Addendum 147a)** **Date of Implementation:** June 2014 **Monitoring Process**: Will be monitored through daily "cleaning schedule" **Person Responsible:** Food Service Supervisor, Dietary Staff **14). Corrective Actions :** Current process is already in place; cleaning and sanitizing of internal components are performed twice yearly **(See Addendum 148, 148a).** **Date of Implementation:** April 29, 2014 Monitoring Process: Monitor quarterly and/or as needed **Person Responsible:** Director of Facilities & Director of Dietary Department and Food Services Supervisor **15) Corrective Actions:** Tube Feedings & Evening hours: Reviewed and revised policy FNS.025 Dispensing Nutritional Products **(see Addendum 143)** and FNS.040 Guidelines for the Use of Parenteral Nutrition Therapy and will send for motions of approval **(See Addendum 149).** **Date of Implementation:** Education started 6/14/2014; target completion of policy August 31, 2014 **Monitoring Process:** On initial dietary assessments and on weekly basis through "Clinical Tube Feeding Audit" form conducted by the dietician. **Person Responsible:** Dietician **Culver City** **16. Corrective Actions:** Completed "Small Equipment Cleaning" in-service with production staff; included roster to document attendance/participation **(See Addendum 150).** **Date of Implementation**: 4/29/14	6/30/2014 4/29/2014 6/14/2014 4/29/2014

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A 749	Continued From page 162 washing hands with soap and water or applying alcohol-hand rub. Hand Hygiene is important prevention strategy for avoiding Healthcare Acquired Infections. The hands of personnel serve as a critical reservoir of infectious agents. 3. On March 25, 2014, at 10:20 a.m., during an observation tour with Staff E, a contact isolation sign was posted on the door of randomly selected patient (Patient 54). Staff E was wearing gown and gloves and checked the patient's heplock/intravenous line, the oxygen tubing, and the indwelling catheter bag. With the same gloved hands, Staff E touched the gastrostomy tube feeding bag to check the label. During a concurrent interview, Staff E stated she was unaware that she did not wash her hands or apply hand sanitizer after removing the gloves. 4. On March 24, 2014, at 10:20 a.m., during provision of care observation of Patient 23, RN 5 with gloved hands started to check the patient's indwelling catheter bag to see the amount of urine. The RN proceeded to touching the G-Tube feeding bag to check the label, the wrist restraint and the patient. The RN failed to change gloves and performed hand hygiene when performing dirty task to clean task. During a concurrent interview, RN 5 stated she failed to change gloves in when performing dirty task to clean task. 5. On March 24, 2014 at 10:05 a.m., during observation tour of the intensive care (ICU) unit, the PT (pharmacist technician) was noted to to pull out the medication cassette from the	A 749	(Continued from page 162) **Monitoring Process:** Random audits conducted by executive chef to ensure compliance. **Person Responsible:** Executive Chef **17. Corrective Actions**: Immediate removal/replacement of identified cutting boards was completed. **Date of Implementation:** 3/25/14 **Monitoring Process:** Random audits conducted by executive chef to assess condition of cutting boards and purchase/replace when needed. **Person Responsible:** Executive Chef **18. Corrective Actions:** Twice yearly cleaning/sanitizing of internal components to be performed by outside vendor (Redline Air) **(134, 134a).** **Date of Implementation:** Serviced June 2014; to re-occur every six months. **Monitoring Process:** Cleaning/sanitizing of ice machine (twice yearly) is documented on log sheet attached to unit **(see Addendum 135)**. **Person Responsible**: Director of Facilities & Director of Food & Nutrition **19. Corrective Actions**: Conducted "Soda Fountain Sanitizer" training with retail staff. Daily/Weekly/Monthly sanitizing requirements are documented as completed on log sheet posted on back of dispenser. **(see Addendum 138, 138a)**. **Date of Implementation:** 4/17/14 **Monitoring Process**: Completion documented on "Fountain Beverage Dispenser Cleaning/Sanitizing Log" and reviewed weekly by executive chef. **Person Responsible**: Executive Chef **Van Nuys** **20) Corrective Actions:** Will provide staff education to include review of policy Infection Control FNS.042; Cleaning, sanitizing of ice machine will be performed twice yearly and will be documented on log sheet attached to unit **(see Addendum 148, 148a).**	3/25/2014 6/30/2014 4/17/2014

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A 749	Continued From page 163 medication refrigerator and put it on the floor. The PT took out a vial of medication, then placed back the insulin cassette to the refrigerator without disinfecting it. During a concurrent interview, PT stated that she should have not placed on the floor and if she did she should have disinfected the medication cassette. Before putting it back together with other cassettes in the medication refrigerator. Hollywood campus 6. On March 24, 2014, at 8:30 a.m., during a provision of care observation with RN 3 the following was noted: a. The randomly selected patient (Patient 56) had a peripheral intravenous (IV) line on the left arm which was not labeled with date, time and initial when it was initially placed. b. Patient 23 had a peripheral intravenous (IV) line on the right hand which was not labeled with date, time and initial when it was initially placed. c. Randomly selected patient (Patient 57) had a peripheral intravenous (IV) line on the right forearm which was not labeled with date, time and initial when it was initially placed. d. Randomly selected patient (Patient 58) had a peripheral intravenous (IV) line on the left forearm which was not labeled with date, time and initial when it was initially placed.	A 749	(Continued from page 163) **Date of Implementation:** Target date of implementation for education July 1, 2014; target date for cleaning and sanitizing July 31, 2014 **Monitoring Process:** Monitoring will be managed through weekly and monthly cleaning logs **Person Responsible:** RD, Director and Food Services supervisors **21) Corrective Action:** The new dietary policy for infection control includes a section on hand hygiene practice and technique for dietary workers **(see Addendum 137).** In-service on proper hand hygiene by the dietary staff will be given by infection control. Hand hygiene will be monitored during the bimonthly Infection Control rounds (see rounds worksheet attached). **Date of Implementation:** Policy (7/2014); In-service (7/15/14); Rounds (7/1/14) **Monitoring:** Rounds to be done bimonthly by infection control with hand hygiene audits during rounds. **Responsible Person**: Infection Control Coordinator **22) Corrective Actions:** Dietary department instituted a new log for the cool-down process for food and staff has been in-serviced. Thawing process was revised and staff was in-serviced. Ice machine cleaning was initiated and log was created by dietary. In addition, dietary conducted in-services on proper apron use and sanitizing of work areas. In-service on manual washing and sanitizing of dishes will be conducted by dietary. Infection Control to in-service dietary staff on hand hygiene and general infection control. Infection control reviewed these in-services, logs and processes and will conduct audits on the log sheets during bimonthly dietary infection control rounds for a minimum of 3 months; attached is Infection Control Rounding sheet, and IC dietary policy addressing hand hygiene, among other things **(see Addendum 91, 46, 46a 137).** **Date of Implementation:** 7/1/14 **Monitoring Process**: Infection Control rounding and review of logs. **Person Responsible**: Infection Control Coordinator; Dietary Supervisor; Lead Dietician	7/1/2014 7/1/2014 7/1/2014

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A 749	Continued From page 164 According to the facility's policy and procedure on Intravenous Therapy-Initiation and Management of Peripheral Intravenous Lines dated November 20, 2012, label the IV sites with the date, gauge of needle and initials. The IV sites may remain in place for up to 96 hours unless there are signs and symptoms of infection. The IV tubing set changes are every 96 hours and label the IV tubing with a date. 7. On March 24, 2014, at 11:30 a.m., during a tour with RN 3, the randomly selected patient (Patient 55) was receiving 2 liters of oxygen via nasal cannula, on a indwelling catheter and was on telemetry monitor. The AN after touching the indwelling catheter bag and tubing proceeded to pick up the telemetry box from the side of the bed and placed it on the patient's chest without performing hand washing or applying hand sanitizer. 8. On March 24, 2014, at 11:30 a.m., the randomly selected patient (Patient 53) had the G-Tube feeding bag label did not have the time when the feeding bag was initially hung. Culver City Campus 9. On March 25, 2014 at 10:20 a.m., during the observation tour of the unit the following was noted:	A 749	(Continued from page 164) **23) Corrective Actions:** Staff re-education to include review of policy Defrosting Meat FNS.010 and a new process “meat pull sheet” has been created and dietary staff have been trained on how to properly defrost meat **(see Addendum 140, 140a).** **Date of Implementation:** 4/23/2014; Staff validation competency will begin July 15-31, 2014 **Monitoring Process:** Will be managed through Staff Validation Competency “Return Demonstration/Comprehension log” will be done twice yearly and will be maintained in employee file **Responsible person:** RD, Director Dietary Department and Food Services Supervisor	4/23/2014

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A 749	Continued From page 165 a. There was a gastrostomy tube (GT) feeding bag of Diabetic Source formula hanging on the feeding pump pole and labeled the bag was hang on March 25, 2014 at 60 milliliters {ml)/hour (hr) for the randomly selected patient (Patient 54). However there was no time when the bag was initially hung. b. The randomly selected patient (Patient 59) had a peripheral intravenous (IV) line on the left forearm which was not labeled with a date, time and initial when it was placed. The patient was also observed receiving Ferlicit (iron medication) by IV and the IV tubing was not labeled with date, time and initial. c. Patient 15 had a midline peripheral IV line located in the right antecubital arm which was not labeled with date, time and intial when it was placed. d. There was a G-Tube feeding bag Fibersource HN running at 50 cc/hr with no date and time it was hung for the Patient 15. There was a 0.9% normal saline IV bag running at 75 cc/hr which did not have a label as to patient name, when it was hung and who hung it. According to the facility's policy and procedure on Enteral Nutrition Support dated January 2014, closed system enteral feeding bag should be dated, timed and initialed when the formula bottle is spiked. 10. On March 26, 2014, at 10:30 a.m., during an	A 749		

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A 749	Continued From page 166 initial tour, of the open behavior health unit, room 603 had a sign which read " Closed this AM." There was a man with white coveralls and a disinfectant canister going into the room. Staff S stated the room was closed due to bed bugs. A review of the Census Log dated March 21, 2014, disclosed two patients were in room 603. Shower Room 3, directly across the nurses' station, in the locked unit had a sign which read "Closed Needs to be Sanitized." Reviews of Pest Prevention Service Reports revealed the following dated: a. On January 8, 2014, a serviced was done for bed bugs in Room 509. b. On January 15, 2014, a serviced was done for bed bugs in Room 632. c. On March 7, 2014, a serviced was done for bed bugs in Room 603. d. On March 18, 2014, a serviced was done for bed bugs in Room 540. e. On March 21, 2014, a serviced was done for bed bugs in Room 603. An email communication dated April 9, 2014, at 4:22p.m., from Staff B (corporate vice president/quality risk management) disclosed the facility had no policy regarding how to identify, report, investigate and control of infections for bed bugs. The email communication indicated "the bed bug issue was confined to one room 603, on the behavioral health unit. There were three (3) documented incidents of which a service request was put in for pest control company. According to a facility's policy titled Pest Control dated May 2012 disclosed the purpose was to provide a sanitary, rodent, and pest free	A 749		

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A 749	Continued From page 167 environment. The procedure included housekeeping supervisor would log all pest control complaints. The housekeeping supervisor would accompany the pest control technician on treatment rounds within the department1S area responsibility. Hollywood campus 11. On March 241 2014 at approximately 10:40 a.m., a large stainless steel pan containing slices of meat was observed in the refrigerator. Dietary Staff (DS) 4 stated the pan contained the Roast Beef for the lunch meal. A temperature check revealed the roast was 74. 8 degrees Fahrenheit (F). DS 4 stated the roast was approximately 40 pounds and that he had sliced it that morning at approximately 9 a.m. He stated that he had not checked the temperature before slicing and added water after slicing. Staff 2, who was present during the concurrent interview, stated there was no cooling log to show how the roast was monitored during the cooling the period. He stated that cooks cools the roast, leaves it at room temperature for 2 hours till it reaches 160 degrees F. The roast is then put in the refrigerator and the morning cook comes in the next morning and slices it. Improper cooling is a major factor causing food borne illness. Foods that have been cooked and held at improper temperatures promote the growth of disease causing microorganisms that may have survived the cooking process. Large or	A 749		

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A 749	Continued From page 168 dense items such as roasts may require interventions (e.g. placing foods in shallow pans, cutting roasts into smaller portions, utilizing water baths and stirring periodically) in order to be chilled safely within an allowed time period. Cooked foods subject to time and temperature control safety foods are best cooled rapidly within 2 hours from 135 degrees to 70 degrees F and within 4 more hours to the temperature of 41 degrees F. The total time for cooling from 135 degrees to 41 degrees should not exceed *6* hours (Centers for Medicare and Medicaid, Appendix P, State Operations Manual.) 12. At approximately 3:30 p.m. on March 24, 2014, it was determined that the water temperature of the high temperature was not hot enough to properly sanitize dishes and other cooking utensils. The water temperature was 119.5 degrees F. The required minimum temperature for a high temperature is of 180 degrees F. There was a discrepancy between DS 3 and Staff 10 on when hospital staff became aware that the temperature of the machine was not adequate and should not be used to dish washing. Staff 10 stated at approximately 3:35 pm that a part in the machine needed to be replaced and that he had informed DS 3. Inside the dish room were cleaned cooking utensils, pots and pans that had been washed in machine within the time frame after CE stated he had informed Dietary Staff *6* that the dish machine needed a part and should not be used. Staff 2, who was present during the interview, instructed OS 3 to rewash the items and sanitize manually in the sink. 13. At approximately 11:10 a.m. on March 24,	A 749		

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A 749	Continued From page 169 2014, a food blender stored away as clean was observed on the counter. There was a light brown and cream colored substance on the rubber gasket and the base of the plastic food container of the blender. DS 4 stated it had been used earlier that morning to blend oatmeal. The standard of practice is that all removal parts of food service equipment are washed and sanitized. Improperly sanitized food contact surfaces could support the growth of microorganisms that could cause food borne illness resulting in cross-contamination of food prepared in/on the equipment. 14. At approximately 3:40 p.m. on March 24, 2014, the preventive maintenance for the ice machine was reviewed. It was noted there was a build-up of black particles on both sides of the ice shield (a plastic cover over the ice production area). In an interview with Staff 10, he stated that the machine interior should be cleaned every two months. There was no documented evidence that this was done. 15. Patient 9 was admitted with diagnoses including anemia (low blood iron), insulin dependent diabetes (high blood sugar), sacral decubitus (open sore on the top of the upper buttocks), end stage renal disease (when the kidneys are not able to work at a level for day - to day life) with dialysis (treatment that removes wastes in the blood done by healthy kidneys). Electronic record review showed on March 23, 2014 at 12: 25 a.m., there was an order for Novasource Renal, (a specialized tube feeding for patients with kidney disease) Give 20 milliliters {ml)/hour (hr) via PEG (percutaneous endoscopic gastrostomy tube). A medical procedure where a tube is passed into the stomach through the	A 749		

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A 749	Continued From page 170 abdominal wall. There were additional instructions "every evening hours." RN 18 stated in an interview at approximately 5:45p.m. on March 24, 2014 on the definition of "evening hours" was 7 p.m. to 7 a.m. Inspection of the tube at approximately 5:50p.m. showed a feeding bag hung in the patient's room with approximately 150 ml of a light brown colored liquid left in the bag. The tube feeding bag had a blue colored cap which indicated that the tube feeding was poured into the bag. The bag was dated March 24, 2014 was not timed. It could not be determined how long the bag had been hung and how much Patient 9 received. This kind of tube feeding where hospital nursing staff has to pour the feeding into a bag is called an "open" system. The system where the tube feeding is pre-filled and sealed from the factory is called a closed system. The recommended time that tube feeding in an "open system" can be left hanging is 4 hours to prevent growth of microorganisms. RN 19 stated that at 7 p.m. the pump is turned on and whatever feeding that is left in the bag is allowed to infuse into the patient. He stated that at midnight all the bags are changed and new bags hung. RN 19 also stated that a new bag is hung at the beginning of each shift while RN 18 stated it was changed at 12 midnight. Neither RN 18 nor RN 19 was able to state how much feeding was poured into the bag, when it was hung. Review of hospital policy titled, "Enteral and Total Parenteral Nutrition" dated November 2012 did not include information on hang times and how to	A 749		

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A 749	Continued From page 171 prevent microbial growth. The hospital lacked an effective system to ensure that tube feeding in an open system was hung in a manner that would not support the growth of microorganisms that could cause food borne illness. Culver City campus 16. At approximately 11:24 a.m. on March 25, 2014, a food blender stored away as clean was observed on the counter. There was a light brown and cream colored substance on the rubber gasket and the base of the plastic food container of the blender. Next to the blender was a Robot Coupe (food processor) also stored away as clean. There was an unidentifiable light brown colored substance on the lid. Staff 3 who was present during the observation stated that the hospital policy was to remove all the removable parts. She instructed on the dietary staff to remove the two pieces of equipment and rewash. At approximately 3:00p.m. on March 25, 2014, the robot coupe was observed in the same area stored away as clean. There was once again a dried on substance on the lid. Staff 3 who was present during the observation could not provide any explanation as to why the piece of equipment had not been properly cleaned. The standard of practice is that all removal parts of food service equipment are washed and sanitized. Improperly sanitized food contact surfaces could support the growth of microorganisms that could cause food borne illness resulting in cross-contamination of food prepared in/on the equipment. 17. At approximately 3:10p.m. on March 25, 2014, two cutting boards stored away were	A 749		

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A 749	Continued From page 172 observed with dark colored substances in the cut groove marks. Staff 3 acknowledged the presence of the unidentifiable black colored substances and stated the boards will be replaced. Improperly sanitized food contact surfaces could support the growth of microorganisms that could cause food borne illness resulting in cross-contamination of food prepared in/on the equipment. 18. On March 25, 2014 beginning at 3 p.m., at the Culver City campus the preventive maintenance of the ice machine was reviewed. In a concurrent interview with Staff 5 he described he process. He stated that a) the hospital installed an automatic cleaning system for the unit; b) that with the installation of this unit required no additional maintenance and c) that the hospital contracted with a vendor to complete manufacturers' required maintenance. The bottle of chemical in the unit was labeled as an ice machine cleaner. In an interview on March 26, 2014 beginning at 9:35a.m., with REP 1 from the contracted vendor described how the automatic cleaning system worked. He described a process whereby the chemical would circulate through the ice producing mechanism two times/month. He also stated that the ice machine cleaner was the only chemical circulated. Posted on the interior panel of the ice machine was manufacturers' guidance for both a cleaning and sanitizing process. 19. In an interview March 26, 2014 beginning at 9 am, with Dietary Staff (DS) 1 the maintenance of the coke machine syrup connectors was reviewed. DS 1 stated that when she changed the syrup boxes the connectors were rinsed in a	A 749		

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A 749	Continued From page 173 bucket of hot water. On March 26, 2014 at 1:30 p.m., Staff 2 stated that she has previously attempted to obtain manufacturers' instructions for the dispensing unit; however was told by the purchasing group that it was a closed system and did not require any additional maintenance. She also stated that the vendor was trying to contact the manufacturer for guidance. As of April 1, 2014 at 5 p.m., the hospital was unable to provide manufacturers' guidance. On April 2, 2014 at 9 a.m., the surveyor reviewed of the soft drink vendors' web page and noted that it provided comprehensive guidance for daily, weekly and monthly cleaning of the syrup connectors and unit, which included a cleaning and sanitizing procedure. Van Nuys campus 20. In an interview on March 27, 2014 beginning at 10:30 a.m., with Staff 6 at the Van Nuys campus the preventive maintenance for the ice machine was reviewed. It was noted there was a buildup of black particles on both sides of the ice shield (a plastic cover over the ice production area) as well as the water supply tube. He stated he was unsure of the substance but thought it may be a disintegration of the foam on the interior of the shield. It was also noted that in the interior of the machine there was a white calcified substance, identified by Staff 6 as a mineral build up. Staff 6 described a preventive maintenance process that was limited to cleaning the filters, checking the pump and vacuuming dust on the interior of the machine. Review on March 27, 2014 at 4:15p.m., the manufacturers' guidance for cleaning and sanitizing of the ice machine was reviewed with Staff 6. He acknowledged that this process was not being followed.	A 749		

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A 749	Continued From page 174 21. On March 27, 2014 beginning at 8:20 a.m., DS 1 was observed in the dish room of the Van Nuys campus. It was noted that placed dirty Dishes in the dishwasher, wiped his hands dry with a paper towel and returned to food production activities. It was also noted that after the food production activities he placed gloves on his hands and began removing cleaned and Sanitized dishes. Review of hospital policy titled "Hand Hygiene " dated 11/12 guided staff that " 4.2.1 Soap and water is required: 4.2.1.1Any Time hands are visibly dirty …" It was also noted That the hand washing procedure was intended to be used by healthcare workers in a patient Care setting … " Additionally it was noted that the procedure included alcohol based hand rub to be used in clinical situations. The policy did not include any specific guidance for food service workers. In an interview on March 28, 2014 at 1:30 pm, with the Vice President of Quality she stated that this was the only policy that the hospital had. 22. Potentially hazardous foods (PHF) are those are capable of supporting bacterial growth associated with foodborne illness. PHF's require time/temperature control for food safety during all stages of receiving, storage, production and distribution. PHF's that are cooked and held for use at a later time must be monitored for time/temperature control within specified time/frames (Food Code, 2013). During initial kitchen tour on March 27, 2014 beginning at 8 a.m., it was noted that there were leftover cooked egg rolls and tofu stir fry in the refrigerator adjacent to the trayline. In an interview on March 27, 2014 at 8:55 a.m., with Staff 2 she stated that if leftovers were saved	A 749		

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A 749	Continued From page 175 they would be taken off the steam table, put into Another container, covered, labeled, dated and put in the refrigerator. She also stated that to ensure food safety when the leftovers were served they would be heated to an internal temperature of 165°. She further stated there was not temperature monitoring of these leftovers once they were refrigerated. Additional observation on March 27, 2014 at 9:30 a.m. noted there were 15 packages of five pound rolls of raw, fully thawed ground beef. In a concurrent interview with Staff 1 she stated that the meat was thawed on March 24, 2014 to be used on 3/29/14 for spaghetti. She further stated that the item would be cooked for the cafeteria at lunch time and the leftovers would be used for the patient dinner meal. She also stated that after lunch meal the leftovers would be put in the refrigerator and reheated for dinner and that there would be no temperature monitoring between lunch and dinner. In an interview with Registered Dietitian (RD 1) 3 she stated that she did not do any routine foodservice oversight; however would provide training and guidance if asked to do so. Review of position description titled " Clinical Dietitian" effective 4/1/06 noted that under the general responsibilities section this position was responsible to "observe and implement proper food handling and storage to assure safe quality nutrition." On March 28, 2014 beginning at 10:25 a.m., interviews were held with Staff K. The surveyor requested a description of the environment of care rounds. She stated that 2-3 times a year the department was reviewed for refrigerator/freezer	A 749		

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A 749	Continued From page 176 temperature and dishwasher logs, the physical Environment of the department; dating of food; cleanliness of equipment and the ice machine. She also stated the rounds were usually conducted with a hospital engineer and the department manager. She was also stated that The departmental policies did not go to the Infection control committee for review prior for implementation. Staff K also stated that the Health system recently acquired the Van Nuys campus and that all hospital policies/procedures were combined. Review of a copy of the Van Nuys campus environment of care rounds dated 1/23/14 noted that the evaluation included the cafeteria, kitchen, dishwasher, freezer, dry storage and office areas. It was also noted that cleanliness, labeling of food storage issues were identified. There was no evaluation or identification of the operational processes within the department related to food handling practices, specifically practices related to time/temperature control of potentially hazardous foods (PHF). PHF's are those foods capable of supporting bacterial growth associated with foodborne illness (USDA Food Code, 2013) and require effective monitoring systems for food safety. Review of departmental document titled "Storage And Use of Leftovers" dated 11/12 noted that while a procedure was developed for handling of leftover foods, it did not meet safe food handling standards, rather was limited to labeling and dating of foods. It did not include monitoring cooling of leftovers. In addition, some of the temperatures identified as requirements were outdated and did not meet current temperatures outlined in the 2013 Food Code.	A 749		

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A 749	Continued From page 177 23. During initial tour on March 27, 2014 beginning at 8 a.m., it was noted there were 15 packages of five pound rolls of raw, fully thawed ground beef. In a concurrent interview with Staff 1 she stated that the meat was thawed on March 24, 2014 to be used on 3/29/14 (5 days after removal from the freezer) for spaghetti. She also stated she was unsure if there was a policy regarding the procedure for thawing meats. Hospital policy titled “Defrosting Meats “ dated 11/12 guided staff to remove frozen meats two days in advance. The United States Department of Agriculture, Food Safety and Inspection Service (8/6/13) noted that ground beef may contain multiple bacterial strains. Extensive Holding of thawed meats provide an environment for increased bacterial growth. 16. During food production observation on March 27, 2014 beginning at 10:30 a.m., DS 1 Was observed preparing to transfer food into a Baking pan. He was observed taking a towel from a clean linen bin and wiping excess water from the pan. It would be the standard of practice to ensure that all dishware was dry before storage. Review undated of departmental policy and procedure manual revealed that there was no comprehensive ware washing procedure. In an interview with the RD 1 she stated that she did a cursory review of the policy/procedure manual; however she did not complete routine oversight of dietetic services. The standard of practice for storage of all equipment and utensils would be to ensure that after cleaning and sanitizing they were air-dried. Equipment and utensils may not be cloth dried except utensils that have been air-dried may be polished with cloths that are maintained clean	A 749		

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A 749	Continued From page 178 and dry.	A 749		
A 940	482.51 SURGICAL SERVICES If the hospital provides surgical services, the services must be well organized and provided in Accordance with acceptable standards Practice. If outpatient surgical services are Offered the services must be consistent in quality With inpatient care in accordance with the Complexity of services offered. This CONDITION is not met as evidenced by: Based on observation, review of facility documents and staff interview, the facility failed to meet the Condition of Participation in Surgical Services by failing to: 1. Ensure the surgical instruments and sterilized gowns that were opened on the back table prior to the surgery were constantly monitored and not Be left unattended in accordance with the recommendation from the Association of Operative Room Nursing (AORN). This deficient practice had the potential for contamination of the Surgical room with microorganisms which may affect the health and safety of the patients Receiving surgical services in the hospital (Refer To A 951). 2. Ensure the temperature and humidity were monitored in the autoclave room in accordance with recommendation from AAMI (Association for Advanced Medical Instrument). This defiant practice promote microbial growth and can result in contamination of sterile items (Refer to A 951). 3. To ensure a medical history and physical (H&P) examination completed and documented	A 940	**Culver City** **1) Corrective Actions:** Surgical Staff will be re- in serviced on the hospital's policy Aseptic Technique SUR.002 with a focus on the expectation that the sterile field should be constantly monitored and maintained. Unguarded sterile fields should be considered contaminated. Without direct observation, there is no way to ensure sterility. The sterile field should be prepared as close as possible to the time of use. The sterility of an opened sterile field is event related. There is no specified amount of time that opened sterile supplies in an unused room can remain sterile. **(See Addendum 151, 151a, 151b).** **Date of Implementation:** Staff in-service completed on April 17, 2014. **Monitoring Process:** The Director of Perioperative Services and/ or designee will conduct monitoring activity to include monthly audits of a minimum of 20 OR cases to ensure rooms are not being left unattended after supplies are opened. Targeted compliance is 100%. Compliance data will be reported to the Surgery Committee and the Quality Council and the Governing Board on a quarterly basis until optimal compliance is achieved. **Person Responsible:** Director Perioperative Services **2).Corrective Actions:** Red Line Air Conditioning Service to assess decontamination area for proper exhaust. A temperature and Humidity gauge will be installed in the Decontamination Room in Central Processing. Room temperature and humidity will be monitored and recorded on a daily basis by Plant Operations and Central Processing Staff**. (see Addendum 152, 152a)** Corrective actions will be taken and documented when minimum parameters are not met. . ASHE, AORN, and AAMI, guideline parameters for Soiled/ decontaminated areas are temperature 60-65 degrees and 20-60% humidity. Digital gauges will replace the Analog gauges in those areas where the monitoring of temperature and humidity is required on June 18, 2014. **Date of Implementation:** June 17,2014 Red Line Air Conditioning to assess decontamination area for proper exhaust.; June 18,2014 installation of digital gauges in areas requiring monitoring of temperature and humidity; June 18,2014. Daily Monitoring of Temperature and Humidity in Central Processing **Monitoring Process:** Monitoring activity will include a verification of the Decontamination Room daily temperature and humidity log by the Director of Perioperative Services. Compliance data will be reported to the Infection Prevention Committee and the Quality Council on a quarterly basis until optimal compliance is achieved. **Person(s) Responsible:** Director Perioperative Services & Director Plant Operations **3).Corrective Actions**: The hospital's leadership will ensure that its medical staff is re-educated on required documentation in the medical record to include the necessity for the signature, date and time of all entries in the medical record.	4/17/2014 6/17/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	050135	A. BUILDING **01 – SOUTHERN CALIFORNIA HOSPITAL AT HOLLYWOOD** B. WING _____	**04/01/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN CALIFORNIA HOSPITAL AT HOLLYWOOD	**6245 DE LONGPRE AVE HOLLYWOOD, CA 90028**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 940	Continued From page 179 24 hours after admission prior to the surgery Requiring anesthesia services for Patient 28 (Refer to A 952). 4. Ensure a tracheostomy set was available in the operating room suites in Hollywood campus. This deficient practice created the risk of poor health outcome in the event that a patient required a tracheostomy tray (Refer to A 959). The cumulative effect of these systemic practices Resulted in the hospital's inability to provide safe and effective surgical services.	A 940	(Continued from page 179) **(see Addendum 153)** **3).Corrective Actions**: The hospital's leadership will ensure that its medical staff is re-educated on required documentation in the medical record to include the necessity for the signature, date and time of all entries in the medical record. **(see Addendum 153).** Pre-op H & P Update form has been revised to include a designated place for physician signature, date and time**. (see Addendum 153a, 153b)** **Date of Implementation:** Pre-op H & P Update form presented at the Anesthesia and Surgery Committee Meeting of June 9, 2014. **Monitoring Process:** The Director of Perioperative Services will conduct a review of a minimum of 30 Pre-op H& P Update Progress Records per month. Compliance data will be reported through Surgery Committee Meeting, the Quality Council, and the Governing Board on a quarterly basis until compliance is achieved. **Person Responsible**: Director Perioperative Services & Director Medical Staff Office A 940 Continued on page 180a.	6/9/2014
A 951	482.51 (b) OPERATING ROOM POLICIES Surgical services must be consistent with needs and resources. Policies governing surgical care must be designed to assure the achievement and maintenance of high standards of medical practice and patient care. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide a safe environment and maintain high standards of care for patients receiving surgical services by failing to; 1. Ensure the surgical instruments and sterilized gowns that were opened on the back table prior to the surgery were constantly monitored and not be left unattended in accordance with recommendation from the Association of Perioperative room Nursing (AORN). This Deficient practice had the potential for contamination of the surgical room with microorganisms which may affect the health and safety of the patients receiving surgical services	A 951	**Culver City** **1) Corrective Actions:** Surgical Staff will be re- in-serviced on the hospital's policy Aseptic Technique SUR.002 **(see Addendum 155, 155a, 155b, 155c)** with a focus on the expectation that the sterile field should be constantly monitored and maintained. Unguarded sterile fields should be considered contaminated. Without direct observation, there is no way to ensure sterility. The sterile field should be prepared as close as possible to the time of use. The sterility of an opened sterile field is event related. There is no specified amount of time that opened sterile supplies in an unused room can remain sterile. **Date of Implementation:** Staff in-service completed April 17, 2014. **Monitoring Process:** The Director of Perioperative Services and/ or designee will conduct monitoring activity to include monthly audits of a minimum of 30 OR cases to ensure rooms are not being left unattended after supplies are opened. Targeted compliance is 100%. Compliance data will be reported to the Surgery Committee and the Quality Council and the Governing Board on a quarterly basis until optimal compliance is achieved. **Person Responsible:** Director Perioperative Services	4/17/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	050135	A. BUILDING **01 – SOUTHERN CALIFORNIA HOSPITAL AT HOLLYWOOD** B. WING _____	**04/01/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN CALIFORNIA HOSPITAL AT HOLLYWOOD	**6245 DE LONGPRE AVE HOLLYWOOD, CA 90028**

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A 951	Continued From page 180 in the hospital. 1. Ensure the temperature and humidity were Monitored in the autoclave room in accordance with recommendation from AAMI (Association for Advanced Medical Instrument). This deficient practice promote microbial growth and result in contamination of sterile items. Findings: During the initial tour with Staff D in the operating Room (OR) suites and Autoclave Room of the Culver city campus on March 25, 2014 between 9:03 a.m. and 10 a.m., the following was observed: 1. In OR #2, the surgical instruments and sterilized gowns on the back table were opened to the air at 9:38 a.m. Scrub technician (ST) 1 Was about to go out of the room to scrub his Hands without constantly monitoring the sterile field until the surveyor intervened. During the concurrent interview, ST 1 stated he had to prepare the surgical instruments to be ready for surgical procedures. The patient was brought into the room at 10:15 a.m., which was 37 minutes after the surgical instruments were opened on the back table. According to Perioperative Standards and Recommended Practices for 2013 of the AORN Recommendation VII Sterile fields should be constantly monitored. VII.a. Once created, a sterile field should not be left unattended until the operative or other invasive procedure is completed. 2. There was no thermometer and humidity	A 951	(Continued from page 180) **2) Corrective Actions**: Red Line Air Conditioning Service to assess decontamination area for proper exhaust. A temperature and Humidity gauge will be installed in the Decontamination Room in Central Processing. Room temperature and humidity will be monitored and recorded on a daily basis by Plant Operations and Central Processing Staff **(see Addendum 156, 156a).** Corrective actions will be taken and documented when minimum parameters are not met. . ASHE, AORN, and AAMI, guideline parameters for Soiled/ decontaminated areas are temperature 60-65 degrees and 20-60% humidity. Digital gauges will replace the Analog gauges in those areas where the monitoring of temperature and humidity is required on June 18, 2014. **Date of Implementation**: June 17, 2014 Red Line Air Conditioning to assess decontamination area for proper exhaust. June 18, 2014 installation of digital gauges in areas requiring monitoring of temperature and humidity. June 18, 2014 Daily Monitoring of Temperature and Humidity in Central Processing **Monitoring Process:** Monitoring activity will include a verification of the Decontamination Room daily temperature and humidity log by the Director of Perioperative Services. Compliance data will be reported to the Infection Prevention Committee and the Quality Council on a quarterly basis until optimal compliance is achieved. **Person(s) Responsible:** Director Perioperative Services & Director Plant Operations	6/17/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	050135	A. BUILDING **01 – SOUTHERN CALIFORNIA HOSPITAL AT HOLLYWOOD** B. WING _____	**04/01/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN CALIFORNIA HOSPITAL AT HOLLYWOOD	**6245 DE LONGPRE AVE** **HOLLYWOOD, CA 90028**

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A 951	Continued From page 181 display in the Autoclave Room, where all surgical instruments trays were wrapped and sterilized in the steam autoclaves. According to Staff D, the temperature and humidity were centrally monitored by the maintenance services. A review of the "Third Shift Surgery Check List " dated March 25. 2-14 disclosed the temperature and Humidity for all operating rooms and recovery room had been monitored and recorded. However, there was no documentation that the temperature and humidity to the Autoclave Room had been monitored and recorded. During an interview with Staff B on March 25, 2014, 2014 at 4 p.m., she stated that the temperature and humidity to the Autoclave Room had not been monitored and recorded. According to AAMI (Association for Advanced Medical Instrument) (2014) Chapter 3: Design Consideration 3.3.6.5 Temperature General work areas should have a temperature controlled between 20˚C and 23˚C (68◦F and 73◦F). The decontamination area should have a temperature controlled between 16˚C and 18˚C (60˚F and 65˚F). The temperature in sterilization equipment access rooms should be controlled between 24˚C and 29˚C (75˚ F and85˚ F) or as recommended by the equipment manufacturer. The temperature in sterile storage and personnel support areas (e.g., toilets, showers, locker room) may be as high as 24 ˚C (75˚ F). Independent monitors should be located in each of the areas where temperature should be controlled; temperature should be recorded daily. Processing personnel in each work area are responsible for monitoring and recording the	A 951		

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A 951	Continued From page 182 temperature to ensure that the correct temperature is being achieved. Rationale: Work areas should be comfortable for properly attired personnel. Comfort is a particular consideration in the decontamination area, where PPE is worn for long periods of time and where temperatures suitable for general work areas might be uncomfortably hot. Also, bacteria thrive at high temperatures; cool temperatures in the Decontamination area might help minimize Bioburden. Although AIA (2006) allows the temperature in clean work areas to be as high as 24˚ C (75˚ F), the consensus of the AAMI Committee was to recommend consistent temperature ranges for all general work areas. Controlling the temperature in sterilization equipment access rooms promotes higher efficiency of the equipment contained within the enclosures. For additional information on temperature control, see AIA (2006). 3.3.6.6 Relative humidity Relative humidity should be controlled between 30% and 60% in all work areas except the sterile storage area, where the relative humidity should not exceed 70%. An independent humidity monitor should be located in each area that requires controlled relative humidity. Relative humidity should be recorded daily. Processing personnel in each work area are responsible for monitoring and recording the relative humidity to ensure that the correct relative humidity is being achieved. NOTE-Ideal relative humidity in the preparation And packaging area is 50% and should not be less than 35% for best results in achieving sterilization. In the decontamination area, the recommended range of relative humidity should	A 951		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	050135	A. BUILDING **01 – SOUTHERN CALIFORNIA HOSPITAL AT HOLLYWOOD** B. WING _____	**04/01/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN CALIFORNIA HOSPITAL AT HOLLYWOOD	**6245 DE LONGPRE AVE HOLLYWOOD, CA 90028**

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A 951	Continued From page 183 be maintained to the extent possible, but temporary elevations might occur because of the type and quantity of cleaning and decontamination equipment. Humidifiers may be installed to maintain the recommended humidity level seasonally (e.g., during the winter months, when the heating system is functioning). If duct humidifiers are located upstream of the final filters, they should be placed at least 15 feet (4.57 meters) upstream of the final filters. For ductwork with duct mounted humidifiers, there should be a means of water removal. An adjustable high-limit humidistat should be locteddownstream of the humidifier to reduce the potential for condensation inside the duct. All duct takeoffs should be sufficiently downstream of the humidifier to ensure complete moisture absorption. Steam humidifiers should be used. Reservoir-type water spray or evaporative pan humidifiers should not be used. Rationale: Relative humidities higher than those recommended can promote microbial growth and thus increase bioburden. Relative humidity lower than 30% will permit absorbent materials to become excessively dry, which can adversely affect certain sterilization parameters (such as steam penetration) and the performance of some products (such as BIs and CIs). Thus, for best results, the committee recommends an ideal relative humidity level of 50% and a minimum level of 35%. The recommended range for relative humidity was largely based on AIA (2006).	A 951		
A 952	482.51 (b) (1) HISTORY AND PHYSICAL Prior to surgery or a procedure requiring	A 952	**Culver City and Hollywood Campuses** **1-3 Corrective Actions:** • Non-compliance discussed and corrective actions addressed at the Medical Executive Committee (MEC).	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	050135	A. BUILDING **01 – SOUTHERN CALIFORNIA HOSPITAL AT HOLLYWOOD** B. WING _____	**04/01/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN CALIFORNIA HOSPITAL AT HOLLYWOOD	**6245 DE LONGPRE AVE HOLLYWOOD, CA 90028**

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A 952	Continued From page 184 Anesthesia services and except in the case of Emergencies: (i) A medical history and physical examination must be completed and documented no more than 30 days before or 24 hours after admission or registration. (ii) An updated examination of the patient, including any changes in the patient's condition, must be completed and documented within 24 hours after admission or registration when the medical history and physical examination are completed within 30 days before admission or registration. This STANDARD is not met as evidenced by: Based on record review and interview, the facility Failed to ensure a medical history and physical (H&P) examination completed and documented 24 hours after admission prior to the surgery Requiring anesthesia services for Patient 28. This deficient practice placed the patient at risk of Unrecognized medical conditions and substandard health outcome for that patient. Findings: A review of the Operative/Invasive Procedure Report disclosed Patient 28 had undergone a surgical procedure-retropubic uretheral suspension (used to treat urinary incontinence by lifting the sagging bladder neck and urethra that may have dropped abnormally low in the pelvic area) on March 15, 2014. The clinical record was reviewed and disclosed a History and Physical was completed on March 20, 2014. Another Short Form History and Physical was completed on March 21, 2014. The PRE-OP	A 952	• The Chief of Staff issued a memo, dated June 19, 2014, to All Medical and Allied Staff Members to serve as a reminder notice that pursuant to the Medical Staff Rules and Regulations that a medical history and physical examination must be completed and documented no more than 30 days before or 24 hours after admission or registration, but prior to surgery or procedure requiring anesthesia services. The medical history and physical examination must be placed in the patient's medical record within 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services. • Medical Staff leadership will continue to monitor progress and work with Administration to improve compliance with documentation standards. • Audit results reported to the hospital's Quality and Medical Record Committee and Medical Executive Committee. **Date of Implementation:** • Non-compliance discussed and corrective actions addressed at the Medical Executive Committee meeting on June 17, 2014. • Chief of Staff communication dated June 19, 2014. • Monitoring of H&P's prior to surgery – ongoing • Audit results reported to the hospital's Quality and Medical Record Committee and Medical Executive Committee – June 2014 and quarterly as required. **Monitoring Process:** • The HIM Manager and/or designee will conduct monthly audits of patient charts to review for the timely completion of history and physical examinations prior to surgery. • Numerator = Number of history and physical present no more than 30 days prior to admission or 24 hours after admission or registration but prior to surgery / Denominator – Number of total charts reviewed. • The sample size will be based on monthly discharges, per the following guidelines: o Sample all cases for a population size of fewer than 30 cases o Sample 30 cases for a population size of 30–100 cases o Sample 50 cases for a population size of 101–500 cases o Sample 70 cases for a population size of more than 500 cases	6/17/2014 6/19/2014 6/19/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	050135	A. BUILDING **01 – SOUTHERN CALIFORNIA HOSPITAL AT HOLLYWOOD** B. WING _____	**04/01/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN CALIFORNIA HOSPITAL AT HOLLYWOOD	**6245 DE LONGPRE AVE** **HOLLYWOOD, CA 90028**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 952	Continued From page 185 H& P Update was reviewed and disclosed there was no change in H&P. However, there was no documentation when the PRE-OP H& P Update had been completed. During the concurrent interview with Staff J on March 25,2014 at 10:05 a.m., she stated the PRE-OP H& P Update had not been completed.	A 952	(Continued from page 185) • Targeted compliance is 90% • Monitoring activity will commence for a period not to exceed 4 months to ensure that compliance is achieved and sustained. • Random audits will be performed thereafter. • Results of the audits will be reported to the hospital's Quality and Medical Record Committee and Medical Executive Committee. **Person Responsible:** HIM Administrator and/or designee	
A 956	482.51(b)(3) REQUIRED OPERATING ROOM EQUIPMENT The following equipment must be available to the operating room suites: call-in system, cardiac monitor, resuscitator, defibrillator, aspirator, and tracheotomy set. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure a tracheostomy set was available in the operating room suites in Hollywood campus. This deficient practice created the risk of poor health outcome in the event that a patient required a tracheostomy tray. Findings: During the initial tour with RN 7 in the operating room suites of the Hollywood Campus on March 24, 2014 between 9:58a.m. and 11 a.m., there was no tracheostomy set available. According to RN 7, there was no a tracheostomy set available in the operating room suites. According to the facility's policy and procedure for "Required Emergency Equipment:" 4.1 Policy C. The following equipment will be maintained in the Surgical Services Department: 7. tracheostomy set."	A 956	**Hollywood** **Corrective Actions:** Emergency tracheostomy tray prepared and are now available in the OR suites Staff meeting with ORT was held immediately on March 25, 2014 include review of Policy Required Emergency Equipment and the need to ensure a tracheostomy tray is prepared and available in OR suites**(157, 157a)** **Date of Implementation:** March 27, 2014 **Monitoring Process:** Monitoring will be managed through daily rounds by OR lead tech to ensure all supplies are accounted for and readily available and to include in EOC rounds **Person Responsible:** ORT, Nursing leadership & EOC members	3/25/2014 3/27/2014

RESPONSE TO DEFICIENCIES
EXHIBIT P CMS Statements of Deficiency

Nix Health System

TEXAS DEPARTMENT OF STATE HEALTH SERVICES

1100 West 49th Street • Austin, Texas 78756
P.O. Box 149347 • Austin, Texas 78714-9347
1-888-963-7111 • www tiqlts.state.tx.us

KIRK COLE
INTERIM COMMISSIONER

2303 SE Military Dr. Bldg. 514
San Antonio, Texas 78223

November 13, 2015

Administrator
Nix Health Care System
414 Navarro, Suite 600
San Antonio, TX 78205

Dear Administrator:

Enclosed is the CMS-2567 Statement of Deficiencies and Plan of Correction Forms for federal deficiencies and the State forms for State deficiencies cited during a Health Survey conducted at your facility on October 29, 2015. Please type your plans of correction and proposed completion dates on the enclosed forms. Your signature is required on page one of each set of deficiencies. The enclosed forms need to be returned to this office within ten days from the date of receipt. Please keep a copy of the forms for your files.

On the enclosed list of deficiencies, please follow these instructions:

1. Enter on the form provided a plan of correction for each deficiency cited; please assure that each plan of correction clearly indicates the corrective action to be taken; rebuttals to or explanations for the deifciencies cannot be construed as acceptable plans of correction; proper names cannot be used. Please include the mechanism for monitoring to assure compliance.
2. The plan should address improving the processes that led to the deficiency cited.
3. The plan must include the procedure for implementing the acceptable plan of correction for each deficiency cited.
4. A completion date of correction for each deifciency cited must be included.
5. The monitoring procedure to ensure that the plan of correction is effective and that the specific deficiency cited remains corrected and/or in compliance with regulatory requirements.

6. The plan must include the title of the person responsible for implementing the acceptable plan of correction. DO NOT use proper names.
7. Enter a date of completion for each deifciency.
5. Return the completed plans of correction to this office by email, fax or mail.

Please note acceptance of a plan of correction to any alleged noncompliance does not preclude a proposal to assess administrative penalties and/or to otherwise take disciplinary action for that or any alleged noncompliance.

Should you have any questions, please call me at 210-531-4532. Thank you for your cooperation.

Sincerely,

Mr. Larrie Collier, Program Administrator
Health Facility Compliance Division

Enclosure

CMS-2567 Forms

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	450130	A. BUILDING _____ B. WING _____	10/29/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NIX HEALTH CARE SYSTEM	44 14 NAVARRO, SUITE 600 SAN ANTONIO, TX 78205

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY R LSC IDENTIFYING INFORMATION)	ID PREFIX 1 TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 000	INITIAL COMMENTS	A 0001		

Note: The CMS-2567 (Statement of Deficiencies) , is an official, legal document. All information must remain unchanged except for entering the plan of correction, correction dates, and the signature space. Any discrepancy in the original deficiency citation (s) will be reported to the Dallas Regional Office (RO) for referral to the Office of the Inspector General (01G) for possible fraud. If information is inadvertently changed by the provider/supplier, the State Survey Agency (SA) should be notified immediately.

An unannounced full survey was conducted on site. An entrance conference was held with the hospital delegated-representatives the morning of ! 10/26/15. The hospital delegated-representatives were informed this survey would be conducted according to the survey protocol in the State Operations Manual, Chapter 5, section 5100 and Appendix A, and according to 42 CFR 482 the Conditions of Participation for Hospitals.

Survey findings were presented at an exit conference on the afternoon of 10/29/15 with hospital delegated-representatives. The preliminary survey findings were presented and facility staff were given the opportunity to ask questions and provide additional information.

A 454	482.24(c)(2) CONTENT OF RECORD: ORDERS DATED & SIGNED All orders, including verbal orders, must be dated, timed, and authenticated promptly by the ordering practitioner or by another practitioner who is responsible for the care of the patient only if such a practitioner is acting in accordance with State	A 454	1. Policy will be updated to reflect 96 hours as time frame for authentication 2. Flags for the charts will be placed in all nursing units for nurses to use during the 12 and 24 hour chart check	11/27/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | ((6) DATE

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDERSUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	450130	A. BUILDING _____ B. WING _____	10/29/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NIX HEALTH CARE SYSTEM	4 14 NAVARRO, SUITE 600 SAN ANTONIO, TX 78205

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 454	Continued From page 1 law, including scope-of-practice laws, hospital policies, and medical staff bylaws, rules, and regulations. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure all orders, including verbal and telephone orders were authenticated promptly by the ordering practitioner or by another practitioner who was responsible for the care of the Patient in accordance with State law, Hospital policies, and medical staff by laws, rules, and regulations for 5 of 21 patient records reviewed (#1, #2, #3, #9, and #12). This deficient practice could affect the authenticity and accuracy of Patients verbal and telephone orders taken and transcribed by others that require authentication by physician signature. Findings included: Review of the facility's Medical Staff By Laws approved 05/31/13, and Medical Staff Rules and Regulations revealed the following: , 'Telephone/Verbal ord rs must be authenticated within 48 hours" from the time of order. Patient #1 Record review on 10/28/15 of Patient #1's records revealed he had Telephone/Verbal Physician Orders for medications, g-tube feedings, and discharge orders, during his admission of 09/17/15 to 09/20/15, that were not signed or authenticated by a physician until 10/23/15.	A 454:	3. Education will be conducted with physicians and nursing staff regarding 96 hour compliance 4. Nurses will be instructed on using the flags in the charts during chart checks 5. Directors will conduct weekly audits with the goal of 90% compliance for 96 hour authentication. 6. Results of audits will be reported to PI /Quality, MEC and Governing Board until a sustained compliance of 90% is met for 3 consecutive months. Responsible Person: CNO Quality Director Unit Directors	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	450130	A. BUILDING _____ B. WING _____	10/29/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NIX HEALTH CARE SYSTEM	414 NAVARRO, SUITE 600 SAN ANTONIO, TX 78205

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 464	Continued From page 2 Patient #2 Record review on 10/28/15 of Patient #2's records revealed he had Telephone/Verbal Physician Orders for admission to the facility, a bedside swallow test, a cardiac diet, case management consult, occupational therapy and physical therapy evaluations, and medications, during his admission of 08/07/15 to 08/09/15, that were not signed or authenticated by a physician until 08/27/15. Patient #3 Record review on 10/28/15 of Patient #3's records revealed she had Telephoneverbal Physician Orders for medications and emergency medications for agitation, during her admisson of 08/03/15 to 08/19/15, that were not signed or authenticated by a physician until 09/14/15. Patient #9 Record review on 10/28/15 of Patient #9's records revealed he had TelephoneVerbal Physician Orders for Restraints, Emergency Medications, and Seclusion that had not been signed or authenticated by a physician as of 10/28/15. The following Restraint/Seclusion records were reviewed: 1.) On 10/10/15 at 20:40 Physician A was notified and a Verbal/Telephone Order was obtained for a Physical Restraint for Patient #9 at 20:40. The Restraint/Seclusion Verbal/Telephone Order had not been signed in the area for Physician's Signature to include authentication. 2.) On 10/21/15 at 20:10 Physician B was notified	A 454;		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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A 454	Continued From page 3	A 454		

and Verbal/Telephone Order was obtained for a Mechanical Restraint (Restraint Chair) and Emergency Medications; Ativan and Benadryl to be administered to Patient #9. The Restraint/Seclusion Verbal/Telephone Order had not been signed in the area for Physician's Signature to include authentication.

3.) On 10/22/15 at 1500 Physician C was notified and a Verbal/Telephone Order was obtained for a Physical Hold, Mechanical Restraint (Restraint Chair), and Emergency Medication of Benadryl to be administered to Patient #9. The Restraint/Seclusion Verbal/Telephone Order had not been signed in the area for Physician's Signature to include authentication.

4.) On 10/23/15 at 15:00 Physician C was notified and a Verbal/Telephone Order was obtained for a Physical Hold, Mechanical Restraint (Restraint Chair), Seclusion, and Emergency Medication of Benadryl to be administered to Patient #9. The Restraint/Seclusion Verbal/Telephone Order had not been signed in the area for Physician's Signature to include authentication.

5.) On 10/23/15 at 21:42 Physician C was notified and a Verbal/Telephone Order was obtained for a Physical Hold and Emergency Medication of Benadryl to be administered to Patient #9. The Restraint/Seclusion Verbal/Telephone Order had not been signed in the area for Physician's Signature to include authentication.

6.) On 10/26/15 at 14:50 Physician B was notified and a Verbal/Telephone Order was obtained for a Physical Hold and Emergency Medication of Zyprexa to be administered to Patient #9. The Restraint/Seclusion Verbal/Telephone Order had

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A 454	Continued From page 4	A 454		

not been signed in the area for Physician's Signature to include authentication.

Patient #12

Record review on 10/28/15 of Patient #12's records revealed he was admitted to the facility on 10/22/15. Patient #12's Admission Orders, Medication Orders, and Physician Certification dated 10/22/15 at 00:45 had not been signed or authenticated by a physician as of 10/28/15 (6 days past/144 hours).

Further review of Patient #12's Physician Orders revealed the following Telephone Order (TO) that : had not been signed or authenticated by a physician as of 10/28/15:
10/22/15 at 00:45 TO for the following medications: Tylenol 325 milligrams (mg), Hydroxyzine HCL 25 mg, Loperamide 2mg, Lorazepam (Ativan)1 mg, and milk of magnesium 400 mg.

During an interview on 10/29/15 at 10:40 AM with the facility's Chief Nursing Officer (CNO) and Director of Risk Management confirmed the following Patient records (# **1,** #2 #9, and #12) had Verbal/Telephone Orders that had not been signed or authenticated. The CNO stated that Verbal/Telephone Orders had to be signed within the facility's Policy; By Laws; which was 48 hours from the time of the order. The Director of Risk Management stated that the Psychiatrist would sign their own Restraint/Seclusion Verbal/Telephone Orders when doing rounds and reviewing charts. The Director of Risk Management confirmed that Patient #9 had 6 Restraint/Seclusion Verbal/Telephone Orders that had not been signed or authenticated. The

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A454	Continued From page 5 Director of Risk Management stated there were 3 different Doctors with outstanding Verbal/Telephone Orders and confirmed there was no other method to authenticate other than their signatures.	A 4541		
A 503	482.25(b)(2)(ii) CONTROLLED DRUGS KEPT (LOCKED Drugs listed in Schedules II, Ill, IV, and V of the Comprehensive Drug Abuse Prevention and Control Act of 1970 must be kept locked within a ; secure area. This STANDARD is not met as evidenced by: Based on observation, interviews and record reviews the facility failed to ensure drugs listed in schedules II, Ill, and V of the Comprehensive Drug Abuse Prevention and Control Act were kept locked within a secure area. Findings include: Observations conducted on 10/27/15 from 9:30 a.m. to 12:00 p.m. at the facility's specialty psychiatric hospital revealed the following: An open top red container which was approximately 2 to 3 feet tall was observed in the medication preparation area next to the door leading out to the nurse's station. The medication room door was open/ unlocked. The container was 213 full of various sharps (needles, syringes with liquid in them, suture removal kits, ect ...) and unidentified medications (pills). On the wall behind the container was a hand written note which stated "Not a waste can" In an interview conducted on 10/27/15 at 10:30 a.m., LVN-A stated that she (LVN-A) has voiced concern about the open top container with her	A 503'	1. Process to improve controlled substances involves education of staff regarding securement of Class II, III, IV and V medications and how to return/waste narcotics appropriately. All remaining liquid narcotics will be drawn up and wasted in the sink with running water and two nurses observing/signing off on the waste. 2. Staff will be tested and must pass written test after education with a grade of at least 95%. Staff who do not meet the 95% threshold will have remedial education and retake the test until a satisfactory grade is achieved. 3. 90% of nursing staff will complete the test by Nov 27th with a passing grade. 4. Directors will do observations in the med rooms to ensure compliance with narcotic wasting. Results of audits will be reported to PI /Quality, MEC and Governing Board until a sustained compliance of 90% is met for 3 consecutive months.	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NIX HEALTH CARE SYSTEM	44 14 NAVARRO, SUITE 600 SAN ANTONIO, TX 78205

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A 503	A 503 Continued From page 6 manager, because she "got tired of people throwing trash in there (container)." During further i interview, LVN-A further revealed that nursing staff were also disposing of unused narcotic medications in the same open top container. In an interview conducted on 10/27/15 at 10:40 a.m., the Executive Director of the specialty psychiatric hospital confirmed the above findings. Record review of the facility policy entitled Pyxis Drug Administration, Returning, & Wasting, dated November 2003 revealed in part the following: Controlled substances not used must be placed in locked return bin in medstation. If the package is opened, it should be wasted. If the contents of a controlled drug vial or mpule are drawn up and not administered, or partially administered, the contents must be wasted at the pyxis unit and witnessed by another licensed nurse or pharmacist. Wasted controlled medications will be documented via the medstation, flushed in a sink or drain and witnessed by a licensed nurse or pharmacist. Record review of the facility policy entitled Controlled Drugs- Disposition/ Destruction revealed in part the following: * When controlled drugs must be returned, a licensed contract service shall be utilized for the return of products. When controlled drugs cannot be returned to the manufacturer, distributor, or other source of supply, the Director of Pharmacy or designee shall destroy or dispose of these drugs in accordance with current destruction or disposition procedure of the DEA and this state.	A 503	1. Process to improve controlled substances involves education of staff regarding securement of Class II, III, IV and V medications and how to return/waste narcotics appropriately. All remaining liquid narcotics will be drawn up and wasted in the sink with running water and two nurses observing/signing off on the waste. 2. Staff will be tested and must pass written test after education with a grade of at least 95%. Staff who do not meet the 95% threshold will have remedial education and retake the test until a satisfactory grade is achieved. 3. 90% of nursing staff will complete the test by Nov 27th with a passing grade. 4. Directors will do observations in the med rooms to ensure compliance with narcotic wasting. Results of audits will be reported to PI /Quality, MEC and Governing Board until a sustained compliance of 90% is met for 3 consecutive months. Responsible Person: CNO Quality Director Unit Directors	11/27/15

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A 701	! Continued From page 7 482.41(a) MAINTENANCE OF PHYSICAL PLANT The condition of the physical plant and the overall hospital environment must be developed and maintained in such a manner that the safety and well-being of patients are assured. This STANDARD is not met as evidenced by: Based on observations and interviews, the facility failed to ensure the condition of the overall hospital environment was maintained for the safety and well-being of the patients. The findings include: Observations conducted on 10/27/15 from 9:30 a.m. to 12:00 p.m., at the facility' s Specialty Psychiatric Hospital revealed that the patient bathrooms contained sink faucets with long metal handles. In an interview conducted on 10/27/15 at the time of discovery, the Executive Director of Psychiatric Services revealed that the sink faucets in the facility were not breakaway faucets. On 10/28/15 at 11:15 a.m., observations in the pharmacy revealed: -The pharmacy work counter had chipped paint and exposed plywood, ensuring the counter was no longer a wipe able surface. The face of one cabinet drawer was held together by clear tape. Several of the drawer handles were either missing or loose. -What was described to the surveyor as a portable air conditioning " unit, when the unit is turned on, pools water on the lfoor. - The medication refrigerator had a thick accumulation of dust and debris underneath, with mold observed in the condensation drainage	A 701	1. All sinks in behavioral health units will be retrofitted with appropriate faucet handles to assure a safe environment for this patient population. 2. The pharmacy will have counter tops repaired, air conditioning unit repaired or replaced, and a tiles will be replaced under the refrigerator. Project Authorization will be submitted for approval by 11/30/15. Estimated date for approval and completion of project is 90 days. Counter tops will be refinished by 12/31/15. AC unit was fixed on 11/ 23/15. Work orders for the pharmacy have been placed through maintained to replace floor tile on 11/20/15. 3. Sinks for the behavior health unit will be ordered and changed out by a contractor. Quality Director will round on units to ensure project completion by said date Responsible Person: VP Facilities Management	

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A 701	Continued From page 8 area. Interview with the Director of Pharmacy (DOP) on 10/28/15 at 11:25 a.m. revealed the pharmacy needs a new work counter. The DOP also revealed the water pooling on the floor from the portable air conditioning unit is a problem as it causes mold and a slipping hazard.	A 701		
A 749	482.42(a)(1) INFECTION CONTROL PROGRAM The infection control officer or officers must develop a system for identifying, reporting, investigating, and controlling infections and communicable diseases of patients and personnel. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to develop, and implement a system for identifying and controlling infections and communicable diseases within the hospital. The facility failed to: 1.) Ensure staffs were knowledgeable in the use of disinfectant wipes used to disinfect equipment being removed from isolation rooms and 2.) Ensure staffs at the specialty psychiatric hospital disposed of sharps in approved closed top sharps containers for disposal and 3,) Ensure staffs consumed food and/or drinks in approved areas outside the patient care area. Findings included: 1.) Observations conducted on 10/27/15 from 12:30 p.m. to 5:30 p.m. of the medical/ surgical floors revealed the following: Clorox germicidal disinfectant wipes (used for C- Difficille toxin) were not available on the patient care lfoors for staff use.	A 749:	1. ICP produced educational material that address use of disinfectant wipes and dwell time 2. All open sharps containers were removed and replaced with closed top containers on 10/27/15 3. Staff involved were counseled the day of the survey and in-services were conducted with all supervisors. Additionally all staff at the Babcock location will complete a read and sign of the Standard and Transmission Based Precautions by Dec 4, 2015. 1. Instructions for disinfectant wipes were places on all isolation carts on 10/27. Education was conducted at the skills fairs dated 11/3, 11/4, and 11/10. 2. Sharps Containers were replaced on 10/27/15 3. Read and sign with all staff members at Babcock location	1. 2/28/16 2. 10/27/15 3. 12/4/15

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A 749	Continued From page 9 In an interview conducted on 10/27/15 at 4:15 p.m., Registered Nurse (RN)-A stated that if they (staff) receive a patient with C- Difficille (C-Diff) , they have to contact housekeeping services to obtain Clorox germicidal disinfectant wipes, as they are not kept on the floor for use. When asked how long staff waited to remove equipment, which was disinfected with the Clorox wipes, from isolation rooms RN-A stated " Im not sure. " In an interview conducted on 10/27/15 at 4:30 p.m., the facility Chief Nursing Officer (CNO) stated that facility staff should be using Virex wipes to disinfect equipment used in C-Diff isolation rooms. In an interview conducted on 10/27/15 at 4:45 p.m., the facility Infection Control Practitioner revealed that staffs were supposed to be using germicidal Clorox wipes to disinfect C-Diff isolation rooms, with a wait time of **10** minutes before removing any disinfected equipment from isolation rooms. In an interview conducted on 10/27/15 at 5:00 p.m., Certified Nurse' s Aide- A (CNA) stated he routinely disinfects isolation equipment with bleach, but he was not sure how long to wait before removing equipment from the isolation rooms. He further revealed that Clorox wipes were not kept on the patient care lfoors, and that they (Clorox Wipes) must be brought to the floor by housekeeping. In an interview conducted on 10/27/15 at 5:20 p.m. Licensed Vocational Nurse (LVN)-B stated I that he was unsure how long to wait removing equipment from isolation rooms that	A 749	1. ICP will do monthly observation audits to ensure staff are compliant with process for disinfecting equipment. Results of audits will be sent to PI, MEC, and the Board until a sustained compliance of >90% is met for 3 consecutive months. 2. Director of Environment Services doing weekly audits to ensure compliance. Results of audits will be sent to PI, MEC, and the Board until a sustained compliance of >90% is met for 3 consecutive months. 3. Completed read and sign will be sent to Director of Quality and presented at PI/MEC and the Board in December. Responsible person: ICP Environmental Services Director VP BH Services	

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A 7491	Continued From page 10	A 7491		

had been disinfected with the Clorox germicidal wipes. He further stated, " I know it' s less than an hour. "

Record reviews of the facility' s Infection Control Program Plan, dated 2015, revealed in part the following:

VI- Education and Training: Education and training of healthcare workers in infection control interventions that interrupt disease transmission and reduce healthcare associated infection rates.

All new employees received education and training in infection control during general hospital orientation.

Current employees will receive education and training in infection control annually.

The responsibility for staff education falls on the Department Director in close collaboration with the Infection Control Preventionist.

2.) Observations conducted on 10/27/15 from 9:30 a.m. to 12:00 p.m. at the facility's specialty psychiatric hospital revealed the following:

An open top red container which was approximately 2 to 3 feet tall was observed in the medication preparation area next to the door leading out to the nurse ' s station. The medication room door was open/ unlocked. The container was 2/3 full of various sharps (needles, syringes with liquid in them, suture removal kits, ect ...) and unidentified medications (pills). On the wall behind the container was a hand written note which stated " Not a waste can "

In an interview conducted on 10/27/15 at 10:30 a.m., LVN-A stated that she (LVN-A) has voiced I concern about the open top container with her manager, because she " got tired of people

further interview, LVN-A further revealed that

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A 749	Continued From page 11 nursing staff were also disposing of unused narcotic medications in the same open top container. In an interview conducted on 10/27/15 at 10:40 a.m., the Executive Director of the specialty psychiatric hospital confirmed the above findings. 3.) On 10/27/15 at 10:40 am. during a tour of the facility's specialty psychiatric hospital , a facility staff member was observed "squatting" in the work area hallway eating what was observed to be a candy bar. Several patients were walking ! around the staff member. Interview on 10/27/15 at 11:30 am. with the facility Vice President of Clinical Services of Behavioral Services confirmed the facility staff member was employed by the facility. The staff revealed to her "he was eating a breakfast bar, not a candy bar." Further interview confirmed the staff should not have been eating in the hallway. When asked if the facility had a policy in regards to staff not eating or drinking at their work , stations, the facility stated they did not have a policy. But handed the surveyor the following print out from Occupational Safety and Health Administration (OSHA) regulations: " OSHA/Blood Borne Pathogen Regulations Policy 1910.1030" stated in part "OSHA's blood borne pathogens standard prohibits the consumption of food and drink in areas in which work involving exposure or potential exposure to blood or other potentially infectious material place, or where the potential for contamination of work surfaces exist."	A 749		

SODState Forms

Texas Department of State Health Services

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	000415	A. BUILDING: _____ B. WING _____	**10/29/2015**

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NIX HEALTH CARE SYSTEM	**414 NAVARRO, SUITE** 600 **SAN ANTONIO, TX** 78205

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X 000	**INITIAL COMMENTS** Note: The State Form is an official, legal document. All information must remain unchanged except for entering the plan of correction, correction dates, and the signature space. Any discrepancy in the original deficiency citation(s) will be referred to the Office of the Texas Attorney General (OAG) for possible fraud. If information is inadvertently changed by the provider/supplier the State Survey Agency (SA) should be notified immediately. An unannounced licensure inspection was conducted on site. An entrance conference was held with the hospital delegated-representatives the morning of 10/26/15. The hospital delegated-representatives were informed this survey would be conducted according to the Texas Administrative Code (TAC), Chapter 133. Survey findings were presented at an exit conference on the afternoon of 10/29/15 with hospital delegated-representatives. The preliminary survey findings were presented and facility staff were given the opportunity to ask questions and provide additional information.	**X** 000		
X 241	133.41(g) infection Control Infection control. There shall be an active program for the prevention, control, and surveillance of infections and communicable diseases.	X 241	1. ICP produced educational material that address use of disinfectant wipes and dwell time 2. All open sharps containers were removed and replaced with closed top containers on 10/27/15 3. Staff involved were counseled the day of the survey and in-services were conducted with all supervisors. Additionally all staff at the Babcock location will complete a read and sign of the Standard and Transmission Based Precautions by Dec 4, 2015.	1. 2/28/16 2. 10/27/15 3. 12/4/15

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

Texas Department of State Health Services

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NIX HEALTH CARE SYSTEM	4 14 NAVARRO, SUITE 600 SAN ANTONIO, TX 78205

(X4) ID PREFIX i TAG 1	SUMMARY STATEMENT OF EFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
X 2414	Continued From page 1 ThisRequirement isnot metasevidencedby: easedonobservationinterviewsandrecord reviews the facility failed to ensure drugs listed in schedules II, III, and V of the Comprehensive Drug Abuse Prevention and Control Act were kept locked within a secure area. Findings include: Observations conducted on 10/27/15 from 9:30 a.m. to 12:00 p.m. at the facility' s specialty psychiatric hospital revealed the following: An open top red container which was approximately 2 to 3 feet tall was observed in the medication preparation area next to the door leading out to the nurse's station. The medication room door was open/ unlocked. The container was 2/3 full of various sharps (needles, syringes with liquid in them, suture removal kits, ect ...) and unidentified medications (pills). On the wall behind the container was a hand written note which stated "Not a waste can" In an interview conducted on 10/27/15 at 10:30 a.m., LVN-A stated that she (LVN-A) has voiced concern about the open top container with her manager, because she "got tired of people throwing trash in there (container)." During further interview, LVN-A further revealed that nursing staff were also disposing of unused narcotic medications in the same open top container. In an interview conducted on 10/27/15 at 10:40 a.m., the Executive Director of the specialty psychiatric hospital confirmed the above findings. Record review of the facility policy entitled Pyxis Drug Administration, Returning, & Wasting, dated November 2003 revealed in part the following: Controlled substances not used must be	X241	1. Instructions for disinfectant wipes were places on all isolation carts on 10/27. Education was conducted at the skills fairs dated 11/3, 11/4, and 11/10. 2. Sharps Containers were replaced on 10/27/15 3. Read and sign with all staff members at Babcock. 1. ICP will do monthly observation audits to ensure staff are compliant with process for disinfecting equipment. Results of audits will be sent to PI, MEC, and the Board until a sustained compliance of >90% is met for 3 consecutive months. 2. Director of Environment Services doing weekly audits to ensure compliance. Results of audits will be sent to PI, MEC, and the Board until a sustained compliance of >90% is met for 3 consecutive months. 3.Completed read and sign will be sent to Director of Quality and presented at PI/MEC and the Board in December. Location. Responsible Person: ICP Environmental Services Director VP BH Services	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	000415	A. BUILDING: _____ B. WING _____	10/29/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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X241	Continued From page 2 placed in locked return bin in medstation. If the package is opened, it should be wasted. If the contents of a controlled drug vial or ampule are drawn up and not administered, or partially administered, the contents must be wasted at the Pyxis unit and witnessed by another licensed nurse or pharmacist. Wasted controlled medications will be documented via the medstation, flushed in a sink or drain and witnessed by a licensed nurse or pharmacist. Record review of the facility policy entitled Controlled Drugs- Disposition/ Destruction revealed in part the following: When controlled drugs must be returned, a licensed contract service shall be utilized for the return of products. When controlled drugs cannot be returned to the manufacturer, distributor, or other source of supply, the Director of Pharmacy or designee shall destroy or dispose of these drugs in accordance with current destruction or disposition procedure of the DEA and this state. Based on observation, interview and record review, the facility failed to develop, and implement a system for identifying and controlling infections and communicable diseases within the hospital. The facility failed to: 1.) Ensure staffs were knowledgeable in the use of disinfectant wipes used to disinfect equipment 1 being removed from isolation rooms and 2.) Ensure staffs at the specialty psychiatric hospital disposed of sharps in approved closed	X241		

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X 241	Continued From page 3 top sharps containers for disposal and 3,) Ensure staffs consumed food and/or drinks in approved areas outside the patient care area. Findings included: 1.) Observations conducted on 10/27/15 from 12:30 p.m. to 5:30 p.m. of the medical/ surgical floors revealed the following: Clorox germicidal disinfectant wipes (used for C- Difficille toxin) were not available on the patient care floors for staff use. In an interview conducted on 10/27/15 at 4:15 p.m., Registered Nurse (RN)-A stated that if they (staff) receive a patient with C- Difficille (C-Diff) they have to contact housekeeping services to obtain Clorox germicidal disinfectant wipes, as they are not kept on the floor for use. When asked how long staff waited to remove equipment, which was disinfected with the Clorox wipes, from isolation rooms RN-A stated " Im not sure. " In an interview conducted on 10/27/15 at 4:30 p.m., the facility Chief Nursing Officer (CNO) stated that facility staff should be using Virex wipes to disinfect equipment used in C-Diff isolation rooms. In an interview conducted on 10/27/15 at 4:45 p.m., the facility Infection Control Practitioner revealed that staffs were supposed to be using germicidal Clorox wipes to disinfect C-Diff isolation rooms, with a wait time of 10 minutes before removing any disinfected equipment from isolation rooms. In an interview conducted on 10/27/15 at 5:00 p.m., Certified Nurse ' s Aide- A (CNA) stated he routinely disinfects isolation equipment with bleach, but he was not sure how long to wait	X 241		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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X 241	Continued From page 4	X 241		

before removing equipment from the isolation rooms, He further revealed that Clorox wipes were not kept on the patient care floors, and that they (Clorox Wipes) must be brought to the floor by housekeeping.

In an interview conducted on 10/27/15 at 5:20 p.m. Licensed Vocational Nurse (LVN)-B stated that he was unsure how long to wait before removing equipment from isolation rooms that had been disinfected with the Clorox germicidal wipes. He further stated, " I know it' s less than an hour. "

Record reviews of the facility' s Infection Control Program Plan, dated 2015, revealed in part the following:

VI- Education and Training: Education and training of healthcare workers in infection control interventions that interrupt disease transmission and reduce healthcare associated infection rates.

All new employees received education and training in infection control during general hospital orientation.

Current employees will receive education and training in infection control annually.

The responsibility for staff education falls on the Department Director in close collaboration with the Infection Control Preventionist.

2.) Observations conducted on **10/27/15** from 9:30 a.m. to 12:00 p.m. at the facility's specialty psychiatric hospital revealed the following:

An open top red container which was approximately 2 to 3 feet tall was observed in the medication preparation area next to the door leading out to the nurse ' s station. The medication room door was open/ unlocked. The container was 2/3 full of various sharps (needles, syringes with liquid in them, suture removal kits,

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X 241	Continued From page 5	X 241		

ect ...) and unidentified medications (pills). On the wall behind the container was a hand written note which stated " Not a waste can "
In an interview conducted on 10/27/15 at 10:30 a.m., LVN-A stated that she (LVN-A) has voiced concern about the open top container with her manager, because she " got tired of people throwing trash in there (container). " During further interview, LVN-A further revealed that nursing staff were also disposing of unused narcotic medications in the same open top container.

In an interview conducted on 10/27/15 at 10:40 a.m., the Executive Director of the specialty psychiatric hospital confirmed the above findings.

3.) On 10/27/15 at 10:40 a.m. during a tour of the facility's specialty psychiatric hospital , a facility staff member was observed "squatting" in the work area hallway eating what was observed to be a candy bar. Several patients were walking around the staff member.

Interview on 10/27/15 at 11:30 a.m. with the facility Vice President of Clinical Services of Behavioral Services confirmed the facility staff member was employed by the facility. The staff revealed to her "he was eating a breakfast bar, not a candy bar." Further interview confirmed the staff should not have been eating in the hallway.

When asked if the facility had a policy in regards to staff not eating or drinking at their work stations, the facility stated they did not have a policy. But handed the surveyor the following print out from Occupational Safety and Health Administration (OSHA) regulations:

" OSHA/Blood Borne Pathogen Regulations

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X 241	Continued From page 6 Policy 1910.1030" stated in part "OSHA's blood borne pathogens standard prohibits the consumption of food and drink in areas in which work involving exposure or potential exposure to blood or other potentially infectious material place, or where the potential for contamination of work surfaces exist."	X 241		
X 288	133.41(j)(7) Authentication of entries ; Medical record services. The hospital shall have a medical record service that has administrative responsibility for medical records. A medical record shall be maintained for every individual who presents to the hospital for evaluation or treatment. All verbal orders must be dated, timed, and authenticated within 96 hours by the prescriber or another practitioner who is responsible for the care of the patient and has been credentialed by the medical staff and granted privileges which are consistent with the written orders.	X 288	1. Policy will be updated to reflect 96 hours as time frame for authentication 2. Flags for the charts will be placed in all nursing units for nurses to use during the 12 and 24 hour chart check 1.Education will be conducted with physicians and nursing staff regarding 96 hour compliance 2. Nurses will be instructed on using the flags in the charts during chart check. Directors will conduct weekly audits with the goal of 90% compliance with 96 hour authentication. Results of audits will be reported to PI /Quality, MEC and Governing Board until a sustained compliance of 90% is met for 3 consecutive months. Responsible Person: CNO Quality Director Unit Directors	11/27/2015

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X 288	Continued From page 7	X 288		

This Requirement is not met as evidenced by:
Based on record review and interview, the facility failed to ensure all orders, including verbal and telephone orders were authenticated promptly by the ordering practitioner or by another practitioner who was responsible for the care of the Patient in accordance with State law, Hospital policies, and medical staff by laws, rules, and regulations for 5 of 21 patient records reviewed (#1, #2, #3, #9, and #12).

This deficient practice could affect the authenticity and accuracy of Patients verbal and telephone orders taken and transcribed by others that require authentication by physician signature.

Findings included:

Review of the facility's Medical Staff By Laws approved 05/31/13, and Medical Staff Rules and Regulations revealed the following: , "TelephoneNerbal orders must be authenticated within 48 hours" from the time of order.

Patient #1

Record review on 10/28/15 of Patient #1's records revealed he had TelephoneNerbal

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA I ENTIFICATION NUMBER:	(X2) MULTIPLE C NSTRUCTION	(X3) DATE SURVEY COMPLETED
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X 288	Continued From page 8 Physician Orders for medications, g-tube feedings, and discharge orders, during his admission of 09/17/15 to 09/20/15, that were not signed or authenticated by a physician until 10/23/15. Patient #2 Record review on 10/28/15 of Patient #2's records revealed he had Telephone/Verbal Physician Orders for admission to the facility, a beside swallow test, a cardiac diet, case management consult, occupational therapy and physical therapy evaluations, and medications, during his admission of 08/07/15 to 08/09/15, that were not signed or authenticated by a physician until 08/27/15. Patient #3 Record review on 10/28/15 of Patient #3's records revealed she had TelephoneNerbal Physician Orders for medications and emergency medications for agitation, during her admisson of 08/03/15 to 08/19/15, that were not signed or authenticated by a physician until Patient #9 Record review on 10/28/15 of Patient #9's records revealed he had TelephoneNerbal Physician Orders for Restraints, Emergency Medications, and Seclusion that had not been signed or authenticated by a physician as of 10/28/15. The following Restraint/Seclusion records were reviewed: 1.) On 10/10/15 at 20:40 Physician A was notified and a Verbal/Telephone Order was obtained for a Physical Restraint for Patient #9 at 20:40. The	X 288		

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X 288	Continued From page 9 Restraint/Seclusion Verbal/Telephone Order had not been signed in the area for Physician's Signature to include authentication. 2.) On 10/21/15 at 20:10 Physician B was notified and a Verbal/Telephone Order was obtained for a Mechanical Restraint (Restraint Chair) and Emergency Medications; Ativan and Benadryl to be administered to Patient #9. The Restraint/Seclusion Verbal/Telephone Order had not been signed in the area for Physician's Signature to include authentication. 3.) On 10/22/15 at 1500 Physician C was notified and a Verbal/Telephone Order was obtained for a Physical Hold, Mechanical Restraint (Restraint Chair), and Emergency Medication of Benadryl to be administered to Patient #9. The Restraint/Seclusion Verbal/Telephone Order had not been signed in the area for Physician's Signature to include authentication. 4.) On 10/23/15 at 15:00 Physician C was notified and a Verbal/Telephone Order was obtained for a Physical Hold, Mechanical Restraint (Restraint Chair), Seclusion, and Emergency Medication of Benadryl to be administered to Patient #9. The Restraint/Seclusion Verbal Telephone Order had not been signed in the area for Physician's Signature to include authentication. 5.) On 10/23/15 at 21:42 Physician C was notified and a Verbal Telephone Order was obtained for a Physical Hold and Emergency Medication of Benadryl to be administered to Patient #9. The Restraint/Seclusion Verbal/Telephone Order had not been signed in the area for Physician's Signature to include authentication. 6.) On 10/26/15 at 14:50 Physician B was notified	1 X 288		

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X 288	Continued From page 10	X 288		

and a Verbal/Telephone Order was obtained for a Physical Hold and Emergency Medication of Zyprexa to be administered to Patient #9. The Restraint/Seclusion Verbal/Telephone Order had not been signed in the area for Physician's Signature to include authentication.

Patient #12

Record review on 10/28/15 of Patient #12's records revealed he was admitted to the facility on 10/22/15. Patient #12's Admission Orders, Medication Orders, and Physician Certification dated 10/22/15 at 00:45 had not been signed or authenticated by a physician as of 10/28/15 (6 days past/144 hours).

Further review of Patient #12's Physician Orders revealed the following Telephone Order (TO) that had not been signed or authenticated by a physician as of 10/28/15:
10/22/15 at 00:45 TO for the following medications: Tylenol 325 milligrams (mg), Hydroxyzine HCL 25 mg, Loperamide 2mg, Lorazepam (Ativan)1 mg, and milk of magnesium 400 mg.

During an interview on 10/29/15 at 10:40 AM with the facility's Chief Nursing Officer (CNO) and Director of Risk Management confirmed the following Patient records (# 1, #2 #9, and #12) had Verbal/Telephone Orders that had not been signed or authenticated. The CNO stated that Verbal/Telephone Orders had to be signed within the facility's Policy; By Laws; which was 48 hours from the time of the order, The Director of Risk Management stated that the Psychiatrist would sign their own Restraint/Seclusion Verbal/Telephone Orders when doing rounds and reviewing charts. The Director of Risk

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X 288	Continued From page 11 Management confirmed that Patient #9 had 6 Restraint/Seclusion Verbal/Telephone Orders that had not been signed or authenticated. The Director of Risk Management stated there were 3 different Doctors with outstanding VerbaliTelephone Orders and confirmed there was no other method to authenticate other than their signatures.	X 288		
X 466	133.41(05) Control and distribution Pharmacy Services. Delivery of Services. In order to provide patient safety, drugs and biologicals shall be controlled and distributed in accordance with applicable standards of practice, consistent with federal and state laws. This Requirement is not met as evidenced by: Based on observation, interviews and record reviews the facility failed to ensure drugs listed in schedules II, Ill, and V of the Comprehensive Drug Abuse Prevention and Control Act were kept locked within a secure area. Findings include: Observations conducted on 10/27/15 from 9:30 a.m. to 12:00 p.m. at the facility' s specialty psychiatric hospital revealed the following: An open top red container which was approximately 2 to 3 feet tall was observed in the 1 medication preparation area next to the door	X 466	1. Process to improve controlled substances involves education of staff regarding securement of Class II, III, IV and V medications and how to return/waste narcotics appropriately. All remaining liquid narcotics will be drawn up and wasted in the sink with running water and two nurses observing/signing off on the waste. 1. Staff will be tested and must pass written test after education with a grade of at least 95%. Staff who do not meet the 95% threshold will have remedial education and retake the test until a satisfactory grade is achieved. 1. 90% of nursing staff will complete the test by Nov 27th with a passing grade. 2. Directors will do observations in the med rooms to ensure compliance with narcotic wasting. Results of audits will be reported to PI /Quality, MEC and Governing Board until a sustained compliance of 90% is met for 3 consecutive months. Responsible person: CNO Quality Director Unit Directors	11/27/15

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X 466	Continued From page 12	X 465		

leading out to the nurse's station. The medication room door was open/ unlocked. The container was 2/3 full of various sharps (needles, syringes with liquid in them, suture removal kits, eet ...) and unidentified medications (pills). On the wall behind the container was a hand written note which stated "Not a waste can"

in an interview conducted on 10/27/15 at 10:30 a.m., LVN-A stated that she (LVN-A) has voiced concern about the open top container with her manager, because she "got tired of people throwing trash in there (container)." During further interview, LVN-A further revealed that nursing staff were also disposing of unused narcotic medications in the same open top container.

In an interview conducted on 10/27/15 at 10:40 a.m., the Executive Director of the specialty psychiatric hospital confirmed the above findings.

Record review of the facility policy entitled Pyxis Drug Administration, Returning, & Wasting, dated November 2003 revealed in part the following:

Controlled substances not used must be placed in locked return bin in medstation. If the package is opened, it should be wasted.

If the contents of a controlled drug vial or ampule are drawn up and not administered, or partially administered, the contents must be wasted at the pyxis unit and witnessed by another licensed nurse or pharmacist.

Wasted controlled medications will be documented via the medstation, flushed in a sink or drain and witnessed by a licensed nurse or pharmacist.

Record review of the facility policy entitled Controlled Drugs- Disposition/ Destruction revealed in part the following:

When controlled drugs must be returned, a

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X 466	Continued From page 13 licensed contract service shall be utilized for the return of products. When controlled drugs cannot be returned to the manufacturer, distributor, or other source of supply, the Director of Pharmacy or designee shall destroy or dispose of these drugs in accordance with current destruction or disposition procedure of the DEA and this state.	X 466		
X1036	133.47(c)(2) Posting requirements Abuse And Neglect Issues. Abuse and neglect of individuals with mental illness, and illegal, unethical, and unprofessional conduct. The requirements of this subsection are in addition to the requirements of subsection (b) of this section. Posting requirements. A facility shall prominently and conspicuously post for display in a public area that is readily visible to patients, residents, volunteers, employees, and visitors a statement of the duty to report abuse and neglect, or illegal, unethical or unprofessional conduct in accordance with HSC, §161.132(e). The statement shall be in English and in a second language appropriate to the demographic makeup of the community served and contain the number of the department's patient information and complaint line at (888) 973-0022. This Requirement is not met as evidenced by: Based on observation and interview, the facility	X1036	1. Temporary signage with required elements regarding the duty to report abuse and neglect, or illegal, unethical or unprofessional conduct with the TDSHS patient information and complaint phone number was placed throughout the system 10/25 - 10/27. 2. Formal permanent signs will replace temporary signs in all waiting areas, elevator landings and admitting by December 4, 2015. Formal permanent signs will be ordered by VP of Plant Operations and replace temporary signs in all waiting areas, all waiting areas, elevator landings and admitting by December 4, 2015. Director of Quality will do walking rounds to ensure all new signs are in place by required date. Responsible Person: VP Facilities Management	12/4/15

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	000415	A. BUILDING: _____ B. WING _____	10/29/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NIX HEALTH CARE SYSTEM	4 14 NAVARRO, SUITE 600 SAN ANTONIO, TX 78205

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
X1036	Continued From page 14 failed to prominently and conspicuously post for display in a public area that is readily visible to patients, residents, volunteers, employees, and visitors; a statement of the duty to report abuse and neglect, or illegal,unethical or unprofessional conduct in accordance with the Texas Health and Safety Code (HSC), and ensure the statement contains the number of the department's patient information and complaint line at (888) 973-0022. This deficient practice affected the rights of Patients Findings included: Observation conducted on 10/26/15 at 2:25 PM in the facility's emergency room of the facility's lobby/waiting area revealed a poster of Patient's Rights dated 09/01/2013. The posting failed to contain a statement of the duty to report abuse and neglect, or illegal, unethical or unprofessional conduct in accordance with the HSC §161.132(e); and failed to ensure it contained the number of the Texas Department of State Health Services patient information and complaint line at (888) 973-0022. Further observation conducted on 10/26/15 at 3:00 PM in the facility admission area did not reveal a posting of the department's (DSHS) patient information and complaint line phone number, or a statement of the duty to report abuse and neglect, or illegal, unethical or unprofessional conduct in accordance with the HSC §161.132(e). Continued observation conducted on 10/27/15 at 10:30 AM in the facility outpatient clinic and outpatient rehabilitation area did not reveal a	X1036		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDERSUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	000415	A. BUILDING: _____ B. WING _____	10129/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NIX HEALTH CARE SYSTEM	4 14 NAVARRO, SUITE 600 SAN ANTONIO, TX 78205

	SUMMARY STATEMENT OF DEFICIENCIES	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)
X1036	Continued From page 15 posting of the department's (DSHS) patient information and complaint line phone number, or a statement of the duty to report abuse and neglect, or illegal, unethical or unprofessional conduct in accordance with the HSC §161.132(e). During an interview on 10/27/15 at 12:30 PM with the facility's Director of Performance Improvement confirmed the department's (DSHS) patient information and complaint line phone number (888-973-0022) were not posted in the facility or a statement of the duty to report abuse and neglect, or illegal, unethical or unprofessional i conduct in accordance with the HSC §161.132(e).	X1036

November 16, 2015

Jeanette Salinas
Patient Quality Care Unit
Health Care Quality Section
Texas Department of State Health Services
2303 SE Military Dr. Bldg. 514
San Antonio, TX 78223

Re: Provider Number 450130
Complaint Number TX00223777

Dear Ms. Salinas:

We acknowledge receipt of your letter in regards to the result of a survey conducted by Texas Department of State Health Services on October 28, 2015 at Nix Health Care System.

We look forward to continuing to work with you in the administration of the Medicare Program.

Sincerely,

Joseph W. Rafferty, Interim CEO

cc: Larrie Collier, Program Administrator

TEXAS DEPARTMENT OF STATE HEALTH SERVICES

DAVID L. LAKEY, M.D.
COMMISSIONER

1100 West 49th Street • Austin, Texas 78756
P.O. Box 149347 • Austin, Texas 78714-9347
1-888-963-7111 • www.dshs.state.tx.us

2303 SE Military Dr. Bldg. 514
San Antonio, Texas 78223

November 13, 2015

Administrator
Nix Health Care System
414 Navarro, Suite 600
San Antonio, TX 78205

Re: Provider Number 450130
Complaint Number TX00223777

Dear Administrator:

I am pleased to inform you that as a result of the Texas Department of State Health Services substantial allegation survey conducted on **October 28, 2015, Nix Health Care System** was found in compliance with the applicable Medicare Conditions of Participation. We thank you for your cooperation and look forward to working with you on a continuing basis in the administration of the Medicare program. If you have any questions please contact Mr. Larrie Collier, Program Administrator, at 210-531-4532.

Sincerely,

Jeanette Salinas
Patient Quality Care Unit
Health Care Quality Section
Texas Deptartment of State Health Services

CMS-2567 Forms

Complaint

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	450130	A. BUILDING _____ B. WING _____	C 10/28/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NIX HEALTH CARE SYSTEM	414 NAVARRO, SUITE 600 SAN ANTONIO, TX 78205

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 000	INITIAL COMMENTS Note: The CMS-2567 (Statement of Deficiencies) is an official, legal document. All information must remain unchanged except for entering the plan of correction, correction dates, and the signature space. Any discrepancy in the original deficiency citation (s) will be reported to the Dallas Regional Office (RO) for referral to the Office of the Inspector General (OIG) for possible fraud. If information is inadvertently changed by the provider/supplier, the State Survey Agency (SA) should be notified immediately. An unannounced complaint survey (TX 00223777) was conducted on site. An entrance conference was held with the hospital delegated-representatives the morning of 10/26/15. The hospital delegated-representatives were informed of the purpose and process of the complaint survey with an opportunity for questions was provided. Complaint TX 00223777 was unsubstantiated. Complaint survey findings were presented at an exit conference on the afternoon of 10/29/15 with hospital delegated-representatives. The preliminary survey findings were presented and facility staff were given the opportunity to ask questions and provide additional information.	A 000		

Joseph W. Rafferty — LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Interim CEO — TITLE

11/17/15 — (X6) DATE

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

SOD-State Forms

Texas Department of State Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	000415	A. BUILDING: _____ B. WING _____	C 10/28/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NIX HEALTH CARE SYSTEM	414 NAVARRO, SUITE 600 SAN ANTONIO, TX 78205

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
X 000	INITIAL COMMENTS Note: The State Form is an official, legal document. All information must remain unchanged except for entering the plan of correction, correction dates, and the signature space. Any discrepancy in the original deficiency citation(s) will be referred to the Office of the Texas Attorney General (OAG) for possible fraud. If information is inadvertently changed by the provider/supplier, the State Survey Agency (SA) should be notified immediately. An unannounced complaint survey (TX 00223777) was conducted on site. An entrance conference was held with the hospital delegated-representatives the morning of 10/26/15. The hospital delegated-representatives were informed of the purpose and process of the complaint survey with an opportunity for questions was provided. Complaint TX 00223777 was unsubstantiated. Complaint survey findings were presented at an exit conference on the afternoon of 10/29/15 with hospital delegated-representatives. The preliminary survey findings were presented and facility staff were given the opportunity to ask questions and provide additional information.	X 000		

Joseph W. Rafferty — Interim CEO — 11/17/15

SOD - State Form
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

November 16, 2015

Mr. Larrie Collier
Program Administrator
Health Facility Compliance Division
Texas Department of State Health Services
2303 SE Military Dr. Bldg. 514
San Antonio, TX 78223

Re: CMS-2567

Dear Mr. Collier:

We acknowledge receipt of your letter in regards to the result of a health survey conducted by Texas Department of State Health Services on October 27, 2015 at Nix Health Care System. We are submitting the signature page as requested.

We look forward to continuing to work with you in the administration of the Medicare Program.

Sincerely,

Joseph W. Rafferty, Interim CEO

TEXAS DEPARTMENT OF STATE HEALTH SERVICES

KIRK COLE
INTERIM COMMISSIONER

1100 W. 49th Street • Austin, Texas 78756
1-888-963-7111 • http://www.dshs.state.tx.us

Health Facility Licensing and Compliance Division
2303 SE Military Dr. Bldg. 514
San Antonio, Texas 78223

11/13/2015

Administrator
Nix Health Care System
, 414 Navarro, Suite 600
San Antonio, TX 78205

Dear Administrator:

Enclosed is the CMS-2567 Statement of Deficiencies Plan of Correction form indicating no deficiencies were cited as a result of a Health Survey conducted at your facility on October 27, 2015. Your signature is required on page one. The enclosed form needs to be returned to this office within ten (10) days of receipt of this letter. You may keep a copy for your files.

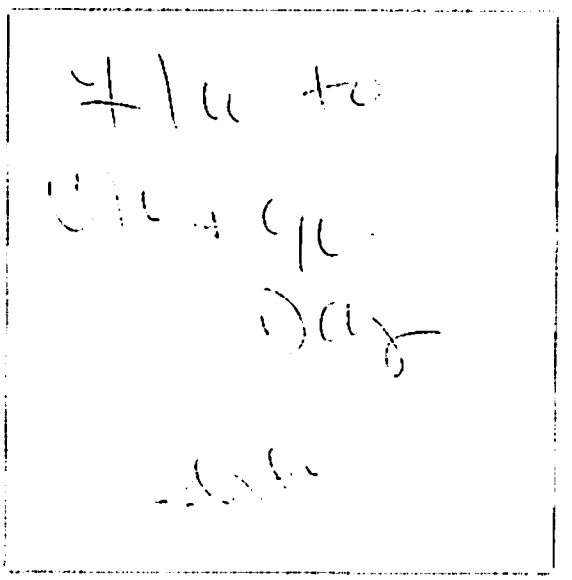
Should you have any questions, please contact me at 210-531-4532. Thank you for your cooperation.

Sincerely,

Mr. Larrie Collier, Program Administrator
Health Facility Compliance Division

Enclosure

CMS-2567 Forms



DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	450130	A. BUILDING _____ B. WING _____	R-C 10/27/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NIX HEALTH CARE SYSTEM	414 NAVARRO, SUITE 600 SAN ANTONIO, TX 78205

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{A 000}	INITIAL COMMENTS The CMS - 2567 (Statement of Deficiencies) is an official, legal document. All information must remain unchanged except for entering the plan of correction, correction dates and the signature space. Any discrepancy in the original deficiency citation (s) will be reported to Dallas Regional Office (RO) for referral to the Office of Inspector General (OIG) for possible fraud if information is inadvertently changed by the provider/supplier, the State Survey Agency (SA) should be notified immediately. An unannounced follow up survey visit was conducted from 10/26/15 to 10/27/15 to conduct the follow-up survey for complaint investigation (TX 00218998). An entrance conference was conducted on 10/26/15 in the conference room of the facility with the hospital delegated administrative staff. The purpose and process of the follow-up survey were discussed and an opportunity for questions was provided. An exit conference was conducted on 10/29/15 in the conference room. The hospital delegated administrative staff were in attendance. Preliminary findings of this survey were discussed and an opportunity for questions was provided.	{A 000}		

Joseph W. Rafferty — Interim CED — 11/17/15

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

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

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
450130	A. Building B. Wing	10/27/2015

Name of Facility	Street Address, City, State, Zip Code
NIX HEALTH CARE SYSTEM	414 NAVARRO, SUITE 600 SAN ANTONIO, TX 78205

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix A0115 Reg. # 482.13 LSC	Correction Completed 10/27/2015	ID Prefix A0145 Reg. # 482.13(c)(3) LSC	Correction Completed 10/27/2015	ID Prefix A0392 Reg. # 482.23(b) LSC	Correction Completed 10/27/2015
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By ____ State Agency	Reviewed By	Date:	Signature of Surveyor: [signature]	Date: 10/27/15
Reviewed By ____ CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 8/10/2015	____	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO

SOD-State Forms

Texas Department of State Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	000415	A. BUILDING: _____ B. WING _____	R-C 10/27/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NIX HEALTH CARE SYSTEM	414 NAVARRO, SUITE 600 SAN ANTONIO, TX 78205

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{X 000}	INITIAL COMMENTS Note: The State Form is an official, legal document. All information must remain unchanged except for entering the plan of correction, correction dates, and the signature space. Any discrepancy in the original deficiency citation(s) will be referred to the Office of the Texas Attorney General (OAG) for possible fraud. If information is inadvertently changed by the provider/supplier, the State Survey Agency (SA) should be notified immediately. An unannounced follow up survey visit was conducted from 10/26/15 to 10/27/15 to conduct the follow-up survey for complaint investigation (TX 00218998). An entrance conference was conducted on 10/26/15 in the conference room of the facility with the hospital delegated administrative staff. The purpose and process of the follow-up survey were discussed and an opportunity for questions was provided. An exit conference was conducted on 10/29/15 in the conference room. The hospital delegated administrative staff were in attendance. Preliminary findings of this survey were discussed and an opportunity for questions was provided.	{X 000}		

Joseph W. Rafferty — Interim CEO — 11/17/15

SOD - State Form
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Texas Department of State Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	000415	A. BUILDING: _____ B. WING _____	R-C 10/27/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NIX HEALTH CARE SYSTEM	414 NAVARRO, SUITE 600 SAN ANTONIO, TX 78205

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{Y 000}	25 TAC 134 INITIAL COMMENTS Note: The State Form is an official, legal document. All information must remain unchanged except for entering the plan of correction, correction dates, and the signature space. Any discrepancy in the original deficiency citation(s) will be referred to the Office of the Texas Attorney General (OAG) for possible fraud. If information is inadvertently changed by the provider/supplier, the State Survey Agency (SA) should be notified immediately. An unannounced follow up survey visit was conducted from 10/26/15 to 10/27/15 to conduct the follow-up survey for complaint investigation (TX 00218998). An entrance conference was conducted on 10/26/15 in the conference room of the facility with the hospital delegated administrative staff. The purpose and process of the follow-up survey were discussed and an opportunity for questions was provided. An exit conference was conducted on 10/29/15 in the conference room. The hospital delegated administrative staff were in attendance. Preliminary findings of this survey were discussed and an opportunity for questions was provided.	{Y 000}		

SOD - State Form

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

AH Form Approved
11/10/2015

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
000415	A. Building B. Wing	10/27/2015

Name of Facility	Street Address, City, State, Zip Code
NIX HEALTH CARE SYSTEM	414 NAVARRO, SUITE 600 SAN ANTONIO, TX 78205

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix Y0313 Reg. # 134.46(c)(3)(A) LSC	Correction Completed 10/27/2015	ID Prefix Y0523 Reg. # 404.154(24) LSC	Correction Completed 10/27/2015	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor: Laura Gonzalez	Date: 10/27/15
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 8/10/2015

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO

AH Form Approved
11/10/2015

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
000415	A. Building B. Wing	10/27/2015

Name of Facility	Street Address, City, State, Zip Code
NIX HEALTH CARE SYSTEM	414 NAVARRO, SUITE 600 SAN ANTONIO, TX 78205

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix X0365 Reg. # 133.41(o)(2)(B) LSC	Correction Completed 10/27/2015	ID Prefix X0794 Reg. # 133.42(a)(1) LSC	Correction Completed 10/27/2015	ID Prefix X1037 Reg. # 133.47(c)(3)(A) LSC	Correction Completed 10/27/2015
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor: Laura Gonzalez	Date: 10/27/15
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 8/10/2015

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO

Terry J. Fontenot, FACHE
Chief Executive Officer
Nix Health Care System

October 1, 2015

Larrie Collier, MPA
HFC Manager-San Antonio Zone
Patient Quality Care Unit
Texas Department of State Health Services

via email: larrie.collier@dshs.state.tx.us

Re: CCN 450130, Intake #TX00218998

Dear Mr. Collier:

Please accept the following pages as the Nix Health Care System plan of correction for deficiencies cited during our August 10, 2015 complaint survey conducted by Texas Department of State Health Services, sent by email to: larrie.collier@dshs.state.tx.us.

Please confirm receipt by return email to: terryjfontenot@nixhealth.com, when you have received these items so we may preserve for our records.

Sincerely,

Terry J. Fontenot

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

09/10/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	460130	A. BUILDING _____ B. WING _____	8/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NIX HEALTH CARE SYSTEM	414 NAVARRO, SUITE 600 SAN ANTONIO, TX 78205

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN F CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	compteTioN DATE
A 000	INITIAL COMMENTS The CMS - 2567 (Statement of Deficiencies) is an official, legal document. AU information must remain unchanged except for entering the plan of correction, correction dates and the signature space. Any discrepancy in the original deficiency citation (s) will be reported to Dallas Regional Office (RO) for referral to the Office of Inspector General (010) for possible fraud if information is inadvertently changed by the provider/supplier, the State Survey Agency (SA) should be notified immediately. An unannounced visit was conducted from 08/06/15 to 08/10/15 to conduct a survey for complaint investigation (TX 00218998). An entrance conference was conducted on 08/06/15 In the conference room of the facility with the Director of Risk Management. The purpose *and* process of the complaint survey were discussed and an opportunity for questions was provided. Complaint, TX 00218998, was substantiated with federal deficiencies cited. An exit conference was conducted on 08/10/15 in the conference room. The Director of Risk Management, the Vice President of clinical Services, the Nursing Clinical Director, and Interim Behavioral Health Administrator were in attendance. Preliminary findings of the survey were discussed and an opportunity for questions was provided.	A 000		

LABORATORY DIRECTORS OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE CEO | (xe) DATE 10-1-15

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIEFUOLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	450130	A. BUILDING _____ a.WING _____	C 08/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NIX HEALTH CARE SYSTEM	4414 NAVARRO, SUITE 600 SAN ANTONIO, TX 78205

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(xs) COMPLETION OATE
A 115	Continuation from page 1 482.13 PATIENT RIGHTS A hospital must protect and promote each patient's rights. This CONDITION Is not met as evidenced by: Based on record review and interview, the facility failed to ensure specific patient rights were protected and promoted, and implement their written policy and procedures that protect and promote each patient's rights for 1 of 1 patients (Patient #1) reviewed with a rights violation complaint. Specifically, the facility failed to ensure Patient #1's rights to be free from all forms of abuse or harassment by falling to prevent, protect, investigate, and report/respond to a sexual assault allegation made by Patient #1 against another Patient (#2); as a result of facility neglect. On 04/27/15, Patient #1 reported to the unit's Registered Nurse (RN) an allegation of sexual assault from another Patient, (#2); who had a history of inappropriate sexual behaviors. The allegation was reported to the Medical Doctor, the Nursing Manager, and local Police Department (PD). However, this allegation was not reported to the state health care regulatory agency by any facility employees, in accordance with their policy. In addition, this allegation was not thoroughly investigated by the facility for the identification of neglect and/or a corrective action plan to prevent repeat incidence in accordance with the facility's policy. Refer to A 0145 for evidence of specific findings. The effect of these deficient practices resulted in the facility's inability to meet the Condition of	A 115	**Plan for Correction, Improving Processes, and Procedure Implementation**: The facility has implemented a policy titled "Managing Inappropriate Sexual Behaviors for Inpatient Hospitalization' which describes the process for identifying and managing patients who display such behaviors and the protective measures that will be taken to ensure that patients and staff are protected from potential sexual abuse. Clinical staff will be educated on the hospital's policy titled "Managing Inappropriate Sexual Behaviors for Inpatient Hospitalization" and moving forward, staff competence will be assessed upon hire and during annual competence assessment. All Behavioral Health Hospital staff members will be re-inserviced on the hospital's policy titled "Assessment and Reporting of Abuse and Neglect" to ensure their full understanding of the hospital's policy and their responsibility for ensuring that all patients are protected from abuse, neglect, or exploitation while under the care of the hospital. **Monitoring and Tracking procedures Monitoring/Tracking Procedures**: A monitoring process has been implemented in which all cases of potential or actual inappropriate sexual behaviors are identified will be escalated up to the VP of Clinical Services to ensure that the hospital's policy for managing such behaviors is implemented to mitigate threats to surrounding patient population and staff. The medical records for such cases will be reviewed to ensure that the documentation reflects adherence to the hospital's policy to include assessment, ongoing reassessment, and treatment planning. Any observations of non-compliance with the hospital's policy will be remediated immediately. The monitoring process will commence for a minimum of 90 days to ensure that the hospital's policy and processes are hardwired. Formal reports of compliance will be reported up to the hospital's Quality Council, MEC, and Governing Body for review and immediate action, if necessary. **Responsible Person**: VP of Clinical Services or designee	October, 6, 2015 September 30, 2015

STATEMENT OF DEFICIENCIES AND *PLAN* OF CORRECTION	(X1) PROVIDEFUSUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	450130	A BUILDING _____ B. WNG _____	C 08/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NIX HEALTH CARE SYSTEM	414 NAVARRO, SUITE 600 SAN ANTONIO, TX 78205

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	0(5) COMPLETION
	Continued From page 2			
A 145	482.13(c) (3) PATIENT RIGHTS: FREE FROM ABUSE/HARASSMENT The patient has the right to be free from all forms of abuse or harassment. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure the patient's rights tr be free from all forms of abuse or harassment by failing to prevent, protect, investigate, and report/respond to an allegation of neglect in accordance with their policy, for 1 of 1 patients reviewed (Patient #1) with a complaint allegation of sexual assault against another patient (Patient #2). On 04/27/15, Patient #1 reported to the unit's Registered Nurse (RN) an allegation of sexual assault from another Patient, (#2); who had a history of Inappropriate sexual behaviors. The allegation was reported to the Medical Doctor, the Nursing Manager, and local Police Department (PD). However, this allegation was not reported to the state health care regulatory agency by any facility employees in accordance with their policy. In addition, this allegation was not thoroughly investigated by the facility for the identification of neglect and/or a corrective action plan to prevent repeat Incidence; in accordance with the facility's policy. This deficient practice could affect the prevention of possible unidentified abuse, neglect, or mistreatment for all patients in the facility; by compromising their safety. Findings Included:	A145	**Plan for Correction, Improving Processes, and Procedure Implementation:** The facility has implemented a policy titled "Managing Inappropriate Sexual Behaviors for Inpatient Hospitalization' which describes the process for identifying and managing patients who display such behaviors and the protective measures that will be taken to ensure that patients and staff are protected from potential sexual abuse. Clinical staff will be educated on the hospital's policy titled "Managing Inappropriate Sexual Behaviors for Inpatient Hospitalization" and moving forward, staff competence will be assessed upon hire and during annual competence assessment. All Behavioral Health Hospital staff members will be re-inserviced on the hospital's policy titled "Assessment and Reporting of Abuse and Neglect" to ensure their full understanding of the hospital's policy and their responsibility for ensuring that all patients are protected from abuse, neglect, or exploitation while under the care of the hospital. **Monitoring and Tracking procedures Monitoring/Tracking Procedures:** A monitoring process has been implemented in which all cases of potential or actual inappropriate sexual behaviors are identified will be escalated up to the VP of Clinical Services to ensure that the hospital's policy for managing such behaviors is implemented to mitigate threats to surrounding patient population and staff. The medical records for such cases will be reviewed to ensure that the documentation reflects adherence to the hospital's policy to include assessment, ongoing reassessment, and treatment planning. Any observations of non-compliance with the hospital's policy will be remediated immediately. The monitoring process will commence for a minimum of 90 days to ensure that the hospital's policy and processes are hardwired. Formal reports of compliance will be reported up to the hospital's Quality Council, MEC, and Governing Body for review and immediate action, if necessary. **Responsible Person**: VP of Clinical Services or designee	October 6, 2015 September 30, 2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(Xi} PROVIDERISUPPLIEWCLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	450130	A. BUILDING _____ B. WING _____	C 08110/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NIX HEALTH CARE SYSTEM	4414 NAVARRO, SUITE 800 SAN ANTONIO, TX 78205

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(xs) COMPLETION DATE
A 145	Continued From page 3 Review of Patient #1's Complaint Fcirm dated 05/15/15, indicated the following in part: On 04/27/15 at approximately 11:30 AM, Patient #1 was admitted to the facility's "Psychiatric Emergency Services (PES) unit and received medication to help her sleep and calm down. Patient #1 reported shortly after she received the medications; she was asleep in her bed when she "felt someone touching my vagina and butt. I felt a hard pressure. I jumped up and another male patient (#2j jumped out from under my covers." Patient #1 stated she went to find a staff member (Mental Health Worker-A), to report what had happened. Patient #1 indicated she noticed her entire "crotch area [paper gown] was torn exposing her "vagina and butt." Patient #1 indicated the facility staff called the Police Department (PD) for Patient #1 to make a report. Patient #1 reported the staff apologized to her for the incident; "but they had an emergency on another floor and they were short staffed, so every staff member had left." Patient #1 indicated she was "so upset and scared; so they gave me more coeds to put me to sleep." Patient #1 stated the facility had done nothing more to help her; there were no witnesses but she be'ieved there were cameras in the hall. Patient #1 stated she found out that Patient #2 had done this before and the Police Officer who responded stated that "he (Patient #21 has a history of doing this, why was he unsupervised?" Review of the facility's Policy titled, Abuse Reporting-External and Internal, last reviewed January 2012 revealed the following definitions: Psychological Abuse Included; humiliation and harassment.	A 145		

STATEMENT OF DEFICIENCIES AN PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREETADDRESS, CITY, STATE, ZIP CODE
NIX HEALTH CARE SYSTEM	414 NAVARRO, SUITE 600 SAN ANTONIO, TX 70205

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTI N SH ULD BE CROSS•REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION
A 145	Continued From page 4 Sexual Abuse included: sexual harassment, sexual coercion, and sexual assault. Review of the facility's Policy titled, Assessment and Reporting of Abuse and Neglect, last reviewed February 2013 revealed Neglect included the failure to provide for one's self the goods or services including medical services, which are necessary to avoid physical or emotional harm or pain or the failure of a caretaker to provide the goods or services. The policy Indicated the facility "prohibits neglect, mental or physical abuse or misappropriation of property, of patients by staff, visitors, or other patients." The facility "will report aildgations and release information to the proper authorities, according to federal regulations, state speciifc rules and regulation and (facility] practice guidelines." Further review of the policy indicated, in part 1. Reporting allegations of abuse and/or neglect occurring while the patient is under the care in the facility: All alleged violations concerning abuse and neglect while the patient is under the care of the facility will be reported to the Compliance Officer or designee, who will advise the on-call administrator/designee. As appropriate, the facility will report the incident to appropriate state, federal and protective/regulatory agencies, and/or law enforcement agencies and conduct an internal investigation within a maximum of five working days of the incident The Texas Department of state Health Services (DSHS) is the regulatory body for reporting concerns of hospitals, psychiatric hospitals (Including private psychiatric facilities), and various other medical facilities.	A 145		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIERICLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY. STATE, ZIP CODE
NIX HEALTH CARE SYSTEM	414 NAVARRO, SUITE 600 SAN ANTONIO, TX 78205

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A 145	Continued From page 5 2. Investigations are always prompt comprehensive and responsive to the situation, well conducted, and contain founded conclusions. The investigation may include, but are not limited to the following: -Interviews conducted with Individuals having first-hand knowledge of the incident -Follow-up resolution -Corrective action plan to prevent repeat incidence. -Reports made to appropriate state health care regulatory agency. Review of the facility's Original Event report dated **04/27/15** at 12:15 PM completed by the unit RN revealed Patient #1 reported, "She was lying in bed asleep, when she felt Patient [#2] putting pressure around *her* buttocks area, and then touching her perinea! area. Patient [#1] reported sitting up in bed shock and scared, and found Patient [#2] was up In her face with his finger to his mouth telling her to be quiet not to tell. She found her paper scrub button Corned on the outer left side. MD [Medical Doctor], Nurse Manager notified, Patient made a police comrli[illegible] ?D interviewed Patient #1 and accused, Patient #2. "Patient visible distraught, but no other physical problems noted at this time." Further review of the Original Event Indicated the Event was documented as "Attempted Rape/Rape/Sexual Assault." Factors included; "Unit busy code greens called on other unit, and high acute of unit" The Original Event report did not include any documentation that this allegation was reported to the state health care regulatory agency by any facility employees, in accordance with the facility's policy. The Original Event report	A 145		

STATEMENT OF DEFICIENCIES AND PI AN OF CORRECTION	(XI) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	450130	A BUILDING _____ B. WING _____	C 0811012015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY. STATE, ZIP CODE
NIX **HEALTH CARE SYSTEM**	**414** NAVARRO, SUITE GOO **SAN ANTONIO, TX 18205**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVEACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	OcP COMPLETION DATE
A 145	Continued From page 8 did not Include documentation that this allegation was thoroughly investigated by the facility for the Identification of neglect and/or a corrective action plan to prevent repeat incidence; in accordance with the facility's policy. The Compliance Ofifcer/Director of Risk Management (RM) acknowledged receipt of the Original Event report dated 04/27/15 at 12:15 PM electronically on 05/06/15 documenting Patient #1 made a Police Report. Review of the local PD report dated 04/27/15 at 12:45PM revealed Patient #1 wanted to report that, "she was a sleep In her room, when she awaken and felt pressure around her buttock and vaginal area. When she fully awaken, she observed [Patient #2] in bed with her." Patient #1 further stated that Patient #2 told her "Don't tell anyone," before he left her room. Patient #1 did not feel Patient #2 penetrate her at any time, but the hospital [paper gown] pajama that she was wearing had a tear between the leg area. Patient #2 denied being in bed with Patient #1, or touching her. The report was deemed as "Disorderly Conduct" and Patient #1 was advised to contact the special victim's unit to4ile charges against Patient #2. "The Hospital staff was advised to monitor [Patient #2's] movement more closely." Record review of the medical record of Patient #1 revealed she was a 37 year-old female admitted to the psychiatric facility on 04/27/18 at 0830 under Emergency Detention (ED) when she cut her wrist and called a friend to call Police. Patient #1 has a history of Depression with Anxiety. Further review of Patient #1's permanent records revealed no documentation following the sexual	A 145		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(xi) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREETADDRESS, CITY, STATE, ZIP CODE
NIX HEALTH CARE SYSTEM	414 NAVARRO, SUITE 600 SAN ANTONIO, TX 78205

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC1 EN11FYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X1 compLETioN DATE
A 145	t Continued From page 7 assault allegation that she made on 04/27/15 against Patient #2. There was no documentation In her record that she received a physical and/or psychological assessment following her allegation on 04/27/15. There was a Telephone Physician Order (PO) on 04/27/15 at 12:30 PM (following the allegation) for Ativan (an anti-anxiety) 2 milligrams by mouth "now" without documentation of the reason for the emergency medication. The only documentation in Patient #1's record regarding her allegation against Patient #2 was a Behavioral Team Progress Note dated 05/01/15 at 12:25 completed by Licensed Social Worker- A that indicated "Patient discussed being sexually assaulted by Patient [#2] in the [facility's] PES unit. Review of Patient #1's Daily Observation Notes for 04/27/15 revealed the following: At 11:30-MHW-A documented 10 (1=On unit, and 0=Quiet/Calm). At 11:45-MHW-A documented 1B (On unit, and B=Irt Bed Awake). At 12:00-MHW-A documented 1BA On unit, In Bed Awake, and A=agitated/restlesg). At 12:15 MHW-A documented 1BA. At 12:30, 12:45, 13:00, 13:15, 13:30, and 13:45-MHW-A documented 1A (On Unit and agitated/restless). Record review of Patient #2's medical records revealed the following: Patient #2's Psychiatric Evaluation dated 04/24/15 revealed he was a 30 year old male admitted to the PES unit on 04/24/15 with a history of schizoaffective disorder and traumatic brain injury (TBI). Patient #2 was admitted on an ED basis with a history of aggressive behaviors	A 145		

STATEMENT OF DEFICIENCIES AN PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	450130	A. BUILDING _____ B. WING _____	C 0E01012015

NAME OF PROVIDER OR SUPPLIER	STREETADDRESS, CITY, STATE, ZIP CODE
NIX HEALTH CARE SYSTEM	414 NAVARRO, SUITE 600 SAN ANTONIO, TX 78205

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A 145	Continued From page 8	A 145		

requiring emergency medications to calm him. Patient #2 had recently been discharged from this facility 4-5 weeks prior and has had multiple inpatient treatment episodes over the years (7 inpatient admissions in the previous 5 months). Patient #2 was documented with a known history of aggression and a "history of inappropriate sexual behavior on the unit (masturbating)."

Patient #2 had documented borderline intellectual functioning with poor insight, poor judgment, and poor impulse control.

A Behavioral Nursing Shift Assessment completed by the unit RN on 04/27/15 at 18:08 that Patient #2 was found by a female patient touching on her body while she was asleep in bed. MD, and Nurse Manager notified.

A Telephone PO dated 04/27/15 at 2015 for Patient #2 to be transferred to a higher acuity; sister facility.

A Behavior Team Progress noted dated 04/27/15 at 1855 revealed Patient #2 was transferred to a sister facility by the Sheriff's Department.

Review of the facility's Incident Event dated 04/27/15 at 11:37 AM confirmed a Code Green was called for another Patient (#3] in the Child/Adolescent Unit requiring Restraints/Seclusion. Patient #3 required physical restraint at 11:36 AM, and emergency medications at 11:96 AM. Patient #3 was released from restraint at 12:26 PM. This Code Green occurred during the same time frames of Patient #1's allegation on 04/27/15.

Review of the facility's Policy titled, Psychiatric

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	450130	BUILDING _____ B. WING _____	C 08/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NIX HEALTH CARE SYSTEM	414 NAVARRO, SUITE 600 SAN ANTONIO, TX 76205

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVEACTIDN SHOUL BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	ots) COMPLETION DATE
A 145	Continued From page 9 Emergencies-Code Green, last reviewed January 2012 revealed a Code Green was a Psychiatric Emergency. Code Green will be implemented by any unit personnel in the event of unmanageable behavior of an individual to prevent harm to that individual, patients, hospital personnel and/or others the general hospital area. D. Individuals responding to Code Green will meet in announced area. Available personnel is necessary to control atmosphere through a show of strength and caring or to assist in physical management. Interview on 08/06/15 at 12:35 PM with the PES unit RN revealed she completed Patient #1's admission assessment to the PES unit on 04/27/15, The unit RN indicated Patients were provided with paper scrubs to wear without other undergarments. The unit RN stated that on 04/27/15 at approximately 11:30 AM to 12:00 PM, "Code Greens" were going on; and "staff were busy". The unit RN stated there was a Code Green on another unit (child/adoles,n0 and a Code Green was called in the lobby;` due to a patient needing to be "put in a [restraint] chair' because they were tearing up the lobby. The unit RN stated she left the unit to respond to the Code Green in the other unit (child/adolescent) and when she arrived; there was another RN responding, so she went to the Code Green in the lobby because they needed an RN to assist with "putting the patient in the [restraint] chair." The unit RN stated she returned to the PES unit following the Code Greens to "something else going on at the end of the unit" that she responded to. The unit RN stated she could not remember if it was LVN-A or LVN-B working on 04/27/15; but that she thought the LVN stayed back in the PES unit when she left *and*	A 145		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(Xi) PROVIDER/SUPPUERICLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	450130	A BUILDING _____ B. WING _____	C 08110/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NIX HEALTH CARE SYSTEM	414 NAVARRO, SUITE 600 SAN ANTONIO, TX 78205

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH EFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE EFICIENCY)	(55) comp:xi:0N DATE
A 145	Continued From page 10 responded to the two Code Greens. The unit RN stated she was notified that during the Code Greens Patient #2 went into Patient #1's bedroom; and Patient #1 made an allegation of sexual assault. The unit RN stated she spoke with Patient #1 who reported that she was asleep in her bedroom and "she felt pressure" causing her to awake to Patient #2 touching her In the buttock and perinea' area. The unit RN stated that Patient #1's paper pants were "torn on the side." The unit RN stated the local PD was called. The unit RN stated she spoke to Patient #2 and he said, "1 touched her, but didn't do anything else." The unit RN stated he admitted that he "touched her and ripped her paper pants." The unit RN stated that Patient **#2** knew that the unit was "chaotic" and knew what Code Green meant; and that is when he "took advantage" of the situation. The unit RN stated she believed that Patient #2 sexually assaulted Patient #1 given the facts, and his own admission. The unit RN stated she notiifed the MD, Social Worker, and Nursing Manager of the allegation. The unit RN Indicated she documented the sexual assault 61legation made by Patient #1 on the Facility's Event Report; however, confirmed she did not document the sexual assault allegation in Patient #1's record following the incident. The unit RN stated she offered for Patient #1 to have a Sexual Assault Nurse Examination (SANE) completed at another facility If she wanted; but Patient #1 declined, stating she did not believe Patient #2 actually raped her. Interview on 08/06/15 at 04:45 PM with MHW-A revealed she was the only MHW working on 04/27/15 in the PES unit; along with the unit RN and a Licensed Vocational Nurse (LVN). MHW-A	A 145		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	460130	A. BUILDING _____ BAYING _____	C 06/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE. ZIP CODE
NIX HEALTH CARE SYSTEM	44 14 NAVARRO, SUITE 600 SAN ANTONIO, TX 78205

(X4)10 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE EFICIENGY)	(x5) COMPLETION DATE
A 145	Continued From page 11 stated she was pulled to the PES unit at 9:15 AM and was unfamiliar to the PES unit; but was told by the leaving MHW to "watch it" for Patient #2, however, she did not know the specific reason why. MHW-A stated the females were assigned rooms on one side, and males on the other side. MHW-A stated during the morning on 04/27/15 at approximately 11:30 AM-12:00 PM it was a "hectic/busy" day with "Code Green's being called." MHW-A stated that security'was usually on the PES unit; but on 04/27/15 at the time of the allegation; "security could not be found." MHW-A stated on 04/27/15 at around 11:30-12:00 PM she stayed in the unit when the Code Greens were called and was "getting something out of the supply closet." MHW-A indicated the unit RN "responded to the Code Green" leaving the unit; telling her she [unit RN] would be back. IVIHIN-A did not remember if LVN-A or LVN-B was working on 04/27/15; but further staled she did not remember any LVN being in the unit during the time of the allegation made by Patient #1. MHVV-A stated shortly after this Patient #1 "lfagged her (MHW-Al down" to her bedroom, and into the restroom of the bedroom where she reported that Patient #2 came into her room and touched her buttocks and vaginal area while she was sleeping in her bed. MHW-A stated that Patient #1's gown was torn around the buttock area and she offered to call the local PD for Patient #1 to make a report. MHW-A stated she then reported the incidenVailegation to the unit RN. MHW-A stated she was later told that Patient #2 had been an inpatient to the facility many times before, and he "knows the system; knows what Code Green means." MHW-A stated she had seen Patient #2 "walking out of her [Patient #1] room a few times" and further stated "right before she lfagged me down, he had	A 145		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NIX HEALTH CARE SYSTEM	414 NAVARRO, SUITE 500 SAN ANTONIO, TX 78205

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A 145	Continued From page 12 walked out of her room". MHW-A indicated she told Patient #2 "not to go in to other people's rooms." MHW-A confirmed she had not documented the allegation reported by Patient #1 against Patient #2; but that she "told (unit RN]." interview on 08/10115at 1:20 PM with Patient #1 revealed on 04/27/15 at approximatyy 11:30-11:45 AM she was in her assiOned bedroom sleeping after she received multiple medications following her admission. Patient #1 stated she awoke after she "felt pressur'ein her buttock and vaginal area. Patient #1 stated that Patient #2 was present telling her not to tell anyone. Patient #1 stated that she noticed her paper pants were ripped and she was not actually aware what all Patient #2 actually did because she "was conked out" after taking multiple medications. Patient #1 stated she knows he touched her because that was what woke her up. Patient #1 stated she was very upset, "freaked out," and asked the MD for an "AIDS" test. Patient #1 stated the unit RN indicated to the nursing staff (LVN) to "give her more meds" because she was "upset, crying, and freaking out." Patient #1 stated she then received the Ativan for her anxiety, to "help me calm down." Patient #1 stated the local PD came and she made a report. Patient #1 stated she was told by the unit RN that "Code Green's" were called and "everyone had to leave the unit" which allowed the opportunity for Patient #2 to go into her room unsupervised. Interview on 08/10/15 at 2:20 PM with Security Guard-A revealed he was employed by the facility to maintain security and the safety of patients. The Security Guard-A stated Patient #2 had a	A 145		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(XI) PROVIDERISUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP C DE
NIX HEALTH CARE SYSTEM	414 NAVARRO, SUITE 600 SAN ANTONIO, TX 78205

04) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEbED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVEACTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETlON DATE
A 145	Continued From page 13 history of inappropriate sexual behavior of "masturbating in front of females." The Security Guard-A stated he assisted with "viewing the video" footage for evidence following the allegation on 04/27/15 made be Patient #1 against Patient #2. The Security Guard stated the video footage from 04/27/15 showed a total of "four times" that Patient #2 went Into Patient #1's room; and the last time Patient #2 came out of Patient #1's room; she was observed to come out of the room a few minutes later. The Security Guard stated that Patient #2 had already been assigned to the front "seclusion room" of the PES unit as his bedroom due to his history of masturbating. The Security Guard stated on the video footage Patient #2 could be seen coming from his room; "looking side to side" down the hallway, and then going into Patient #1's room. The Security Guard stated that female and male patient rooms were separated and that Patient #2 was not supposed to be going into Fiatient #1's room for any reason. Interview on 08/10/15 at 2:50 PM with MD-A revealed ***he*** was notified of Patient #1's sexual assault allegation against Patient #2 on 04/27/15. MD-A stated he discussed with Patient #1 the option of a "Rape Kit" but she "declined." MD-A stated he understood the allegation made by Patient #1 to be "only touching with no penetration." MD-A stated that Patient #1 was "distressed" about the incident and he ordered Ativan for Patient #1's anxiety following the incident. MD-A stated Patient #1 had already been distressed emotionally because of her ED inpatient admission; and really did not even want to take the Ativan. MD-A stated he recalled there was a Code Green called where staff left the unit In response to the Code Green; which letf less	A 145		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECT! N	(XI) PROVIDER/SUPPLIERJCUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREETADDRESS, CITY, STATE, ZIP CODE
NIX HEALTH CARE SYSTEM	414 NAVARRO, SUITE 500 SAN ANTONIO, TX 78206

(X4) to PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION GATE
A 145	Continued From page 14	A 145		

staffing in the unit. MD-A confirmed that he did not document In Patient #1's records his contact or discussion with Patient #1 following her allegation.

Interview on 08/10/15 at 3:00 PM with the facility's Risk Manager (RM) Indicated that she was aware of the alleged sexual assault allegation made by Patient #1 on 04/27/15 against Patient #2[1]; however, she had not been notified until 05/06/15 via the facility's Incident/Event electronic system because there had not been any harm documented in order to elevate the notification. The RM stated the staffing ratio on the PES unit was 1 staff to 4 patients. The RM indicated on 04/27/15 the patient census in the PES unit was 11; requiring 3 staff. The RM stated the first required staff is an RN, and then second could be a LVN, and/or MHW. The RM confirmed for 11 patients the required staffing would be 3. The RM stated the PES unit was to always have a licensed nurse present and available in the unit. The RM confirmed that she had not reported the sexual assault allegation made by Patient #1 on 04/27/15 against Patient #2 to the state health care regulatory agency, Department of State Health Services (DSHS); which was determined

to have occurred as a result of Insufficient staffing in the PES unit during episodes of Code Green's. The RM further confirmed the facility had not completed a thorough investigation with documented findings specific to this allegation for the determination of Neglect and/or a corrective action plan to prevent repeat incidence; in accordance with the facility's policy. The RM stated she had not seen or viewed the video footage following this allegation due to the video being unavailable after 05/06/15; following her

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(XI) PROVIDER/SUPPLIEFUCLIA IDENTIFICATION NUMBER!	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREETAI)DRESS, CITY, STATE, ZIP CODE
NIX HEALTH CARE SYSTEM	414 NAVARRO, SUITE SOO SAN ANTONIO, TX MOE

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	4X5) COMPLETION DATE
A 145	Continued From page 15 electronic notification. Interview on 08/10/15 at 3:15 PM with Licensed Social Worker (LSW)-A stated she assisted Security Guard-A in viewing the video footage on 04/27/15 after Patient #1 made a sexual assault allegation against Patient #2. LSW-A stated that during the allegation on 04/27/15; Patient #2 could be seen on the camera "looking both ways" and then would go into Patient #1's bedroom. LSW-A st ted they were able to count this event occurring a "couple of limes" where Patient #2 would go into Patient #1's bedroom and remain there "a couple of minutes" each time. LSW-A stated she saw on the video where MHW-A had been in the "Patient evaluation room " during these time periods; where a supply closet *was* located. LSW-A stated Patient #2 had a history of "exposing his self, public masturbatiOn, and talks sexually to other women." LSW-A stated that Patient #2 has publically masturbated in front of her during an assessment interview. Interview on 08/10/15 at 4:15 PM with LVN-A stated he was present and worked the PES unit on 04/27/15. LVN-A stated that on 04/27/15 there were Code Greens called on another unit, and in the facility's lobby about the same time. LVN-A stated he responded to the Code Green in the lobby to assist due to a "fight." LVN-A indicated he had left the unit for approximately 15 minutes. Interview on 08/10/15 at 4:30 PM with the Vice President (VP) of Clinical Services confirmed that she was notified of the sexual allegation made by Patient #1 against Patient #2 on 04127/15;	A 145		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NIX HEALTH CARE SYSTEM	414 NAVARRO, SUITE 600 SAN ANTONIO, TX 78205

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC I ENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	9(?) COMPLETION DATE
A 145	Continued From page 16 however, she had not been notified until 05/06/15 via the facility's Incident/Event electronic system because there ***had*** not been any harm documented in order to elevate the notification. The VP of Clinical Services indicated that an 04/27/15 the Nursing Clinical Directii'r (Nurse Manager) had been notified immediately following Patient #1's allegation and she had not obtained information that indicated Patient #1's allegation had occurred due to insufifcient staffing in the PES unit when Code Green's had been called; leaving the unit without a RN available. The VP of Clinical Services stated that the unit RN was not supposed to leave the unit and there should always be a Licensed Nurse in the unit during a Code Green; that "it is a judgement call." The VP of Clinical Services stated she had not ***seen*** or viewed the video footage following this allegation due to the video being unavailable after 05/06/15; following her electronic notification. Interview on 08/10/15 at 4:40 PM with the Nursing Clinical Director (Nurse Manager) stated she was immediately notified by the PES unit RN on 04/27/15 of Patient #1's sexual allegation against Patient #2. The Nursing Clinical Director Indicated she "separated" the Patients, talked to both of them, and Patient #1 saw the Doctor. The Nursing Clinical Director stated she spoke to the unit RN about the allegation but pad not been notified or received information that the RN and LVN had left the PES unit to respond to Code Greens which letf the unit without a RN and/or licensed nurse available. The Nursing Clinical Director stated she had not seen or viewed the video footage following this allegation.	A 145		
A 392	482.23(b) STAFFING AND DELIVERY OF CARE	A 392		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE. ZIP CODE
NIX HEALTH CARE SYSTEM I	414 NAVARRO, SUITE 600 SAN ANTONIO, TX 78205

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	Co) COMPLETION DATE
A 392	Continued From page 17 The nursing service must have adequate numbers of licensed registered nurses, licensed practical (vocational) nurses, and other personnel to provide nursing care to all patients as needed. There must be supervisory and staff personnel for each department or nursing unit to ensure, when needed, the immediate availability of a registered nurse for bedside care of any patient. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure there were sufficient numbers of licensed registered nurses (RN), licensed vocational nurses (LVN), and other personnel immediately available at all times in the unit to ensure the provision of care and supervision for patients {Patient #1 and #2) as required resulting in an allegation of neglect. Specifically, on 04/27/15, Patient #1 reported to the unit's Registered Nurse (RN) an allegation of sexual assault from another Patient (#2), who had a history of inappropriate sexual behaviors, after the unit RN and LVN left their assigned unit to respond to "Code Green's" (psychiatric emergencies) in other units/areas of the facility. This deficient practice affected Patient #1's provision of care and compromised her safety resulting In allegation of Neglect due to insufficient staffing in the unit. Findings Included: Review of Patient #1's Complaint Form dated 05/15/15 indicated the following in part: On 04/27/15 at approximately 11:30 AM Patient #1 was admitted to the facility's "Psychiatric	A 392	**Plan for Correction, Improving Processes, and Procedure Implementation**: To mitigate the depletion of hospital staff on the BHU due to Code Green responses in the hospital and to ensure the protection of all patients on the unit, a staff member will be posted in each patient care area of the Behavioral Health Hospital until the Code Green incident is resolved. Hospital Staff will be in-serviced on their roles during Code Green incidents with a specific emphasis on the expectation that all patient care areas be manned throughout the entirety of the incident. Staff competence will be assessed upon hire and annually thereafter. **Monitoring/Tracking Procedures**: Observations of non-compliance will be remediated immediately. Formal reports of compliance will be reported up to the hospital's Quality Council, MEC, and Governing Body for review and immediate action, if necessary. **Responsible Person**: VP of Clinical Services or designee	September 30, 2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	fX1) PR VIDER/SUPPLIERICLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	450130	A. BUILDING _____ B. WING _____	C 08/1012016

NAME OF PROVIDER OR SUPPLIER	STREETADDRESS, CITY, STATE, ZIP CODE
NIX HEALTH CARE SYSTEM	4414 NAVARRO, SUITE 600 SAN ANTONIO, TX 78205

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A 392	Continued From page 18 Emergency Services (PES) unit and.received medication to help her sleep and calm down. Patient #1 reported shortly after she received the medications; she was asleep in her bed when she "felt someone touching my vagina and butt I felt a hard pressure. I jumped up and another male patient (#2) jumped out from under my covers." Patient #1 stated she went to find a staff member (Mental Health Worker-A), to report what had happened. Patient #1 indicated she noticed her entire "crotch area [paper gown] was torn exposing her "vagina and butt." Patient #1 indicated the facility staff called the Police Department (PD) for Patient #1 to make a report. Patient #1 reported the staff apologized to her for the incident; "but they had an emergency on another floor and they were short staffed, so every staff member had lefr Patient #1 indicated she was 'sapset and scared; so they gave me more meds to put me to sleep." Patient #1 stated the facility had done nothing more to help her; there were no witnesses but she believed there were cameras in the hall. Patient #1 stated she found out that Patient #2 had done this before and the Police Officer who responded stated that; "he [Patient #2] has a history of doing this; why was he unsupervised?" Review of the facility's Policy titled, Abuse Reporting-External and internal, last reviewed January 2012 revealed the following definitions: Psychological Abuse included; humiliation and harassment. Sexual Abuse included; sexual harassment, sexual coercion, and sexual assault. Review of the facility's Policy titled, Assessment and Reporting of Abuse and Neglect, last reviewed February 2013 revealed Neglect	A 392		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREETADDRESS, CITY, STATE. ZIP CODE
NIX HEALTH CARE SYSTEM	414 NAVARRO, SUITE 600 SAN ANTONIO, TX 78205

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A 392	Continued From page 19 included the failure to provide for one's self the goods or services Including medical services, which are necessary to avoid physical or emotional harm or pain or the failure of a caretaker to provide the goods or services. The policy indicated the facility "prohibits neglect, mental or physical abuse or misappropriation of property, of patients by staff, visitors, or other patients." The facility "will report allegations and release information to the proper authorities, according to federal regulations, state specific rules and regulation and [facility] practice guidelines." Review of the facility's Original Event report dated 04/27/15 at 12:15 PM completed by the unit RN revealed Patient #1 reported, "She was lying in bed asleep, when she felt Patient [#2] putting pressure around her buttocks area, and then touching her perineal area. Patient] #1] reported sitting up in bed shock and scared, and found Patient *(#21* was up in her face with his finger to his mouth telling her to be quiet not to tell. She found **her paper** scrub button tomel on the outer left side. MD [Medical Doctor], Nurge Manager notified, Patient made a police complaint." PD interviewed Patient #1 and accused, Patient #2. "Patient visible distraught, but no other physical problems noted at this time." Further review of the Original Event indicated the Event was documented *as* "Attempted Rape/Rape/Sexual Assault." Factors included; "Unit busy code greens called on other unit, and high acute of unit." Record review of the medical record of Patient #1 revealed she was a 37 year-old female admitted to the psychiatric facility on 04/27/15 at 0830	A 392		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER1SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NIX HEALTH CARE SYSTEM	414 NAVARRO, SUITE 600 SAN ANTONIO, TX 78205

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A 392	Continued From page 20 under Emergency Detention (ED) when she cut her wrist and called a friend to call Police. Patient #1 has a history of Depression with Anxiety. Further review of Patient #1's permanent records revealed no documentation following the sexual assault allegation that she made on 04/27/15 against Patient #2. There was no documentation in her record that she received a physical and/or psychological assessment following her allegation an 04/27/15. There was a Telephone Physician Order (PO) on 04/27/15 at 12:30 PM (following the allegation) for Ativan (an anti-anxiety) 2 milligrams by mouth "now" without documentation of the reason for the emergency medication. The only documentation in Patient #1's record regarding her allegation against Patient #2 was a Behavioral Team Progress Note dated 05/01/15 at 12:28 completed by Licensed Social Worker- A that Indicated "Patient discussed being sexually assaulted by Patient [#2] In the [facility's) PES unit. Review of Patient #1's Daily Observation Notes for 04/27/15 revealed the following: At 11:30-MHW-A documented 14 (1=On unit, and OrQuiet/Calm). At 11:45-MHW-A documented 1B (On unit, and B=In Bed Awake). At 12:00-MHW-A documented IBA (On unit, In Bed Awake, and A=agitated/restless). At 12:15 MHW-A documented 1 BA. At 12:30, 12:45, 13:00, 13:15, 13:30, and 13:45-MHW-A documented IA (On Unit and agitated/restless). Record review of Patient #2's medical records revealed the following:	A 392		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(Xi) PROVIDER/SUPPLIERICLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY. STATE. ZIP CODE
NIX HEALTH CARE SYSTEM	414 NAVARRO, SUM 600 SAN ANTONIO, TX 78205

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A 392	Continued From page 21' Patient #2's Psychiatric Evaluation dated 04/24/15 revealed he was a 30 year old male admitted to the PES unit on 04/24/15 with a history of schizoaffective disorder and traumatic brain injury (TBI). Patient #2 was admitted on an ED basis with a history of aggressive behaviors requiring emergency medications to calm him. Patient #2 had recently been discharged from this facility 4-5 weeks prior and has had multiple inpatient treatment episodes over the years (7 inpatient admissions in the previous,5 months). Patient #2 was documented with a known history of aggression and a "history of Inappropriate sexual behavior on the unit (masturbating)." Patient #2 had documented borderline intellectual functioning with poor insight, poor Judgment, and poor impulse control. A Behavioral Nursing Shift Assessment completed by the unit RN on 04/27/15 at 18:08 that Patient #2 was found by a female patient touching on her body while she was asleep in bed. MD, and Nurse Manager notified. A Telephone PO dated 04/27/15 at 2015 for Patient #2 to be transferred to a higher acuity; sister facility. A Behavior Team Progress noted dgted 04/27/15 at 1855 revealed Patient #2 was transferred to a sister facility by the Sheriff's Department. Review of the facility's Incident Event dated 04/27/15 at 11:37 AM confirmed a Code Green was called for another Patient [#3] in the Child/Adolescent Unit requiring Restraints/Seclusion. Patient #3 required physical restraint at 11:36 AM, and emergency medications at 11:46 AM. Patient #3 was	A 392		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NIX HEALTH CARE SYSTEM	414 NAVARRO, SUITE 000 SAN ANTONIO, TX 70205

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A 392	Continued From page 22 released from restraint at 12:26 PM. This Code Green occurred during the same time frames of Patient #1's allegation on 04/27/15. Review of the facility's Policy titled, Psychiatric Emergencies-Code Green, last reviewed January 2012 revealed a Code Green was a Psychiatric Emergency. Code Green will be implemented by any unit personnel in the event of unmanageable behavior of an individual to prevent harm to that individual, patients, hospital personnel and/or others the general hospital area. D. Individuals responding to Code Green will meet In announced area. Available personnel is necessary to control atmosphere through a show of strength and caring or to assist in physical management. Interview on 08/08/15 at 12:35 PM with the PES unit RN revealed she completed Patient #1's admission assessment to the PES unit on 04/27/15. The unit RN indicated Patients were provided with paper scrubs to wear without other undergarments. The unit RN on 04/27/15 at approximately 11:30 AM to 1 2:00 PM, "Code Greens" were going on; and "staff were busy". The unit RN stated there was a Code Green on another unit (child/adolescent) and a Code Green was called In the lobby; due to a patient needing to be "put in a [restraint] chair" because they were tearing up the lobby. The unit RN stated she left the unit to respond to the Code Green in the other unit (child/adolescent) and when she arrived; there was another RN responding, so she went to the Code Green in the lobby because they needed an RN to assist with "putting the patient in the [restraint] chair." The unit RN stated she returned to the PES unit following the Code Greens to "something else	A 392		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PR VIDEFU3UPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE. ZIP CO E
NIX HEALTH CARE SYSTEM	414 NAVARRO, SUITE 500 SAN ANTONIO, TX 78205

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A 392	Continued From page 23 going on at the end of the unit" that she responded to. The unit RN stated she could not remember if it was LVN-A or LVN-B working on 04/27/15; but that she thought the LVN stayed back in the PES unit when she left and responded to the two Code Greens. The unit RN stated she was notified that during the Code Greens Patient #2 went into Patient #1's bedroom; and Patient #1 made an allegation of sexual assault. The unit RN stated she spoke with Patient #1 who reported that she was asleep in her bedroom and "she felt pressure" causing *her* to awake to Patient #2 touching ter in the buttock and perinea! area. The unit RN stated that Patient #1's paper pants were "torn on the side." The unit RN stated the local PD was called. The unit RN stated she spoke to Patient #2 and he said, "I touched her, but didn't do anything else." The unit RN slated he admitted that he "touched her and ripped her paper pants." The unit RN stated that Patient #2 knew that the unit was "chaotic" and knew what Code Green meant; and that is when he "took advantage" of the situation. The unit RN slated she believed that Patient #2 sexually assaulted Patient #1 given the facts, and his own admission, The unit RN stated she notified the MD, Social Worker, and Nursing Manager of the allegation. The unit RN indicated she documented the sexual assault allegation made by Patient #1 on the facility's Event Report; however, confirmed she did not document the sexual assault allegation in Patient #1's record following the incident. The unit RN stated she offered for Patient #1 to have a Sexual Assault Nurse Examination (SANE) completed at another facility if she wanted; but Patient #1 declined, stating she did not believe Patient #2 actually raped her. I	A 392		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	450130	A. BUILDING _____ B. WING _____	C 08/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NIX HEALTH CARE SYSTEM	414 NAVARRO, SUITE GOO SAN ANTONIO, TX 78205

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE/ACTION SHOULD BE CROSS-REFERENCED TO *THE* APPROPRIATE DEFICIENCY)	txs) COMPLETION DATE
A 392	Continued From page 24 Interview on 08/06/15 at 04:45 PM with MHW-A revealed she was the only MHW w9king on 04/27/15 in the PES unit; along with the unit RN and a Licensed Vocational Nurse (LVN). MHW-A stated she was pulled to the PES unit at 9:15 AM and was unfamiliar to the PES unit; but was told by the leaving MHW to "watch it" for Patient #2, however, she did not know the specific reason why. MHW-A stated the females were assigned rooms on one side, and males on the other side. MHW-A stated during the morning on 04/27/15 at approximately 11:30 AM-12:00 PM it was a "hectic/busy" day with "Code Green's being called." MHW-A stated that security was usually on the PES unit; but on 04/27/15 at the time of the allegation; "security could not be found." MHW-A stated on 04/27/15 at around 11:30-12:00 PM she stayed In the unit when the Code Greens were called and was "getting something out of the supply closet." MHW-A indicated the unit RN "responded to the Code Green" leaving the unit; telling her she [unit RNJ would be back. MHW-A did not remember if LVN-A or LVN-B was working on 04/27/15; but further stated she did not remember any LVN being in the unit during the time of the allegation made by Patient #1. MHW-A stated shortly after this Patient #1 "lfagged her [MHW-A] down" to her bedroom, and nto the restroom of the bedroom where she reported that Patient #2 came into her room and touched her buttocks and vaginal area while she was sleeping in her bed. MHW-A stated that Patient #1's gown was torn around the buttock area and she offered to call the local PD for Patient #1 to make a report. MHW-A stated she then reported the incident/allegation to the unit RN. MHW-A stated she was later told that Patient #2 had been an inpatient to the facility many times before, and he "knows the system;	A 392		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDETUSUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREETADDRESS, CITY. STATE, MP CODE
NIX HEALTH CARE SYSTEM	414 NAVARRO, SUITE 600 SAN ANTONIO, TX 78205

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A 392	Continued From page 25 knows what Code Green means." MHW-A stated she had seen Patient #2 "walking out of her [Patient #1] room a few times" and further stated "right before she flagged me down, he had walked out of her room". MHW-A indicated she told Patient #2 "not to go in to other people's rooms." MHW-A confirmed she had not documented the allegation reported by Patient #1 against Patient #2; but that she "told [unit RN]." Interview on 08/10115at 1:20 PM with Patient #1 revealed on 04/27/15 at approximately 11:30-11:45 AM she was in her assigned bedroom sleeping after she received multiple medications following her admission, Patient #1 stated she awoke after she "felt pressure on her buttock and vaginal area. Patient #1 stated that Patient #2 was present telling her not to tell anyone. Patient #1 stated that she noticed her paper pants were ripped ***and*** she was not actually aware what all Patient #2 actually did because she "was conked out" after taking multiple medications. Patient #1 stated she knows he touched her because that was what woke her up. Patient #1 stated she was very upset, "freaked out," and asked the MD for an "AIDS" test. Patient #1 stated the unit RN indicated to the nursing staff (LVN) to "give her more meds" because she was "upset, crying, and freaking out." Patient #1 stated she then received the Ativan for her anxiety, to "help me calm down." Patient #1 stated the local PD came and she made a report. Patient #1 stated she was told by the unit RN that "Code Green's" were called and "everyone had to leave the unit" which allowed the opportunity for Patient #2 to go into her room unsupervised.	A 392		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/ELIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREETADDRESS, CITY, STATE, ZIP CODE
NIX HEALTH CARE SYSTEM	414 NAVARRO, SUITE 600 **SAN ANTONIO, TX 78205**

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A 392	Continued From page 26 interview on 08/10/15 at 2:20 PM with Security Guard-A revealed he was employed by the facility to maintain security and the safety of patients. The Security Guard-A stated Patient #2 had a history of inappropriate sexual behavior of "masturbating in front of females." The Security Guard-A stated he assisted with "viewing the video" footage for evidence following the allegation on 04/27/15 made be Patent #1 against Patient #2. The Security Guard stated the video footage from 04/27/15 showed a total of "four times" that Patient #2 went into Patient #1's room; and the last time Patient #2 came out of Patient #1's room; she was observed to come out of the room a few minutes later. The Security Guard stated that Patient #2 had already been assigned to the front "seclusion room" of the PES unit as his bedroom due to his history of masturbating. The Security Guard stated on the video footage Patient #2 could be seen coming from his room; "looking side to side" down the hallway, and then going into Patient #1's room. The Security Guard stated that female and male patient rooms were separated and that Patient #2 was not supposed to be going into Patient #1's room for any reason. Interview on 08/10/15 at 2:50 PM with MD-A revealed he was notified of Patient #1's sexual assault allegation against Patient #2 on 04/27/15. MD-A stated he discussed with Patient #1 the option of a "Rape Kit" but she "declined." MD-A stated he understood the allegation made by Patient #1 to be "only touching with tIO penetration." MD-A stated that Patient #1 was "distressed" about the incident and he ordered Ativan for Patient #1's anxiety following the incident. MD-A slated Patient #1 had already been distressed emotionally because of her ED	A 392		

STATEMENT OF EFICIENCIES AND PLAN OF CORRECTION	(Xi) PROVIDERISUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A 392	Continued From page 27 Inpatient admission; and really did not even want to take the Ativan. MD-A stated he recalled there was a Code Green called where staff left the unit In response to the Code Green; which left less staffing in the unit. Interview on 08/10/15 at 3:00 PM with the facility's Risk Manager (RM) indicated that she was aware of the alleged sexual assault allegation made by Patient #1 on 04/27/15 against Patient #2; however, she had not been notified until 05/06/15 via the facility's Incident/Event electronic system because there had not been any harm documented In order to elevate the notification. The RM stated the stafifng ratio on the PES unit was 1 staff to 4 patients, The RM indicated on 04/27/15 the patient census in the PES unit was 11; requiring 3 staff. The RM stated the first required staff is an RN, and then second could be a LVN, and/or MHW. The RM confirmed for 11 patients the required staffing would ire 3. The RM stated the PES unit was to always have a licensed nurse present and available in the unit. The RM stated she had not seen or viewed the video footage following this allegation due to the video being unavailable after 05/06/15; following her electronic notification. The RM stated there would not be documentation of the Code Green that may have occurred on 04/27/15 in the facility's lobby waiting area; if the patient had not yet been assessed for care. Interview on 08/10/15 at 3:15 PM with Licensed Social Worker (LSW)-A stated she assisted Security Guard-A in viewing the video footage on 04/27/15 after Patient #1 made a sexual assault allegation against Patient #2. LSW-A stated that	A 392		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NIX HEALTH CARE SYSTEM	**414 NAVARRO, SUITE** BOO SAN ANTONIO, TX 70205

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A 392	Continued From page 28 during the allegation on 04127/15; Patient #2 could be seen on the camera "looking both ways" and then would go into Patient #1's bedroom. LSW-A stated they were able to count this event occurring a "couple of times" where Patient #2 would go into Patient #1's bedroom and remain there "a couple of minutes" each time. LSW-A stated she saw on the video where MHW-A had been in the "Patient evaluation room" during these time periods; where a supply ?Inset was located. LSW-A stated Patient #2 hpd a history of "exposing his self, public masturbation, and talks sexually to other women." LSW-A stated that Patient #2 has publically masturbated in front of her during an assessment interview. Interview on 08/10/15 at 415 PM with LVN-A stated he was present and worked the PES unit on 04/27/15. LVN-A staled that on 04/27/15 there were Code Greens called on another unit, and In the facility's lobby about the same time. LVN-A stated he responded to the Code Green in the lobby to assist due to a "fight." LVN-A indicated he had left the unit for approximately 15 minutes. Interview on 08/10/15 at 4:30 PM with the Vice President (VP) of Clinical Services confirmed that she was notified of the sexual allegation made by Patient #1 against Patient #2 on 04/27/15; however, she had not been notified until 05/06/15 via the facility's Incident/Event electronic system because there had not been any harm documented in order to elevate the notification. The VP of Clinical Services i that on 04/27/16 the Nursing Clinica l Direct& (Nurse Manager) had been notified immediately following Patient #1's allegation and she had not obtained	A 392		

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A 392	Continued From page 29 Information that Indicated Patient #1's allegation had occurred due to Insufficient staffing in the PES unit when Code Green's had been called; leaving the unit without a RN available. The VP of Clinical Services stated that the unit RN was not supposed to leave the unit and there should always be a Licensed Nurse In the unit during a Code Green; that it's a judgement call." The VP of Clinical Services stated she had not seen or viewed the video footage following this allegation due to the video being unavailable after 05/06/15; following her electronic notification. Interview on 08/10/15 at 4:40 PM with the Nursing Clinical Director (Nurse Manager) she was immediately notified by the PES un it RN on 04/27d/15 of Patient #1's sexual allegation against Patient #2. The Nursing Clinical Director indicated she "separated" the Patients, talked to both of them, and Patient #1 saw the Doctor. The Nursing Clinical Director stated she spoke to the unit RN about the allegation but,had.not been notified or received information that the RN and LVN had left the PES unit to respond to Code Greens which letf the unit without a RN and/or licensed nurse available. The Nursing Clinical Director stated she had not seen or viewed the video footage following this allegation.	A 392		

SOD-State Forms

Texas Department of State Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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Y 000	25 TAC 134 INITIAL COMMENTS Note: The State Form is an official, legal document. All information must remain unchanged except for entering the plan of correction, correction dates, and the signature space. Any discrepancy in the original deficiency citation(s) will be referred to the Office of the Texas Attorney General (OAG) for possible fraud. If information is inadvertently changed by the provider/supplier, the State Survey Agency (SA) should be notified immediately. An unannounced visit was conducted from 08/06/15 to 08/10/15 to conduct a survey for complaint investigation (TX 00218998). An entrance conference was conducted on 08/06/15 in the conference room of the facility with the Director of Risk Management. The purpose and process of the complaint survey were discussed and an opportunity for questions was provided. Complaint, TX 00218998, was substantiated with state violations cited. An exit conference was conducted on 08/10/15 in the conference room. The Director of Risk Management, the Vice President of Clinical Services, the Nursing Clinical Director, and Interim Behavioral Health Administrator were in attendance. Preliminary findings of the survey were discussed and an opportunity for questions was provided.	Y 000		
Y 313	134.46(c)(3)(A) Abuse & Neglect: Reporting responsibility Reporting abuse and neglect. A person, including an employee, volunteer, or other person	Y 313	**Plan of Correction** **Y313** Mandatory read and sign in-service for all front-line behavioral health staff to include nursing, MHT, NP, social workers, intake/assessment, security and admitting to be completed by 9/14/15.	**9/14/15**

SOD - State Form

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Angela Dial — TITLE: VP, Behavioral Health Svcs — (X6) DATE: 9/9/15

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Y 313	Continued From page 1 associated with the facility who reasonably believes or who knows of information that would reasonably cause a person to believe that the physical or mental health or welfare of a patient of the facility who is receiving mental health or chemical dependency services has been, is, or will be adversely affected by abuse or neglect (as those terms are defined in this subsection) by any person shall as soon as possible report the information supporting the belief to the department or to the appropriate state health care regulatory agency in accordance with HSC, §161.132(a). This REQUIREMENT is not met as evidenced by: Based on interview and record review, facility employees failed to report an allegation of neglect to the state health care regulatory agency, the Department of State Health Services (DSHS); and in accordance with their policy, for 1 of 1 patients reviewed (Patient #1) with a complaint allegation of sexual assault against another patient (Patient #2). Specifically, on 04/27/15, Patient #1 reported to the unit's Registered Nurse (RN) an allegation of sexual assault from another Patient, (#2); who had a history of inappropriate sexual behaviors. The allegation was reported to the Medical Doctor, the Nursing Manager, and local Police Department (PD); however, this allegation was not reported to the state health care regulatory agency by any facility employees, in accordance with their policy. This deficient practice could affect the prevention of possible unidentified abuse, neglect, or mistreatment for all patients in the facility; by	Y 313	Mandatory In-services to be conducted on 9/14, 9/16, and 9/18 for all behavioral health staff with multiple offerings in order to ensure all staff are able to attend one of these educational events. The mandatory in-service will reinforce the hospital policy regarding Assessment and Reporting of Abuse and Neglect, reinforce the need to document outlier events affecting patients, and roll out the Code Green Response Protocol. The Code Green Response Protocol includes the following: 1.) reinforces assigning a specific Code Green response team to include back up for breaks as appropriate as well as for census level and unit acuity to ensure appropriate staffing is left on inpatient units, 2.) provides instruction for responding in the event multiple codes are called at the same time. to insure patient and staff safety, 3.) Psychiatric Emergency Service Unit (PES) staff will not respond to Code Greens unless the unit is overstaffed for its current population, 4.) reinforces that all supervisors will respond to Code Green, 5.) reinforces what should happen to maintain safety on the units when the Code Green team responds which includes: a.) suspension of non-essential tasks, b.) cohort the patients as much as possible to control the situation and monitor for safety,	

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Y 313	Continued From page 2 compromising their safety. Findings Included: Review of Patient #1's Complaint Form dated 05/15/15 indicated the following in part: On 04/27/15 at approximately 11:30 AM Patient #1 was admitted to the facility's "Psychiatric Emergency Services (PES) unit and received medication to help her sleep and calm down. Patient #1 reported shortly after she received the medications; she was asleep in her bed when she "felt someone touching my vagina and butt. I felt a hard pressure. I jumped up and another male patient [#2] jumped out from under my covers." Patient #1 stated she went to find a staff member (Mental Health Worker-A), to report what had happened. Patient #1 indicated she noticed her entire "crotch area [paper gown] was torn exposing her "vagina and butt." Patient #1 indicated the facility staff called the Police Department (PD) for Patient #1 to make a report. Patient #1 reported the staff apologized to her for the incident; "but they had an emergency on another floor and they were short staffed, so every staff member had left." Patient #1 indicated she was "so upset and scared; so they gave me more meds to put me to sleep." Patient #1 stated the facility had done nothing more to help her; there were no witnesses but she believed there were cameras in the hall. Patient #1 stated she found out that Patient #2 had done this before and the Police Officer who responded stated that; "he [Patient #2] has a history of doing this; why was he unsupervised?" Review of the facility's Policy titled, Abuse Reporting-External and Internal, last reviewed January 2012 revealed the following definitions: Psychological Abuse included; humiliation and	Y 313	c.) response team clearly communicates to their charge when they leave from and return to the unit. Additional topics for the mandatory in-service include: a decision tree to reinforce the policy on reporting and follow-up of suspected/reported allegations of abuse/neglect of a patient during hospitalization and in treating patients identified as having ordered sexual precautions. Follow up in-servicing is planned for February 2016 to include participation by same staff members to continue reinforcement of policies.	

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Y 313	Continued From page 3 harassment. Sexual Abuse included; sexual harassment, sexual coercion, and sexual assault. Review of the facility's Policy titled, Assessment and Reporting of Abuse and Neglect, last reviewed February 2013 revealed Neglect included the failure to provide for one's self the goods or services including medical services, which are necessary to avoid physical or emotional harm or pain or the failure of a caretaker to provide the goods or services. The policy indicated the facility "prohibits neglect, mental or physical abuse or misappropriation of property, of patients by staff, visitors, or other patients." The facility "will report allegations and release information to the proper authorities, according to federal regulations, state specific rules and regulation and [facility] practice guidelines." Further review of the policy indicated, in part: 1. Reporting allegations of abuse and/or neglect occurring while the patient is under the care in the facility: All alleged violations concerning abuse and neglect while the patient is under the care of the facility will be reported to the Compliance Officer or designee, who will advise the on-call administrator/designee. As appropriate, the facility will report the incident to appropriate state, federal and protective/regulatory agencies, and/or law enforcement agencies and conduct an internal investigation within a maximum of five working days of the incident. The Texas Department of state Health Services (DSHS) is the regulatory body for reporting concerns of hospitals, psychiatric hospitals (including private psychiatric facilities), and various other medical facilities.	Y 313		

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Y 313	Continued From page 4 Review of the facility's Original Event report dated 04/27/15 at 12:15 PM completed by the unit RN revealed Patient #1 reported, "She was lying in bed asleep, when she felt Patient [#2] putting pressure around her buttocks area, and then touching her perineal area. Patient[#1] reported sitting up in bed shock and scared, and found Patient [#2] was up in her face with his finger to his mouth telling her to be quiet not to tell. She found her paper scrub button torned on the outer left side. MD [Medical Doctor], Nurse Manager notified, Patient made a police complaint." PD interviewed Patient #1 and accused, Patient #2. "Patient visible distraught, but no other physical problems noted at this time." Further review of the Original Event indicated the Event was documented as "Attempted Rape/Rape/Sexual Assault." Factors included; "Unit busy code greens called on other unit, and high acute of unit." The Original Event report did not include any documentation that this allegation was reported to the state health care regulatory agency by any facility employees, in accordance with the facility's policy. The Original Event report did not include documentation that this allegation was thoroughly investigated by the facility for the identification of neglect and/or a corrective action plan to prevent repeat incidence; in accordance with the facility's policy. The Compliance Officer/Director of Risk Management (RM) acknowledged receipt of the Original Event report dated 04/27/15 at 12:15 PM electronically on 05/06/15 documenting Patient #1 made a Police Report. Review of the local PD report dated 04/27/15 at 12:45PM revealed Patient #1 wanted to report that, "she was a sleep in her room, when she awaken and felt pressure around her buttock and	Y 313		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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Y 313	Continued From page 5 vaginal area. When she fully awaken, she observed [Patient #2] in bed with her." Patient #1 further stated that Patient #2 told her "Don't tell anyone," before he left her room. Patient #1 did not feel Patient #2 penetrate her at any time, but the hospital [paper gown] pajama that she was wearing had a tear between the leg area. Patient #2 denied being in bed with Patient #1, or touching her. The report was deemed as "Disorderly Conduct" and Patient #1 was advised to contact the special victim's unit to file charges against Patient #2. "The Hospital staff was advised to monitor [Patient #2's] movement more closely." Record review of the medical record of Patient #1 revealed she was a 37 year-old female admitted to the psychiatric facility on 04/27/15 at 0830 under Emergency Detention (ED) when she cut her wrist and called a friend to call Police. Patient #1 has a history of Depression with Anxiety. Further review of Patient #1's permanent records revealed no documentation following the sexual assault allegation that she made on 04/27/15 against Patient #2. There was no documentation in her record that she received a physical and/or psychological assessment following her allegation on 04/27/15. There was a Telephone Physician Order (PO) on 04/27/15 at 12:30 PM (following the allegation) for Ativan (an anti-anxiety) 2 milligrams by mouth "now" without documentation of the reason for the emergency medication. The only documentation in Patient #1's record regarding her allegation against Patient #2 was a Behavioral Team Progress Note dated 05/01/15 at 12:28 completed by Licensed Social Worker- A that indicated "Patient discussed being sexually assaulted by Patient [#2] in the [facility's] PES	Y 313		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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Y 313	Continued From page 6 unit. Review of Patient #1's Daily Observation Notes for 04/27/15 revealed the following: At 11:30-MHW-A documented 1Q (1=On unit, and Q=Quiet/Calm). At 11:45-MHW-A documented 1B (On unit, and B=In Bed Awake). At 12:00-MHW-A documented 1BA (On unit, In Bed Awake, and A=agitated/restless). At 12:15 MHW-A documented 1BA. At 12:30, 12:45, 13:00, 13:15, 13:30, and 13:45-MHW-A documented 1A (On Unit and agitated/restless). Record review of Patient #2's medical records revealed the following: Patient #2's Psychiatric Evaluation dated 04/24/15 revealed he was a 30 year old male admitted to the PES unit on 04/24/15 with a history of schizoaffective disorder and traumatic brain injury (TBI). Patient #2 was admitted on an ED basis with a history of aggressive behaviors requiring emergency medications to calm him. Patient #2 had recently been discharged from this facility 4-5 weeks prior and has had multiple inpatient treatment episodes over the years (7 inpatient admissions in the previous 5 months). Patient #2 was documented with a known history of aggression and a "history of inappropriate sexual behavior on the unit (masturbating)." Patient #2 had documented borderline intellectual functioning with poor insight, poor judgment, and poor impulse control. A Behavioral Nursing Shift Assessment completed by the unit RN on 04/27/15 at 18:08 that Patient #2 was found by a female patient touching on her body while she was asleep in	Y 313		

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Y 313	Continued From page 7 bed. MD, and Nurse Manager notified. A Telephone PO dated 04/27/15 at 2015 for Patient #2 to be transferred to a higher acuity; sister facility. A Behavior Team Progress noted dated 04/27/15 at 1855 revealed Patient #2 was transferred to a sister facility by the Sheriff's Department. Review of the facility's Incident Event dated 04/27/15 at 11:37 AM confirmed a Code Green was called for another Patient [#3] in the Child/Adolescent Unit requiring Restraints/Seclusion. Patient #3 required physical restraint at 11:36 AM, and emergency medications at 11:46 AM. Patient #3 was released from restraint at 12:26 PM. This Code Green occurred during the same time frames of Patient #1's allegation on 04/27/15. Review of the facility's Policy titled, Psychiatric Emergencies-Code Green, last reviewed January 2012 revealed a Code Green was a Psychiatric Emergency. Code Green will be implemented by any unit personnel in the event of unmanageable behavior of an individual to prevent harm to that individual, patients, hospital personnel and/or others the general hospital area. D. Individuals responding to Code Green will meet in announced area. Available personnel is necessary to control atmosphere through a show of strength and caring or to assist in physical management. Interview on 08/06/15 at 12:35 PM with the PES unit RN revealed she completed Patient #1's admission assessment to the PES unit on 04/27/15. The unit RN indicated Patients were provided with paper scrubs to wear without other	Y 313		

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Y 313	Continued From page 8 undergarments. The unit RN stated that on 04/27/15 at approximately 11:30 AM to 12:00 PM, "Code Greens" were going on; and "staff were busy". The unit RN stated there was a Code Green on another unit (child/adolescent) and a Code Green was called in the lobby; due to a patient needing to be "put in a [restraint] chair" because they were tearing up the lobby. The unit RN stated she left the unit to respond to the Code Green in the other unit (child/adolescent) and when she arrived; there was another RN responding, so she went to the Code Green in the lobby because they needed an RN to assist with "putting the patient in the [restraint] chair." The unit RN stated she returned to the PES unit following the Code Greens to "something else going on at the end of the unit" that she responded to. The unit RN stated she could not remember if it was LVN-A or LVN-B working on 04/27/15; but that she thought the LVN stayed back in the PES unit when she left and responded to the two Code Greens. The unit RN stated she was notified that during the Code Greens Patient #2 went into Patient #1's bedroom; and Patient #1 made an allegation of sexual assault. The unit RN stated she spoke with Patient #1 who reported that she was asleep in her bedroom and "she felt pressure" causing her to awake to Patient #2 touching her in the buttock and perineal area. The unit RN stated that Patient #1's paper pants were "torn on the side." The unit RN stated the local PD was called. The unit RN stated she spoke to Patient #2 and he said, "I touched her, but didn't do anything else." The unit RN stated he admitted that he "touched her and ripped her paper pants." The unit RN stated that Patient #2 knew that the unit was "chaotic" and knew what Code Green meant; and that is when he "took advantage" of the situation. The unit RN stated she believed that	Y 313		

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Y 313	Continued From page 9 Patient #2 sexually assaulted Patient #1 given the facts, and his own admission. The unit RN stated she notified the MD, Social Worker, and Nursing Manager of the allegation. The unit RN indicated she documented the sexual assault allegation made by Patient #1 on the facility's Event Report; however, confirmed she did not document the sexual assault allegation in Patient #1's record following the incident. The unit RN stated she offered for Patient #1 to have a Sexual Assault Nurse Examination (SANE) completed at another facility if she wanted; but Patient #1 declined, stating she did not believe Patient #2 actually raped her. The unit RN confirmed she had not reported this allegation to the state health care regulatory agency (DSHS). Interview on 08/06/15 at 04:45 PM with MHW-A revealed she was the only MHW working on 04/27/15 in the PES unit; along with the unit RN and a Licensed Vocational Nurse (LVN). MHW-A stated she was pulled to the PES unit at 9:15 AM and was unfamiliar to the PES unit; but was told by the leaving MHW to "watch it" for Patient #2, however, she did not know the specific reason why. MHW-A stated the females were assigned rooms on one side, and males on the other side. MHW-A stated during the morning on 04/27/15 at approximately 11:30 AM-12:00 PM it was a "hectic/busy" day with "Code Green's being called." MHW-A stated that security was usually on the PES unit; but on 04/27/15 at the time of the allegation; "security could not be found." MHW-A stated on 04/27/15 at around 11:30-12:00 PM she stayed in the unit when the Code Greens were called and was "getting something out of the supply closet." MHW-A indicated the unit RN "responded to the Code Green" leaving the unit; telling her she [unit RN] would be back. MHW-A	Y 313		

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Y 313	Continued From page 10 did not remember if LVN-A or LVN-B was working on 04/27/15; but further stated she did not remember any LVN being in the unit during the time of the allegation made by Patient #1. MHW-A stated shortly after this Patient #1 "flagged her [MHW-A] down" to her bedroom, and into the restroom of the bedroom where she reported that Patient #2 came into her room and touched her buttocks and vaginal area while she was sleeping in her bed. MHW-A stated that Patient #1's gown was torn around the buttock area and she offered to call the local PD for Patient #1 to make a report. MHW-A stated she then reported the incident/allegation to the unit RN. MHW-A stated she was later told that Patient #2 had been an inpatient to the facility many times before, and he "knows the system; knows what Code Green means." MHW-A stated she had seen Patient #2 "walking out of her [Patient #1] room a few times" and further stated "right before she flagged me down, he had walked out of her room". MHW-A indicated she told Patient #2 "not to go in to other people's rooms." MHW-A confirmed she had not documented the allegation reported by Patient #1 against Patient #2; but that she "told [unit RN]." Interview on 08/10/15at 1:20 PM with Patient #1 revealed on 04/27/15 at approximately 11:30-11:45 AM she was in her assigned bedroom sleeping after she received multiple medications following her admission. Patient #1 stated she awoke after she "felt pressure" in her buttock and vaginal area. Patient #1 stated that Patient #2 was present telling her not to tell anyone. Patient #1 stated that she noticed her paper pants were ripped and she was not actually aware what all Patient #2 actually did because she "was conked out" after taking multiple medications. Patient #1 stated she knows he	Y 313		

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Y 313	Continued From page 11 touched her because that was what woke her up. Patient #1 stated she was very upset, "freaked out," and asked the MD for an "AIDS" test. Patient #1 stated the unit RN indicated to the nursing staff (LVN) to "give her more meds" because she was "upset, crying, and freaking out." Patient #1 stated she then received the Ativan for her anxiety, to "help me calm down." Patient #1 stated the local PD came and she made a report. Patient #1 stated she was told by the unit RN that "Code Green's" were called and "everyone had to leave the unit" which allowed the opportunity for Patient #2 to go into her room unsupervised. Interview on 08/10/15 at 2:20 PM with Security Guard-A revealed he was employed by the facility to maintain security and the safety of patients. The Security Guard-A stated Patient #2 had a history of inappropriate sexual behavior of "masturbating in front of females." The Security Guard-A stated he assisted with "viewing the video" footage for evidence following the allegation on 04/27/15 made be Patient #1 against Patient #2. The Security Guard stated the video footage from 04/27/15 showed a total of "four times" that Patient #2 went into Patient #1's room; and the last time Patient #2 came out of Patient #1's room; she was observed to come out of the room a few minutes later. The Security Guard stated that Patient #2 had already been assigned to the front "seclusion room" of the PES unit as his bedroom due to his history of masturbating. The Security Guard stated on the video footage Patient #2 could be seen coming from his room; "looking side to side" down the hallway, and then going into Patient #1's room. The Security Guard stated that female and male patient rooms were separated and that Patient #2	Y 313		

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Y 313	Continued From page 12 was not supposed to be going into Patient #1's room for any reason. Interview on 08/10/15 at 2:50 PM with MD-A revealed he was notified of Patient #1's sexual assault allegation against Patient #2 on 04/27/15. MD-A stated he discussed with Patient #1 the option of a "Rape Kit" but she "declined." MD-A stated he understood the allegation made by Patient #1 to be "only touching with no penetration." MD-A stated that Patient #1 was "distressed" about the incident and he ordered Ativan for Patient #1's anxiety following the incident. MD-A stated Patient #1 had already been distressed emotionally because of her ED inpatient admission; and really did not even want to take the Ativan. MD-A stated he recalled there was a Code Green called where staff left the unit in response to the Code Green; which left less staffing in the unit. MD-A confirmed that he did not document in Patient #1's records his contact or discussion with Patient #1 following her allegation. Interview on 08/10/15 at 3:00 PM with the facility's Risk Manager (RM) indicated that she was aware of the alleged sexual assault allegation made by Patient #1 on 04/27/15 against Patient #2'; however, she had not been notified until 05/06/15 via the facility's Incident/Event electronic system because there had not been any harm documented in order to elevate the notification. The RM stated the staffing ratio on the PES unit was 1 staff to 4 patients. The RM indicated on 04/27/15 the patient census in the PES unit was 11; requiring 3 staff. The RM stated the first required staff is an RN, and then second could be a LVN, and/or MHW. The RM confirmed for 11 patients the required staffing would be 3. The RM	Y 313		

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Y 313	Continued From page 13 stated the PES unit was to always have a licensed nurse present and available in the unit. The RM confirmed that she had not reported the sexual assault allegation made by Patient #1 on 04/27/15 against Patient #2 to the state health care regulatory agency, Department of State Health Services (DSHS); which was determined to have occurred as a result of insufficient staffing in the PES unit during episodes of Code Green's. The RM further confirmed the facility had not completed a thorough investigation with documented findings specific to this allegation for the determination of Neglect and/or a corrective action plan to prevent repeat incidence; in accordance with the facility's policy. The RM stated she had not seen or viewed the video footage following this allegation due to the video being unavailable after 05/06/15; following her electronic notification. Interview on 08/10/15 at 3:15 PM with Licensed Social Worker (LSW)-A stated she assisted Security Guard-A in viewing the video footage on 04/27/15 after Patient #1 made a sexual assault allegation against Patient #2. LSW-A stated that during the allegation on 04/27/15; Patient #2 could be seen on the camera "looking both ways" and then would go into Patient #1's bedroom. LSW-A stated they were able to count this event occurring a "couple of times" where Patient #2 would go into Patient #1's bedroom and remain there "a couple of minutes" each time. LSW-A stated she saw on the video where MHW-A had been in the "Patient evaluation room" during these time periods; where a supply closet was located. LSW-A stated Patient #2 had a history of "exposing his self, public masturbation, and talks sexually to other women." LSW-A stated that Patient #2 has publically masturbated in front of	Y 313		

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Y 313	Continued From page 14 her during an assessment interview. Interview on 08/10/15 at 4:15 PM with LVN-A stated he was present and worked the PES unit on 04/27/15. LVN-A stated that on 04/27/15 there were Code Greens called on another unit, and in the facility's lobby about the same time. LVN-A stated he responded to the Code Green in the lobby to assist due to a "fight." LVN-A indicated he had left the unit for approximately 15 minutes. Interview on 08/10/15 at 4:30 PM with the Vice President (VP) of Clinical Services confirmed that she was notified of the sexual allegation made by Patient #1 against Patient #2 on 04/27/15; however, she had not been notified until 05/06/15 via the facility's Incident/Event electronic system because there had not been any harm documented in order to elevate the notification. The VP of Clinical Services indicated that on 04/27/15 the Nursing Clinical Director (Nurse Manager) had been notified immediately following Patient #1's allegation and she had not obtained information that indicated Patient #1's allegation had occurred due to insufficient staffing in the PES unit when Code Green's had been called; leaving the unit without a RN available. The VP of Clinical Services stated that the unit RN was not supposed to leave the unit and there should always be a Licensed Nurse in the unit during a Code Green; that "it is a judgement call." The VP of Clinical Services stated she had not seen or viewed the video footage following this allegation due to the video being unavailable after 05/06/15; following her electronic notification. The VP of Clinical Services confirmed she had not reported this allegation to the state health care regulatory agency (DSHS).	Y 313		

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Y 313	Continued From page 15 Interview on 08/10/15 at 4:40 PM with the Nursing Clinical Director (Nurse Manager) stated she was immediately notified by the PES unit RN on 04/27d/15 of Patient #1's sexual allegation against Patient #2. The Nursing Clinical Director indicated she "separated" the Patients, talked to both of them, and Patient #1 saw the Doctor. The Nursing Clinical Director stated she spoke to the unit RN about the allegation but had not been notified or received information that the RN and LVN had left the PES unit to respond to Code Greens which left the unit without a RN and/or licensed nurse available. The Nursing Clinical Director stated she had not seen or viewed the video footage following this allegation. The Nursing Clinical Director confirmed she had not reported this allegation to the state health care regulatory agency (DSHS).	Y 313		
Y 523	404.154(24) Rights: Persons Receiving Mental Health Srvs The right to be free from mistreatment, abuse, neglect, and exploitation. See 40 TAC Chapter 710, Subchapter A (concerning Abuse and Neglect of Persons Served by TXMHMR Facilities), 40 TAC Chapter 710, Subchapter B (concerning Client Abuse and Neglect in Community Mental Health and Mental Retardation Centers), and 40 TAC Chapter 710, Subchapter C (concerning Patient Abuse in Private Psychiatric Facilities). This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure the patient's rights to be free from	Y 523	**Plan of Correction** **Y523** Mandatory read and sign in-service for all front-line behavioral health staff to include nursing, MHT, NP, social workers, intake/assessment, security and admitting to be completed by 9/14/15. Mandatory In-services to be conducted on 9/14, 9/16, and 9/18 for all behavioral health staff with multiple offerings in order to ensure all staff are able to attend one of these educational events. The mandatory in-service will reinforce the hospital policy regarding Assessment and Reporting of Abuse and Neglect, reinforce the need to document outlier events affecting patients, and roll out the	9/14/15

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Y 523	Continued From page 16 all forms of abuse or harassment by failing to prevent, protect, investigate, and report/respond to an allegation of neglect in accordance with their policy, for 1 of 1 patients reviewed (Patient #1) with a complaint allegation of sexual assault against another patient (Patient #2). On 04/27/15, Patient #1 reported to the unit's Registered Nurse (RN) an allegation of sexual assault from another Patient, (#2); who had a history of inappropriate sexual behaviors. The allegation was reported to the Medical Doctor, the Nursing Manager, and local Police Department (PD); however, this allegation was not reported to the state health care regulatory agency by any facility employees, in accordance with their policy. In addition, this allegation was not thoroughly investigated by the facility for the identification of neglect and/or a corrective action plan to prevent repeat incidence; in accordance with the facility's policy. This deficient practice could affect the prevention of possible unidentified abuse, neglect, or mistreatment for all patients in the facility; by compromising their safety. Findings Included: Review of Patient #1's Complaint Form dated 05/15/15 indicated the following in part: On 04/27/15 at approximately 11:30 AM Patient #1 was admitted to the facility's "Psychiatric Emergency Services (PES) unit and received medication to help her sleep and calm down. Patient #1 reported shortly after she received the medications; she was asleep in her bed when she "felt someone touching my vagina and butt. I felt a hard pressure. I jumped up and another male patient [#2] jumped out from under my covers."	Y 523	Code Green Response Protocol. The Code Green Response Protocol includes the following: 1.) reinforces assigning a specific Code Green response team to include back up for breaks as appropriate as well as for census level and unit acuity to ensure appropriate staffing is left on inpatient units, 2.) provides instruction for responding in the event multiple codes are called at the same time. to insure patient and staff safety, 3.) Psychiatric Emergency Service Unit (PES) staff will not respond to Code Greens unless the unit is overstaffed for its current population, 4.) reinforces that all supervisors will respond to Code Green, 5.) reinforces what should happen to maintain safety on the units when the Code Green team responds which includes: a.) suspension of non-essential tasks, b.) cohort the patients as much as possible to control the situation and monitor for safety, c.) response team clearly communicates to their charge when they leave from and return to the unit. Additional topics for the mandatory in-service include: a decision tree to reinforce the policy on reporting and follow-up of suspected/reported allegations of abuse/neglect of a patient during hospitalization and in treating patients identified as having ordered	

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Y 523	Continued From page 17 Patient #1 stated she went to find a staff member (Mental Health Worker-A), to report what had happened. Patient #1 indicated she noticed her entire "crotch area [paper gown] was torn exposing her "vagina and butt." Patient #1 indicated the facility staff called the Police Department (PD) for Patient #1 to make a report. Patient #1 reported the staff apologized to her for the incident; "but they had an emergency on another floor and they were short staffed, so every staff member had left." Patient #1 indicated she was "so upset and scared; so they gave me more meds to put me to sleep." Patient #1 stated the facility had done nothing more to help her; there were no witnesses but she believed there were cameras in the hall. Patient #1 stated she found out that Patient #2 had done this before and the Police Officer who responded stated that; "he [Patient #2] has a history of doing this; why was he unsupervised?" Review of the facility's Policy titled, Abuse Reporting-External and Internal, last reviewed January 2012 revealed the following definitions: Psychological Abuse included; humiliation and harassment. Sexual Abuse included; sexual harassment, sexual coercion, and sexual assault. Review of the facility's Policy titled, Assessment and Reporting of Abuse and Neglect, last reviewed February 2013 revealed Neglect included the failure to provide for one's self the goods or services including medical services, which are necessary to avoid physical or emotional harm or pain or the failure of a caretaker to provide the goods or services. The policy indicated the facility "prohibits neglect, mental or physical abuse or misappropriation of property, of patients by staff, visitors, or other	Y 523	sexual precautions. Follow up in-servicing is planned for February 2016 to include participation by same staff members to continue reinforcement of policies.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 523	Continued From page 18 patients." The facility "will report allegations and release information to the proper authorities, according to federal regulations, state specific rules and regulation and [facility] practice guidelines." Further review of the policy indicated, in part: 1. Reporting allegations of abuse and/or neglect occurring while the patient is under the care in the facility: All alleged violations concerning abuse and neglect while the patient is under the care of the facility will be reported to the Compliance Officer or designee, who will advise the on-call administrator/designee. As appropriate, the facility will report the incident to appropriate state, federal and protective/regulatory agencies, and/or law enforcement agencies and conduct an internal investigation within a maximum of five working days of the incident. The Texas Department of state Health Services (DSHS) is the regulatory body for reporting concerns of hospitals, psychiatric hospitals (including private psychiatric facilities), and various other medical facilities. 2. Investigations are always prompt, comprehensive and responsive to the situation, well conducted, and contain founded conclusions. The investigation may include, but are not limited to the following: -Interviews conducted with individuals having first-hand knowledge of the incident. -Follow-up resolution -Corrective action plan to prevent repeat incidence. -Reports made to appropriate state health care regulatory agency. Review of the facility's Original Event report dated	Y 523		

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Y 523	Continued From page 19 04/27/15 at 12:15 PM completed by the unit RN revealed Patient #1 reported, "She was lying in bed asleep, when she felt Patient [#2] putting pressure around her buttocks area, and then touching her perineal area. Patient[#1] reported sitting up in bed shock and scared, and found Patient [#2] was up in her face with his finger to his mouth telling her to be quiet not to tell. She found her paper scrub button torned on the outer left side. MD [Medical Doctor], Nurse Manager notified, Patient made a police complaint." PD interviewed Patient #1 and accused, Patient #2. "Patient visible distraught, but no other physical problems noted at this time." Further review of the Original Event indicated the Event was documented as "Attempted Rape/Rape/Sexual Assault." Factors included; "Unit busy code greens called on other unit, and high acute of unit." The Original Event report did not include any documentation that this allegation was reported to the state health care regulatory agency by any facility employees, in accordance with the facility's policy. The Original Event report did not include documentation that this allegation was thoroughly investigated by the facility for the identification of neglect and/or a corrective action plan to prevent repeat incidence; in accordance with the facility's policy. The Compliance Officer/Director of Risk Management (RM) acknowledged receipt of the Original Event report dated 04/27/15 at 12:15 PM electronically on 05/06/15 documenting Patient #1 made a Police Report. Record review of the medical record of Patient #1 revealed she was a 37 year-old female admitted to the psychiatric facility on 04/27/15 at 0830 under Emergency Detention (ED) when she cut her wrist and called a friend to call Police. Patient #1 has a history of Depression with Anxiety.	Y 523		

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Y 523	Continued From page 20 Further review of Patient #1's permanent records revealed no documentation following the sexual assault allegation that she made on 04/27/15 against Patient #2. There was no documentation in her record that she received a physical and/or psychological assessment following her allegation on 04/27/15. There was a Telephone Physician Order (PO) on 04/27/15 at 12:30 PM (following the allegation) for Ativan (an anti-anxiety) 2 milligrams by mouth "now" without documentation of the reason for the emergency medication. The only documentation in Patient #1's record regarding her allegation against Patient #2 was a Behavioral Team Progress Note dated 05/01/15 at 12:28 completed by Licensed Social Worker- A that indicated "Patient discussed being sexually assaulted by Patient [#2] in the [facility's] PES unit. Review of Patient #1's Daily Observation Notes for 04/27/15 revealed the following: At 11:30-MHW-A documented 1Q (1=On unit, and Q=Quiet/Calm). At 11:45-MHW-A documented 1B (On unit, and B=In Bed Awake). At 12:00-MHW-A documented 1BA (On unit, In Bed Awake, and A=agitated/restless). At 12:15 MHW-A documented 1BA. At 12:30, 12:45, 13:00, 13:15, 13:30, and 13:45-MHW-A documented 1A (On Unit and agitated/restless). Record review of Patient #2's medical records revealed the following: Patient #2's Psychiatric Evaluation dated 04/24/15 revealed he was a 30 year old male admitted to the PES unit on 04/24/15 with a history of schizoaffective disorder and traumatic	Y 523		

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Y 523	Continued From page 21	Y 523		

brain injury (TBI). Patient #2 was admitted on an ED basis with a history of aggressive behaviors requiring emergency medications to calm him. Patient #2 had recently been discharged from this facility 4-5 weeks prior and has had multiple inpatient treatment episodes over the years (7 inpatient admissions in the previous 5 months). Patient #2 was documented with a known history of aggression and a "history of inappropriate sexual behavior on the unit (masturbating)." Patient #2 had documented borderline intellectual functioning with poor insight, poor judgment, and poor impulse control.

A Behavioral Nursing Shift Assessment completed by the unit RN on 04/27/15 at 18:08 that Patient #2 was found by a female patient touching on her body while she was asleep in bed. MD, and Nurse Manager notified.

A Telephone PO dated 04/27/15 at 2015 for Patient #2 to be transferred to a higher acuity; sister facility.

A Behavior Team Progress noted dated 04/27/15 at 1855 revealed Patient #2 was transferred to a sister facility by the Sheriff's Department.

Review of the facility's Incident Event dated 04/27/15 at 11:37 AM confirmed a Code Green was called for another Patient [#3] in the Child/Adolescent Unit requiring Restraints/Seclusion. Patient #3 required physical restraint at 11:36 AM, and emergency medications at 11:46 AM. Patient #3 was released from restraint at 12:26 PM. This Code Green occurred during the same time frames of Patient #1's allegation on 04/27/15.

Review of the facility's Policy titled, Psychiatric

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Y 523	Continued From page 22 Emergencies-Code Green, last reviewed January 2012 revealed a Code Green was a Psychiatric Emergency. Code Green will be implemented by any unit personnel in the event of unmanageable behavior of an individual to prevent harm to that individual, patients, hospital personnel and/or others the general hospital area. D. Individuals responding to Code Green will meet in announced area. Available personnel is necessary to control atmosphere through a show of strength and caring or to assist in physical management. Interview on 08/06/15 at 12:35 PM with the PES unit RN revealed she completed Patient #1's admission assessment to the PES unit on 04/27/15. The unit RN indicated Patients were provided with paper scrubs to wear without other undergarments. The unit RN stated that on 04/27/15 at approximately 11:30 AM to 12:00 PM, "Code Greens" were going on; and "staff were busy". The unit RN stated there was a Code Green on another unit (child/adolescent) and a Code Green was called in the lobby; due to a patient needing to be "put in a [restraint] chair" because they were tearing up the lobby. The unit RN stated she left the unit to respond to the Code Green in the other unit (child/adolescent) and when she arrived; there was another RN responding, so she went to the Code Green in the lobby because they needed an RN to assist with "putting the patient in the [restraint] chair." The unit RN stated she returned to the PES unit following the Code Greens to "something else going on at the end of the unit" that she responded to. The unit RN stated she could not remember if it was LVN-A or LVN-B working on 04/27/15; but that she thought the LVN stayed back in the PES unit when she left and responded to the two Code Greens. The unit RN	Y 523		

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Y 523	Continued From page 23 stated she was notified that during the Code Greens Patient #2 went into Patient #1's bedroom; and Patient #1 made an allegation of sexual assault. The unit RN stated she spoke with Patient #1 who reported that she was asleep in her bedroom and "she felt pressure" causing her to awake to Patient #2 touching her in the buttock and perineal area. The unit RN stated that Patient #1's paper pants were "torn on the side." The unit RN stated the local PD was called. The unit RN stated she spoke to Patient #2 and he said, "I touched her, but didn't do anything else." The unit RN stated he admitted that he "touched her and ripped her paper pants." The unit RN stated that Patient #2 knew that the unit was "chaotic" and knew what Code Green meant; and that is when he "took advantage" of the situation. The unit RN stated she believed that Patient #2 sexually assaulted Patient #1 given the facts, and his own admission. The unit RN stated she notified the MD, Social Worker, and Nursing Manager of the allegation. The unit RN indicated she documented the sexual assault allegation made by Patient #1 on the facility's Event Report; however, confirmed she did not document the sexual assault allegation in Patient #1's record following the incident. The unit RN stated she offered for Patient #1 to have a Sexual Assault Nurse Examination (SANE) completed at another facility if she wanted; but Patient #1 declined, stating she did not believe Patient #2 actually raped her. Interview on 08/06/15 at 04:45 PM with MHW-A revealed she was the only MHW working on 04/27/15 in the PES unit; along with the unit RN and a Licensed Vocational Nurse (LVN). MHW-A stated she was pulled to the PES unit at 9:15 AM and was unfamiliar to the PES unit; but was told	Y 523		

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Y 523	Continued From page 24 by the leaving MHW to "watch it" for Patient #2, however, she did not know the specific reason why. MHW-A stated the females were assigned rooms on one side, and males on the other side. MHW-A stated during the morning on 04/27/15 at approximately 11:30 AM-12:00 PM it was a "hectic/busy" day with "Code Green's being called." MHW-A stated that security was usually on the PES unit; but on 04/27/15 at the time of the allegation; "security could not be found." MHW-A stated on 04/27/15 at around 11:30-12:00 PM she stayed in the unit when the Code Greens were called and was "getting something out of the supply closet." MHW-A indicated the unit RN "responded to the Code Green" leaving the unit; telling her she [unit RN] would be back. MHW-A did not remember if LVN-A or LVN-B was working on 04/27/15; but further stated she did not remember any LVN being in the unit during the time of the allegation made by Patient #1. MHW-A stated shortly after this Patient #1 "flagged her [MHW-A] down" to her bedroom, and into the restroom of the bedroom where she reported that Patient #2 came into her room and touched her buttocks and vaginal area while she was sleeping in her bed. MHW-A stated that Patient #1's gown was torn around the buttock area and she offered to call the local PD for Patient #1 to make a report. MHW-A stated she then reported the incident/allegation to the unit RN. MHW-A stated she was later told that Patient #2 had been an inpatient to the facility many times before, and he "knows the system; knows what Code Green means." MHW-A stated she had seen Patient #2 "walking out of her [Patient #1] room a few times" and further stated "right before she flagged me down, he had walked out of her room". MHW-A indicated she told Patient #2 "not to go in to other people's rooms." MHW-A confirmed she had not	Y 523		

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Y 523	Continued From page 25 documented the allegation reported by Patient #1 against Patient #2; but that she "told [unit RN]." Interview on 08/10/15at 1:20 PM with Patient #1 revealed on 04/27/15 at approximately 11:30-11:45 AM she was in her assigned bedroom sleeping after she received multiple medications following her admission. Patient #1 stated she awoke after she "felt pressure" in her buttock and vaginal area. Patient #1 stated that Patient #2 was present telling her not to tell anyone. Patient #1 stated that she noticed her paper pants were ripped and she was not actually aware what all Patient #2 actually did because she "was conked out" after taking multiple medications. Patient #1 stated she knows he touched her because that was what woke her up. Patient #1 stated she was very upset, "freaked out," and asked the MD for an "AIDS" test. Patient #1 stated the unit RN indicated to the nursing staff (LVN) to "give her more meds" because she was "upset, crying, and freaking out." Patient #1 stated she then received the Ativan for her anxiety, to "help me calm down." Patient #1 stated the local PD came and she made a report. Patient #1 stated she was told by the unit RN that "Code Green's" were called and "everyone had to leave the unit" which allowed the opportunity for Patient #2 to go into her room unsupervised. Interview on 08/10/15 at 2:20 PM with Security Guard-A revealed he was employed by the facility to maintain security and the safety of patients. The Security Guard-A stated Patient #2 had a history of inappropriate sexual behavior of "masturbating in front of females." The Security Guard-A stated he assisted with "viewing the video" footage for evidence following the	Y 523		

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Y 523	Continued From page 26 allegation on 04/27/15 made be Patient #1 against Patient #2. The Security Guard stated the video footage from 04/27/15 showed a total of "four times" that Patient #2 went into Patient #1's room; and the last time Patient #2 came out of Patient #1's room; she was observed to come out of the room a few minutes later. The Security Guard stated that Patient #2 had already been assigned to the front "seclusion room" of the PES unit as his bedroom due to his history of masturbating. The Security Guard stated on the video footage Patient #2 could be seen coming from his room; "looking side to side" down the hallway, and then going into Patient #1's room. The Security Guard stated that female and male patient rooms were separated and that Patient #2 was not supposed to be going into Patient #1's room for any reason. Interview on 08/10/15 at 2:50 PM with MD-A revealed he was notified of Patient #1's sexual assault allegation against Patient #2 on 04/27/15. MD-A stated he discussed with Patient #1 the option of a "Rape Kit" but she "declined." MD-A stated he understood the allegation made by Patient #1 to be "only touching with no penetration." MD-A stated that Patient #1 was "distressed" about the incident and he ordered Ativan for Patient #1's anxiety following the incident. MD-A stated Patient #1 had already been distressed emotionally because of her ED inpatient admission; and really did not even want to take the Ativan. MD-A stated he recalled there was a Code Green called where staff left the unit in response to the Code Green; which left less staffing in the unit. MD-A confirmed that he did not document in Patient #1's records his contact or discussion with Patient #1 following her allegation.	Y 523		

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Y 523	Continued From page 27 Interview on 08/10/15 at 3:00 PM with the facility's Risk Manager (RM) indicated that she was aware of the alleged sexual assault allegation made by Patient #1 on 04/27/15 against Patient #2'; however, she had not been notified until 05/06/15 via the facility's Incident/Event electronic system because there had not been any harm documented in order to elevate the notification. The RM stated the staffing ratio on the PES unit was 1 staff to 4 patients. The RM indicated on 04/27/15 the patient census in the PES unit was 11; requiring 3 staff. The RM stated the first required staff is an RN, and then second could be a LVN, and/or MHW. The RM confirmed for 11 patients the required staffing would be 3. The RM stated the PES unit was to always have a licensed nurse present and available in the unit. The RM confirmed that she had not reported the sexual assault allegation made by Patient #1 on 04/27/15 against Patient #2 to the state health care regulatory agency, Department of State Health Services (DSHS); which was determined to have occurred as a result of insufficient staffing in the PES unit during episodes of Code Green's. The RM further confirmed the facility had not completed a thorough investigation with documented findings specific to this allegation for the determination of Neglect and/or a corrective action plan to prevent repeat incidence; in accordance with the facility's policy. The RM stated she had not seen or viewed the video footage following this allegation due to the video being unavailable after 05/06/15; following her electronic notification. Interview on 08/10/15 at 3:15 PM with Licensed Social Worker (LSW)-A stated she assisted Security Guard-A in viewing the video footage on	Y 523		

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Y 523	Continued From page 28 04/27/15 after Patient #1 made a sexual assault allegation against Patient #2. LSW-A stated that during the allegation on 04/27/15; Patient #2 could be seen on the camera "looking both ways" and then would go into Patient #1's bedroom. LSW-A stated they were able to count this event occurring a "couple of times" where Patient #2 would go into Patient #1's bedroom and remain there "a couple of minutes" each time. LSW-A stated she saw on the video where MHW-A had been in the "Patient evaluation room" during these time periods; where a supply closet was located. LSW-A stated Patient #2 had a history of "exposing his self, public masturbation, and talks sexually to other women." LSW-A stated that Patient #2 has publically masturbated in front of her during an assessment interview. Interview on 08/10/15 at 4:15 PM with LVN-A stated he was present and worked the PES unit on 04/27/15. LVN-A stated that on 04/27/15 there were Code Greens called on another unit, and in the facility's lobby about the same time. LVN-A stated he responded to the Code Green in the lobby to assist due to a "fight." LVN-A indicated he had left the unit for approximately 15 minutes. Interview on 08/10/15 at 4:30 PM with the Vice President (VP) of Clinical Services confirmed that she was notified of the sexual allegation made by Patient #1 against Patient #2 on 04/27/15; however, she had not been notified until 05/06/15 via the facility's Incident/Event electronic system because there had not been any harm documented in order to elevate the notification. The VP of Clinical Services indicated that on 04/27/15 the Nursing Clinical Director (Nurse Manager) had been notified immediately following	Y 523		

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Y 523	Continued From page 29 Patient #1's allegation and she had not obtained information that indicated Patient #1's allegation had occurred due to insufficient staffing in the PES unit when Code Green's had been called; leaving the unit without a RN available. The VP of Clinical Services stated that the unit RN was not supposed to leave the unit and there should always be a Licensed Nurse in the unit during a Code Green; that "it is a judgement call." The VP of Clinical Services stated she had not seen or viewed the video footage following this allegation due to the video being unavailable after 05/06/15; following her electronic notification. Interview on 08/10/15 at 4:40 PM with the Nursing Clinical Director (Nurse Manager) stated she was immediately notified by the PES unit RN on 04/27d/15 of Patient #1's sexual allegation against Patient #2. The Nursing Clinical Director indicated she "separated" the Patients, talked to both of them, and Patient #1 saw the Doctor. The Nursing Clinical Director stated she spoke to the unit RN about the allegation but had not been notified or received information that the RN and LVN had left the PES unit to respond to Code Greens which left the unit without a RN and/or licensed nurse available. The Nursing Clinical Director stated she had not seen or viewed the video footage following this allegation.	Y 523		

SOD-State Forms

Texas Department of State Health Services

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X 000	INITIAL COMMENTS Note: The State Form is an official, legal document. All information must remain unchanged except for entering the plan of correction, correction dates, and the signature space. Any discrepancy in the original deficiency citation(s) will be referred to the Office of the Texas Attorney General (OAG) for possible fraud. If information is inadvertently changed by the provider/supplier, the State Survey Agency (SA) should be notified immediately. An unannounced visit was conducted from 08/06/15 to 08/10/15 to conduct a survey for complaint investigation (TX 00218998). An entrance conference was conducted on 08/06/15 in the conference room of the facility with the Director of Risk Management. The purpose and process of the complaint survey were discussed and an opportunity for questions was provided. Complaint, TX 00218998, was substantiated with state violations cited. An exit conference was conducted on 08/10/15 in the conference room. The Director of Risk Management, the Vice President of Clinical Services, the Nursing Clinical Director, and Interim Behavioral Health Administrator were in attendance. Preliminary findings of the survey were discussed and an opportunity for questions was provided.	X 000		
X 365	133.41(o)(2)(B) Staffing: adequate personnel Nursing Services. Staffing and delivery of care.	X 365	**Plan of Correction** **X365** Mandatory In-services to be conducted on 9/14, 9/16, and 9/18 for all behavioral health staff with multiple offerings in	9/18/15

SOD - State Form

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Angela Dreal — TITLE: VP, Behavioral Health Svcs — (X6) DATE: 9/11/15

Texas Department of State Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	000415	A. BUILDING: _____ B. WING _____	C 08/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NIX HEALTH CARE SYSTEM	414 NAVARRO, SUITE 600 SAN ANTONIO, TX 78205

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
X 365	Continued From page 1 (B) There shall be adequate numbers of RNs, licensed vocational nurses (LVNs), and other personnel to provide nursing care to all patients as needed. . This Requirement is not met as evidenced by: Based on record review and interview, the facility failed to ensure there were sufficient numbers of licensed registered nurses (RN), licensed vocational nurses (LVN), and other personnel immediately available at all times in the unit to ensure the provision of care and supervision for patients (Patient #1 and #2) as required; resulting in an allegation of Neglect. Specifically, on 04/27/15, Patient #1 reported to the unit's Registered Nurse (RN) an allegation of sexual assault from another Patient (#2), who had a history of inappropriate sexual behaviors, after the unit RN and LVN left their assigned unit to respond to "Code Green's" (psychiatric emergencies) in other units/areas of the facility. This deficient practice affected Patient #1's provision of care and compromised her safety resulting in allegation of Neglect due to insufficient staffing in the unit.	X 365	order to ensure all staff are able to attend one of these educational events. The mandatory in-service will reinforce the hospital policy regarding Assessment and Reporting of Abuse and Neglect, reinforce the need to document outlier events affecting patients, and roll out the Code Green Response Protocol. The Code Green Response Protocol includes the following: 1.) reinforces assigning a specific Code Green response team to include back up for breaks as appropriate as well as for census level and unit acuity to ensure appropriate staffing is left on inpatient units, 2.) provides instruction for responding in the event multiple codes are called at the same time. to insure patient and staff safety, 3.) Psychiatric Emergency Service Unit (PES) staff will not respond to Code Greens unless the unit is overstaffed for its current population, 4.) reinforces that all supervisors will respond to Code Green, 5.) reinforces what should happen to maintain safety on the units when the Code Green team responds which includes: a.) suspension of non-essential tasks, b.) cohort the patients as much as possible to control the situation and monitor for safety, c.) response team clearly communicates to their charge when they leave from and return to the unit. Follow up in-servicing is planned for February 2016 to include participation by same staff members to continue reinforcement of policies.	

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X 365	Continued From page 2 Findings Included: Review of Patient #1's Complaint Form dated 05/15/15 indicated the following in part: On 04/27/15 at approximately 11:30 AM Patient #1 was admitted to the facility's "Psychiatric Emergency Services (PES) unit and received medication to help her sleep and calm down. Patient #1 reported shortly after she received the medications; she was asleep in her bed when she "felt someone touching my vagina and butt. I felt a hard pressure. I jumped up and another male patient [#2] jumped out from under my covers." Patient #1 stated she went to find a staff member (Mental Health Worker-A), to report what had happened. Patient #1 indicated she noticed her entire "crotch area [paper gown] was torn exposing her "vagina and butt." Patient #1 indicated the facility staff called the Police Department (PD) for Patient #1 to make a report. Patient #1 reported the staff apologized to her for the incident; "but they had an emergency on another floor and they were short staffed, so every staff member had left." Patient #1 indicated she was "so upset and scared; so they gave me more meds to put me to sleep." Patient #1 stated the facility had done nothing more to help her; there were no witnesses but she believed there were cameras in the hall. Patient #1 stated she found out that Patient #2 had done this before and the Police Officer who responded stated that; "he [Patient #2] has a history of doing this; why was he unsupervised?" Review of the facility's Policy titled, Abuse Reporting-External and Internal, last reviewed January 2012 revealed the following definitions: Psychological Abuse included; humiliation and harassment.	X 365		

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X 365	Continued From page 3 Sexual Abuse included; sexual harassment, sexual coercion, and sexual assault. Review of the facility's Policy titled, Assessment and Reporting of Abuse and Neglect, last reviewed February 2013 revealed Neglect included the failure to provide for one's self the goods or services including medical services, which are necessary to avoid physical or emotional harm or pain or the failure of a caretaker to provide the goods or services. The policy indicated the facility "prohibits neglect, mental or physical abuse or misappropriation of property, of patients by staff, visitors, or other patients." The facility "will report allegations and release information to the proper authorities, according to federal regulations, state specific rules and regulation and [facility] practice guidelines." Review of the facility's Original Event report dated 04/27/15 at 12:15 PM completed by the unit RN revealed Patient #1 reported, "She was lying in bed asleep, when she felt Patient [#2] putting pressure around her buttocks area, and then touching her perineal area. Patient[#1] reported sitting up in bed shock and scared, and found Patient [#2] was up in her face with his finger to his mouth telling her to be quiet not to tell. She found her paper scrub button torned on the outer left side. MD [Medical Doctor], Nurse Manager notified, Patient made a police complaint." PD interviewed Patient #1 and accused, Patient #2. "Patient visible distraught, but no other physical problems noted at this time." Further review of the Original Event indicated the Event was documented as "Attempted Rape/Rape/Sexual Assault." Factors included; "Unit busy code greens called on other unit, and high acute of unit."	X 365		

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X 365	Continued From page 4 Record review of the medical record of Patient #1 revealed she was a 37 year-old female admitted to the psychiatric facility on 04/27/15 at 0830 under Emergency Detention (ED) when she cut her wrist and called a friend to call Police. Patient #1 has a history of Depression with Anxiety. Further review of Patient #1's permanent records revealed no documentation following the sexual assault allegation that she made on 04/27/15 against Patient #2. There was no documentation in her record that she received a physical and/or psychological assessment following her allegation on 04/27/15. There was a Telephone Physician Order (PO) on 04/27/15 at 12:30 PM (following the allegation) for Ativan (an anti-anxiety) 2 milligrams by mouth "now" without documentation of the reason for the emergency medication. The only documentation in Patient #1's record regarding her allegation against Patient #2 was a Behavioral Team Progress Note dated 05/01/15 at 12:28 completed by Licensed Social Worker- A that indicated "Patient discussed being sexually assaulted by Patient [#2] in the [facility's] PES unit. Review of Patient #1's Daily Observation Notes for 04/27/15 revealed the following: At 11:30-MHW-A documented 1Q (1=On unit, and Q=Quiet/Calm). At 11:45-MHW-A documented 1B (On unit, and B=In Bed Awake). At 12:00-MHW-A documented 1BA (On unit, In Bed Awake, and A=agitated/restless). At 12:15 MHW-A documented 1BA. At 12:30, 12:45, 13:00, 13:15, 13:30, and 13:45-MHW-A documented 1A (On Unit and agitated/restless).	X 365		

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X 365	Continued From page 5 Record review of Patient #2's medical records revealed the following: Patient #2's Psychiatric Evaluation dated 04/24/15 revealed he was a 30 year old male admitted to the PES unit on 04/24/15 with a history of schizoaffective disorder and traumatic brain injury (TBI). Patient #2 was admitted on an ED basis with a history of aggressive behaviors requiring emergency medications to calm him. Patient #2 had recently been discharged from this facility 4-5 weeks prior and has had multiple inpatient treatment episodes over the years (7 inpatient admissions in the previous 5 months). Patient #2 was documented with a known history of aggression and a "history of inappropriate sexual behavior on the unit (masturbating)." Patient #2 had documented borderline intellectual functioning with poor insight, poor judgment, and poor impulse control. A Behavioral Nursing Shift Assessment completed by the unit RN on 04/27/15 at 18:08 that Patient #2 was found by a female patient touching on her body while she was asleep in bed. MD, and Nurse Manager notified. A Telephone PO dated 04/27/15 at 2015 for Patient #2 to be transferred to a higher acuity; sister facility. A Behavior Team Progress noted dated 04/27/15 at 1855 revealed Patient #2 was transferred to a sister facility by the Sheriff's Department. Review of the facility's Incident Event dated 04/27/15 at 11:37 AM confirmed a Code Green was called for another Patient [#3] in the Child/Adolescent Unit requiring	X 365		

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X 365	Continued From page 6 Restraints/Seclusion. Patient #3 required physical restraint at 11:36 AM, and emergency medications at 11:46 AM. Patient #3 was released from restraint at 12:26 PM. This Code Green occurred during the same time frames of Patient #1's allegation on 04/27/15. Review of the facility's Policy titled, Psychiatric Emergencies-Code Green, last reviewed January 2012 revealed a Code Green was a Psychiatric Emergency. Code Green will be implemented by any unit personnel in the event of unmanageable behavior of an individual to prevent harm to that individual, patients, hospital personnel and/or others the general hospital area. D. Individuals responding to Code Green will meet in announced area. Available personnel is necessary to control atmosphere through a show of strength and caring or to assist in physical management. Interview on 08/06/15 at 12:35 PM with the PES unit RN revealed she completed Patient #1's admission assessment to the PES unit on 04/27/15. The unit RN indicated Patients were provided with paper scrubs to wear without other undergarments. The unit RN stated that on 04/27/15 at approximately 11:30 AM to 12:00 PM, "Code Greens" were going on; and "staff were busy". The unit RN stated there was a Code Green on another unit (child/adolescent) and a Code Green was called in the lobby; due to a patient needing to be "put in a [restraint] chair" because they were tearing up the lobby. The unit RN stated she left the unit to respond to the Code Green in the other unit (child/adolescent) and when she arrived; there was another RN responding, so she went to the Code Green in the lobby because they needed an RN to assist with "putting the patient in the [restraint] chair." The	X 365		

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X 365	Continued From page 7 unit RN stated she returned to the PES unit following the Code Greens to "something else going on at the end of the unit" that she responded to. The unit RN stated she could not remember if it was LVN-A or LVN-B working on 04/27/15; but that she thought the LVN stayed back in the PES unit when she left and responded to the two Code Greens. The unit RN stated she was notified that during the Code Greens Patient #2 went into Patient #1's bedroom; and Patient #1 made an allegation of sexual assault. The unit RN stated she spoke with Patient #1 who reported that she was asleep in her bedroom and "she felt pressure" causing her to awake to Patient #2 touching her in the buttock and perineal area. The unit RN stated that Patient #1's paper pants were "torn on the side." The unit RN stated the local PD was called. The unit RN stated she spoke to Patient #2 and he said, "I touched her, but didn't do anything else." The unit RN stated he admitted that he "touched her and ripped her paper pants." The unit RN stated that Patient #2 knew that the unit was "chaotic" and knew what Code Green meant; and that is when he "took advantage" of the situation. The unit RN stated she believed that Patient #2 sexually assaulted Patient #1 given the facts, and his own admission. The unit RN stated she notified the MD, Social Worker, and Nursing Manager of the allegation. The unit RN indicated she documented the sexual assault allegation made by Patient #1 on the facility's Event Report; however, confirmed she did not document the sexual assault allegation in Patient #1's record following the incident. The unit RN stated she offered for Patient #1 to have a Sexual Assault Nurse Examination (SANE) completed at another facility if she wanted; but Patient #1 declined, stating she did not believe Patient #2 actually raped her.	X 365		

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X 365	Continued From page 8 Interview on 08/06/15 at 04:45 PM with MHW-A revealed she was the only MHW working on 04/27/15 in the PES unit; along with the unit RN and a Licensed Vocational Nurse (LVN). MHW-A stated she was pulled to the PES unit at 9:15 AM and was unfamiliar to the PES unit; but was told by the leaving MHW to "watch it" for Patient #2, however, she did not know the specific reason why. MHW-A stated the females were assigned rooms on one side, and males on the other side. MHW-A stated during the morning on 04/27/15 at approximately 11:30 AM-12:00 PM it was a "hectic/busy" day with "Code Green's being called." MHW-A stated that security was usually on the PES unit; but on 04/27/15 at the time of the allegation; "security could not be found." MHW-A stated on 04/27/15 at around 11:30-12:00 PM she stayed in the unit when the Code Greens were called and was "getting something out of the supply closet." MHW-A indicated the unit RN "responded to the Code Green" leaving the unit; telling her she [unit RN] would be back. MHW-A did not remember if LVN-A or LVN-B was working on 04/27/15; but further stated she did not remember any LVN being in the unit during the time of the allegation made by Patient #1. MHW-A stated shortly after this Patient #1 "flagged her [MHW-A] down" to her bedroom, and into the restroom of the bedroom where she reported that Patient #2 came into her room and touched her buttocks and vaginal area while she was sleeping in her bed. MHW-A stated that Patient #1's gown was torn around the buttock area and she offered to call the local PD for Patient #1 to make a report. MHW-A stated she then reported the incident/allegation to the unit RN. MHW-A stated she was later told that Patient #2 had been an inpatient to the facility many times before, and he "knows the system;	X 365		

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X 365	Continued From page 9 knows what Code Green means." MHW-A stated she had seen Patient #2 "walking out of her [Patient #1] room a few times" and further stated "right before she flagged me down, he had walked out of her room". MHW-A indicated she told Patient #2 "not to go in to other people's rooms." MHW-A confirmed she had not documented the allegation reported by Patient #1 against Patient #2; but that she "told [unit RN]." Interview on 08/10/15at 1:20 PM with Patient #1 revealed on 04/27/15 at approximately 11:30-11:45 AM she was in her assigned bedroom sleeping after she received multiple medications following her admission. Patient #1 stated she awoke after she "felt pressure" in her buttock and vaginal area. Patient #1 stated that Patient #2 was present telling her not to tell anyone. Patient #1 stated that she noticed her paper pants were ripped and she was not actually aware what all Patient #2 actually did because she "was conked out" after taking multiple medications. Patient #1 stated she knows he touched her because that was what woke her up. Patient #1 stated she was very upset, "freaked out," and asked the MD for an "AIDS" test. Patient #1 stated the unit RN indicated to the nursing staff (LVN) to "give her more meds" because she was "upset, crying, and freaking out." Patient #1 stated she then received the Ativan for her anxiety, to "help me calm down." Patient #1 stated the local PD came and she made a report. Patient #1 stated she was told by the unit RN that "Code Green's" were called and "everyone had to leave the unit" which allowed the opportunity for Patient #2 to go into her room unsupervised. Interview on 08/10/15 at 2:20 PM with Security	X 365		

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X 365	Continued From page 10 Guard-A revealed he was employed by the facility to maintain security and the safety of patients. The Security Guard-A stated Patient #2 had a history of inappropriate sexual behavior of "masturbating in front of females." The Security Guard-A stated he assisted with "viewing the video" footage for evidence following the allegation on 04/27/15 made be Patient #1 against Patient #2. The Security Guard stated the video footage from 04/27/15 showed a total of "four times" that Patient #2 went into Patient #1's room; and the last time Patient #2 came out of Patient #1's room; she was observed to come out of the room a few minutes later. The Security Guard stated that Patient #2 had already been assigned to the front "seclusion room" of the PES unit as his bedroom due to his history of masturbating. The Security Guard stated on the video footage Patient #2 could be seen coming from his room; "looking side to side" down the hallway, and then going into Patient #1's room. The Security Guard stated that female and male patient rooms were separated and that Patient #2 was not supposed to be going into Patient #1's room for any reason. Interview on 08/10/15 at 2:50 PM with MD-A revealed he was notified of Patient #1's sexual assault allegation against Patient #2 on 04/27/15. MD-A stated he discussed with Patient #1 the option of a "Rape Kit" but she "declined." MD-A stated he understood the allegation made by Patient #1 to be "only touching with no penetration." MD-A stated that Patient #1 was "distressed" about the incident and he ordered Ativan for Patient #1's anxiety following the incident. MD-A stated Patient #1 had already been distressed emotionally because of her ED inpatient admission; and really did not even want to take the Ativan. MD-A stated he recalled there	X 365		

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X 365	Continued From page 11 was a Code Green called where staff left the unit in response to the Code Green; which left less staffing in the unit. Interview on 08/10/15 at 3:00 PM with the facility's Risk Manager (RM) indicated that she was aware of the alleged sexual assault allegation made by Patient #1 on 04/27/15 against Patient #2'; however, she had not been notified until 05/06/15 via the facility's Incident/Event electronic system because there had not been any harm documented in order to elevate the notification. The RM stated the staffing ratio on the PES unit was 1 staff to 4 patients. The RM indicated on 04/27/15 the patient census in the PES unit was 11; requiring 3 staff. The RM stated the first required staff is an RN, and then second could be a LVN, and/or MHW. The RM confirmed for 11 patients the required staffing would be 3. The RM stated the PES unit was to always have a licensed nurse present and available in the unit. The RM stated she had not seen or viewed the video footage following this allegation due to the video being unavailable after 05/06/15; following her electronic notification. The RM stated there would not be documentation of the Code Green that may have occurred on 04/27/15 in the facility's lobby waiting area; if the patient had not yet been assessed for care. Interview on 08/10/15 at 3:15 PM with Licensed Social Worker (LSW)-A stated she assisted Security Guard-A in viewing the video footage on 04/27/15 after Patient #1 made a sexual assault allegation against Patient #2. LSW-A stated that during the allegation on 04/27/15; Patient #2 could be seen on the camera "looking both ways" and then would go into Patient #1's bedroom.	X 365		

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X 365	Continued From page 12 LSW-A stated they were able to count this event occurring a "couple of times" where Patient #2 would go into Patient #1's bedroom and remain there "a couple of minutes" each time. LSW-A stated she saw on the video where MHW-A had been in the "Patient evaluation room" during these time periods; where a supply closet was located. LSW-A stated Patient #2 had a history of "exposing his self, public masturbation, and talks sexually to other women." LSW-A stated that Patient #2 has publically masturbated in front of her during an assessment interview. Interview on 08/10/15 at 4:15 PM with LVN-A stated he was present and worked the PES unit on 04/27/15. LVN-A stated that on 04/27/15 there were Code Greens called on another unit, and in the facility's lobby about the same time. LVN-A stated he responded to the Code Green in the lobby to assist due to a "fight." LVN-A indicated he had left the unit for approximately 15 minutes. Interview on 08/10/15 at 4:30 PM with the Vice President (VP) of Clinical Services confirmed that she was notified of the sexual allegation made by Patient #1 against Patient #2 on 04/27/15; however, she had not been notified until 05/06/15 via the facility's Incident/Event electronic system because there had not been any harm documented in order to elevate the notification. The VP of Clinical Services indicated that on 04/27/15 the Nursing Clinical Director (Nurse Manager) had been notified immediately following Patient #1's allegation and she had not obtained information that indicated Patient #1's allegation had occurred due to insufficient staffing in the PES unit when Code Green's had been called; leaving the unit without a RN available. The VP	X 365		

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X 365	Continued From page 13 of Clinical Services stated that the unit RN was not supposed to leave the unit and there should always be a Licensed Nurse in the unit during a Code Green; that "it is a judgement call." The VP of Clinical Services stated she had not seen or viewed the video footage following this allegation due to the video being unavailable after 05/06/15; following her electronic notification. Interview on 08/10/15 at 4:40 PM with the Nursing Clinical Director (Nurse Manager) stated she was immediately notified by the PES unit RN on 04/27d/15 of Patient #1's sexual allegation against Patient #2. The Nursing Clinical Director indicated she "separated" the Patients, talked to both of them, and Patient #1 saw the Doctor. The Nursing Clinical Director stated she spoke to the unit RN about the allegation but had not been notified or received information that the RN and LVN had left the PES unit to respond to Code Greens which left the unit without a RN and/or licensed nurse available. The Nursing Clinical Director stated she had not seen or viewed the video footage following this allegation.	X 365		
X 794	133.42(a)(1) Patient rights requirements: all hospitals Patient Rights. Patient rights requirements for all hospitals. A hospital shall adopt, implement, and enforce a policy to ensure patients' rights.	X 794	**Plan of Correction** **X 794** Mandatory read and sign in-service for all front-line behavioral health staff to include nursing, MHT, NP, social workers, intake/assessment, security and admitting to be completed by 9/14/15. Mandatory In-services to be conducted on 9/14, 9/16, and 9/18 for all behavioral health staff with multiple offerings in order to ensure all staff are able to attend one of these educational events. The mandatory in-service will reinforce the	9/14/15

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X 794	Continued From page 14 This Requirement is not met as evidenced by: Based on interview and record review, the facility failed to ensure the patient's rights to be free from all forms of abuse or harassment by failing to prevent, protect, investigate, and report/respond to an allegation of neglect in accordance with their policy, for 1 of 1 patients reviewed (Patient #1) with a complaint allegation of sexual assault against another patient (Patient #2). On 04/27/15, Patient #1 reported to the unit's Registered Nurse (RN) an allegation of sexual assault from another Patient, (#2); who had a history of inappropriate sexual behaviors. The allegation was reported to the Medical Doctor, the Nursing Manager, and local Police Department (PD); however, this allegation was not reported to the state health care regulatory agency by any facility employees, in accordance with their policy. In addition, this allegation was not thoroughly investigated by the facility for the identification of	X 794	hospital policy regarding Assessment and Reporting of Abuse and Neglect, reinforce the need to document outlier events affecting patients, and roll out the Code Green Response Protocol. The Code Green Response Protocol includes the following: 1.) reinforces assigning a specific Code Green response team to include back up for breaks as appropriate as well as for census level and unit acuity to ensure appropriate staffing is left on inpatient units, 2.) provides instruction for responding in the event multiple codes are called at the same time. to insure patient and staff safety, 3.) Psychiatric Emergency Service Unit (PES) staff will not respond to Code Greens unless the unit is overstaffed for its current population, 4.) reinforces that all supervisors will respond to Code Green, 5.) reinforces what should happen to maintain safety on the units when the Code Green team responds which includes: a.) suspension of non-essential tasks, b.) cohort the patients as much as possible to control the situation and monitor for safety, c.) response team clearly communicates to their charge when they leave from and return to the unit. Additional topics for the mandatory in-service include: a decision tree to reinforce the policy on reporting and follow-up of suspected/reported	

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X 794	Continued From page 15 neglect and/or a corrective action plan to prevent repeat incidence; in accordance with the facility's policy. This deficient practice could affect the prevention of possible unidentified abuse, neglect, or mistreatment for all patients in the facility; by compromising their safety. Findings Included: Review of Patient #1's Complaint Form dated 05/15/15 indicated the following in part: On 04/27/15 at approximately 11:30 AM Patient #1 was admitted to the facility's "Psychiatric Emergency Services (PES) unit and received medication to help her sleep and calm down. Patient #1 reported shortly after she received the medications; she was asleep in her bed when she "felt someone touching my vagina and butt. I felt a hard pressure. I jumped up and another male patient [#2] jumped out from under my covers." Patient #1 stated she went to find a staff member (Mental Health Worker-A), to report what had happened. Patient #1 indicated she noticed her entire "crotch area [paper gown] was torn exposing her "vagina and butt." Patient #1 indicated the facility staff called the Police Department (PD) for Patient #1 to make a report. Patient #1 reported the staff apologized to her for the incident; "but they had an emergency on another floor and they were short staffed, so every staff member had left." Patient #1 indicated she was "so upset and scared; so they gave me more meds to put me to sleep." Patient #1 stated the facility had done nothing more to help her; there were no witnesses but she believed there were cameras in the hall. Patient #1 stated she found out that Patient #2 had done this before and the Police Officer who responded stated that;	X 794	allegations of abuse/neglect of a patient during hospitalization and in treating patients identified as having ordered sexual precautions. Follow up in-servicing is planned for February 2016 to include participation by same staff members to continue reinforcement of policies.	

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X 794	Continued From page 16 "he [Patient #2] has a history of doing this; why was he unsupervised?" Review of the facility's Policy titled, Abuse Reporting-External and Internal, last reviewed January 2012 revealed the following definitions: Psychological Abuse included; humiliation and harassment. Sexual Abuse included; sexual harassment, sexual coercion, and sexual assault. Review of the facility's Policy titled, Assessment and Reporting of Abuse and Neglect, last reviewed February 2013 revealed Neglect included the failure to provide for one's self the goods or services including medical services, which are necessary to avoid physical or emotional harm or pain or the failure of a caretaker to provide the goods or services. The policy indicated the facility "prohibits neglect, mental or physical abuse or misappropriation of property, of patients by staff, visitors, or other patients." The facility "will report allegations and release information to the proper authorities, according to federal regulations, state specific rules and regulation and [facility] practice guidelines." Further review of the policy indicated, in part: 1. Reporting allegations of abuse and/or neglect occurring while the patient is under the care in the facility: All alleged violations concerning abuse and neglect while the patient is under the care of the facility will be reported to the Compliance Officer or designee, who will advise the on-call administrator/designee. As appropriate, the facility will report the incident to appropriate state, federal and protective/regulatory agencies, and/or law enforcement agencies and conduct an internal investigation within a maximum of five	X 794		

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X 794	Continued From page 17 working days of the incident. The Texas Department of state Health Services (DSHS) is the regulatory body for reporting concerns of hospitals, psychiatric hospitals (including private psychiatric facilities), and various other medical facilities. 2. Investigations are always prompt, comprehensive and responsive to the situation, well conducted, and contain founded conclusions. The investigation may include, but are not limited to the following: -Interviews conducted with individuals having first-hand knowledge of the incident. -Follow-up resolution -Corrective action plan to prevent repeat incidence. -Reports made to appropriate state health care regulatory agency. Review of the facility's Original Event report dated 04/27/15 at 12:15 PM completed by the unit RN revealed Patient #1 reported, "She was lying in bed asleep, when she felt Patient [#2] putting pressure around her buttocks area, and then touching her perineal area. Patient[#1] reported sitting up in bed shock and scared, and found Patient [#2] was up in her face with his finger to his mouth telling her to be quiet not to tell. She found her paper scrub button torned on the outer left side. MD [Medical Doctor], Nurse Manager notified, Patient made a police complaint." PD interviewed Patient #1 and accused, Patient #2. "Patient visible distraught, but no other physical problems noted at this time." Further review of the Original Event indicated the Event was documented as "Attempted Rape/Rape/Sexual Assault." Factors included; "Unit busy code greens called on other unit, and high acute of	X 794		

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X 794	Continued From page 18 unit." The Original Event report did not include any documentation that this allegation was reported to the state health care regulatory agency by any facility employees, in accordance with the facility's policy. The Original Event report did not include documentation that this allegation was thoroughly investigated by the facility for the identification of neglect and/or a corrective action plan to prevent repeat incidence; in accordance with the facility's policy. The Compliance Officer/Director of Risk Management (RM) acknowledged receipt of the Original Event report dated 04/27/15 at 12:15 PM electronically on 05/06/15 documenting Patient #1 made a Police Report. Review of the local PD report dated 04/27/15 at 12:45PM revealed Patient #1 wanted to report that, "she was a sleep in her room, when she awaken and felt pressure around her buttock and vaginal area. When she fully awaken, she observed [Patient #2] in bed with her." Patient #1 further stated that Patient #2 told her "Don't tell anyone," before he left.her room. Patient #1 did not feel Patient #2 penetrate her at any time, but the hospital [paper gown] pajama that she was wearing had a tear between the leg area. Patient #2 denied being in bed with Patient #1, or touching her. The report was deemed as "Disorderly Conduct" and Patient #1 was advised to contact the special victim's unit to file charges against Patient #2. "The Hospital staff was advised to monitor [Patient #2's] movement more closely." Record review of the medical record of Patient #1 revealed she was a 37 year-old female admitted to the psychiatric facility on 04/27/15 at 0830 under Emergency Detention (ED) when she cut	X 794		

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X 794	Continued From page 19 her wrist and called a friend to call Police. Patient #1 has a history of Depression with Anxiety. Further review of Patient #1's permanent records revealed no documentation following the sexual assault allegation that she made on 04/27/15 against Patient #2. There was no documentation in her record that she received a physical and/or psychological assessment following her allegation on 04/27/15. There was a Telephone Physician Order (PO) on 04/27/15 at 12:30 PM (following the allegation) for Ativan (an anti-anxiety) 2 milligrams by mouth "now" without documentation of the reason for the emergency medication. The only documentation in Patient #1's record regarding her allegation against Patient #2 was a Behavioral Team Progress Note dated 05/01/15 at 12:28 completed by Licensed Social Worker- A that indicated "Patient discussed being sexually assaulted by Patient [#2] in the [facility's] PES unit. Review of Patient #1's Daily Observation Notes for 04/27/15 revealed the following: At 11:30-MHW-A documented 1Q (1=On unit, and Q=Quiet/Calm). At 11:45-MHW-A documented 1B (On unit, and B=In Bed Awake). At 12:00-MHW-A documented 1BA (On unit, In Bed Awake, and A=agitated/restless). At 12:15 MHW-A documented 1BA. At 12:30, 12:45, 13:00, 13:15, 13:30, and 13:45-MHW-A documented 1A (On Unit and agitated/restless). Record review of Patient #2's medical records revealed the following: Patient #2's Psychiatric Evaluation dated 04/24/15 revealed he was a 30 year old male	X 794		

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X 794	Continued From page 20 admitted to the PES unit on 04/24/15 with a history of schizoaffective disorder and traumatic brain injury (TBI). Patient #2 was admitted on an ED basis with a history of aggressive behaviors requiring emergency medications to calm him. Patient #2 had recently been discharged from this facility 4-5 weeks prior and has had multiple inpatient treatment episodes over the years (7 inpatient admissions in the previous 5 months). Patient #2 was documented with a known history of aggression and a "history of inappropriate sexual behavior on the unit (masturbating)." Patient #2 had documented borderline intellectual functioning with poor insight, poor judgment, and poor impulse control. A Behavioral Nursing Shift Assessment completed by the unit RN on 04/27/15 at 18:08 that Patient #2 was found by a female patient touching on her body while she was asleep in bed. MD, and Nurse Manager notified. A Telephone PO dated 04/27/15 at 2015 for Patient #2 to be transferred to a higher acuity; sister facility. A Behavior Team Progress noted dated 04/27/15 at 1855 revealed Patient #2 was transferred to a sister facility by the Sheriff's Department. Review of the facility's Incident Event dated 04/27/15 at 11:37 AM confirmed a Code Green was called for another Patient [#3] in the Child/Adolescent Unit requiring Restraints/Seclusion. Patient #3 required physical restraint at 11:36 AM, and emergency medications at 11:46 AM. Patient #3 was released from restraint at 12:26 PM. This Code Green occurred during the same time frames of Patient #1's allegation on 04/27/15.	X 794		

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X 794	Continued From page 21 Review of the facility's Policy titled, Psychiatric Emergencies-Code Green, last reviewed January 2012 revealed a Code Green was a Psychiatric Emergency. Code Green will be implemented by any unit personnel in the event of unmanageable behavior of an individual to prevent harm to that individual, patients, hospital personnel and/or others the general hospital area. D. Individuals responding to Code Green will meet in announced area. Available personnel is necessary to control atmosphere through a show of strength and caring or to assist in physical management. Interview on 08/06/15 at 12:35 PM with the PES unit RN revealed she completed Patient #1's admission assessment to the PES unit on 04/27/15. The unit RN indicated Patients were provided with paper scrubs to wear without other undergarments. The unit RN stated that on 04/27/15 at approximately 11:30 AM to 12:00 PM, "Code Greens" were going on; and "staff were busy". The unit RN stated there was a Code Green on another unit (child/adolescent) and a Code Green was called in the lobby; due to a patient needing to be "put in a [restraint] chair" because they were tearing up the lobby. The unit RN stated she left the unit to respond to the Code Green in the other unit (child/adolescent) and when she arrived; there was another RN responding, so she went to the Code Green in the lobby because they needed an RN to assist with "putting the patient in the [restraint] chair." The unit RN stated she returned to the PES unit following the Code Greens to "something else going on at the end of the unit" that she responded to. The unit RN stated she could not remember if it was LVN-A or LVN-B working on 04/27/15; but that she thought the LVN stayed	X 794		

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X 794	Continued From page 22 back in the PES unit when she left and responded to the two Code Greens. The unit RN stated she was notified that during the Code Greens Patient #2 went into Patient #1's bedroom; and Patient #1 made an allegation of sexual assault. The unit RN stated she spoke with Patient #1 who reported that she was asleep in her bedroom and "she felt pressure" causing her to awake to Patient #2 touching her in the buttock and perineal area. The unit RN stated that Patient #1's paper pants were "torn on the side." The unit RN stated the local PD was called. The unit RN stated she spoke to Patient #2 and he said, "I touched her, but didn't do anything else." The unit RN stated he admitted that he "touched her and ripped her paper pants." The unit RN stated that Patient #2 knew that the unit was "chaotic" and knew what Code Green meant; and that is when he "took advantage" of the situation. The unit RN stated she believed that Patient #2 sexually assaulted Patient #1 given the facts, and his own admission. The unit RN stated she notified the MD, Social Worker, and Nursing Manager of the allegation. The unit RN indicated she documented the sexual assault allegation made by Patient #1 on the facility's Event Report; however, confirmed she did not document the sexual assault allegation in Patient #1's record following the incident. The unit RN stated she offered for Patient #1 to have a Sexual Assault Nurse Examination (SANE) completed at another facility if she wanted; but Patient #1 declined, stating she did not believe Patient #2 actually raped her. Interview on 08/06/15 at 04:45 PM with MHW-A revealed she was the only MHW working on 04/27/15 in the PES unit; along with the unit RN and a Licensed Vocational Nurse (LVN). MHW-A	X 794		

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X 794	Continued From page 23 stated she was pulled to the PES unit at 9:15 AM and was unfamiliar to the PES unit; but was told by the leaving MHW to "watch it" for Patient #2, however, she did not know the specific reason why. MHW-A stated the females were assigned rooms on one side, and males on the other side. MHW-A stated during the morning on 04/27/15 at approximately 11:30 AM-12:00 PM it was a "hectic/busy" day with "Code Green's being called." MHW-A stated that security was usually on the PES unit; but on 04/27/15 at the time of the allegation; "security could not be found." MHW-A stated on 04/27/15 at around 11:30-12:00 PM she stayed in the unit when the Code Greens were called and was "getting something out of the supply closet." MHW-A indicated the unit RN "responded to the Code Green" leaving the unit; telling her she [unit RN] would be back. MHW-A did not remember if LVN-A or LVN-B was working on 04/27/15; but further stated she did not remember any LVN being in the unit during the time of the allegation made by Patient #1. MHW-A stated shortly after this Patient #1 "flagged her [MHW-A] down" to her bedroom, and into the restroom of the bedroom where she reported that Patient #2 came into her room and touched her buttocks and vaginal area while she was sleeping in her bed. MHW-A stated that Patient #1's gown was torn around the buttock area and she offered to call the local PD for Patient #1 to make a report. MHW-A stated she then reported the incident/allegation to the unit RN. MHW-A stated she was later told that Patient #2 had been an inpatient to the facility many times before, and he "knows the system; knows what Code Green means." MHW-A stated she had seen Patient #2 "walking out of her [Patient #1] room a few times" and further stated "right before she flagged me down, he had walked out of her room". MHW-A indicated she	X 794		

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X 794	Continued From page 24 told Patient #2 "not to go in to other people's rooms." MHW-A confirmed she had not documented the allegation reported by Patient #1 against Patient #2; but that she "told [unit RN]." Interview on 08/10/15at 1:20 PM with Patient #1 revealed on 04/27/15 at approximately 11:30-11:45 AM she was in her assigned bedroom sleeping after she received multiple medications following her admission. Patient #1 stated she awoke after she "felt pressure" in her buttock and vaginal area. Patient #1 stated that Patient #2 was present telling her not to tell anyone. Patient #1 stated that she noticed her paper pants were ripped and she was not actually aware what all Patient #2 actually did because she "was conked out" after taking multiple medications. Patient #1 stated she knows he touched her because that was what woke her up. Patient #1 stated she was very upset, "freaked out," and asked the MD for an "AIDS" test. Patient #1 stated the unit RN indicated to the nursing staff (LVN) to "give her more meds" because she was "upset, crying, and freaking out." Patient #1 stated she then received the Ativan for her anxiety, to "help me calm down." Patient #1 stated the local PD came and she made a report. Patient #1 stated she was told by the unit RN that "Code Green's" were called and "everyone had to leave the unit" which allowed the opportunity for Patient #2 to go into her room unsupervised. Interview on 08/10/15 at 2:20 PM with Security Guard-A revealed he was employed by the facility to maintain security and the safety of patients. The Security Guard-A stated Patient #2 had a history of inappropriate sexual behavior of "masturbating in front of females." The Security	X 794		

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X 794	Continued From page 25 Guard-A stated he assisted with "viewing the video" footage for evidence following the allegation on 04/27/15 made be Patient #1 against Patient #2. The Security Guard stated the video footage from 04/27/15 showed a total of "four times" that Patient #2 went into Patient #1's room; and the last time Patient #2 came out of Patient #1's room; she was observed to come out of the room a few minutes later. The Security Guard stated that Patient #2 had already been assigned to the front "seclusion room" of the PES unit as his bedroom due to his history of masturbating. The Security Guard stated on the video footage Patient #2 could be seen coming from his room; "looking side to side" down the hallway, and then going into Patient #1's room. The Security Guard stated that female and male patient rooms were separated and that Patient #2 was not supposed to be going into Patient #1's room for any reason. Interview on 08/10/15 at 2:50 PM with MD-A revealed he was notified of Patient #1's sexual assault allegation against Patient #2 on 04/27/15. MD-A stated he discussed with Patient #1 the option of a "Rape Kit" but she "declined." MD-A stated he understood the allegation made by Patient #1 to be "only touching with no penetration." MD-A stated that Patient #1 was "distressed" about the incident and he ordered Ativan for Patient #1's anxiety following the incident. MD-A stated Patient #1 had already been distressed emotionally because of her ED inpatient admission; and really did not even want to take the Ativan. MD-A stated he recalled there was a Code Green called where staff left the unit in response to the Code Green; which left less staffing in the unit. MD-A confirmed that he did not document in Patient #1's records his contact or discussion with Patient #1 following her	X 794		

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X 794	Continued From page 26 allegation. Interview on 08/10/15 at 3:00 PM with the facility's Risk Manager (RM) indicated that she was aware of the alleged sexual assault allegation made by Patient #1 on 04/27/15 against Patient #2'; however, she had not been notified until 05/06/15 via the facility's Incident/Event electronic system because there had not been any harm documented in order to elevate the notification. The RM stated the staffing ratio on the PES unit was 1 staff to 4 patients. The RM indicated on 04/27/15 the patient census in the PES unit was 11; requiring 3 staff. The RM stated the first required staff is an RN, and then second could be a LVN, and/or MHW. The RM confirmed for 11 patients the required staffing would be 3. The RM stated the PES unit was to always have a licensed nurse present and available in the unit. The RM confirmed that she had not reported the sexual assault allegation made by Patient #1 on 04/27/15 against Patient #2 to the state health care regulatory agency, Department of State Health Services (DSHS); which was determined to have occurred as a result of insufficient staffing in the PES unit during episodes of Code Green's. The RM further confirmed the facility had not completed a thorough investigation with documented findings specific to this allegation for the determination of Neglect and/or a corrective action plan to prevent repeat incidence; in accordance with the facility's policy. The RM stated she had not seen or viewed the video footage following this allegation due to the video being unavailable after 05/06/15; following her electronic notification. Interview on 08/10/15 at 3:15 PM with Licensed	X 794		

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X 794	Continued From page 27 Social Worker (LSW)-A stated she assisted Security Guard-A in viewing the video footage on 04/27/15 after Patient #1 made a sexual assault allegation against Patient #2. LSW-A stated that during the allegation on 04/27/15; Patient #2 could be seen on the camera "looking both ways" and then would go into Patient #1's bedroom. LSW-A stated they were able to count this event occurring a "couple of times" where Patient #2 would go into Patient #1's bedroom and remain there "a couple of minutes" each time. LSW-A stated she saw on the video where MHW-A had been in the "Patient evaluation room" during these time periods; where a supply closet was located. LSW-A stated Patient #2 had a history of "exposing his self, public masturbation, and talks sexually to other women." LSW-A stated that Patient #2 has publically masturbated in front of her during an assessment interview. Interview on 08/10/15 at 4:15 PM with LVN-A stated he was present and worked the PES unit on 04/27/15. LVN-A stated that on 04/27/15 there were Code Greens called on another unit, and in the facility's lobby about the same time. LVN-A stated he responded to the Code Green in the lobby to assist due to a "fight." LVN-A indicated he had left the unit for approximately 15 minutes. Interview on 08/10/15 at 4:30 PM with the Vice President (VP) of Clinical Services confirmed that she was notified of the sexual allegation made by Patient #1 against Patient #2 on 04/27/15; however, she had not been notified until 05/06/15 via the facility's Incident/Event electronic system because there had not been any harm documented in order to elevate the notification. The VP of Clinical Services indicated that on	X 794		

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X 794	Continued From page 28 04/27/15 the Nursing Clinical Director (Nurse Manager) had been notified immediately following Patient #1's allegation and she had not obtained information that indicated Patient #1's allegation had occurred due to insufficient staffing in the PES unit when Code Green's had been called; leaving the unit without a RN available. The VP of Clinical Services stated that the unit RN was not supposed to leave the unit and there should always be a Licensed Nurse in the unit during a Code Green; that "it is a judgement call." The VP of Clinical Services stated she had not seen or viewed the video footage following this allegation due to the video being unavailable after 05/06/15; following her electronic notification. Interview on 08/10/15 at 4:40 PM with the Nursing Clinical Director (Nurse Manager) stated she was immediately notified by the PES unit RN on 04/27d/15 of Patient #1's sexual allegation against Patient #2. The Nursing Clinical Director indicated she "separated" the Patients, talked to both of them, and Patient #1 saw the Doctor. The Nursing Clinical Director stated she spoke to the unit RN about the allegation but had not been notified or received information that the RN and LVN had left the PES unit to respond to Code Greens which left the unit without a RN and/or licensed nurse available. The Nursing Clinical Director stated she had not seen or viewed the video footage following this allegation.	X 794		
X1037	133.47(c)(3)(A) Reporting responsibility: reporting abuse & n Abuse And Neglect Issues. Abuse and neglect of individuals with mental illness, and illegal, unethical, and unprofessional	X1037	**Plan of Correction** **X 1037** Mandatory read and sign in-service for all front-line behavioral health staff to include nursing, MHT, NP, social workers, intake/assessment, security and	9/14/15

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X1037	Continued From page 29 conduct. Reporting responsibility. Reporting abuse and neglect. A person, including an employee, volunteer, or other person associated with the facility who reasonably believes or who knows of information that would reasonably cause a person to believe that the physical or mental health or welfare of a patient of the facility who is receiving mental health or chemical dependency services has been, is, or will be adversely affected by abuse or neglect (as those terms are defined in this subsection) by any person shall as soon as possible report the information supporting the belief to the department or to the appropriate state health care regulatory agency in accordance with HSC, §161.132(a). This Requirement is not met as evidenced by: Based on interview and record review, facility employees failed to report an allegation of neglect to the state health care regulatory agency, the Department of State Health Services (DSHS); and in accordance with their policy, for 1 of 1 patients reviewed (Patient #1) with a complaint allegation of sexual assault against another patient (Patient #2). Specifically, on 04/27/15, Patient #1 reported to the unit's Registered Nurse (RN) an allegation of sexual assault from another Patient, (#2); who had a history of inappropriate sexual behaviors. The allegation was reported to the Medical Doctor, the Nursing Manager, and local Police	X1037	admitting to be completed by 9/14/15. Mandatory In-services to be conducted on 9/14, 9/16, and 9/18 for all behavioral health staff with multiple offerings in order to ensure all staff are able to attend one of these educational events. The mandatory in-service will reinforce the hospital policy regarding Assessment and Reporting of Abuse and Neglect, reinforce the need to document outlier events affecting patients, and roll out the Code Green Response Protocol. Additional topics for the mandatory in-service include: a decision tree to reinforce the policy on reporting and follow-up of suspected/reported allegations of abuse/neglect of a patient during hospitalization and in treating patients identified as having ordered sexual precautions. Follow up in-servicing is planned for February 2016 to include participation by same staff members to continue reinforcement of policies.	

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X1037	Continued From page 30 Department (PD); however, this allegation was not reported to the state health care regulatory agency by any facility employees, in accordance with their policy. This deficient practice could affect the prevention of possible unidentified abuse, neglect, or mistreatment for all patients in the facility; by compromising their safety. Findings included: Review of Patient #1's Complaint Form dated 05/15/15 indicated the following in part: On 04/27/15 at approximately 11:30 AM Patient #1 was admitted to the facility's "Psychiatric Emergency Services (PES) unit and received medication to help her sleep and calm down. Patient #1 reported shortly after she received the medications; she was asleep in her bed when she "felt someone touching my vagina and butt. I felt a hard pressure. I jumped up and another male patient [#2] jumped out from under my covers." Patient #1 stated she went to find a staff member (Mental Health Worker-A), to report what had happened. Patient #1 indicated she noticed her entire "crotch area [paper gown] was torn exposing her "vagina and butt." Patient #1 indicated the facility staff called the Police Department (PD) for Patient #1 to make a report. Patient #1 reported the staff apologized to her for the incident; "but they had an emergency on another floor and they were short staffed, so every staff member had left." Patient #1 indicated she was "so upset and scared; so they gave me more meds to put me to sleep." Patient #1 stated the facility had done nothing more to help her; there were no witnesses but she believed there were cameras in the hall. Patient #1 stated she found out that Patient #2 had done this before	X1037		

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X1037	Continued From page 31 and the Police Officer who responded stated that; "he [Patient #2] has a history of doing this; why was he unsupervised?" Review of the facility's Policy titled, Abuse Reporting-External and Internal, last reviewed January 2012 revealed the following definitions: Psychological Abuse included; humiliation and harassment. Sexual Abuse included; sexual harassment, sexual coercion, and sexual assault. Review of the facility's Policy titled, Assessment and Reporting of Abuse and Neglect, last reviewed February 2013 revealed Neglect included the failure to provide for one's self the goods or services including medical services, which are necessary to avoid physical or emotional harm or pain or the failure of a caretaker to provide the goods or services. The policy indicated the facility "prohibits neglect, mental or physical abuse or misappropriation of property, of patients by staff, visitors, or other patients." The facility "will report allegations and release information to the proper authorities, according to federal regulations, state specific rules and regulation and [facility] practice guidelines." Further review of the policy indicated, in part: 1. Reporting allegations of abuse and/or neglect occurring while the patient is under the care in the facility: All alleged violations concerning abuse and neglect while the patient is under the care of the facility will be reported to the Compliance Officer or designee, who will advise the on-call administrator/designee. As appropriate, the facility will report the incident to appropriate state, federal and protective/regulatory agencies, and/or law enforcement agencies and conduct an	X1037		

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X1037	Continued From page 32 internal investigation within a maximum of five working days of the incident. The Texas Department of state Health Services (DSHS) is the regulatory body for reporting concerns of hospitals, psychiatric hospitals (including private psychiatric facilities), and various other medical facilities. Review of the facility's Original Event report dated 04/27/15 at 12:15 PM completed by the unit RN revealed Patient #1 reported, "She was lying in bed asleep, when she felt Patient [#2] putting pressure around her buttocks area, and then touching her perineal area. Patient[#1] reported sitting up in bed shock and scared, and found Patient [#2] was up in her face with his finger to his mouth telling her to be quiet not to tell. She found her paper scrub button torned on the outer left side. MD [Medical Doctor], Nurse Manager notified, Patient made a police complaint." PD interviewed Patient #1 and accused, Patient #2. "Patient visible distraught, but no other physical problems noted at this time." Further review of the Original Event indicated the Event was documented as "Attempted Rape/Rape/Sexual Assault." Factors included; "Unit busy code greens called on other unit, and high acute of unit." The Original Event report did not include any documentation that this allegation was reported to the state health care regulatory agency by any facility employees, in accordance with the facility's policy. The Original Event report did not include documentation that this allegation was thoroughly investigated by the facility for the identification of neglect and/or a corrective action plan to prevent repeat incidence; in accordance with the facility's policy. The Compliance Officer/Director of Risk Management (RM) acknowledged receipt of the Original Event report	X1037		

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X1037	Continued From page 33 dated 04/27/15 at 12:15 PM electronically on 05/06/15 documenting Patient #1 made a Police Report. Review of the local PD report dated 04/27/15 at 12:45PM revealed Patient #1 wanted to report that, "she was a sleep in her room, when she awaken and felt pressure around her buttock and vaginal area. When she fully awaken, she observed [Patient #2] in bed with her." Patient #1 further stated that Patient #2 told her "Don't tell anyone," before he left her room. Patient #1 did not feel Patient #2 penetrate her at any time, but the hospital [paper gown] pajama that she was wearing had a tear between the leg area. Patient #2 denied being in bed with Patient #1, or touching her. The report was deemed as "Disorderly Conduct" and Patient #1 was advised to contact the special victim's unit to file charges against Patient #2. "The Hospital staff was advised to monitor [Patient #2's] movement more closely." Record review of the medical record of Patient #1 revealed she was a 37 year-old female admitted to the psychiatric facility on 04/27/15 at 0830 under Emergency Detention (ED) when she cut her wrist and called a friend to call Police. Patient #1 has a history of Depression with Anxiety. Further review of Patient #1's permanent records revealed no documentation following the sexual assault allegation that she made on 04/27/15 against Patient #2. There was no documentation in her record that she received a physical and/or psychological assessment following her allegation on 04/27/15. There was a Telephone Physician Order (PO) on 04/27/15 at 12:30 PM (following the allegation) for Ativan (an anti-anxiety) 2	X1037		

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X1037	Continued From page 34 milligrams by mouth "now" without documentation of the reason for the emergency medication. The only documentation in Patient #1's record regarding her allegation against Patient #2 was a Behavioral Team Progress Note dated 05/01/15 at 12:28 completed by Licensed Social Worker- A that indicated "Patient discussed being sexually assaulted by Patient [#2] in the [facility's] PES unit. Review of Patient #1's Daily Observation Notes for 04/27/15 revealed the following: At 11:30-MHW-A documented 1Q (1=On unit, and Q=Quiet/Calm). At 11:45-MHW-A documented 1B (On unit, and B=In Bed Awake). At 12:00-MHW-A documented 1BA (On unit, In Bed Awake, and A=agitated/restless). At 12:15 MHW-A documented 1BA. At 12:30, 12:45, 13:00, 13:15, 13:30, and 13:45-MHW-A documented 1A (On Unit and agitated/restless). Record review of Patient #2's medical records revealed the following: Patient #2's Psychiatric Evaluation dated 04/24/15 revealed he was a 30 year old male admitted to the PES unit on 04/24/15 with a history of schizoaffective disorder and traumatic brain injury (TBI). Patient #2 was admitted on an ED basis with a history of aggressive behaviors requiring emergency medications to calm him. Patient #2 had recently been discharged from this facility 4-5 weeks prior and has had multiple inpatient treatment episodes over the years (7 inpatient admissions in the previous 5 months). Patient #2 was documented with a known history of aggression and a "history of inappropriate sexual behavior on the unit (masturbating)."	X1037		

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X1037	Continued From page 35 Patient #2 had documented borderline intellectual functioning with poor insight, poor judgment, and poor impulse control. A Behavioral Nursing Shift Assessment completed by the unit RN on 04/27/15 at 18:08 that Patient #2 was found by a female patient touching on her body while she was asleep in bed. MD, and Nurse Manager notified. A Telephone PO dated 04/27/15 at 2015 for Patient #2 to be transferred to a higher acuity; sister facility. A Behavior Team Progress noted dated 04/27/15 at 1855 revealed Patient #2 was transferred to a sister facility by the Sheriff's Department. Review of the facility's Incident Event dated 04/27/15 at 11:37 AM confirmed a Code Green was called for another Patient [#3] in the Child/Adolescent Unit requiring Restraints/Seclusion. Patient #3 required physical restraint at 11:36 AM, and emergency medications at 11:46 AM. Patient #3 was released from restraint at 12:26 PM. This Code Green occurred during the same time frames of Patient #1's allegation on 04/27/15. Review of the facility's Policy titled, Psychiatric Emergencies-Code Green, last reviewed January 2012 revealed a Code Green was a Psychiatric Emergency. Code Green will be implemented by any unit personnel in the event of unmanageable behavior of an individual to prevent harm to that individual, patients, hospital personnel and/or others the general hospital area. D. Individuals responding to Code Green will meet in announced area. Available personnel is necessary to control atmosphere through a show	X1037		

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X1037	Continued From page 36 of strength and caring or to assist in physical management. Interview on 08/06/15 at 12:35 PM with the PES unit RN revealed she completed Patient #1's admission assessment to the PES unit on 04/27/15. The unit RN indicated Patients were provided with paper scrubs to wear without other undergarments. The unit RN stated that on 04/27/15 at approximately 11:30 AM to 12:00 PM, "Code Greens" were going on; and "staff were busy". The unit RN stated there was a Code Green on another unit (child/adolescent) and a Code Green was called in the lobby; due to a patient needing to be "put in a [restraint] chair" because they were tearing up the lobby. The unit RN stated she left the unit to respond to the Code Green in the other unit (child/adolescent) and when she arrived; there was another RN responding, so she went to the Code Green in the lobby because they needed an RN to assist with "putting the patient in the [restraint] chair." The unit RN stated she returned to the PES unit following the Code Greens to "something else going on at the end of the unit" that she responded to. The unit RN stated she could not remember if it was LVN-A or LVN-B working on 04/27/15; but that she thought the LVN stayed back in the PES unit when she left and responded to the two Code Greens. The unit RN stated she was notified that during the Code Greens Patient #2 went into Patient #1's bedroom; and Patient #1 made an allegation of sexual assault. The unit RN stated she spoke with Patient #1 who reported that she was asleep in her bedroom and "she felt pressure" causing her to awake to Patient #2 touching her in the buttock and perineal area. The unit RN stated that Patient #1's paper pants were "torn on the side." The unit RN stated the local PD was called.	X1037		

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X1037	Continued From page 37 The unit RN stated she spoke to Patient #2 and he said, "I touched her, but didn't do anything else." The unit RN stated he admitted that he "touched her and ripped her paper pants." The unit RN stated that Patient #2 knew that the unit was "chaotic" and knew what Code Green meant; and that is when he "took advantage" of the situation. The unit RN stated she believed that Patient #2 sexually assaulted Patient #1 given the facts, and his own admission. The unit RN stated she notified the MD, Social Worker, and Nursing Manager of the allegation. The unit RN indicated she documented the sexual assault allegation made by Patient #1 on the facility's Event Report; however, confirmed she did not document the sexual assault allegation in Patient #1's record following the incident. The unit RN stated she offered for Patient #1 to have a Sexual Assault Nurse Examination (SANE) completed at another facility if she wanted; but Patient #1 declined, stating she did not believe Patient #2 actually raped her. The unit RN confirmed she had not reported this allegation to the state health care regulatory agency (DSHS). Interview on 08/06/15 at 04:45 PM with MHW-A revealed she was the only MHW working on 04/27/15 in the PES unit; along with the unit RN and a Licensed Vocational Nurse (LVN). MHW-A stated she was pulled to the PES unit at 9:15 AM and was unfamiliar to the PES unit; but was told by the leaving MHW to "watch it" for Patient #2, however, she did not know the specific reason why. MHW-A stated the females were assigned rooms on one side, and males on the other side. MHW-A stated during the morning on 04/27/15 at approximately 11:30 AM-12:00 PM it was a "hectic/busy" day with "Code Green's being called." MHW-A stated that security was usually	X1037		

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X1037	Continued From page 38 on the PES unit; but on 04/27/15 at the time of the allegation; "security could not be found." MHW-A stated on 04/27/15 at around 11:30-12:00 PM she stayed in the unit when the Code Greens were called and was "getting something out of the supply closet." MHW-A indicated the unit RN "responded to the Code Green" leaving the unit; telling her she [unit RN] would be back. MHW-A did not remember if LVN-A or LVN-B was working on 04/27/15; but further stated she did not remember any LVN being in the unit during the time of the allegation made by Patient #1. MHW-A stated shortly after this Patient #1 "flagged her [MHW-A] down" to her bedroom, and into the restroom of the bedroom where she reported that Patient #2 came into her room and touched her buttocks and vaginal area while she was sleeping in her bed. MHW-A stated that Patient #1's gown was torn around the buttock area and she offered to call the local PD for Patient #1 to make a report. MHW-A stated she then reported the incident/allegation to the unit RN. MHW-A stated she was later told that Patient #2 had been an inpatient to the facility many times before, and he "knows the system; knows what Code Green means." MHW-A stated she had seen Patient #2 "walking out of her [Patient #1] room a few times" and further stated "right before she flagged me down, he had walked out of her room". MHW-A indicated she told Patient #2 "not to go in to other people's rooms." MHW-A confirmed she had not documented the allegation reported by Patient #1 against Patient #2; but that she "told [unit RN]." Interview on 08/10/15at 1:20 PM with Patient #1 revealed on 04/27/15 at approximately 11:30-11:45 AM she was in her assigned bedroom sleeping after she received multiple medications following her admission. Patient #1	X1037		

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X1037	Continued From page 39 stated she awoke after she "felt pressure" in her buttock and vaginal area. Patient #1 stated that Patient #2 was present telling her not to tell anyone. Patient #1 stated that she noticed her paper pants were ripped and she was not actually aware what all Patient #2 actually did because she "was conked out" after taking multiple medications. Patient #1 stated she knows he touched her because that was what woke her up. Patient #1 stated she was very upset, "freaked out," and asked the MD for an "AIDS" test. Patient #1 stated the unit RN indicated to the nursing staff (LVN) to "give her more meds" because she was "upset, crying, and freaking out." Patient #1 stated she then received the Ativan for her anxiety, to "help me calm down." Patient #1 stated the local PD came and she made a report. Patient #1 stated she was told by the unit RN that "Code Green's" were called and "everyone had to leave the unit" which allowed the opportunity for Patient #2 to go into her room unsupervised. Interview on 08/10/15 at 2:20 PM with Security Guard-A revealed he was employed by the facility to maintain security and the safety of patients. The Security Guard-A stated Patient #2 had a history of inappropriate sexual behavior of "masturbating in front of females." The Security Guard-A stated he assisted with "viewing the video" footage for evidence following the allegation on 04/27/15 made be Patient #1 against Patient #2. The Security Guard stated the video footage from 04/27/15 showed a total of "four times" that Patient #2 went into Patient #1's room; and the last time Patient #2 came out of Patient #1's room; she was observed to come out of the room a few minutes later. The Security Guard stated that Patient #2 had already been	X1037		

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X1037	Continued From page 40 assigned to the front "seclusion room" of the PES unit as his bedroom due to his history of masturbating. The Security Guard stated on the video footage Patient #2 could be seen coming from his room; "looking side to side" down the hallway, and then going into Patient #1's room. The Security Guard stated that female and male patient rooms were separated and that Patient #2 was not supposed to be going into Patient #1's room for any reason. Interview on 08/10/15 at 2:50 PM with MD-A revealed he was notified of Patient #1's sexual assault allegation against Patient #2 on 04/27/15. MD-A stated he discussed with Patient #1 the option of a "Rape Kit" but she "declined." MD-A stated he understood the allegation made by Patient #1 to be "only touching with no penetration." MD-A stated that Patient #1 was "distressed" about the incident and he ordered Ativan for Patient #1's anxiety following the incident. MD-A stated Patient #1 had already been distressed emotionally because of her ED inpatient admission; and really did not even want to take the Ativan. MD-A stated he recalled there was a Code Green called where staff left the unit in response to the Code Green; which left less staffing in the unit. MD-A confirmed that he did not document in Patient #1's records his contact or discussion with Patient #1 following her allegation. Interview on 08/10/15 at 3:00 PM with the facility's Risk Manager (RM) indicated that she was aware of the alleged sexual assault allegation made by Patient #1 on 04/27/15 against Patient #2'; however, she had not been notified until 05/06/15 via the facility's Incident/Event electronic system because there had not been any harm	X1037		

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X1037	Continued From page 41 documented in order to elevate the notification. The RM stated the staffing ratio on the PES unit was 1 staff to 4 patients. The RM indicated on 04/27/15 the patient census in the PES unit was 11; requiring 3 staff. The RM stated the first required staff is an RN, and then second could be a LVN, and/or MHW. The RM confirmed for 11 patients the required staffing would be 3. The RM stated the PES unit was to always have a licensed nurse present and available in the unit. The RM confirmed that she had not reported the sexual assault allegation made by Patient #1 on 04/27/15 against Patient #2 to the state health care regulatory agency, Department of State Health Services (DSHS); which was determined to have occurred as a result of insufficient staffing in the PES unit during episodes of Code Green's. The RM further confirmed the facility had not completed a thorough investigation with documented findings specific to this allegation for the determination of Neglect and/or a corrective action plan to prevent repeat incidence; in accordance with the facility's policy. The RM stated she had not seen or viewed the video footage following this allegation due to the video being unavailable after 05/06/15; following her electronic notification. Interview on 08/10/15 at 3:15 PM with Licensed Social Worker (LSW)-A stated she assisted Security Guard-A in viewing the video footage on 04/27/15 after Patient #1 made a sexual assault allegation against Patient #2. LSW-A stated that during the allegation on 04/27/15; Patient #2 could be seen on the camera "looking both ways" and then would go into Patient #1's bedroom. LSW-A stated they were able to count this event occurring a "couple of times" where Patient #2 would go into Patient #1's bedroom and remain	X1037		

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X1037	Continued From page 42 there "a couple of minutes" each time. LSW-A stated she saw on the video where MHW-A had been in the "Patient evaluation room" during these time periods; where a supply closet was located. LSW-A stated Patient #2 had a history of "exposing his self, public masturbation, and talks sexually to other women." LSW-A stated that Patient #2 has publically masturbated in front of her during an assessment interview. Interview on 08/10/15 at 4:15 PM with LVN-A stated he was present and worked the PES unit on 04/27/15. LVN-A stated that on 04/27/15 there were Code Greens called on another unit, and in the facility's lobby about the same time. LVN-A stated he responded to the Code Green in the lobby to assist due to a "fight." LVN-A indicated he had left the unit for approximately 15 minutes. Interview on 08/10/15 at 4:30 PM with the Vice President (VP) of Clinical Services confirmed that she was notified of the sexual allegation made by Patient #1 against Patient #2 on 04/27/15; however, she had not been notified until 05/06/15 via the facility's Incident/Event electronic system because there had not been any harm documented in order to elevate the notification. The VP of Clinical Services indicated that on 04/27/15 the Nursing Clinical Director (Nurse Manager) had been notified immediately following Patient #1's allegation and she had not obtained information that indicated Patient #1's allegation had occurred due to insufficient staffing in the PES unit when Code Green's had been called; leaving the unit without a RN available. The VP of Clinical Services stated that the unit RN was not supposed to leave the unit and there should always be a Licensed Nurse in the unit during a	X1037		

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X1037	Continued From page 43 Code Green; that "it is a judgement call." The VP of Clinical Services stated she had not seen or viewed the video footage following this allegation due to the video being unavailable after 05/06/15; following her electronic notification. The VP of Clinical Services confirmed she had not reported this allegation to the state health care regulatory agency (DSHS). Interview on 08/10/15 at 4:40 PM with the Nursing Clinical Director (Nurse Manager) stated she was immediately notified by the PES unit RN on 04/27d/15 of Patient #1's sexual allegation against Patient #2. The Nursing Clinical Director indicated she "separated" the Patients, talked to both of them, and Patient #1 saw the Doctor. The Nursing Clinical Director stated she spoke to the unit RN about the allegation but had not been notified or received information that the RN and LVN had left the PES unit to respond to Code Greens which left the unit without a RN and/or licensed nurse available. The Nursing Clinical Director stated she had not seen or viewed the video footage following this allegation. The Nursing Clinical Director confirmed she had not reported this allegation to the state health care regulatory agency (DSHS).	X1037		

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X 000	INITIAL COMMENTS Note: The State Form is an official, legal document. All information must remain unchanged except for entering the plan of correction, correction dates, and the signature space. Any discrepancy in the original deficiency citation(s) will be referred to the Office of the Texas Attorney General (OAG) for possible fraud. If information is inadvertently changed by the provider/supplier, the State Survey Agency (SA) should be notified immediately. An unannounced visit was completed from 04/08/15 to 04/09/15 to conduct a complaint investigation survey (TX 00212197). An entrance conference was conducted in the conference room of the facility. In attendance were the Director of Social Services, and the Vice President of Clinical Services. The purpose and process of the complaint survey were discussed and an opportunity for questions was provided. Complaint TX 00212197 was substantiated with violations cited. An exit conference was conducted in the afternoon of 04/09/15 in the facility conference room. The Director of Risk Management was in attendance. Preliminary findings of the survey were discussed and an opportunity for questions was provided.	X 000		
X 123	133.41(c)(8)(A) Discharge and continuing care plan Comprehensive Medical Rehabilitation Services. Discharge and continuing care plan. The patient's interdisciplinary team shall prepare a written continuing care plan that addresses the	X 123	1) 133.41 c 8 A Discharge and Continuing Care Plan Corrective Action : For all new medical diagnoses the APN will immediately consult with attending psychiatrist and pending approval will be added by the APN immediately in axis as part of the discharge summary. At discharge nursing staff will document	5/15/15

SOD - State Form
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE SUP/COO — (X6) DATE 5/1/15

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X 123	Continued From page 1 patient's needs for care after discharge. (A) The continuing care plan for the patient shall include recommendations for treatment and care and information about the availability of resources for treatment or care. This Requirement is not met as evidenced by: Based on a record review and interview, the hospital failed to ensure that discharge instructions included the written referral for follow-up/continuing care as ordered by the Advanced Nurse Practitioner (ANP). Patient #1's discharge summary completed by the Psychiatrist did not include her newly diagnosed Diabetes made by the ANP on 01/17/15; or the follow-up care recommended for her Primary Care Physician (PCP) by the ANP. This deficient practice could affect Patient #1's overall health by failure to follow-up and seek treatment of her health conditions. Findings included: Record review of Patient #1's medical record revealed she was admitted on 01/13/15 and discharged 01/20/15 at 18:40. On 01/17/15 the facility's ANP assessed Patient #1's laboratory results for a Hemoglobin, A1C at 7.24 (normal results less than 6.5) and indicated that she had "[Diabetes Mellitus] (DM)". ANP documented that she would place Patient #1 on a 2000 American Diabetes Association (ADA) diet, have the	X 123	education to patient and or guardian (as appropriate) for need and recommended follow-up with PCP. Ongoing compliance will be checked daily via nursing 12 and 24 hr chart checks. All nursing staff will be in-serviced by Behavioral Health Nursing Administration by 5/15/15.	

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X 123	Continued From page 2 dietician see patient before discharge, and documented that Patient #1 needed to follow up with her PCP. Record review of the Discharge Instructions dated 01/20/15 presented and signed by Patient #1's mother/guardian revealed only "Follow-up appointments" were for the Psychiatrist and Individual Therapist appointments. The area of Follow-up appointments for Primary Care Physician was documented "Deferred." Further review revealed discharge diagnosis for AXIS III: Medical problems were- "Asthma, gastro esophageal reflux disease (GERD)." The Discharge Summary diagnosis did not include Diabetes Mellitus as diagnosed by the ANP on 01/17/15. Record review of Patient #1's written complaint completed by her mother/guardian, undated, revealed when her daughter was discharged on 01/20/15; "they did blood work on her [Patient #1] and never told me she has Diabetes. My daughter told me, I confronted the nurses, they said they don't tell me; papers are sent home when she leaves; and that it's not that bad." Record review of the facility's Medical Staff Bylaws; Rules and Regulations approved by the Board of Control May 31, 2013, revealed the following; Where there is need of a discharge summary, a clinical resume covering the necessary five (5) points including the final diagnosis and authenticated by the attending Practitioner is sufficient to exclude the completion of the face sheet. Necessary five (5) points: (1) Why was the patient admitted?	X 123		

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X 123	Continued From page 3 (2) Pertinent findings. (3) What was done? Procedures performed and treatment rendered (4) Condition on discharge. (5) Instructions, including medications, diet, physical activity, if any, and follow-up. During an interview on 04/08/15 at 4:45 PM with the ANP, she stated that she diagnosed Patient #1 with DM on 01/17/15 following her laboratory test results, Hemoglobin A1C; positive for Diabetes. ANP stated she wanted Patient #1 to follow-up with her PCP following discharge because she did not want to initiate medication therapy that she was not able to monitor. ANP confirmed Patient #1's Discharge Summary and Instructions dated 01/20/15 failed to document her new diagnosis of Diabetes Mellitus and the recommended follow-up with her PCP. ANP stated that the nurse completing the Discharge Instructions did not pick that up from her record and the Psychiatrist did not add it to her final diagnosis upon discharge. During an interview on 04/09/15 at 8:55 AM with Patient #1's mother/guardian revealed she was not told when her daughter was discharged on 01/20/15 that she had Diabetes; or that she needed to follow-up with her PCP.	X 123		
			2) 133.42 a 1 A Patient Rights Requirements	
X 795	133.42(a)(1)(A) Patient rights requirements: all hospitals Patient Rights. Patient rights requirements for all hospitals. A hospital shall adopt, implement, and enforce a policy to ensure patients' rights. The written policy shall include:	X 795	a. Corrective Action - Updated signage in the NMC mailroom and statement with address included in the patient handbooks. Signage in NMC mailroom will be installed and BH patient handbooks will be updated by and completed by the Director of Risk Management.	5/15/15

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X 795	Continued From page 4 (A) the right of the patient to the hospital's reasonable response to his or her requests and needs for treatment or service, within the hospital's capacity, its stated mission, and applicable law and regulation; This Requirement is not met as evidenced by: Based on record review and interview, the facility failed to implement and ensure the rights for 1 of 1 Patient (# 1) reviewed for rights. Specifically, the facility failed to: 1.) Ensure prompt resolution of grievances within 30 days; as indicated by the facility's Complaints and Grievances policy and; 2.) Ensure reasonable access to care and services upon request of Patient #1's mother/guardian regarding the need for assessment and treatment. This deficient practice affected Patient #1's rights when the facility failed to address concerns, complaints, and grievances related to the patient	X 795	b. Corrective Action - For medical complaints lasting 24 hours and requiring PRN medication the patient will receive a medical consult within 24 hours. If symptoms persist after the medical consult and any ordered follow-up has been satisfied the APN will address the patient's complaints with the attending psychiatrist for further recommendations. Ongoing compliance will be checked daily via nursing 12 and 24 hr chart checks. All nursing staff will be in-serviced by Behavioral Health Nursing Administration by 5/15/15.	5/15/15

Texas Department of State Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	000415	A. BUILDING: _____ B. WING _____	C 04/09/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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X 795	Continued From page 5 rights, safety, and satisfaction. Findings included: 1.) Record review of the facility's Patient Complaints and Grievances Policy, last reviewed 11/2013 revealed the following: Grievances: 1.) Upon receipt of a grievance, the receiving department will indicate the date of receipt and sent the grievance to Quality/Risk Department. 2.) The Director of Risk Management or designee will investigate all grievances. 3.) A written response for the initial acknowledgment of the grievance is sent within 7 to 10 days of the person filing the grievance. 4.) A written resolution is sent within a stated number of days, but will not exceed 30 days unless notification is sent to the complainant prior to the expiration of the above stated period. The Director of Risk Management or designee will develop a written response to the patient. 5.) A copy of the completed Grievance From Written Complaint and response letter will be sent to the Chief Compliance Officer or the hospital's General Counsel for review before being mailed to the person filing the grievance. Record review of the Department of State Health Services (DSHS) Complainant Investigative Report (CIR) TX 00212197 revealed that Patient #1's mother/guardian alleged complaints towards the facility which included a substantive quality of care issues, and a perceived violation of her daughter/patient's (#1) rights when she received services on 01/13/2015 to 01/20/2015. Record review of the facility's Complaints and Grievances specific for Patient #1 revealed the facility had received the same alleged complaints	X 795		

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X 795	Continued From page 6 and grievance letter (TX 00212197) towards the facility regarding her daughter's/Patient #1's care while an inpatient at the facility from 01/13/2015 to 01/20/2015. Further review revealed this letter was sent and postmarked from the sender/complainant on 02/02/2015 (over 60 days ago) to the Patient Advocate at the address of the facility that provided the services and care to Patient #1 from 01/13/2015 to 01/20/2015. Record review of the letter provided to this surveyor from Patient #1's mother/guardian/complainant revealed a letter of acknowledgment by the facility's Director of Risk Management, dated 03/08/2015 (over 30 days from the post mark of 02/02/2015); acknowledging receipt of Patient #1's/complainants concerns. Further review revealed the concerns were received by the Quality Review Department, and the complainant could expect a written response within 30 days. Further review of the facility's Complaints and Grievances specifically for Patient #1 revealed the facility's Risk Manager sent an acknowledgment letter to the complainant that was dated 03/11/15 (over 30 days from the post mark of 02/02/2015) that stated the facility would send a written response within 30 days. Review on 04/09/15, over 30 days from the letter sent to the complainant dated 03/08/15, revealed there was no documentation that a written resolution was sent to the complainant or a completed investigation regarding her complaints and grievances towards the facility. During an interview on 04/08/15 at 3:50 PM with Director of Risk Management indicated she did not know exactly what day she received the	X 795		

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X 795	Continued From page 7 complaints and grievance from Patient #1's mother/guardian regarding her daughters services from 01/13/15 to 01/20/15 but stated that Patient #1 was readmitted a second time I February (02/10/15) and, "by that time had the letter." The Director of Risk Management indicated she sent an acknowledgment letter in March 2015 and was still investigating the mother's allegations in the letter. Further interview on 04/09/15 at 1:30 PM with the Director of Risk Management confirmed she was over the 30 days to send a written response to Patient #1's mother/guardian/complainant; in accordance with the facility's Complaint and Grievances Policy stating she missed it. The Director of Risk Management indicated she was responsible to ensure the completion and investigation of the Grievance process; and she had delegated this grievance investigation (TX 00212197) to the facility's Patient Advocate, who no longer was employed at the facility and had not completed this grievance resolution. During a phone interview on 04/09/15 at 8:55 AM with Patient #1's guardian/mother/complainant stated she received a letter dated 03/08/2015 from the Director or Risk Management acknowledging receipt of her concerns/complaints. The complainant stated the letter indicated she would receive a written response within 30 days. Further interview revealed that the complainant had not yet received a written response regarding her alleged allegations regarding her daughter's care and services from her visit dated 01/13/2015 to 01/20/2015.	X 795		

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X 795	Continued From page 8 2.) Record review of the DSHS CIR TX 00212197 revealed that Patient #1's mother/guardian alleged written complaints towards the facility, undated, that indicated on January 17th 2015; Patient #1 "had a sore throat. I told the nurse she said she would tell the Doctor. The next day (01/08/15) I visited; she could hardly talk or swallow. Told [Nurse A] the nurse, he said did I want a medical Doctor to see her; I said yes. They said the Doctor ordered her Lozenges and they're giving her them. I said I want the Doctor to check her for strep throat. [Nurse A] said okay, he'd put the request in. When I visited on Monday [01/19/15] no one had seen her [Patient #1]. Complained again the nurse said, Oh they didn't come in today yet. So on Tuesday [01/20/15] she was checked out [discharged] with No Doctor seeing her. That night I had to take her to [a local hospital] and they said she has strep throat." Record review of Patient #1's medical record revealed the following Physician Orders: 01/17/15: Telephone Order (TO) for Cepacol lozenges every 2 hours for sore throat. 01/19/15 at 0700 TO from Psychiatrist A for a "med [medical] consult for sore throat to [rule out] r/o infection." Record review of Patient #1's medication administration records revealed she was administered Acetaminophen 325 milligrams as follows for sore throat pain: 01/17/15 at 1009 with a pain scale of 7, 01/17/15 at 1754 with a pain scale of 0, 01/19/15 at 0824 with a pain scale of 2, and 01/20/15 at 0752 with a pain scale of 8.	X 795		

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X 795	Continued From page 9 Record review of Patient #1's Psychiatrist Progress notes revealed Patient #1 complained to him during assessment of a sore throat on 01/18/15 and 01/19/15. Review of Patient #1's medical record revealed she was discharged on 01/20/15 at 1840; had not been seen for a medical consult for sore throat to r/o infection prior to her discharge and had not been physically assessed. During an interview on 04/08/15 at 4:45 PM with the Advanced Nurse Practitioner (ANP) stated that Patient #1 should have had a med consult before she was discharged on 01/20/15 or within 24 hours of the TO written on 01/19/15 at 0700. ANP stated that she has experienced communication issues from the weekend nurses to notify her when a med consult was needed. During a phone interview on 04/09/15 at 8:55 AM with the complainant, Patient #1's mother/guardian, indicated that her daughter was never seen for assessment or treatment prior to her discharge on 01/20/15 despite repeated requests for assessment by a Doctor. The complainant stated she took her daughter to the hospital on 01/20/15 following discharge from the facility where her daughter was diagnosed with "Strep throat" and prescribed antibiotics for 10 days.	X 795		
X1036	133.47(c)(2) Posting requirements Abuse And Neglect Issues. Abuse and neglect of individuals with mental illness, and illegal, unethical, and unprofessional conduct.	X1036	3) 133.47 c Posting Requirements Corrective Action: Signage with TxDSHS complaint line will be posted in the lobby at both BH campuses and on each patient unit. Temporary signs will be up in these locations no later than 5/15/15 and	7/1/15

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X1036	Continued From page 10 The requirements of this subsection are in addition to the requirements of subsection (b) of this section. Posting requirements. A facility shall prominently and conspicuously post for display in a public area that is readily visible to patients, residents, volunteers, employees, and visitors a statement of the duty to report abuse and neglect, or illegal, unethical or unprofessional conduct in accordance with HSC, §161.132(e). The statement shall be in English and in a second language appropriate to the demographic makeup of the community served and contain the number of the department's patient information and complaint line at (888) 973-0022. This Requirement is not met as evidenced by: Based on observation and interview, the facility failed to prominently and conspicuously post for display in a public area that is readily visible to patients, residents, volunteers, employees, and visitors; a statement of the duty to report abuse and neglect, or illegal, unethical or unprofessional conduct in accordance with the Texas Health and Safety Code (HSC), and ensure the statement contains the number of the department's patient information and complaint line at (888) 973-0022. This deficient practice affected the rights of Patients. Findings included: Observation conducted on 04/08/15 at 12:15 PM of the facility's lobby/waiting area revealed a	X1036	permanent signs will be up by 7/1/15. This will be completed by the Director of Risk Management.	

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X1036	Continued From page 11 poster of Patient's Rights dated 09/01/2013. The posting failed to contain a statement of the duty to report abuse and neglect, or illegal, unethical or unprofessional conduct in accordance with the HSC §161.132(e); and failed to ensure it contained the number of the Texas Department of State Health Services patient information and complaint line at (888) 973-0022. Further observation conducted on 04/08/15 at 3:40 PM throughout the facility did not reveal a posting of the department's (DSHS) patient information and complaint line phone number, or a statement of the duty to report abuse and neglect, or illegal, unethical or unprofessional conduct in accordance with the HSC §161.132(e). During an interview on 04/09/15 at 1:45 PM with the facility's Risk Manager confirmed the department's (DSHS) patient information and complaint line phone number (888-973-0022) were not posted in the facility or a statement of the duty to report abuse and neglect, or illegal, unethical or unprofessional conduct in accordance with the HSC §161.132(e).	X1036		

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A 000	INITIAL COMMENTS The CMS - 2567 (Statement of Deficiencies) is an official, legal document. All information must remain unchanged except for entering the plan of correction, correction dates and the signature space. Any discrepancy in the original deficiency citation (s) will be reported to Dallas Regional Office (RO) for referral to the Office of Inspector General (OIG) for possible fraud if information is inadvertently changed by the provider/supplier, the State Survey Agency (SA) should be notified immediately. An unannounced visit was completed from 04/08/15 to 04/09/15 to conduct a complaint investigation survey (TX 00212197). An entrance conference was conducted in the conference room of the facility. In attendance were the Director of Social Services, and the Vice President of Clinical Services. The purpose and process of the complaint survey were discussed and an opportunity for questions was provided. Complaint TX 00212197 was substantiated with deficiencies cited. An exit conference was conducted in the afternoon of 04/09/15 in the facility conference room. The Director of Risk Management was in attendance. Preliminary findings of the survey were discussed and an opportunity for questions was provided.	A 000		
A 119	482.13(a)(2) PATIENT RIGHTS: REVIEW OF GRIEVANCES [The hospital must establish a process for prompt	A 119	1) 482.3 a 2 Patient Rights: Review of Grievances: Corrective Action: Updated signage in the NMC mailroom and statement with address included in the patient handbooks. Signage in NMC mailroom will be installed and BH	5/15/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: SUP COO — (X6) DATE: 5/1/15

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

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A 119	Continued From page 1 resolution of patient grievances and must inform each patient whom to contact to file a grievance.] The hospital's governing body must approve and be responsible for the effective operation of the grievance process, and must review and resolve grievances, unless it delegates the responsibility in writing to a grievance committee. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure prompt resolution of grievances, and the governing body failed to ensure the effective operation of the grievance process to review and notify complainants of the resolution within 30 days; as indicated by the facility's Complaints and Grievances policy for 1 of 1 patient (#1) reviewed for grievances. Specifically, Patient #1's mother/guardian/ complainant had written a grievance post marked to the facility 02/02/15. The facility's Risk Manager sent an acknowledgment letter to the complainant dated 03/08/15 (over 30 days) stating the facility would send a written response within 30 days. On 04/09/15 (over 30 days) there was no documentation that a written resolution was sent to the complainant or a completed investigation regarding her complaints and grievances. This deficient practice affected Patient #1's rights when the facility failed to address concerns, complaints, and grievances related to the patient rights, safety, and satisfaction. Findings Included: Record review of the facility's Patient Complaints and Grievances Policy, last reviewed 11/2013	A 119	patient handbooks will be updated by 5/15/15 and completed by the Director of Risk Management.	

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A 119	Continued From page 2 revealed the following: Grievances: 1.) Upon receipt of a grievance, the receiving department will indicate the date of receipt and sent the grievance to Quality/Risk Department. 2.) The Director of Risk Management or designee will investigate all grievances. 3.) A written response for the initial acknowledgment of the grievance is sent within 7 to 10 days of the person filing the grievance. 4.) A written resolution is sent within a stated number of days, but will not exceed 30 days unless notification is sent to the complainant prior to the expiration of the above stated period. The Director of Risk Management or designee will develop a written response to the patient. 5.) A copy of the completed Grievance From Written Complaint and response letter will be sent to the Chief Compliance Officer or the hospital's General Counsel for review before being mailed to the person filing the grievance. Record review of the Department of State Health Services (DSHS) Complainant Investigative Report (TX 00212197) revealed that Patient #1's mother/guardian alleged complaints towards the facility which included a substantive quality of care issues, and a perceived violation of her daughter/patient's (#1) rights when she received services on 01/13/2015 to 01/20/2015. Record review of the facility's Complaints and Grievances specific for Patient #1 revealed the facility had received the same alleged complaints and grievance letter (TX 00212197) towards the facility regarding her daughter's/Patient #1's care while an inpatient at the facility from 01/13/2015 to 01/20/2015. Further review revealed this letter was sent and postmarked from the	A 119		

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A 119	Continued From page 3 sender/complainant on 02/02/2015 (over 60 days ago) to the Patient Advocate at the address of the facility that provided the services and care to Patient #1 from 01/13/2015 to 01/20/2015. Record review of the letter provided to this surveyor from Patient #1's mother/guardian/complainant revealed a letter of acknowledgment by the facility's Director of Risk Management, dated 03/08/2015 (over 30 days from the post mark of 02/02/2015); acknowledging receipt of Patient #1's/complainants concerns. Further review revealed the concerns were received by the Quality Review Department, and the complainant could expect a written response within 30 days. Further review of the facility's Complaints and Grievances specifically for Patient #1 revealed the facility's Risk Manager sent an acknowledgment letter to the complainant that was dated 03/11/15 (over 30 days from the post mark of 02/02/2015) that stated the facility would send a written response within 30 days. Review on 04/09/15, over 30 days from the letter sent to the complainant dated 03/08/15, revealed there was no documentation that a written resolution was sent to the complainant or a completed investigation regarding her complaints and grievances towards the facility. During an interview on 04/08/15 at 3:50 PM with Director of Risk Management indicated she did not know exactly what day she received the complaints and grievance from Patient #1's mother/guardian regarding her daughters services from 01/13/15 to 01/20/15 but stated that Patient #1 was readmitted a second time f	A 119		

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A 119	Continued From page 4 February (02/10/15) and, "by that time had the letter." The Director of Risk Management indicated she sent an acknowledgment letter in March 2015 and was still investigating the mother's allegations in the letter. Further interview on 04/09/15 at 1:30 PM with the Director of Risk Management confirmed she was over the 30 days to send a written response to Patient #1's mother/guardian/complainant; in accordance with the facility's Complaint and Grievances Policy stating she missed it. The Director of Risk Management indicated she was responsible to ensure the completion and investigation of the Grievance process; and she had delegated this grievance investigation (TX 00212197) to the facility's Patient Advocate, who no longer was employed at the facility and had not completed this grievance resolution. During a phone interview on 04/09/15 at 8:55 AM with Patient #1's guardian/mother/complainant stated she received a letter dated 03/08/2015 from the Director or Risk Management acknowledging receipt of her concerns/complaints. The complainant stated the letter indicated she would receive a written response within 30 days. Further interview revealed that the complainant had not yet received a written response regarding her alleged allegations regarding her daughter's care and services from her visit dated 01/13/2015 to 01/20/2015.	A 119		
A 468	482.24(c)(2)(vii) CONTENT OF RECORD: DISCHARGE SUMMARY	A 468	2) 482.24 c 2 vii Content of Record: Discharge Summary Corrective Action: For all new medical diagnoses the APN will immediately consult with attending psychiatrist and pending approval will be added by the APN immediately in axis as part of the	5/15/15

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 468	Continued From page 5 [All records must document the following, as appropriate:] Discharge summary with outcome of hospitalization, disposition of care and provisions for follow-up care. This STANDARD is not met as evidenced by: Based on record review and interview, the hospital failed to include a discharge summary with an outcome of hospitalization, a disposition of care, and provisions for follow-up care for 1 of 1 Patient (#1) reviewed. Patient #1's discharge summary completed by the Psychiatrist did not include her newly diagnosed Diabetes Mellitus (DM) made by the Advanced Nurse Practitioner (ANP); or the follow-up care recommended for her Primary Care Physician (PCP) by the ANP. This deficient practice could affect Patient #1's overall health by failure to follow-up and seek treatment of her health conditions. Findings included: Record review of Patient #1's medical record revealed she was admitted on 01/13/15 and discharged 01/20/15 at 18:40. On 01/17/15 the facility's ANP assessed Patient #1's laboratory results for a Hemoglobin, A1C at 7.24 (normal results less than 6.5) and indicated that she had "DM". ANP documented that she would place Patient #1 on a 2000 American Diabetes Association (ADA) diet, have the dietician see patient before discharge, and documented that Patient #1 needed to follow up with her PCP.	A 468	discharge summary. Ongoing compliance will be checked daily via nursing 12 and 24 hr chart checks. All nursing staff will be in-serviced by Behavioral Health Nursing Administration by 5/15/15	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	450130	A. BUILDING _____ B. WING _____	C 04/09/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NIX HEALTH CARE SYSTEM	414 NAVARRO, SUITE 600 SAN ANTONIO, TX 78205

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 468	Continued From page 6 Record review of Patient #1's Interdisciplinary Education completed by the Dietician dated 01/19/15 revealed in part; Patient #1 "is newly diagnosed with diabetes, HA1C 7.24, [Registered Dietician] RD discussed principles of a diabetic diet. Also revealed meal plan for 2000 ADA. [Patient] Pt. was responsive to information given. Provided written educational materials in chart for child/parent review upon discharge." Record review of Patient #1's Discharge Summary dated 01/20/15 completed by the Psychiatrist revealed discharge diagnosis for AXIS III: Medical problems were- "Asthma, gastro esophageal reflux disease (GERD)." The Discharge Summary diagnosis did not include Diabetes Mellitus as diagnosed by the ANP on 01/17/15. Record review of the Discharge Instructions dated 01/20/15 presented and signed by Patient #1's mother/guardian revealed only "Follow-up appointments" were for the Psychiatrist and Individual Therapist appointments. Further review for the area of Follow-up appointments for Primary Care Physician was documented "Deferred." Record review of Patient #1's written complaint completed by her mother/guardian, undated, revealed when her daughter was discharged on 01/20/15; "they did blood work on her [Patient #1] and never told me she has Diabetes. My daughter told me, I confronted the nurses, they said they don't tell me; papers are sent home when she leaves; and that it's not that bad." Record review of the facility's Medical Staff Bylaws; Rules and Regulations approved by the	A 468		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	450130	A. BUILDING _____ B. WING _____	C 04/09/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 468	Continued From page 7 Board of Control May 31, 2013, revealed the following; Where there is need of a discharge summary, a clinical resume covering the necessary five (5) points including the final diagnosis and authenticated by the attending Practitioner is sufficient to exclude the completion of the face sheet. Necessary five (5) points: (1) Why was the patient admitted? (2) Pertinent findings. (3) What was done? Procedures performed and treatment rendered (4) Condition on discharge. (5) Instructions, including medications, diet, physical activity, if any, and follow-up. During an interview on 04/08/15 at 4:45 PM with the ANP, she stated that she diagnosed Patient #1 with DM on 01/17/15 following her laboratory test results, Hemoglobin A1C; positive for Diabetes. ANP stated she wanted Patient #1 to follow-up with her PCP following discharge because she did not want to initiate medication therapy that she was not able to monitor. ANP confirmed Patient #1's Discharge Summary and Instructions dated 01/20/15 failed to document her new diagnosis of Diabetes Mellitus and the recommended follow-up with her PCP. ANP stated that the nurse completing the Discharge Instructions did not pick that up from her record and the Psychiatrist did not add it to her final diagnosis upon discharge. During an interview on 04/09/15 at 8:55 AM with Patient #1's mother/guardian revealed she was not told when her daughter was discharged on 01/20/15 that she had Diabetes; or that she	A 468		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	450130	A. BUILDING _____ B. WING _____	C 04/09/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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A 468 A 837	Continued From page 8 needed to follow-up with her PCP. 482.43(d) TRANSFER OR REFERRAL The hospital must transfer or refer patients, along with necessary medical information, to appropriate facilities, agencies, or outpatient services, as needed, for follow-up or ancillary care. This STANDARD is not met as evidenced by: Based on a record review and interview, the hospital failed to ensure that discharge instructions included the referral for follow-up care as ordered by the Advanced Nurse Practitioner (ANP) along with the necessary medical information. Patient #1's discharge summary completed by the Psychiatrist did not include her newly diagnosed Diabetes Mellitus (DM) made by the ANP on 01/17/15; or the follow-up care recommended for her Primary Care Physician (PCP) by the ANP. This deficient practice could affect Patient #1's overall health by failure to follow-up and seek treatment of her health conditions. Findings included: Record review of Patient #1's medical record revealed she was admitted on 01/13/15 and discharged 01/20/15 at 18:40. On 01/17/15 the facility's ANP assessed Patient #1's laboratory results for a Hemoglobin, A1C at 7.24 (normal results less than 6.5) and indicated that she had "DM". ANP documented that she would place Patient #1 on a 2000 American Diabetes Association (ADA) diet, have the dietician see	A 468 A 837	3) 782.43 d Transfer or Referral Corrective Action: For all new medical diagnoses the APN will immediately consult with attending psychiatrist and pending approval will be added by the APN immediately in axis as part of the discharge summary. At discharge nursing staff will document education to patient and or guardian (as appropriate) for need and recommended follow-up with PCP. Ongoing compliance will be checked daily via nursing 12 and 24 hr chart checks. All nursing staff will be in-serviced by Behavioral Health Nursing Administration by 5/15/15.	5/15/15

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	450130	A. BUILDING _____ B. WING _____	C 04/09/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 837	Continued From page 9 patient before discharge, and documented that Patient #1 needed to follow up with her PCP. Record review of the Discharge Instructions dated 01/20/15 presented and signed by Patient #1's mother/guardian revealed only "Follow-up appointments" were for the Psychiatrist and Individual Therapist appointments. The area of Follow-up appointments for Primary Care Physician was documented "Deferred." Further review revealed discharge diagnosis for AXIS III: Medical problems were- "Asthma, gastro esophageal reflux disease (GERD)." The Discharge Summary diagnosis did not include Diabetes Mellitus as diagnosed by the ANP on 01/17/15. Record review of Patient #1's written complaint completed by her mother/guardian, undated, revealed when her daughter was discharged on 01/20/15; "they did blood work on her [Patient #1] and never told me she has Diabetes. My daughter told me, I confronted the nurses, they said they don't tell me; papers are sent home when she leaves; and that it's not that bad." Record review of the facility's Medical Staff Bylaws; Rules and Regulations approved by the Board of Control May 31, 2013, revealed the following; Where there is need of a discharge summary, a clinical resume covering the necessary five (5) points including the final diagnosis and authenticated by the attending Practitioner is sufficient to exclude the completion of the face sheet. Necessary five (5) points: (1) Why was the patient admitted?	A 837		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A 837	Continued From page 10 (2) Pertinent findings. (3) What was done? Procedures performed and treatment rendered (4) Condition on discharge. (5) Instructions, including medications, diet, physical activity, if any, and follow-up. During an interview on 04/08/15 at 4:45 PM with the ANP, she stated that she diagnosed Patient #1 with DM on 01/17/15 following her laboratory test results, Hemoglobin A1C; positive for Diabetes. ANP stated she wanted Patient #1 to follow-up with her PCP following discharge because she did not want to initiate medication therapy that she was not able to monitor. ANP confirmed Patient #1's Discharge Summary and Instructions dated 01/20/15 failed to document her new diagnosis of Diabetes Mellitus and the recommended follow-up with her PCP. ANP stated that the nurse completing the Discharge Instructions did not pick that up from her record and the Psychiatrist did not add it to her final diagnosis upon discharge. During an interview on 04/09/15 at 8:55 AM with Patient #1's mother/guardian revealed she was not told when her daughter was discharged on 01/20/15 that she had Diabetes; or that she needed to follow-up with her PCP.	A 837		

TEXAS DEPARTMENT OF STATE HEALTH SERVICES

P.O. Box 149347
Austin, Texas 78714-9347
1-888-963-7111

DAVID L. LAKEY, M.D.
COMMISSIONER

TTY: 1-800-735-2989
www.dshs.state.tx.us

Texas Department of State Health Services
Health Facility Compliance Group-San Antonio
2303 SE Military Drive, Bldg 514
San Antonio, TX 78223
Mail Code: 1979

December 16, 2014

NIX Health Care System
414 Navarro, Suite 600
San Antonio Texas 78205

Dear Administrator:

Enclosed are the CMS 2567 and the Statement of Deficiencies forms listing those deficiencies found at your facility on 11-19-14. Please develop a plan of correction for each deficiency cited and return to this office (within ten (10) calendar days from receipt of this letter).

In the space provided on the forms, please provide a plan of correction and completion date for each deficiency. After completing the forms, sign and date at the bottom of page one of each form and return to the address above. It will be necessary to make copies for your records, please make a copy of the Statement of Deficiencies for your records prior to completing the Plan of Correction on that form.

The CMS-2567 (Statement of Deficiencies) is an official, legal document. All information must remain unchanged except for entering the plan of correction, correction dates, and the signature space. Any discrepancy in the original deficiency citation(s) will be reported to the Dallas Regional Office (RO) for referral to the Office of the Inspector General (OIG) for possible fraud. If information is inadvertently changed by the provider/supplier, the State Survey Agency (SA) should by the provider/supplier; the State Survey Agency (SA) should be notified immediately.

PLEASE DO NOT PUNCH HOLES

An approved plan of correction is requisite to continued program participation. You will be notified only if your plan of correction is unacceptable. Certification of your facility cannot be recommended to the Centers for Medicare/Medicaid Services until I have received the completed forms. Therefore, I am requesting that you give this matter priority and that you return the forms to the address above within ten (10) calendar days from receipt of this letter. If you have any questions, do not hesitate to contact my office.

Sincerely,

/S/

Larrie Collier, HFC Manager
Health Facility Compliance Group-San Antonio
(210)531-4946
larrie.collier@dshs.state.tx.us

LC/js
Enclosure

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	450130	A. BUILDING _____ B. WING _____	C 11/19/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NIX HEALTH CARE SYSTEM	414 NAVARRO, SUITE 600 SAN ANTONIO, TX 78205

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 000	INITIAL COMMENTS The CMS - 2567 (Statement of Deficiencies) is an official, legal document. All information must remain unchanged except for entering the plan of correction, correction dates and the signature space. Any discrepancy in the original deficiency citation (s) will be reported to Dallas Regional Office (RO) for referral to the Office of Inspector General (OIG) for possible fraud if information is inadvertently changed by the provider/supplier, the State Survey Agency (SA) should be notified immediately. An unannounced visit was conducted on 11/10/14 to conduct a complaint investigation survey. An entrance conference was conducted in the conference room of the facility. In attendance was the Vice President of Behavioral Health Care and the Patient Advocate. The purpose and process of the complaint survey were discussed and an opportunity for questions was provided. Complaint TX 00203333 was substantiated in the area of patient rights with related standard level deficiencies cited. An exit conference was conducted in the afternoon of 11/19/14 in the facility conference room. The Director of Risk Management was in attendance. Preliminary findings of the survey were discussed and an opportunity for questions was provided.	A 000	Plan of Correction: All Admission, Assessment, Social Work and Nursing Staff will receive formal inservice training to include an attestation to the effect that they have been educated on the legal specifics related to patients with guardians. Staff will demonstrate an understanding of Proper notifications and consents which must be provided to and received from the patient's guardian related to patient's admission, inpatient care and receipt of psychotropic and other medications. The staff member who discovers that a patient has a guardian, regardless of their position, will immediately: 1. Notify the Nursing Supervisor as well as their immediate supervisor upon discovery that the patient has a guardian 2. Contact the Admissions office to inform that patient's guardian must be notified to sign all forms pertaining to the patient's admission and subsequent treatment modalities 3. Work with Supervisor and Admissions staff to ensure that admission, medication and all other consents are reviewed with and signed by the patient's guardian 4. Attempt to acquire copies of legal documents that name the patient's guardian and place such documents in the patient's medical record	
A 131	482.13(b)(2) PATIENT RIGHTS: INFORMED CONSENT The patient or his or her representative (as allowed under State law) has the right to make informed decisions regarding his or her care. The patient's rights include being informed of his or her health status, being involved in care	A 131		

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

Julie Lutz Chief Quality & Compliance Officer 12-23-2014

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	450130	A. BUILDING _____ B. WING _____	C 11/19/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NIX HEALTH CARE SYSTEM	414 NAVARRO, SUITE 600 SAN ANTONIO, TX 78205

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 131	Continued From page 1 planning and treatment, and being able to request or refuse treatment. This right must not be construed as a mechanism to demand the provision of treatment or services deemed medically unnecessary or inappropriate. This STANDARD is not met as evidenced by: Based on record reviews and interviews, it was determined the facility failed to follow their Informed Consent Policy and Procedure that would ensure one of one patient's (patient #1) guardian was given the right to make informed decisions regarding consent to the use of psychotropic medications. This had the potential to affect any patient who had a guardian and was placed on psychotropic medications. Findings included: Record review on 11/10/14 of Informed Consent Policy and Procedure, last reviewed by facility in February 2011, revealed but was not limited to the following: "Written Consent: A written consent form is to be used to obtain authorization prior to the procedure or treatment. When completed, the form serves as a record and evidence that the patient authorized the procedure and accepted the associated risks as disclosed by the physician. Persons under Guardianship (adults or minors): All persons under legal custody of a guardian or conservator shall have permits signed by their legal guardian (as guardian) and a certified copy of his/her official letters of guardianship shall be obtained and placed in and become part of the patients' permanent medical record, prior to receiving treatment."	A 131	5. Ensure that all signed consents received from the patient's guardian are placed in patient's medical record as soon as they are completed Additionally, a form will be developed and approved by forms committee and implemented to ensure that every effort is made to determine whether any patient requiring admission to our services has a guardian, so that appropriate consents will be received prior to a patient's admission. Completion date for the training and implementation of this process: January 15, 2015	

12-23-2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	450130	A. BUILDING _____ B. WING _____	C 11/19/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 131	Continued From page 2 Record review on 11/10/14 of Patient #1's medical record revealed but was not limited to the following: "Annual Report On Condition and Well-Being of Ward and Oath of Guardian signed by Patient's guardian [mother] on 05/07/2014." Patient #1 was documented to have "Mental Retardation" and deemed an Incapacitated person. Record review on 11/10/14 of Patient #1's medical record revealed Consents for Treatment with Psychotropic Medication for Risperdal, dated 08/09/14, for Depakote Extended Release (ER), dated 08/09/14, and Valium, dated 08/11/14. The consents for Risperdal and Depakote ER documented Patient #1 gave verbal consent. The consent for Valium had Patient #1 signing his first name. The guardian did not sign Consents to Treatment with Psychotropic Medication forms. Interview on 11/19/14 at 1:30 PM with Social Worker #1 confirmed she was aware that Patient #1 had a guardian. She stated that information is given to the nursing staff by the social work staff and then it is up to the nursing staff to obtain consents from the guardian.	A 131		

12-23-2014

TRANSMISSION VERIFICATION REPORT

TIME : 05/21/2014 15:21
NAME : NIX HEALTH
FAX : 2102712023
TEL : 2102712188
SER.# : BROJ1J311189

DATE,TIME	05/21 15:19
FAX NO./NAME	9-15128346620
DURATION	00:01:29
PAGE(S)	06
RESULT	OK
MODE	STANDARD ECM

nix HEALTH

FAX:

To:	Glenn Crow/Ginger Smith Texas Department of State Health Services
Fax number:	512-834-6620

From:	Blake Hubbard
Fax number:	210-271-2023
Phone number:	210-579-3133

Date:	May 21, 2014
Number of pages: (including cover)	6

Comments: Please see the attached Plan of Correction

TEXAS DEPARTMENT OF STATE HEALTH SERVICES

DAVID L. LAKEY, M.D.
COMMISSIONER

P.O. Box 149347
Austin, Texas 78714-9347
1-888-963-7111
TTY: 1-800-735-2989
www.dshs.state.tx.us

May 19, 2014

John Striby, Administrator
Nix Behavioral Health Center
1975 Babcock Rd.
San Antonio, TX 78229

Re: Nix Behavioral Health Center 45-0130

Dear Mr. Striby:

Enclosed are the CMS 2567 form listing deficiencies found at your facility on May 14, 2014, and the guidance sheet on How To Write An Acceptable Plan of Correction. Please develop a plan of correction for each deficiency cited and return to this office within (ten) 10 calendar days from receipt of this letter. **In the space provided on the forms, provide a plan of correction and completion date for each deficiency. After completing the forms, sign and date at the bottom of page one of each form and return the original to the address above.** It will be necessary to make copies for your records. **An approved plan of correction is requisite to continued program participation. You will be notified only if your plan of correction is unacceptable.** It will be necessary to make copies for your records. Certification of your facility cannot be recommended to the Centers for Medicare/Medicaid Services until I have received the completed forms. Therefore, I am requesting that you give this matter priority and that you return the forms to the address above within ten (10) calendar days from receipt of this letter. *Please include the above mail code in addressing your correspondence to this office to ensure prompt delivery.* If you have any questions, do not hesitate to contact my office.

To expedite approval, please forward a copy of your plan of correction to this office by fax. Our fax number is (512) 834-6620. If we can be of further assistance, please contact this office at (512) 834-6649.

Sincerely,

Glenn Crow, Architect
Architectural Review Group
Regulatory Licensing Unit

GC/gns

Enclosures

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	450130	A. BUILDING 01 - NIX BEHAVIORAL HEALTH CENTER B. WING _____	05/14/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NIX HEALTH CARE SYSTEM	414 NAVARRO, SUITE 600 SAN ANTONIO, TX 78205

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS A life safety code (LSC) investigation survey was conducted on site on 5/14/2014. An entrance conference was held for the Vice President of Facility Operations on 5/14/2014 to discuss the purpose of the LSC survey, and the survey process was explained. Instructions were provided on writing plans of correction. An opportunity was provided for questions and discussion. The LSC survey was conducted under the authority of Chapter 2 of the State Operations Manual, Appendix A, Acute Care Hospitals, 42CFR482 to determine the Hospital ' s compliance. An LSC exit conference was conducted on 5/14/2014 in the hospital. In attendance were the Vice President of Facility Operations and the Security Officer. The preliminary findings of the survey and the next steps in the survey process were explained. An opportunity was provided for questions and discussion.	K 000		
K 029	NFPA 101 LIFE SAFETY CODE STANDARD Hazardous areas are protected in accordance with 8.4. The areas are enclosed with a one hour fire-rated barrier, with a 3/4 hour fire-rated door, without windows (in accordance with 8.4). Doors are self-closing or automatic closing in accordance with 7.2.1.8. 18.3.2.1 This STANDARD is not met as evidenced by: Based on observation the facility failed to provide adequate hazardous area separation. The inspector observed, while accompanied by	K 029	This item has been corrected. The door closing and latching mechanism was adjusted and repaired such that automatic closing and latching was achieved. Completed May 20, 2014. Ongoing monitoring of door function is accomplished through environmental rounds and inspections. These rounds are performed by a multi-disciplinary group, including facilities, security and nursing personnel. The individual responsible for assuring ongoing compliance will be our Senior Vice President and Chief Operating Officer.	05/20/2014

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X8) DATE
Blake W. Hubbard, FACHE	Senior Vice President & COO	05/21/2014

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	450130	A. BUILDING 01 - NIX BEHAVIORAL HEALTH CENTER B. WING _____	05/14/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NIX HEALTH CARE SYSTEM	414 NAVARRO, SUITE 600 SAN ANTONIO, TX 78205

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 029	Continued From page 1 the Vice President of Facility Operations and the Security Officer during the hours of the inspection from 10:00 am to 12:15 pm on 5/14/2014 that there was the following issue. The soiled utility door at the " A " wing on the second floor did not close and latch properly.	K 029		
K 034	NFPA 101 LIFE SAFETY CODE STANDARD Stairways and smokeproof towers used as exits are in accordance with 7.2. 18.2.2.4 This STANDARD is not met as evidenced by: Based on observation the facility failed to provide adequate stair enclosures. The inspector observed, while accompanied by the Vice President of Facility Operations and the Security Officer during the hours of the inspection from 10:00 am to 12:15 pm on 5/14/2014 that the stairs were being used for storage of construction materials. The following stairs had storage inside of the enclosure, Stair " B " and " D ". " There shall be no enclosed, usable space within an exit enclosure, including under stairs, nor shall any open space within the enclosure be used for any purpose that has the potential to interfere with egress. " NFPA 101, 2000, 7.2.2.5.3.	K 034	This item has been corrected. Items found in the stairwell were related to ongoing renovation project. Items have been removed. Contractors educated as to requirements for egress routes to be clear of obstructions and storage. Nix Health Security to monitor daily to assure clear egress is maintained. Item corrected as of May 20, 2104. The individual responsible for assuring ongoing compliance will be our Senior Vice President and Chief Operating Officer.	05/20/2014
K 211	NFPA 101 LIFE SAFETY CODE STANDARD Where Alcohol Based Hand Rub (ABHR) dispensers are installed in a corridor: o The corridor is at least 6 feet wide o The maximum individual fluid dispenser capacity shall be 1.2 liters (2 liters in suites of rooms) o The dispensers shall have a minimum spacing	K 211	This item has been corrected. The alcohol based hand rub dispensers have been removed and relocated to an appropriate location. Facilities staff educated as to the appropriate installation of such dispensers. Item corrected as of May 20, 2014. The individual responsible for assuring ongoing compliance will be our Senior Vice President and Chief Operating Officer.	05/20/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	450130	A. BUILDING 01 - NIX BEHAVIORAL HEALTH CENTER B. WING _____	05/14/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NIX HEALTH CARE SYSTEM	414 NAVARRO, SUITE 600 SAN ANTONIO, TX 78205

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K 211	Continued From page 2 of 4 ft from each other o Not more than 10 gallons are used in a single smoke compartment outside a storage cabinet. o Dispensers are not installed over or adjacent to an ignition source. o If the floor is carpeted, the building is fully sprinklered. 18.3.2.7, CFR 403.744, 418.100, 460.72, 482.41, 483.70, 483.623, 485.623 This STANDARD is not met as evidenced by: Based on observation the facility failed to provide an acceptable location for alcohol based hand rub dispensers. The inspector observed, while accompanied by the Vice President of Facility Operations and the Security Officer during the hours of the inspection from 10:00 am to 12:15 pm on 5/14/2014 that there were alcohol based hand rubs above or immediately adjacent to electrical switches in the nurse station on the first floor.	K 211		
K9999	FINAL OBSERVATIONS Staff Did Not Have Keys to Locked Fire Extinguisher Cabinets " Physical environment. A physical environment that protects the health and safety of patients, personnel, and the public shall be provided in each facility. The physical premises of the facility and those areas of the facility's physical structure that are used by the patients (including all stairwells, corridors, and passageways) shall meet the local building and fire safety codes and subchapters F and G of this chapter. " - 2004, §134.122 (d)(1)(C). Based on observation the facility failed to provide	K9999	This item has been corrected. All staff were surveyed to ascertain their possession/access to keys necessary to perform their roles within their assigned unit. Any employee found not to have the appropriate keys were immediately issued keys and in-serviced on the associated use and responsibilities. This action was completed on May 20, 2014. Further a multi-disciplinary team, including Administration, Security, Facilities and Nursing has been formed to review the processes surrounding the issuance and use of keys within the facility and units. This team has been charged with a process redesign to assure that all staff have access to necessary keys while on duty. The team will also address unit safety and security and key control.	06/13/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	450130	A BUILDING 01 - NIX BEHAVIORAL HEALTH CENTER B WING _____	05/14/2014

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K9999	Continued From page 3 adequate keys to the staff for the locked fire extinguisher cabinets. The inspector observed, while accompanied by the Vice President of Facility Operations and the Security Officer during the hours of the inspection from 10:00 am to 12:15 pm on 5/14/2014 that there was the following issue. The inspector asked a nurse on the staff if she could open up one of the locked fire extinguisher cabinets. She was not able to open up the cabinet because she had not been issued a key. The Security Officer stated that the locks had been changed and new keys had not been issued.	K9999	The team has been given until June 13, 2014 to implement new and improved processes. The individual responsible for assuring ongoing compliance will be our Senior Vice President and Chief Operating Officer.	
	Window Screens " In building housing for certain types of patients, detention rooms, or a security section, the facility shall provide detention screens to confine or protect building inhabitants, when necessary. " - 2004, §134.122 (n)(3)(A)(viii)(II) Based on observation the facility failed to provide adequate window screens. The inspector observed, while accompanied by the Vice President of Facility Operations and the Security Officer during the hours of the inspection from 10:00 am to 12:15 pm on 5/14/2014 that there were no window screens on the second floor windows that were directly above the Adolescent Recreation Area. One of the windows had been broken out by a patient throwing a football when within the Recreation Area.		This item in in process. The window screens had been ordered on April 30, 2014. These screens are currently in the manufacturing process. The screens will be delivered and installed by June 6, 2014. The individual responsible for assuring ongoing compliance will be our Senior Vice President and Chief Operating Officer.	06/06/2014

TEXAS DEPARTMENT OF STATE HEALTH SERVICES

DAVID L. LAKEY, M.D.
COMMISSIONER

P.O. Box 149347
Austin, Texas 78714-9347
1-888-963-7111
TTY: 1-800-735-2989
www.dshs.state.tx.us

HOW TO WRITE AN ACCEPTABLE PLAN OF CORRECTION

The content of the plan of correction should include the following information:

Who, by title, will be responsible for the plan? DO NOT USE PROPER NAME
What is the plan going to be?
How is the plan going to be implemented?
How is ongoing compliance going to be monitored?

Once you have the answer to the questions listed above, you are ready to document that information on the statement of deficiencies:

* **Begin each plan of correction in the second column of the statement of deficiencies and plan of correction form next to the tag number (i.e. G224).**

* **Type or write legibly the plan that you have developed.**

* **List the date the deficiencies will be corrected in the far right column:**

  If there are no condition-level deficiencies, the date listed must be within 60 days of the survey date listed on top of the form.

  If there are conditions-level deficiencies, the correction date for deficiencies should be within 30 days or less of the survey date. This will allow sufficient evidence for review by surveyors when a follow-up visit is conducted after the 45th day.

* **Each deficiency must have a plan of correction.**

The administrator or responsible person must sign the first page of the statement of deficiencies and plan of correction form, including their title and the date. Return deficiencies with plans of corrections to:

Texas Department of State Health Services
Architectural Review Group – Austin – Mail Code 2835
Attention: Ginger Smith
PO Box 149347
Austin, TX 78714-9347

PRIVACY NOTIFICATION/NOTIFICACION SOBRE PRIVACIDAD

With few exceptions, you have the right to request and be informed about information that the State of Texas collects about you. You are entitled to receive and review the information upon request. You also have the right to ask the state agency to correct any information that is determined to be incorrect. See http://www.dshs.state.tx.us for more information on Privacy Notification. (Reference: Government Code, Section 522.021, 522.023, 559.003 and 559.004)

Tan solo por unas cuantas excepciones, usted tiene el derecho de solicitar y de ser informado sobre la informacion que el Estado de Texas reune sobre usted. A usted se le debe conceder el derecho de recibir y revisar la informacion al requerirla. Usted tambien tiene el derecho de pedir que la agencia estatal corrija cualquier informacion que se ha determinado sea incorrecta. Dirijase a http://www.dshs.state.tx.us para mas informacion sobre la Notification sobre privacidad. (Referencia: *Government Code*, seccion 522.021, 522.023, 559.003 y 559.004)

* * * Communication Result Report (Jan. 3. 2014 4:38PM) * * *

Fax Header) NIX Hospital

Date/Time: Jan. 3. 2014 4:37PM

File No.	Mode	Destination	Pg(s)	Result	Page Not Sent
1101	Memory TX	95314533	P. 5	OK	

Reason for error
E. 1) Hang up or line fail
E. 2) Busy
E. 3) No answer
E. 4) No facsimile connection
E. 5) Exceeded max. E-mail size

nix HEALTH

FAX:

To:	Ms Pamela Shelton, Ms Sonnie Collier
Fax number:	210 531-4533

From:	Adele Giles, SVP, Quality & Compliance
Fax number:	210 587-8141
Phone number:	210 579-3200

Date:	1/3/2014
Number of pages: (including cover)	5

Corrective action plan attached -
Thank you
Adele Giles

Nix Medical Center ■ 414 Navarro, San Antonio, TX 78205 ■ 210.271.1800
Nix Specialty Health Center ■ 4330 Vance Jackson, San Antonio, TX 78230 ■ 210.579.3800
Nix Alamo Heights ■ 5907 Broadway, San Antonio, TX 78209 ■ 210.824.3130
Nix Primary Care Center ■ 700 S. Zarzamora, San Antonio, TX 78207 ■ 210.569.7090
Nix North Orthopaedics Center ■ 9150 Huebner Road, San Antonio, TX 78240 ■ 210.351.6500
Nix Home Care ■ 4402 Vance Jackson, Suite 140, San Antonio, TX 78230 ■ 210.341.0505

nixhealth.com

nix HEALTH

FAX:

To:	Ms Pamela Shelton / Ms Sarai Collier
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Fax number:	210 587-8141
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Corrective action plan attached -

Thank you

Adele Giles

TEXAS DEPARTMENT OF STATE HEALTH SERVICES

DAVID L. LAKEY, M.D.
COMMISSIONER

1100 W. 49th Street • Austin, Texas 78756
1-888-963-7111 • http://www.dshs.state.tx.us
TDD: 512-458-7708

December 20, 2013

Administrator of:
Nix Health Care
414 Navarro, Suite 600
San Antonio, TX. 78205

Dear Administrator:

In reference to the complaint survey conducted at your facility on December 17, 2013, enclosed is the Statement of Deficiencies, for state licensure, which lists the deficiencies cited. **In the space provided on the forms, please provide a plan of correction and completion date for each deficiency. After completing the forms, sign and date at the bottom of page one of each form and return to the address below.** It will be necessary to make copies for your records. **An approved plan of correction is requisite to continued program participation.** Certification of your facility cannot be recommended to the Centers for Medicare and Medicaid Services (CMS) until I have received the completed forms. Therefore, I am requesting that you give this matter priority and that you return the forms to the address below within 10 calendar days from receipt of this letter. If you have any questions, do not hesitate to contact my office.

Sincerely,

/s/ Pam Shelton for
Larrie Collier
Program Administrator
2303 SE Military Drive Bldg. 514
San Antonio, TX. 78223

CJ/PS
Enclosure

Texas Department of State Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	000415	A. BUILDING: _____ B. WING _____	C 12/17/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NIX HEALTH CARE SYSTEM	414 NAVARRO, SUITE 600 SAN ANTONIO, TX 78205

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X 000	INITIAL COMMENTS Note: The State Form is an official, legal document. All information must remain unchanged except for entering the plan of correction, correction dates, and the signature space. Any discrepancy in the original deficiency citation(s) will be referred to the Office of the Texas Attorney General (OAG) for possible fraud. If information is inadvertently changed by the provider/supplier, the State Survey Agency (SA) should be notified immediately. An unannounced visit was conducted on 12/09/13 to conduct a complaint investigation. An entrance conference was conducted in the conference room of the facility . In attendance was the Vice President of Behavioral Health. The purpose and process of the complaint survey were discussed and an opportunity for questions was provided. Complaint TX 00185836 was unsubstantiated with unrelated state licensure violations cited. An exit conference was conducted in the afternoon of 12/17/13 in the facility conference room. The Vice President of Behavioral Health, The Director of Risk Manager, and The Nurse Manager was in attendance. Preliminary findings of the survey were discussed and an opportunity for questions was provided.	X 000		
X 286	133.41(j)(5) Legible, complete entries Medical record services. The hospital shall have a medical record service that has administrative responsibility for medical records. A medical record shall be maintained for every individual who presents to the hospital for evaluation or treatment. Medical record entries must be legible, complete, dated, timed, and authenticated in written or	X 286		

Texas Department of State Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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X 286	Continued From page 1 electronic form by the person responsible for providing or evaluating the service provided, consistent with hospital policies and procedures. . This Requirement is not met as evidenced by: Based on record review and interview, the facility failed to ensure that for one of one patient (Patient #1) clinical records reviewed, all entries were signed, dated and times in accordance with facility policy. Findings included: Record review on 12/09/13 of Patient #1's clinical record revealed the following: Patient #1 was admitted to the facility on 09/13/13 and discharged from the facility on 09/ 20/13. A Pre-Admission Comprehensive Assessment Tool was signed by Physician #1 but was not dated or timed. This Pre-Admission Comprehensive Assessment Tool had a space for a facility social worker to sign and date but was left blank. The Admission Orders and Physician Certification was signed by Physician #1 but was not dated or timed. A Psychiatrist's Progress Note was signed and dated by the physician but no time for the note was noted. Record review on 12/09/13 of three Consents for Psychoactive Medication (Ativan, Risperdal, and Ambien) revealed they were signed by Patient #1 but not dated or timed.	X 286	1. On 1-2-2014, Admission orders policy and procedure was revised: "If the order is a verbal or telephone order, the order is authenticated by the Physician within 48 hours." 2. All physicians in department of psychiatry were re-educated on timing requirements for authentication of telephone/verbal orders. This education was completed on 1-2-2014. 3. Signage reminding physicians and staff to date and time all entries were posted on units 1-2-2014. 4. Date and time "flags" were ordered on 1-2-2014. The flags will be in place and implemented by 1-10-2014. 5. Facility Director of Social Work will re-educate social work staff on requirements for signing, dating, and timing the pre-admission comprehensive assessment tool. This was completed by 1-3-2014. 6. Nursing staff was in-serviced on the requirement to obtain both date and time in addition to patient signature on	

Texas Department of State Health Services

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X 286	Continued From page 2 Record review on 12/17/13 of Admission Orders Policy and Procedure, last reviewed January 2012, revealed the following: If the order is a verbal or telephone order, the co-signature by the physician occurs within 24 hours. Orders are always signed with name, credential, date, and time. Record review on 12/17/13 of Inquiry and Preadmission Assessment Policy and Procedure, last reviewed January 2012, revealed the following: Upon admission, assessments, when appropriate and feasible while the family is available, a licensed, masters level therapist and/or social worker meets with the family so they can contribute data concerning the patient's psychosocial history and also receive information about the program. If this is not feasible, the psychosocial history is scheduled within 72 hours of admission. An LMSW or LCSW reviews and completes all psychosocial histories. Interview on 12/17/13 at 10:50 AM with the facility Director of Medical Records confirmed that all entries in Patient #1's clinical record described above should have been signed, dated and timed per facility policy.	X 286	the consent of treatment with psychoactive medication. This was completed by 1-3-2014. Medical staff was in-serviced on this requirement at the Department of Psychiatry Meeting on 1-2-2014. The "consent to treatment with psychoactive medication" form will be revised to include a line for "time." Currently the form only has a line for date. This will be completed and implemented by 1-7-2014. To demonstrate sustained compliance, a minimum of 30 charts will be reviewed in a 4 month period with goal of 90% compliance for all entries to be dated and timed. - # of dated & timed entries / # of entries.	