ZUCKERBERG SAN FRANCISCO GENERAL
Hospital and Trauma Center

Joint Conference Committee
Regulatory Affairs Status Report for April 2019

I. PENDING SURVEYS

1. DEA annual inspection OBOT/OTOP (due December 2018)
2. Joint Commission Laboratory Accreditation Survey
3. OTOP/OBOT DHCS Survey
4. American College of Surgeons Trauma Certification Visit

II. COMPLETED SURVEYS

1.	PES CMS Complaint Validation	**revisit**	3/25-3/26/2019	Conditional findings in full compliance, anticipate 2567 of 3 minor findings
2.	4A CDPHRLS	**revisit**	4/3-4/4/2019	In full compliance
3.	4A CMS Recertification	**1st revisit**	4/3/-4/4/2019	In full compliance with 4 CoP's, 2 outstanding issues – 2nd revisit pending
4.	UCSF Labor Action		4/10/19	No anticipated deficiencies
5.	Alleged Fall Data Inaccuracy		4/16/2019	Complaint not substantiated, no anticipated deficiencies

III. PLANS OF CORRECTIONS: Reports & Updates

1. CDPH Relicensing Survey 4A Long Term Care, 2/4/2019 – 2/8/2019
   See attached Sheet
2. CMS Recertification Survey 4A Long Term Care, 2/4/2019 – 2/8/2019 and reopened 2/19/2019 – 2/20/2019.
   See attached Sheet
3. CDPH Life Safety Survey 4A Long Term Care, 2/11/2019
   See attached sheet
4. CDPH Abuse Investigation, Policy deficiency (2017)
   See attached Sheet

IV. SITE VISITS

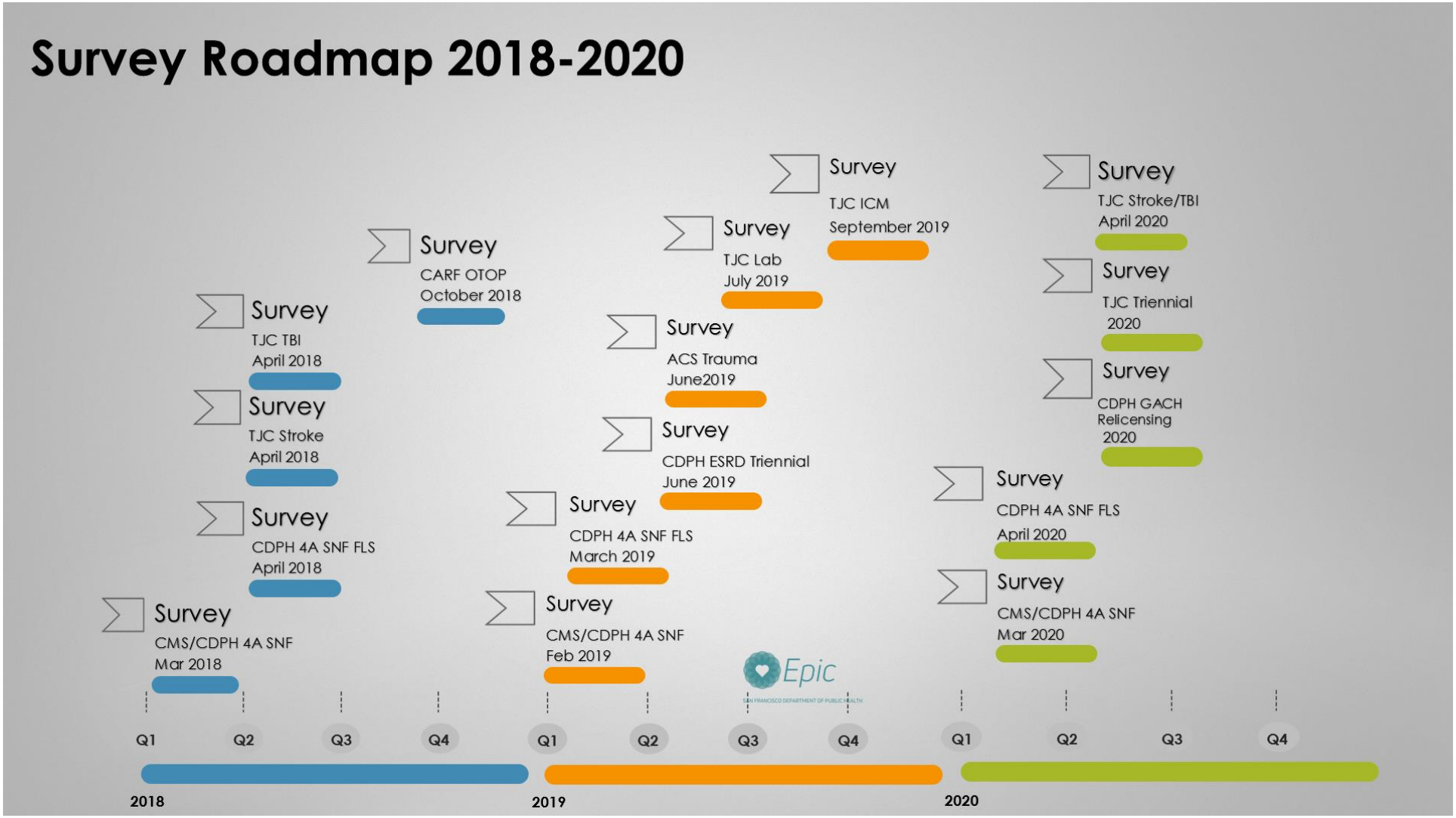
1. CDPH Quality of Care ACE Unit; – Ongoing
2. False Billing ED – Ongoing
3. Quality of Care ICU – Ongoing
4. Unnecessary Uretroscopy 3M Cysto Clinic – Ongoing

Open Case awaiting Investigation by CDPH

1. Nurse staffing – All inpatient units 10/27/2018
2. Alleged Sexual Assault 7C
3. Wrong Site Surgery 11/18 1N Dental/Oral-Maxilla-Facial Surgery

IV. SELF REPORTS

1. Fall resulting in a pelvic fracture. H66
2. Fall resulting in a right shoulder fracture 7C
3. Patient elopement PES
4. Intent to Strike- UCSF Labor Action Affected Departments
5. Wrong Site Surgery 04/19 1N Dental/Oral-Maxilla-Facial Surgery


Survey Roadmap 2018-2020
Survey
TJC TBI
April 2018
Survey
CARF OTOP
October 2018
Survey
TJC Stroke
April 2018
Survey
CDPH 4A SNF FLS
April 2018
Survey
CMS/CDPH 4A SNF
Mar 2018
Survey
TJC ICM
September 2019
Survey
TJC Lab
July 2019
Survey
ACS Trauma
June2019
Survey
CDPH ESRD Triennial
June 2019
Survey
CDPH 4A SNF FLS
March 2019
Survey
CMS/CDPH 4A SNF
Feb 2019
Epic
Survey
TJC Stroke/TBI
April 2020
Survey
TJC Triennial
2020
Survey
CDPH GACH
Relicensing
2020
Survey
CDPH 4A SNF FLS
April 2020
Survey
CMS/CDPH 4A SNF
Mar 2020
Q1
Q2
Q3
Q4
Q1
Q2
Q3
Q4
Q1
Q2
Q3
Q4
2018
2019
2020

4A CDPH Relicensing Survey

Tag C 785 §72305 (b) (4) Physician Services – Medical Director; review of employee health records		
Findings cited by CDPH	Corrective actions implemented	Completion date
The facility failed to ensure the Medical Director reviewed the pre-employment health examination and annual health examinations of employees.	• The Medical Director of 4A has written a letter delegating the responsibility for reviewing employees' pre-employment and annual health examination reports to the Medical Director of Occupational Health Services for ZSFG. • A new Long Term Care Policy has been created and approved delegating the responsibility for reviewing employees' pre-employment and annual health examination reports to the Occupational Health Services for ZSFG.	3/10/2019
Tag C 3690 T22. DIV 5. CH 3. ART 3. §72503 (a)(3) Consumer Information to Be Posted		
Findings cited by CDPH	Corrective actions implemented	Completion date
The facility failed to display the current and flowing week's therapeutic and regular diets for the residents to view.	• Food and Nutrition Staff will round on a Sunday evening to post the therapeutic diet for the forthcoming two week period, and a copy will be left in the Director of Nursing and Activity Coordinators mailbox. • A laminated copy of the complete diet cycle will be permanently posted in the Dining/Activity Room on Unit 4A, with a calendar posted indicating the week number for each week to enable the residents and their visitors to know the diet choices in the forthcoming weeks. Changes made to the predetermined diet schedule will be posted as needed.	3/10/2019
Tag C 4835 T22. DIV 5. CH 3. ART 3. §72535 (a) Employees' Health Examination and Health Records.		
Findings cited by CDPH	Corrective actions implemented	Completion date
Facility failed to complete annual health exam on 4/5 staff reviewed	• The employee with an outstanding Health Exam and the two employees with missing TB Tests were immediately seen in the Occupational Health Department to complete the deficient items. • The cadence of the reports from Occupational Health Services regarding outstanding and completed health exams and TB tests has been changed from annual to monthly to allow the Director of Nursing to schedule staff more frequently for their exams and TB Tests.	3/10/2019
Tag C 4840 T22. DIV 5. CH 3. ART 3. §72535 (b) Employees' Health Examination and Health Records.		
Findings cited by CDPH	Corrective actions implemented	Completion date
Facility failed to complete annual TB testing for 2/5 staff reviewed	• The employee with an outstanding Health Exam and the two employees with missing TB Tests were immediately seen in the Occupational Health Department to complete the deficient items. • The cadence of the reports from Occupational Health Services regarding outstanding and completed health exams and TB tests has been changed from annual to monthly to allow the Director of Nursing to schedule staff more frequently for their exams and TB Tests.	3/10/2019

4A CMS Recertification Survey

This survey resulted in **F LEVEL FINDINGS (widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy)**. This results in a monetary fine from CMS and termination of ZSFG's provider agreement with CMS. The intent to terminate will be rescinded if ZSFG can demonstrate, by the submission of this Corrective Action Plan and a subsequent resurvey that they have corrected all the quoted deficiencies by August 20, 2019.

TAG F 689 **§ 483.25 Quality of Care.**		
Findings cited by CMS	Corrective actions implemented	Completion date
Care plans for fall risk was not implemented for resident 23 as evidenced by the magnet indicating fall risk not being present outside the residents room and on the patient board	• It was identified that there were insufficient magnetic signs to enable staff to place them on all patients at risk, this was immediately corrected by obtaining more of the magnetic signs and placing them outside resident 23's room on the door frame and against their name on the board. • The Charge Nurse to Charge Nurse Handoff tool, shift report has been redesigned to include all "precautions" for patients and the completeness of any visual cues for these precautions on the unit. Re-education has been undertaken with all the Registered Nurses that act as Charge Nurse regarding the updated handoff sheet and the requirements for checking for visual cues being correctly posted for all patients with fall precautions	3/10/2019
TAG F 700 **§483.25 Quality of Care.**		
Findings cited by CMS	Corrective actions implemented	Completion date
The facility failed to obtain consent, and review risks and benefits of bed rails not documented for 12/29 residents	Nursing leadership and Regulatory affairs reviewed the regulation cited and recognized that because the 4A unit at ZSFG uses hospital beds for all patients the facility was not in compliance with consent, risks and benefits being discussed with patients as the bed rails cannot be removed for patients not requiring their use clinically and the two upper rails have the controls for the bed integrated into them. To overcome this ZSFG has undertaken the following changes: • Added information into all patient's admission packets, providing risks and benefits for the upper side rails being raised. This packet is reviewed with each resident upon admission by the Registered Nurse assigned to the resident. All residents then sign this form to demonstrate that they understand the risks and benefits for the upper side rails being installed and their use. • The Registered Nurse will then complete an assessment using a new tool regarding the need for and use of the lower side rails. • For residents with a clinical indication for the lower side rails to be raised, risks and benefits will be documented in the physician pre-printed order form prior to the order being placed and resident consent will be documented on the same form. • New Policy and Procedure, "Bed Entrapment Prevention Program" has been developed regarding the new process • The Nursing Care Plan has been updated to reflect the new documentation and consent process. • Reassessment of safety of patient and need for any continued use of bed rails has been incorporated into the weekly assessment for all residents to ensure that any changes in condition are addressed and communicated to the patient and the attending physician. • All staff working on 4A educated on the new process, including New Policy and Procedure, Bed Rail Safety Assessment & Re-assessment, and Resident Education Guidelines, and the new care planning requirements.	3/10/2019

4A CMS Recertification Survey continued

TAG F 758	**§483.45 Pharmacy Services.**	
Findings cited by CMS	Corrective actions implemented	Completion date
Facility failed to implement a specific target behavior monitoring assessment tool for the use of antidepressant and antipsychotic medications in 6/29 residents	The Process of prescribing, care planning and observing/monitoring of psychotropic medication has been revised. i. When ordering psychotropic medications the provider will include specific, individualized behaviors, signs and symptoms that the medication is being prescribed to address. ii. New Care Plans has been created, with additional behaviors, signs and symptoms described, along with space for individualization regarding the rational for prescribing based upon the Provider Order. iii. The Behavioral Monitoring Record form has been reviewed and revised to individualize the behaviors and signs and symptoms being monitored. These three documents will have the same behaviors, signs and symptoms as each other to enable more accurate observation, assessment and documentation of the effects of the medications.	3/10/2019
TAG F 805	**§483.60 Food and nutrition services.**	
Findings cited by CMS	Corrective actions implemented	Completion date
The facility failed to follow the prescribed therapeutic diet for 1/29 residents, resident 7	Food and Nutrition Services implemented a process for visually identifying diet orders that present patient risk on the patient's tray ticket through the use of color coded stickers. The Senior Food Service Worker and Food Service Supervisor are assigned to double check high risk tray tickets based on level of risk. The pilot program began early March. Due to feedback from patients, adjustments to the process have been made. Re-education with front line staff will begin on Thursday, 3/28/19. The new process will begin on 4/4/19.	3/10/2019
F 867	**§483.75 Quality assurance and performance improvement.**	
Findings cited by CMS	Corrective actions implemented	Completion date
The facility failed to implement updated regulations	By providing the corrective action for TAG F 700, that have been reviewed and approved by Hospital Leadership, ZSFG demonstrates compliance with §483.75 (g)(2)(ii)	3/10/2019
TAG F 880	**§483.80 Infection Control (a)(1)(2)(4)(e)(f)**	
Findings cited by CMS	Corrective actions implemented	Completion date
The facility failed to implement an effective Infection Control program as evidenced by; • In 1/29 residents there was open Oxygen equipment at the bedside of resident 7	• The oxygen equipment that was behind residents 7's bed was immediately discarded • SNF leadership, Respiratory Therapy leadership and Infection Control rounded on the unit and checked each bed space for unnecessary or oxygen equipment. No other unnecessary equipment was discovered. • The Charge Nurse to Charge Nurse Handoff tool (Attachment A), shift report has been redesigned to include review of any patients that have needed oxygen in any emergent situation and includes checking the bed space of any patients and discarding unneeded equipment. Re-education has been undertaken with all the Registered Nurses that act as Charge Nurse regarding the updated handoff sheet and the requirements for handing off oxygen use and checking the bed space and discarding unneeded equipment.	3/10/2019

4A CMS Life Safety Survey

TAG K 345 § 483.90. Fire Alarm System - Testing and Maintenance		
Findings cited by CMS	Corrective actions implemented	Completion date
The facility failed to maintain the Fire Alarm System (FAS) maintenance and testing. This was evidenced by the Fire Alarm Control Panel (FACP) that displayed a trouble signal and missing a semi-annual load voltage test. This could result in the ineffective operation of the FAS in the event of an emergency or fire and affected one of one smoke compartments.	ZSFG will continue to address each "Trouble" on the FAS, testing the devices to ensure that they are not in an "out of service condition." To address the battery testing deficiency ZSFG has made the following changes to the processes used in the annual and semiannual testing of the FAS: 1. Created a matrix of Fire Alarm panel batteries with the appropriate testing frequencies. 2. Conducted load voltage tests on Fire Alarm panel batteries throughout Building 5. All test results were satisfactory and documented. 3. Created work order to automatically generate on semiannual intervals to perform tests, and document testing data.	3/27/2019
TAG K 346. NFPA 110 Fire Alarm – Out of Service		
Findings cited by CDPH/CMS	Corrective actions implemented	Completion date
The facility failed to maintain the Fire Alarm System (FAS). This was evidenced by the failure to notify the authority having jurisdiction. This affected one of one smoke compartments and could result in an incapacitated FAS in the event of a fire.	The Fire Alarm panel serving the ZSFG campus is fully functional. It is tested and maintained on a weekly basis by a fully licensed Fire Alarm inspection and repair contractor. During the Survey, 3/11/2019 Staff 6 as referenced in the findings indicated that there have been troubles on the Fire Alarm panel for years, which was an inarticulate statement. More accurately, the ZSFG campus has 14 buildings with a total of 1.8 million square feet of floor space reporting to the Fire Alarm panel. It is not unusual to have troubles on the panel for a variety of reasons. All troubles are verified, and addressed as necessary. Moving forward ZSFG Facilities will notify Regulatory Affairs of any "Trouble" alarms that cannot be cleared within 4 hours, Regulatory Affairs will then follow ZSFG Administrative Policy 21.03: Unusual Occurrences: Reporting to the California Department of Public Health	3/27/2019
Tag K 363NFPA 110 Corridor - Doors		
Findings cited by CDPH/CMS	Corrective actions implemented	Completion date
The facility failed to maintain the corridor doors. This was evidenced by an obstructed corridor door. This affected one of one smoke compartments and could result in the delay of evacuating during a fire or emergency.	A memo, with read and sign attestation was distributed to staff and displayed on the unit highlighting the need to not block egress or doorways with trashcans and other obstructions. Monitoring of compliance is included in the Environment of Care (EOC) rounding tool used by SNF Leadership on weekly basis Monitoring of compliance has been included in the Charge Nurse Hand-Off Tool, completed at change of shift each day	3/27/2019

4A CMS Life Safety Survey continued.

Tag K 918NFPA 110 Electrical Systems - Essential Electric System Maintenance and Testing		
Findings cited by CDPH/CMS	Corrective actions implemented	Completion date
The facility failed to develop and maintain the Emergency and Standby Power Systems (EPS). This was evidenced by the absence of maintenance and testing records for the EPS. This could result in the ineffective operation of the EPS in the event of an emergency or fire and affected one of one smoke compartments.	In the 2567 received ZSFG have been identified as being out of compliance with NFPA 110 8.4.2.3 NFPA 110 (2010 edition) 8.4.2.3 Diesel-powered EPS installations that do not meet the requirements of 8.4.2 shall be exercised monthly with the available EPSS load and shall be exercised annually with supplemental loads at not less than 50 percent of the EPS nameplate kW rating for 30 continuous minutes and at not less than 75 percent of the EPS nameplate kW rating for 1 continuous hour for a total test duration of not less than 1.5 continuous hours. ZSFG Diesel powered EPS installations meet the requirements stated in NFPA 110 8.4.2, during survey the documentation of compliance with this testing process was not demonstrated to Surveyor 40394. Evidence of testing – as described below in NFPA 110 8.4.2 – is attached as compliance with this aspect of the deficiencies described in the 2567. These reports show monthly compliance of both requirements, with temperatures being greater than 840 degree Fahrenheit (manufacturers recommended temperature) and with a load of 50%, higher than that specified in NFPA. NFPA 110 (2010 edition) 8.4.2 Diesel generator sets in service shall be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods: Loading that maintains the minimum exhaust gas temperature as recommended by the manufacturer Under operating temperature conditions and at not less than 30 percent of the EPS nameplate kW rating	3/27/2019
TAG K 920 NFPA 110 Electrical Equipment - Power Cords and Extension Cords		
Findings cited by CMS	Corrective actions implemented	Completion date
The facility failed to maintain the electrical equipment. This was evidenced by an unapproved power strip. This affected one of one smoke compartments and could result in the ignition of a fire.	A memo, with read and sign attestation is in the process of being distributed to staff and displayed on the unit highlighting the need limit use of powerstrips in resident's rooms. Monitoring of compliance is included in the Environment of Care (EOC) rounding tool used by SNF Leadership on weekly basis Monitoring of compliance has been included in the Charge Nurse Hand-Off Tool, completed at change of shift each day	3/27/2019

Self-Report Resident to Resident Altercation 2017, Abuse Policy

Tag F 607 §483.12(b)(1)-(3) Develop/Implement Abuse/Neglect Policies		
Findings cited by CMS	Corrective actions implemented	Completion date
The facility failed to establish policies that investigate abuse allegations when reporting instructions of abuse did not include reporting all incidents of resident abuse. This failure would result in unreported resident abuse.	ZSFG Administrative Policy 1.01: VICTIMS OF DEPENDENT ADULT/ELDER ABUSE, CHILD ABUSE, ASSAULTIVE AND ABUSIVE CONDUCT, AND RAPE/SEXUAL ASSAULT is under review, the content of this policy will be incorporated into ZSFG Administrative Policy 1.12: ABUSE PREVENTION/PROHIBITION PROGRAM. The outcome will be a single policy, with clear indication of when to report per statutory and legal requirements.	4/24/2019