ZUCKERBERG
SAN FRANCISCO GENERAL
Hospital and Trauma Center

Regulatory Affairs Department

Joint Conference Committee (JCC) Regulatory Affairs Status Report: **October 2017** (September 21, 2017- October 20, 2017)

I. PENDING SURVEYS

A. **Medi-Cal Recertification Survey (PES)-** scheduled for October 24, 2017

II. COMPLETED SURVEYS

A. **No completed surveys since last report**

III. PLANS OF CORRECTIONS: Reports & Updates

A. **Joint Commission Triennial Accreditation Survey** – Plan of Correction submitted September 5,2017 (see attached)
B. **Joint Commission Clinical Laboratory Survey** –Plan of Correction submitted September 20,2017
C. **Unannounced Medicare Deficiency Survey** – (45 day revisit) Plan of Correction submitted October 6, 2017 (see attached)

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High/Widespread	**EC.02.06.01** **EP1** In 3 of 3 areas that provide care to patients with suicidal ideation (SI), it was noted that all three areas had ligature risks noted during tracer activity: **In the Main Emergency Department**: 1. Two patient bathrooms where SI patients are taken had plastic trash can liners. 2. Exposed sink and toilet plumbing. 3. Long emergency call cords. 4. In the main ED in Rms A1-4 suction/oxygen tubing was observed; a metal bedside table and IV pole were also observed. **In the locked Psychiatric Emergency Services (PES) department:** 1. The bathrooms had exposed sink and toilet plumbing and; 2. Shower curtain was not break-away; 3. Sally Port door hardware and closures pose a ligature risk.	**Finding 1:** The Director of Facilities, Chief Engineer and Department of Risk Management will conduct an annual EOC assessment specific to assessment of suicide risk in the ED and Psychiatric units using a specific suicide prevention/psychiatric EOC assessment tool to determine potential vulnerabilities or gaps as they pertain to ligature risks. **Finding 2**: The Associate Hospital Administrator for Facilities/designee, the Director of Facilities, & the Chief Engineer will meet monthly for one quarter to review the Elevator Machine Room rounds results & identified barriers to compliance resolved. The Elevator Machine Room rounds results will be reported monthly for one quarter to Accreditation, Licensing & Certification Committee (ALCC) & to the Joint Conference Committee (JCC).	The Chief Operating Officer (COO) is ultimately responsible for the corrective action & for overall & ongoing compliance Internal: Tosan Boyo Max Bunuan Greg Chase, Bill Kaplow Medical Directors for the ED, Psychiatry, & PES Terry Dentoni Nursing Directors for Psychiatry & the ED	COMPLETE	Greg/Bill/Susan B. **EOC** **ALCC:** **JCC:** Max/Greg/Bill **EOC** **ALCC:** **JCC:**	**Finding 1:** Initiated September 5,2017 and annually thereafter **Finding 2:** Initiated September 5, 2017 and anticipate completion by February 2018

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Continued fr above	4. Moveable chairs were observed in the areas outside of seclusion and in the day room. 5. The Nurses' stations were open to the areas and various computers, cables, and other normal desk furnishings were observed. 6. The Seclusion Room (1B21) was missing a door handle, creating a hole in the door itself. **Psychiatric Inpatient Services (Units 7B, 7C, 7L)** 1. In Psych Unit 7B there were long, exposed electrical cords near the TV in the day room & no protective cover over the television. 2. In Psych Unit 7B, 10 patient rooms had door handles that could serve as a ligature risk. 3. In Psych Unit 7B, sinks near rooms 7B34 and 7B9 had sink handles that could be considered ligature risks. 4. Seclusion room (7B22) sink controls and exposed plumbing above the commode. 5. A walker was located in the room (7B22). 6. In the room's (7B22) hard ceiling, the diffuser had 1" gaps in the louver. 7. The room (7B22) had a small niche hall entry which was not observable from the nurses' station. 8. Barrel hinges on the room door were not sloped (7B22)					

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Continued fr above	9. The room (7B22) at the time was used as a private room and the interior bathroom was unlocked, which potentially allowed patients to access the area. 10. In Psych Unit 7C, 10 patient rooms had door handles that could be considered ligature risks. 11. There were 1 metal bed out of three in the rooms 7L10 and 7L12 and 2 metal beds out of 6 patient rooms on unit 7D which had not yet been replaced and presented a ligature risk. **Other Findings/Observations** 1.The inpatient psych units do not have video monitoring capability of hallways so staff responding to emergencies on one side of the hall could potentially leave the other side of the hall unmonitored for patients at risk for suicide. 2. In the Elevator Machine Room for cars 5, 6, 7 and 8 a plastic 5-gallon bucket filled with oily rags was discovered.					

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High/Pattern	**LD.04.01.07** **EP1** In 5 of 5 patient records reviewed, it was noted the staff was unable to determine the level of risk after completing a suicide risk assessment for patients with suicidal ideations because the system did not identify a score associated with the risk assessment result that could guide the staff to initiate interventions based on the patient's level of risk. Review of policy "Screening, assessment and management of the potentially suicidal patient in a non-psychiatric setting" it was noted the policy did not address what level of monitoring interventions should be put in place based on the level of suicide risk.	QM and clinical frontline managers are conducting random audits to ensure that staff are using the new audit tools correctly.	The Director of Nursing (CNO) is ultimately responsible for the corrective action & for overall & ongoing compliance Internal: Terry Dentoni Chris Colwell MD. Jeff Schmidt David Staconis Melissa Pitts	**OPEN**	Jeff/David/Melissa **ALCC:** **JCC:**	Initiated September 5, 2017 and anticipate completion by March 2018

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High/Pattern	**NPSG.15.01.01** **EP1** **Observation 1:** During an individual patient tracer, the surveyor observed that a patient identified as at risk for suicide was not be visually monitored as required by hospital policy. The hospital counseled and re-educated the staff person on the role and responsibilities of visually monitoring patients that are at risk for suicide. Mitigation risk strategies put into place prior to the end of survey and agreed upon by senior leadership include: 1. All patients presenting to the main emergency department and assessed as at risk for suicide will automatically be placed on one-to-one observation immediately; 2. The organization will augment current staffing in the main ED to accommodate the increase in monitoring and will utilize exempt nursing staff also trained to monitor suicidal patients when non-exempt staff are unavailable. 3. Concurrently, the leadership team reassessed the functionality of cameras that are currently in place in rooms A 1 through 4 and have found these to be fully operational.	QM and clinical frontline managers are conducting random audits to ensure that staff are using the new audit tools correctly. Additionally, as part of the CNO's monthly leadership meeting, a standing agenda item will be added related to compliance with the corrective actions.	The Director of Nursing (CNO) is ultimately responsible for the corrective action & for overall & ongoing compliance. Internal: Terry Dentoni Chris Colwell MD. Terry Dentoni Jeff Schmidt David Staconis Melissa Pitts Tosan Boyo Max Bunuan Greg Chase Bill Kaplow	**OPEN**	Jeff/David/Melissa **ALCC:** **JCC:**	Initiated September 5, 2017 and anticipate completion by March 2018 Initiated September 5, 2017 and anticipate completion by March 2018

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continued fr above	4. The organization plans on working on installing the necessary software needed to have these up and running and then convert over to having all suicidal patients placed in these rooms and have one dedicated and trained staff person continuously monitor these four rooms, to include the assigned staff person to be positioned directly in front of the video monitors; additionally strategies for this assigned person will also include that if this person needs a break they will call by phone to the team lead for a replacement and the position will never be left unattended. A secondary staff person will also be assigned to respond to direct calls from the video monitor staff to respond to any patient attempts for self-harm activity. **Observation 2:** In 4 of 4 patient records reviewed, of patients with suicidal ideations it was noted the risk assessment did not guide staff in determining all the interventions and level of monitoring the patient with suicidal ideations would need based on the results of the suicidal risk assessment.					

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Moderate/Widespread	**EC.02.03.05** **EP19** Building #5 air-handling equipment is not equipped with automatic smoke-detection shutdown devices as required to be installed per NFPA 90A (2010 ed.) 6.4.4.1 and tested in accordance with NFPA 90A (2010 ed.) 6.4.1.	The Hospital Associate Administrator for Facilities Services/designee, the Director of Facilities Services & the Chief Engineer will meet annually to review the documentation of the duct smoke detector annual testing conducted by the organizations' contracted vendor & ensure that any identified issues are resolved. The results of the annual duct smoke detector testing conducted by the contracted vendor will be reported annually to the Environment of Care (EOC(Committee, Accreditation, Licensing, & Certification committee (ALCC) & to the Joint Conference Committee (JCC).	The Chief Operating Officer (COO) is ultimately responsible for the corrective action & for overall & ongoing compliance Internal: Tosan Boyo Max Bunuan Greg Chase Bill Kaplow FLS consultant	**OPEN**	Max/Greg/Bill **EOC:** **ALCC:** **JCC:**	Initiated September 5, 2017 and annually thereafter

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Moderate/Limited	**EC.02.05.01** **EP 15** In 2 of 14 critical pressure relationships, an issue with the airflow was discovered in the following areas: 1. Sterile Processing was observed to be negative to the Clean Storage room HB002G and should be positive (the Clean Storage room had cardboard boxes and vendor transportation bins stored in the room); 2. Sterile Processing was observed to be neutral/negative to the office HB002E and should be positive; 3. the Interventional Radiology OR was negative to the corridor and should be positive.	The leaders/managers of SPD & IR/OR will monitor the daily airflow testing results and report issues identified, including barriers to compliance, in real-time to Facilities Services for resolution. The Hospital Associate Administrator for Facilities Services/designee, the Director of Facilities Services, & the Chief Engineer will meet monthly to review the documentation of the monthly airflow testing results conducted by Facilities Services to ensure that documentation is complete & any identified issues resolved until airflow testing in SPD & IR/OR, is added to the automated tracking system. The results of the monthly airflow testing conducted by Facilities Services of the designated areas with critical pressure relationships will be reported monthly to Accreditation, Licensing & Certification Committee (ALCC) & to the Joint Conference Committee (JCC) until the airflow testing in the designated critical areas is added to the automated tracking system.	The Chief Operating Officer (COO) is ultimately responsible for the corrective action & for overall & ongoing compliance. Internal: Tosan Boyo Max Bunuan Greg Chase Bill Kaplow Terry Dentoni NMs of SPD, IR/OR	**OPEN**	**SPD:** Niki Pin **IR:** Jerry Padilla **OR:** Julianne Sussman Max/Greg/Bill **EOC** **ALCC:** **JCC:**	Initiated September 5, 2017 and and ongoing until airflow testing is added to the automated tracking system Initiated September 5, 2017 and and ongoing until airflow testing is added to the automated tracking system

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Moderate/Limited	**EC.02.05.09** **EP 5** In the ED triage area of Building #25 the medical gas valve Boxes MVB-1-13 and MVB-1-12 were blocked by equipment.	The Hospital Associate Administrator for Facilities/designee, the Director of Facilities Services, the Chief Engineer, & the ED leadership will meet monthly for one quarter to review the ED & Facilities documentation of direct observation rounds results that access to the ED oxygen/medical gas valves is unobstructed & to resolve any identified barriers to compliance. The results of the Facility & ED direct observation rounds regarding access to the ED oxygen/medical gas shut-off valve boxes will be reported monthly for one quarter to Accreditation, Licensing & Certification Committee (ALCC) & to the Joint Conference Committee (JCC).	The Chief Operating Officer (COO) is ultimately responsible for the corrective action & for overall & ongoing compliance Internal: Tosan Boyo Max Bunuan Greg Chase, Bill Kaplow Chris Colwell, Medical Director Terry Dentoni Jeff Schmidt David Staconis Melissa Pitts	**OPEN**	Max/Greg/Bill/Jeff/ David/Melissa **EOC** **ALCC:** **JCC:**	Initiated September 5, 2017and anticipate completion by March 2018
Low/Pattern	**EC.02.05.07** **EP 5** The documentation for the monthly load tests on the generators did not differentiate between the load time and run time of the generators. Building #5 has two generators lacking this information in the calendar years 2015 and 2016. Building #25 has three generators lacking this information since start-up of the building in May 2016 and December 2016.	The Hospital Associate Administrator for Facilities Services/designee, the Director of Facilities Services & the Chief Engineer will meet monthly for one quarter to review the documentation of the monthly load tests on the generators to ensure that the load time & the run time of the generators is documented and issues identified are resolved. The results of the monthly load tests on the generators will be reported monthly for one quarter to Accreditation, Licensing & Certification Committee (ALCC) & to the Joint Conference Committee (JCC).	The Chief Operating Officer (COO) is ultimately responsible for the corrective action & for overall & ongoing compliance Internal: Tosan Boyo Max Bunuan Greg Chase Bill Kaplow	**OPEN**	Max/Greg/Bill **EOC:** **ALCC:** **JCC:**	Initiated September 5, 2017 and anticipate completion by March 2018

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Low/Pattern	**IM.02.01.03** **EP 6** During review of a closed inpatient record, it was noted that the trifold notes had been cut through on the fold and separated into three pages. The cut had compromised the integrity of the notes that were written in the space. In discussion with the health information staff, it was determined that this was a new process that was being used to scan the document.	70 medical record audits of newly discharged patients will be completed each month to ensure the original integrity of all trifold notes remains. The audit will be conducted on a monthly basis until compliance is achieved at 90% or better for three consecutive months. Audit data will be reported on a monthly basis to Accreditation Licensing and Certification Committee (ALCC), Performance Improvement and Patient Safety Committee (PIPS), and Joint Conference Committee (JCC).	The Chief Financial Officer (CFO is ultimately responsible for the corrective action & for overall & ongoing compliance Internal: Valerie Inouye Debra Darden Karen O'Donnell	**OPEN**	Debra/Karen **ALCC:** **PIPS:** **JCC:**	Initiated August 2017 and anticipate completion by April 2018
Low/Pattern	**LS.02.01.30** **EP 3** An issue with the features of the hazardous room was discovered in the following locations: 1. the Storage room HB002A did not close; 2. the Clean utility room H6430 did not close; 3. the Storage room H1801 did not have an automatic closure installed; 4. the Clean Linen room H1832 did not close.	The Hospital Associate Administrator for Facilities Services/designee, the Director of Facilities Services, & the Chief Engineer will meet monthly for one quarter to review the documentation of the weekly inspections checking that the identified hazardous room doors have the proper closure hardware and that the doors continue to close properly & any identified issues resolved. The results of the weekly facility inspections checking that the identified hazardous room doors have the proper closure hardware and that the doors continue to close properly will be reported monthly for one quarter to the Accreditation, Licensing & Certification Committee (ALCC) & to the Joint Conference Committee (JCC).	The Chief Operating Officer (COO) is ultimately responsible for the corrective action & for overall & ongoing compliance Internal: Tosan Boyo Max Bunuan Greg Chase Bill Kaplow	**OPEN**	Max/Greg/Bill **EOC** **ALCC:** **JCC:**	Initiated September 5, 2017 and anticipate completion by March 2018

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Low/Pattern	**MM.05.01.07** **EP 2** During tracer activity and review of the medication room, it was noted that pill splitters are used for multi-patient use which has the potential for cross contamination of patient medications.	The Pharmacy staff will perform monthly medication room unit inspections for 3 months to ensure all actively used pill splitters are labeled with an individual patient name. These audit results will be reported to Joint Nursing Pharmacy, Accreditation, Licensing and Certification Committee, Performance Improvement and Patient Safety Committee, and Joint Conference Committee.	The Director of Pharmaceutical Services is ultimately responsible for the corrective action & for overall & ongoing compliance Internal: Jeanette Cavano Julie Russell Terry Dentoni Jennie Farr Daisy Aguallo	**OPEN**	Jeanette/Julie **JNPC:** **ALCC:** **PIPS:** **JCC:**	Initiated September 2017 and anticipate completion by April 2018.
Low/Limited	**EC.02.02.01** **EP 5** The process for managing (discarding) teeth extracted during oral surgery procedures was reviewed with dental staff. It was noted that there was no system in place to segregate those teeth that contained any amount of mercury-based amalgam from those discarded in with general biomedical waste.	Audits of documentation of appropriate disposal of extracted teeth that contain mercury-based amalgam will be conducted on every patient. This will be accomplished by comparing the number of teeth containing amalgam indicated for removal in the time out (documented in the comment section) and the number of teeth containing amalgam collected in the waste receptacle marked for mercury-based amalgam. The audit will be conducted on a monthly basis until compliance is achieved at 90% or better for three consecutive months. Audit data will be reported on a monthly basis to Accreditation Licensing and Certification Committee (ALCC), Performance Improvement and Patient Safety Committee (PIPS), and Joint Conference Committee (JCC).	The Chief Quality Officer (CQO) is ultimately responsible for the corrective action & for overall & ongoing compliance Internal: Ed Ochi Mike Harris Brian Bast /Medical Director, Oral Surgery Terry Dentoni Rosaly Ferrer Philippa Doyle	**OPEN**	Rosaly/Phillipa **ALCC:** **PIPS:** **JCC:**	Initiated August 2017 and anticipate completion by March 2018.

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Low/Limited	**EC.02.03.05** **EP12** At the time of survey, the organization did not have any documentation to indicate the water-flow test for the standpipe system in Building #5 had been conducted in the last five years. The documentation available indicated other standpipe tests had been conducted but it did not detail the test mention in NFPA 25 (2011 ed.) 6.3.1.	The Hospital Associate Administrator for Facilities Services/designee, the Director of Facilities Services & the Chief Engineer will meet annually to review the documentation of the hydrostatic and water flow tests for the Building 5 standpipe system to ensure that documentation is complete and present.	The Chief Operating Officer (COO) is ultimately responsible for the corrective action & for overall & ongoing compliance Internal: Tosan Boyo Max Bunuan Greg Chase Bill Kaplow	**OPEN**	Max/Greg/Bill **EOC:** **ALCC:** **JCC:**	

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Low/Limited	**EC.02.05.01** **EP 16** The Decontamination Area was positive to the Storage room HB001G and should be negative. The storage room had a door to the corridor allowing airflow from the Decontamination Area to be pushed into the corridor.	The leaders/managers of the Decontamination Room/Storage Room HB001G will monitor the daily airflow testing results and report issues identified, including barriers to compliance, in real-time to Facilities Services for resolution. The Hospital Associate Administrator for Facilities Services/designee, the Director of Facilities Services, & the Chief Engineer will meet monthly to review the documentation of the monthly airflow testing results conducted by Facilities Services to ensure that documentation is complete & any identified issues resolved until airflow testing in the Decontamination Area /Storage Room HB001G is added to the automated tracking system. The results of the monthly airflow testing conducted by Facilities Services of the designated areas with critical pressure relationships will be reported monthly to Accreditation, Licensing & Certification Committee (ALCC) & to the Joint Conference Committee (JCC) until the airflow testing in the designated critical areas is added to the automated tracking system.	The Chief Operating Officer (COO) is ultimately responsible for the corrective action & for overall & ongoing compliance Internal: Tosan Boyo Max Bunuan Greg Chase Bill Kaplow	**OPEN**	**Decontam. Room**: Niki Pin Max/Greg/Bill **EOC:** **ALCC:** **JCC:**	Initiated September 5, 2017 and ongoing until airflow testing is added to the automated tracking system Initiated September and ongoingand ongoing until airflow testing is added to the automated tracking system **ALCC:** Initiated September 5, 2017 and ongoing **JCC:** Initiated September 5, 2017 and ongoing

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Low/Limited	**EC.02.05.05** **EP 6** In the machine room for Elevator #9 two open electrical junction boxes were observed. In Building #5 on the 7th floor inside the north entry to Unit 7D an open electrical junction box was discovered above the ceiling.	The Hospital Associate Administrator for Facilities Services/designee, the Director of Facilities Services, & the Chief Engineer will meet monthly for one quarter to review the documentation of the weekly random inspections checking that the electrical junction box covers are closed any identified barriers to compliance resolved. The results of the weekly random direct inspections will be reported monthly for one quarter to the Accreditation, Licensing & Certification Committee (ALCC) & to the Joint Conference Committee (JCC).	The Chief Operating Officer (COO) is ultimately responsible for the corrective action & for overall & ongoing compliance Internal: Tosan Boyo Max Bunuan Greg Chase Bill Kaplow	**OPEN**	Max/Greg/Bill **EOC:** **ALCC:** **JCC:**	Initiated September 5, 2017 and antic completion by March 29018

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Low/Limited	**IC.02.01.01** **EP 2** An eye wash station located at the Women's Center (5M) laboratory drawing area, positioned in a sink identified as 'dirty', incorporated hinged protective covers to prevent contamination and/or debris building around the flushing spigots. These covers were not in place, as observed and witnessed by staff during the building tour and tracer activities at this site. An eye wash station located at the Outpatient Dialysis Center (Building 100) laboratory drawing area also incorporated hinged protective covers to prevent contamination and/or debris building around the flushing spigots. These covers were not in place, as observed and witnessed by staff during the building tour and tracer activities at this site. The process for drawing up injections using multiple use vials (of vasopressin and/or chloroprocaine) during procedures in the Women's Option Center was reviewed. Staff interviews revealed that multiple use vials were routinely managed and drawn within either of two procedure rooms, at the time of the procedure. This practice posed a risk of cross-contamination and did not conform to CDC recommendations and guidelines addressing the use and management of multiple use vials.	1.The 5M Women's Center & Outpatient Dialysis leaders will monitor that their staff understand and can demonstrate the proper positioning of the unit eyewash station hinged protective covers and resolve any identified barriers to compliance. 1a. The Hospital Associate Administrator for Facilities Services/designee, the Director of Facilities Services, & the Chief Engineer will meet monthly for one quarter to review documentation results of the Facilities Services weekly random inspections of the eyewash station hinged protective covers to ensure that the documentation is complete and issues identified are resolved with the department manager. 1b. The results of the weekly random inspections of unit eyewash station hinged protective covers by both Facilities Services staff & the leaders/designees of 5M & Outpatient Dialysis will be reported monthly for one quarter to the Accreditation, Licensing & Certification Committee (ALCC) & to the Joint Conference Committee (JCC).	The Chief Quality Officer (CQO) is ultimately responsible for the corrective action & for overall & ongoing compliance Internal : Elaine Dekker Max Bunuan Greg Chase Bill Kaplow Jeanette Cavano Rosaly Ferrer Marisella Carranzza	**OPEN**	**1.5M:** Rosaly & Marisella **Outpatient Dialysis:** Rosaly & Jep **1a.** Max/Greg/Bill **1b.** **EOC** **ALCC:** **JCC:** **2. 6G Competency Assessments** Rosaly & Marisella **6G Leadership Team Meeting:** **ALCC:** **PIPS:** **JCC:**	Initiated September 5, 2017and ongoing Initiated September 5, 2017 and anticipate completion by March 2018 Initiated September 5, 2017 and anticipate completion by March 2018

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Continued fr above		2. Competency assessments of each Women's Option Center staff nurse by direct observation will be conducted on a monthly basis to ensure accurate and consistent practice. These observations will continue until 100% compliance has been achieved for three consecutive months. The results of these observations will be reported to the ZSFG Unit 6G Leadership Team meeting, the Accreditation, Licensing, and Certification Committee (ALCC), the Performance Improvement and Patient Safety Committee (PIPS), and the Joint Conference Committee (JCC).				
Low/Limited	**EC.02.04.03** **EP 5** A container of testing strips currently in use for determining the potency (amounts) of chloramine in water used for outpatient renal dialysis had expired in May 2017.	A weekly audit tool was developed to monitor compliance with all findings from the survey. The weekly audit will consist of monitoring each of the findings on a monthly basis until compliance is achieved at 90% or better for three consecutive months. Audit data will be reported on a monthly basis to Accreditation Licensing and Certification Committee (ALCC), Performance Improvement and Patient Safety Committee (PIPS), and Joint Conference Committee (JCC). Audit data will include: All testing strips for determining the potency (amounts) of chloramine are current and not expired.	The Chief Quality Officer (CQO) is ultimately responsible for the corrective action & for overall & ongoing compliance Internal: Elaine Dekker Sam James Rosaly Ferrer	**OPEN**	Rosaly / Jep **ALCC:** **PIPS:** **JCC:**	Initiated July 2017, and anticipate completion by March 2018

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Low/Limited	**LS.02.01.10** **EP 5** The door to the Pre-Action Cabinet room H1029A was part of a one hour fire rated wall and the door did not have a fire rating label. The surveyor discussed the Life Safety deficiency with the organization, and it was determined that the following ILSMs will be implemented until the deficiency has been resolved and according to the organization's ILSM policy: Increase surveillance(EP-8), Conduct education promoting awareness of deficiencies(EP-13)	The replacement of the fire rating label for the Pre-Action Cabinet Room H10029A door will be reported to the Accreditation, Licensing & Certification Committee (ALCC) & to the Joint Conference Committee (JCC). Visual checks of the fire rating label on fire-rated doors will be conducted during monthly EOC and Fire Life Safety rounds for one quarter and will be reassessed thereafter. The results of the EOC & Fire Life Safety rounds regarding fire rating labels on fire-rated doors will be reported monthly for one quarter to Accreditation, Licensing & Certification Committee (ALCC) & to the Joint Conference Committee (JCC).	The Chief Operating Officer (COO) is ultimately responsible for the corrective action & for overall & ongoing compliance Internal: Tosan Boyo Max Bunuan Greg Chase Bill Kaplow	**OPEN**	Max/Greg/Bill **ALCC:** **JCC:** **EOC:** **ALCC:** **JCC:**	Initiated September 5, 2017 and anticipate completion by March 2018
Low/Limited	**LS.02.01.20** **EP 10** In the Area of Refuge for Stair #11 on the first floor, the area was observed to have two Gyn Carts, an infant bed, and 8 IV poles stored in the area.	The Hospital Associate Administrator for Facilities/designee, the Director of Facilities Services, the Chief Engineer, & the ED leadership will meet monthly for one quarter to review the results of the ED documentation of direct observation rounds ensuring that the ED egresses & Areas of Refuge are unobstructed & any identified barriers to compliance are resolved in real time. The results of the ED direct observation rounds ensuring that access to the ED egresses & Areas of Refuge are unobstructed will be reported monthly for one quarter to Accreditation, Licensing & Certification Committee (ALCC) & to the Joint Conference Committee (JCC).	The Chief Operating Officer (COO) is ultimately responsible for the corrective action & for overall & ongoing compliance Internal: Tosan Boyo Max Bunuan Greg Chase Bill Kaplow Chris Colwell MD. Terry Dentoni Jeff Schmidt David Staconis Melissa Pitts	**OPEN**	Max/Greg/Bill/Jeff/ David/Melissa **EOC:** **ALCC:** **JCC:**	Initiated September 5, 2017 & anticipate completion by March 2018

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Low/Limited	**LS.02.01.30** **EP 18** In 2 of 37 above ceiling checks, in Building 25, an issue with the smoke barrier was observed in the following locations: 1. outside room H4419, four unsealed 4" conduits were discovered; 2. in room H1703 an unsealed 1/2" conduit was discovered.	The Hospital Associate Administrator for Facilities Services/designee, the Director of Facilities Services, & the Chief Engineer will meet monthly for one quarter to review any documentation of unsealed conduits found during above ceiling work to ensure that the conduits were subsequently sealed. The results of the documentation review of unsealed conduits found & sealed will be reported monthly for one quarter to Accreditation, Licensing & Certification Committee (ALCC) & to the Joint Conference Committee (JCC).	The Chief Operating Officer (COO) is ultimately responsible for the corrective action & for overall & ongoing compliance Internal: Tosan Boyo Max Bunuan Greg Chase Bill Kaplow	**OPEN**	Max/Greg/Bill **EOC:** **ALCC:** **JCC:**	Initiated September 5, 2017 and anticipate completion by March 2018
Low/Limited	**LS.02.01.35** **EP 4** In 3 of 7 above ceiling checks, in Building #5 on the 7th floor, items were observed on the sprinkler piping in the following locations: 1. outside room 7B19 wire was observed; 2. outside the entry to Unit 7D a wire was tied to the piping; 3. inside the north entry doors to Unit 7C a 1/2" conduit was tied to the sprinkler pipe.	The Hospital Associate Administrator for Facilities Services/designee, the Director of Facilities Services, & the Chief Engineer will meet monthly for one quarter to review any documentation of items on sprinkler pipes found during above ceiling work to ensure that the items were subsequently removed. The results of the documentation review of items on sprinkler pipes found & removed during above ceiling work will be reported monthly for one quarter to Accreditation, Licensing & Certification Committee (ALCC) & to the Joint Conference Committee (JCC).	The Chief Operating Officer (COO) is ultimately responsible for the corrective action & for overall & ongoing compliance Internal: Tosan Boyo Max Bunuan Greg Chase Bill Kaplow	**OPEN**	Max/Greg/Bill **EOC:** **ALCC:** **JCC:**	Initiated September 5, 2017and anticipate completion by March 2018

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Low/Limited	**LS.02.01.35** **EP 6** In the Building #25 walk-in Freezer located in the Kitchen area, items were observed to be stacked on movable shelving within 18" of the bottom of the sprinkler head.	The Hospital Associate Administrator for Facilities, Director of Facilities Services, the Chief Engineer, & the FNS leadership will meet monthly for one quarter to review the results of the weekly random direct observations of the Bldg. 25 walk-in freezer to ensure 18 inches of open space below the sprinkler deflector to the top of storage & to resolve any identified barriers to compliance. The results of the FNS direct observation rounds results of the Bldg. 25 walk-in freezer will be reported monthly for one quarter to Accreditation, Licensing & Certification Committee (ALCC) & to the Joint Conference Committee (JCC).	The Chief Operating Officer (COO) is ultimately responsible for the corrective action & for overall & ongoing compliance Internal: Tosan Boyo Max Bunuan Greg Chase Bill Kaplow FNS leadership	**OPEN**	Max/Greg/Bill/Katie Merriman **EOC:** **ALCC:** **JCC:**	Initiated September 5, 2017 & anticipate completion by March 2018
Low/Limited	**LS.02.01.35** **EP 14** The fire extinguisher in OR #4 was blocked by equipment preventing access to the extinguisher in the event of emergency. The surveyor discussed the Life Safety deficiency with the organization, and it was determined that the following ILSMs will be implemented until the deficiency has been resolved and according to the organization's ILSM policy: Train staff on fire safety features(EP-14)	The Hospital Associate Administrator for Facilities/designee, Director of Facilities Services, the Chief Engineer, & the OR leadership will meet monthly for one quarter to review the random direct observation rounds results that access to the OR fire extinguishers is unobstructed and resolve any identified barriers to compliance. The OR direct observation rounds results will be reported monthly to Accreditation, Licensing & Certification Committee (ALCC) & to the Joint Conference Committee (JCC).	The Chief Operating Officer (COO) is ultimately responsible for the corrective action & for overall & ongoing compliance Internal: Tosan Boyo Max Bunuan Greg Chase Rich Elliot OR Medical Director Terry Dentoni Patty Coggan OR NMs	**OPEN**	Max/Greg/Bill/Rich/ Patty/Julieanne/Niki **EOC:** **ALCC:** **JCC:**	Initiated September 5, 2017 & anticipate completion by March 2018

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Low/Limited	**MM.03.01.01** **EP 7** During tracer activity and review of the medication room, it was noted that the overprotective wrap from multiple 100ml bags of intravenous fluids had been opened. It was noted that there were 2 remaining bags of solutions that did not contain a expiration or do not use beyond date. In discussion with the pharmacy staff it was noted that this is contrary to the hospitals process that requires a 14-day revised expiration/do no use beyond date sticker to be placed on the remaining bags of solution once the overprotective wrap has been opened.	Once per week, nurse manager or designee will audit medication rooms to ensure each opened IV Piggy back solutions (including 50 ml and 100 ml bags of Normal Saline and D5W) has been labeled with a 14-day expiration date from that date of opening. The audit will be conducted on a monthly basis until compliance is achieved at 90% or better for three consecutive months. Audit data will be reported on a monthly basis to Accreditation Licensing and Certification Committee (ALCC), Performance Improvement and Patient Safety Committee (PIPS), and Joint Conference Committee (JCC).	The Director of Pharmaceutical Services is ultimately responsible for the corrective action & for overall & ongoing compliance Internal: Jeanette Cavano Julie Russell Terry Dentoni Elaine Dekker	**OPEN**	Jeanette/Julie/Terry or designee/Elaine **ALCC:** **PIPS:** **JCC:**	Initiated September 5, 2017and ongoing
Low/Limited	**NPSG.03.06.01** **EP 1** Patient's chart was reviewed in endoscopy. Information about patient's home medication at admission was not documented in the chart. According to Physicians note from office patient is on few different medications at home	50 Medication Reconciliation audits of Endoscopy patients will be completed each month. The audit will be conducted on a monthly basis until compliance is achieved at 90% or better for three consecutive months. Audit data will be reported on a monthly basis to Accreditation Licensing and Certification Committee (ALCC), Performance Improvement and Patient Safety Committee (PIPS), and Joint Conference Committee (JCC).	The Chief Nursing Officer is ultimately responsible for the corrective action and for overall and ongoing compliance.	**COMPLETED**	Patty C./Dana N. **ALCC:** **PIPS:** **JCC:**	Initiated September 5, 2017 and anticipate completion by January 2018.

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Low/Limited	**PC.01.02.07** **EP 1** Patient's chart was reviewed in trauma ICU. Patient was admitted from ER early this morning with stab wound in the back. Order for pain assessment every 30 min. for four times was noted on the chart. Pain assessment was done at 6:00 am No pain assessment was documented on chart at 6:30 a.m., 7:00a.m. and at 7:30 a.m.	Audits of documentation of pain assessments when initiating PCAs will be conducted on every patient. The audit will be conducted on a monthly basis until compliance is achieved at 90% or better for three consecutive months. Audit data will be reported on a monthly basis to Accreditation Licensing and Certification Committee (ALCC), Performance Improvement and Patient Safety Committee (PIPS), and Joint Conference Committee (JCC).	The Chief Nursing Officer (CNO) is ultimately responsible for the corrective action & for overall & ongoing compliance. Internal: Terry Dentoni Critical Care Nursing Leadership: Jennie Farr Rhonald Abitona Joy Capacillo	**OPEN**	Jennie/Rhonald/Joy **ALCC:** **PIPS:** **JCC:**	Audits will be done prospectively start date September 5, 2017 Data collected on a monthly basis.
Low/Limited	**RC.02.01.03** **EP 7** Post-operative Right knee patient's chart was reviewed. Estimated blood loss was not documented in post procedure note as required by hospital policy.	The Director of Health Information Systems (HIS) will conduct a one month audit of post procedural notes to ensure required documentation, including estimated blood loss, is present in the medical record. The audit results will be reported to the Medical Executive Committee (MEC), the Accreditation, Licensing & Certification Committee (ALCC) and the Joint Conference Committee (JCC)	The Chief of Staff is ultimately responsible for the corrective action & for overall & ongoing compliance Internal: Todd May Jim Marks Service Chief of provider who failed to document the EBL Debra Darden Karen O'Donnell	**OPEN**	Debra/Karen **MEC:** **ALCC:** **JCC:**	Initiated September 5, 2017and antic. completion by March 2018

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Moderate/Limited	**RC.01.01.01** **EP 8** In one of the open medical records reviewed during the individual tracer activity, there were discrepancies in the wound care documentation verified with the medical director and nurse.	All wound care documentation will be audited on a monthly basis for accuracy and completeness of documentation. The audit will be conducted on a monthly basis until compliance is achieved at 90% or better for three consecutive months. Audit data will be reported on a monthly basis to Accreditation Licensing and Certification Committee (ALCC), Performance Improvement and Patient Safety Committee (PIPS), and Joint Conference Committee (JCC).	The Chief Nursing Officer is ultimately responsible for the corrective action and for overall and ongoing compliance Internal: Terry Dentoni Kathy Ballou Anya Calderon	**OPEN**	Anya/Kathy **ALCC:** **PIPS:** **JCC:**	Initiated September 5, 2017 and antic. completion by March 2018
Low/Widespread	**PC.02.01.03** **EP 1** In one of the open medical records reviewed there were no orders or nurse driven protocol in the medical record for the care of the PICC line. The nurse manager confirmed that this was no currently included in any of the orders for residents with PICC lines unless the PICC line was inserted in the facility	100% of all 4A residents with PICC lines will be audited to ensure PICC line protocol has been placed in the medical records. The audit will be conducted on a weekly basis until compliance is achieved at 90% or better for three consecutive months. Audit data will be reported on a monthly basis to Accreditation Licensing and Certification Committee (ALCC), Performance Improvement and Patient Safety Committee (PIPS), and Joint Conference Committee (JCC).	The Chief Nursing Officer is ultimately responsible for the corrective action and for overall and ongoing compliance Internal: Terry Dentoni Kathy Ballou Anya Calderon	**OPEN**	Anya/Kathy **ALCC:** **PIPS:** **JCC:**	Initiated September 5, 2017 and antic. completion by March 2018
Low/Limited	**RC.02.03.07** **EP 4** In one of the open medical records reviewed the revised admission orders were not authenticated within the five days required by facility policy and procedure. .	Timely (within five days) authentication of medical records will be audited in all charts on a weekly basis until compliance is achieved at 90% or better for three consecutive months. Audit data will be reported on a monthly basis to Accreditation Licensing and Certification Committee (ALCC), Performance Improvement and Patient Safety Committee (PIPS), and Joint Conference Committee (JCC).	The Chief Nursing Officer is ultimately responsible for the corrective action and for overall and ongoing compliance Internal: Terry Dentoni Kathy Ballou Anya Calderon	**OPEN**	Anya/Kathy **ALCC:** **PIPS:** **JCC:**	Initiated September 5, 2017 and antic. completion by March 2018