PDC accepted 11/16/07 SSingleton

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: CA000000101	(X2) MULTIPLE CONSTRUCTION A. BUILDING___ B. Wing______	(X3) DATE SURVEY COMPLETED 10/10/2007
NAME OF PROVIDER OR SUPPLIER **PROVIDENCE SAINT JOSEPH MEDICAL CTR**	STREET ADDRESS, CITY, STATE, ZIP CODE **501 SOUTH BUENA VISTA BURBANK, CA 91505**		

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E 000	Initial Comments The following reflects the findings of the Department of Public Health during a Complaint Investigation. Representing the Department of Public Health Services: Eric Stone, REHS, HFE III Belinda Rarela, RN, HFE I Shirley Singleton, RN, HFE II The inspection was limited to the specific complaint reported and does not represent the findings of a full inspection of the facility. CA00129869 Compliant Intake Number: CA00093971	E 000		
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 require.	E2145	Necrotizing fasciitis is listed as a reportable event only if invasive Group A Streptococci are involved. Since our patient did not grow this organism from either her wound or any other body site fluids, the condition was not reported to the Department of Public Health. There were no other cases of necrotizing fasciitis around this time nor any clusters or outbreaks of infection which would have led to an official report. ACTION: 1. Contact/report unusual occurrences to Department of Public Health in the future relating to necrotizing fasciitis. 2. Providence Saint Joseph Medical Center does and will report all necrotizing fasciitis if the organism is Group A Streptococci meeting the regulatory requirements. (In this case the organism was not Group A Streptococci, therefore, we did not report.)	Currently implemented and ongoing

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Susan [signature]	RN Dir Risk	11/15/07

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			Responsible Person: Susan Taylor, MPH, RN Nurse Epidemiologist	
E2145	This RULE: is not met as evidenced by: Based on record review and interview, the facility staff failed to report to the Department of Public Health (Licensing/Certification) a situation that required a patient with a hospital acquired infection to undergo surgical interventions on five occasions and threatened the health, safety and well being. Findings: On August 30, 2007, during a complaint investigation, a review of Patient A's medical record disclosed the patient was admitted to the short stay surgery department on August 15, 2006, at 6:00 a.m., for a surgical procedure (Laparotomy). A review of the Post Anesthesia Care Record dated August 15, 2006, disclosed Patient A had a exploratory laparotomy and myomectomy and was admitted to the Post Anesthesia Care unit at 10:30 a.m., on the same day. A review of the Consultation note dated August 25, 2006, disclosed Patient A was diagnosed with Necrotizing Fasciitis that required intensive management in the intensive care unit. A review of the Operative Reports dated August 25, 27, 29, 31, 2006 and September 5, 2006 disclosed Patient A had five visits to the operating room for surgical debridement of necrotizing cellulitis of the abdominal wall. In an interview on October 10, 2007 at 2:45 p.m., with Epidemiologist Nurse 1, she stated that the Necrotizing Fasciitis was a single situation and was not considered a "cluster" and therefore she did not report the incident to the Department of Public Health.	E2145		

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E2156	T22 DIV5 CH1 ART7-7-739(s)(4) Infection Control Program (a) A written hospital infection control program for the surveillance, prevention and control of infections shall be adopted and implemented. The program shall include policies and procedures that: (4) Provide a plan for surveillance and control of nosocomial infections including procedures for the investigation and management of outbreaks. This RULE: is not met as evidenced by: Based on medical record review, interview and administrative document review, the facility failed to implement their infection control policy regarding surveillance, prevention and control of nosocomial infections. Findings: A review of Patient A's medical record disclosed the patient was admitted to the facility on August 15, 2006, at 8:00 a.m., with a diagnosis that included uterine fibroids that required surgical removal. A review of the nursing notes dated August 20, 2006, at 8:00 a.m., disclosed Patient A's perineum area was very swollen and red. According to the documentation, "the lower abdomen suprapubic area with steri strips intact and redness to incision and warm to touch." A review of the nursing notes dated August 21, 2006, at 8:00 p.m., documented Patient A's abdomen transverse incision was tender inflamed and was oozing brown drainage, however there was no odor. A review of the infectious Disease Consultation note, dated August 21, 2006, disclosed Patient A had spiked a fever of 103 degree Farenheit, on August 18, 2006, developed erythema of the wound and was diagnosed with a post operative wound infection, fever and leukocytosis (increase in	E2156	1. Daily microbiology reports are reviewed to identify patients that may have grown microorganisms. These are categorized potential socomial and nosocomial infections. Patient AC's wound and body fluid cultures were all negative. 2. Our surveillance program on pages 8 and 9 of the Infection Control manual (previously transmitted) states that we base our plan on known risk factors, the potential for infection and the potential for impacting change. 3. <u>Our focused surveillance</u> includes high-risk, problem prone surgeries and procedures. While we closely follow surgeries in the above group, we do not routinely review gynecological procedures unless a cluster of infections is present. 4. <u>Periodic targeted surveillance</u> is usually conducted on staff-related issues such as blood-borne pathogen exposures and prevention, not on individual patient conditions. 5. <u>Cluster or outbreak investigations</u> are an immediate priority if and when they occur, i.e., 2 or more of the same surgery, same surgeon or same organism. There were no other infections during this time involving the same surgery or same surgeon. Since no organisms were recovered, this aspect could not be reviewed. 6. <u>Communicable Disease exposure</u>. Since there were no organisms recovered, the potential for employee exposures was zero and therefore no investigation was warranted. 7. <u>Post-discharge surveillance</u> is	Infection Control Meeting Scheduled-11/12/2007

number of white blood cells, generally caused by the presence of an infection).

A review of another Consultation Report, dated August 25, 2006, disclosed Patient A was taken to the operating room with a presumptive diagnosis of Necrotizing fasciitis and urgent medical consultation was requested for postoperative care in the intensive care unit.

A review of a Consultation Report, dated August 25, 2006, disclosed Patient A's wound on the lower abdominal area measured 25 X 10 cm., and despite treatment with antibiotics and opening of the wound, Patient A continued to have an aggressive infection requiring a surgical debridement procedure.

A review of a Pathology Report, dated August 31, 2006, disclosed Patient A was diagnosed with necrotizing fasciitis and "fragments of fibrofatty tissue with fat necrosis."

A review of the Operative Reports dated August 25, 127, 29, 31, 2006 and September 5, 2006, disclosed Patient A had five visits to the operating room for surgical debridements of necrotizing cellulites of the abdominal wall.

A review of the Infection Control Meeting Minutes, dated July 11, 2006 and August 22, 2006, disclosed the necrotizing fasciitis that Patient A acquired post operatively had not been discussed and/or addressed in the Committee meetings.

A review of the facility's policy and procedure entitled "Surveillance" for infection control, stipulated that the surveillance plan was based n the medical center's commitment to CQI (Continuous Quality Improvement) process. According to facility policy, the cluster or outbreak investigations becomes the immediate top priority at any time an unexpected occurrence or frequency of infections becomes evident.

routinely conducted on selected outpatient procedures. Patient AC was an inpatient and under current review by this department.

8. Data collection and analysis
The Nurse Epidemiologist makes early morning rounds in the ICU routinely, both for data collection and educational opportunities. In addition, all microbiology reports are reviewed to search for trends. Charts are reviewed as necessary. In the case of patient AC, an infection control worksheet was initiated (previously transmitted) with updates as addition surgeries and wound cultures were performed. Questions by nurses at the bedside on the subject of fasciitis and the need for precautions were answered during rounds both on the night and day shifts. In addition, the nurse epidemiologist discussed the case and lack of microorganism growth with the chair of the Infection Control Committee multiple times during the course of AC's stay. A search was made for similar cases but none were found. Since this was an isolated case with no organisms to review, the Infection Control Committee did not review or discuss it formally. A cluster of infections (2 or more with similar characteristics) would be discussed and be forwarded to the appropriate committee for peer review.
According to our surveillance plan, this surgery would not have been classed with the high-risk procedures normally being monitored, nor would it have elicited attention from

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			culture findings because of the lack of organisms recovered. Data were collected on a worksheet because of the post-operative complication and the possibility of a transmissible organism. This however was not the case. ACTION: 1. The current surveillance plan will be discussed at the next Infection Control Committee meeting and any recommendations will be reviewed and implemented as required. 2. The committee members will discuss the appropriateness of reviewing similar cases as part of the formal agenda at the next Infection Control Committee meeting. 3. Random audits will be conducted based upon recommendations from the Infection Control Committee. Responsible Person: Susan Taylor, MPH, RN Nurse Epidemiologist	
E2156	A request was made by the Evaluator to review the hospital's Quality Improvement/Quality Assurance Program and Committee meeting Minutes for the last 2 quarters of 2006. After approximately 45 minutes, Staff Member 2 presented three documents indicating the documents contained the QA reports for the surgery department. A review of the QA/QI documents presented to the Evaluator and entitled National Patient Safety Goal Data, 4th Quarter 2006, disclosed no evidence of QA/QI Committee Meeting Minutes. There was no documentation of Committee Member involvement in the process and no information related to infection control issues (e.g. hospital acquired nosocomial infections) in the Surgery Department.	E2156	Currently, Infection Control is part of the regular Department of Surgery agenda. ACTION: Infection Control will continue, as previously done, to attend the Department of Surgery meetings and continue to be on the regular agenda. Responsible Persons: Susan Taylor, MPH, RN Nurse Epidemiologist Brenda Lopez, RN, BSHCA Director, QI/Accreditation	Continuous and Ongoing

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	In an interview with Staff Member 2, on October 10, 2007 at 3:10pm, she stated that she did have have any other documents on QA/QI for the surgical department.			
E2229	T22 DIV5 CH1 ART7-70740(a)(16) Patient Health Record Content (16) A discharge summary which shall briefly recapitulate the significant findings and events of the patient's hospitalization, his condition on discharge and the recommendations and arrangements for future care. This RULE: is not met as evidence by: Based on medical record review and interview, the facility failed to ensure a discharge summary included a recapitulation of the events of the patient's hospitalization, the condition of the patient upon discharge, and any recommendations and arrangements for future care for 4 or 4 medical records reviewed. Findings: On August 30, 2007, a review of Patient A's medical record, disclosed the patient was discharged from the facility on October 15, 2006 after a two-month hospitalization for a hospital-acquired infection. There was no documented recapitulation of Patient A's treatments and her responses to the medical and surgical interventions conducted by the hospital doctors and nurses during the two-month stay. A review of a document entitled	E2229	ACTION: 1. The HIM Department will post in the dictation areas in the hospital the needed criteria for a complete discharge summary. HIM will send Dr. Pearson a copy of the dictation education card and a letter from the Chairman of the Medical Record Committee, Dr. Feit, explaining the importance of including all of the criteria required for the discharge summary. 2. The HIM Department will also perform a focus review of Dr. Pearson's records, and any information that is incomplete or does not meet criteria will be reported to the Medical Record and QA/I Committees for follow-up actions. 3. The HIM department will include discharge summary criteria as a part of the on-going closed medical record review performed monthly. 4. Data collection will begin with October discharges. Responsible Persons: Pam Hodge, Manager, HIM Eric Feit, MD, Chm, Med Rec. Com.	Start 11/1/07. Data outcomes will be reported to the Medical Records Committee.

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	Discharge Summary dated October 13, 2006, which was dictated 2 days prior to Patient A's discharge, documented the patient was discharged in excellent health. Another document, entitled Discharge Summary Addendum dated January 22, 2007, disclosed additional information regarding Patient A's discharge, however this discharge addendum was documented 3 months after Patient A was discharged from the facility. A review of 3 other patients closed medical records, who had been discharged from the facility around the same date, disclosed the 3 patients had summaries that did not include a recapitulation of the patients hospital stay. On October 10, 2007, at 4:55 p.m., in an interview with a medical record staff members, she stated that the discharge summaries written by the physician were not "the usual." She further stated that there was a format that the physicians are to follow, however, the identified physician's discharge summaries did not follow the format. On October 10, 2007 at 3:00 pm., in an interview with Administrative Staff Member 1, she stated the discharge summary and the discharge summary addendum for Patient A was unacceptable.			