DEPARTMENT OF HEALTH & HUMAN SERVICES



CENTERS FOR MEDICARE & MEDICAID SERVICES
Consortium For Quality Improvement and Survey & Certification Operations
Western Consortium – Division of Survey & Certification

Refer to: WCDSC--FOIA--DH (SAN FRANCISCO REGIONAL OFFICE)

February 1, 2008

Vickie Travis, President The Managed Care Reform Council P.O. Box 900591 Palmdale, California 93590

Dear Ms. Travis:

This is in response to your Freedom of Information Act request of January 31, 2008 to the Centers for Medicare & Medicaid Services (CMS) for a copy of CMS' October 25, 2007 survey report on Kaiser Foundation Hospital Fresno, the facility's plan of correction, and correspondence associated with the survey.

All records within the scope of your request (i.e. 71 pages) possessed by the San Francisco Regional Office of CMS are hereby released and none are withheld.

Please note that the enclosed plan of correction was not accepted. A new plan of correction is due to CMS on February 8, 2008.

There is no charge for processing this request.

Please let us know if the San Francisco Regional Office of CMS may be of further assistance. You may contact Dan Hersh at (415) 744-3731 for additional information.

Sincerely,

Charlotte Yeh

Acting Regional Administrator

Enclosure

DEPARTMENT OF HEALTH & HUMAN SERVICES



CENTERS FOR MEDICARE & MEDICAID SERVICES
WESTERN CONSORTIUM
DIVISION OF SURVEY AND CERTIFICATION

January 3, 2008

FILE

Administrator Kaiser Foundation Hospital – Fresno 7300 North Fresno St Fresno, CA 93720

Re: Medicare Provider Number 05-0710

Dear Administrator:

Hospitals accredited by the Joint Commission on Accreditation of Healthcare Organization (JCAHO) are "deemed" to meet Medicare Conditions of Participation (COPs) with certain exceptions, not pertinent here. See 42 C.F.R. § 488.4 (a). However, if a validation survey results in a finding that the hospital is out of compliance with one or more of the COPs, the hospital will no longer be deemed to meet any COP. See 42 C.F.R. §488.7(d).

The California Department of Public Health (CDPH), the State Medicare survey agency, reported serious deficiencies from the October 25, 2007 complaint validation survey of your hospital, authorized by this office. Specifically, you do not comply with the following Condition of Participation:

42 C.F.R. 482.12 Governing Body

42 C.F.R. 482.21 OAPI

42 C.F.R. 482.22 Medical Staff

Consequently, effective the date of this letter we are removing your status as a provider deemed to meet Medicare COPs and placing you under the CDPH survey jurisdiction until you demonstrate full compliance. See 42 C.F.R. §488 7(d). This means that the hospital is now subject to all applicable participation and enforcement requirements and may be subject to termination of its Medicare provider agreement.

A description of the deficiencies found by the October 25, 2007 survey is set forth on the enclosed Statement of Deficiencies, Form CMS-2567.

You may submit evidence documenting actions you have taken to correct these deficiencies. Please submit your evidence of correction to address the survey findings to this San Francisco

office and the Fresno DO, CDPH, by close of business, within ten (10) days of receipt of this letter.

Page two - Kaiser Foundation Hospital - Fresno

The evidence of correction is to be entered on the right side of Form CMS-2567, opposite the deficiency, and must be signed and dated by the administrator or other authorized official.

The evidence of correction of each item must contain the following:

- 1. How the correction was accomplished, both temporarily and permanently for each individual affected by the deficient practice, including any system changes that must be made.
- The title of position of the person responsible for correction, e.g. Administrator, Director of Nursing or other responsible supervisory personnel.
 A description of the monitoring process to prevent recurrences of the deficiency, the
- frequency of the monitoring and the individual(s) responsible for the monitoring.

 4. The date when the immediate correction of the deficiency will be accomplished. Normally
- 4. The date when the immediate correction of the deficiency will be accomplished. Normally this will be no more than thirty (30) days from the date of the exit conference.

If we determine that the submission is timely, credible and otherwise acceptable, we may authorize CDPH to conduct a resurvey. If this survey finds that the hospital meets all applicable Medicare Conditions, deemed status will be restored. See 42 C.F.R. §488.7(e). If we do not receive an acceptable, timely submission, or if a resurvey finds that the hospital is not complying with any COP, we will notify you that we are initiating action to terminate the facility's Medicare provider agreement. See 42 C.F.R. §488.7(d). In the meantime, the removal of deemed status does not limit your ability to bill Medicare, nor does it affect JCAHO accreditation.

Copies of this letter are being sent to JCAHO, the CDPH and Medicaid agency.

If you have any questions, please contact Leslie Royall of my staff at 415-744-3417 or Maureen Calacal at 415-744-3727.

Sincerely,

Rufus Arthur, Manager Hospital and Community Care Operations Branch Division of Survey and Certification



January 18, 2008

Rufus Arthur, Manager
Hospital and Community Care Operations Branch
Division of Survey and Certification
Department of Health & Human Services
Centers for Medicare & Medicaid Services
90th 7 Street, Suite 5-300 (5W)
San Francisco, CA 94103-6707

RE:

Medicare Provider Number 05-0710 Complaint Number: CA00129602

Dear Mr. Arthur:

Kaiser Foundation Hospital-Fresno is responding to the Statement of Deficiencies received from your office on January 10, 2008. This was follow-up from a CMS Validation Survey conducted at our hospital in October, 2007.

Susan A. Ryan

Physician-in-Chief Jose J. De Anda

(559) 448-4500

Medical Group Administrator

7300 North Fresno Street Fresno, California 93720-2942

Senior Vice-President/Area Manager Varoujan Altebarmakian, MD

Kaiser Permanente Fresno Medical Center

Attached for your review is our response to the Statement of Deficiencies. Preparation and execution of this Plan of Correction does not constitute admission or agreement by Kaiser Foundation Hospital-Fresno of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies.

Please contact Debrah Prewit, Director of Accreditation Regulation & Licensure, at (559) 448-5997 should you require any additional information. A copy of this report will also be forwarded to the Department of Public Health-Fresno Licensing and Certification office as well as The Joint Commission Office of Quality Monitoring.

Sincerely.

Susan A. Rvan

Hospital Administrator/Sr. Vice-President

CC:

Department of Public Health-Fresno

The Joint Commission

Enclosure - Form 2567

PRINTED: 12/11/2007 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 050710 10/25/2007 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 7300 NORTH FRESNO ST KAISER FOUNDATION HOSPITAL - FRESNO FRESNO, CA 93720 SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5)(X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETION PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) Kaiser Foundation Hospital - Fresno ("Hospital") A 000 INITIAL COMMENTS A 000 underwent a CMS Validation Survey from October 18, 2007 through Thursday, October 25, 2007. The following reflects the findings of the When asked by the Hospital the reason for this Department of Public Health during a survey, the surveyors stated the survey was COMPLAINT VALIDATION SURVEY. initiated in response to an article published in the Los Angeles Times. They stated when articles. Complaint Number: CA 00129602

Category: Quality of Care/Treatment Inspection was limited to the specific complaint investigated and does not represent the findings of a full inspection of the facility. Representing the Department of Public Health: Beverly Griffin, RN, HFEN, Everett Davis, M.D., A 043 482.12 GOVERNING BODY The hospital must have an effective governing body legally responsible for the conduct of the hospital as an institution. 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 staff interviews, credentialing files, and administrative document review; the hospital

failed to have an effective Governing Body legally

responsible for the conduct of the hospital as an

1. The hospital failed to ensure the governing

body verified that the medical staff operated under the medical staff bylaws and the medical staff rules and regulations when the current proctoring was not done as set forth in the

institution as evidenced by:

A043

such as this appear, it is necessary a regulatory investigation of the event mentioned in the article occurs. This article referenced the death of two infants; one infant expired in 2004; the second infant expired in

The Hospital appreciates the opportunity to respond to the allegations noted in the Statement of Deficiencies. After its review of the allegations, the hospital: 1) has identified information which requires clarification and; 2) will exercise its right to provide this clarification and/or corrections in response to the surveyors' summation.

2005. Both of these infants' cases were subject to

the Hospital's peer review process at the time of

their occurrence.

Preparation and execution of this plan of correction does not constitute admission or agreement by Kaiser Foundation Hospital - Fresno of the truth of the facts alleged or conclusions set forth in this Statement of Deficiencies.

All exhibits referenced in this Plan of Correction are available on site at the hospital.

Refer to attached pages 1a through 1 c

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.

Bylaws. (A 48)

ID Prefix TAG	Providers' Plan of Correction	Lead and Completion Date	
A043	The Hospital has an effective Governing Body that is legally responsible for the conduct of the Hospital as an institution. The Hospital has clearly defined roles and responsibilities of its leadership team that identifies the individuals who are responsible for the conduct of the hospital operations. Additionally, the Kaiser Foundation Hospital Board of Directors ("Board") the Hospital's Governing Body, appointed a new Hospital Administrator with an effective date of August, 2005. The Hospital has a matrix of committees that have functional and operational relationships with accountability to the leadership team, including the Hospital Administrator and Medical Executive Committee (MEC) with escalation of important matters to the Board as required by the Professional Staff Bylaws and consistent with legal requirements. A043(1) Proctoring Process The CMS Conditions of Participation (CoP) for Hospitals do not require the performance of	08/01/05 Leads: Assistant Administrator Quality &	
	proctoring. The CoP require that the Medical Staff has a process to assess the competence of medical staff members. The Medical Staff is accountable to the Hospital Governing Body for assuring that there is a process for assessment of medical staff members' competencies. The KFH Fresno Professional Staff Bylaws, which were approved by the Hospital Governing Body, delineate such processes including the requirement for proctoring in Section H-2. The Hospital has an active Medical Staff that is competent in specialty and subspecialty services provided to its patients.	Safety (AAQS), Chief of Quality, Hospital Administrator	
	Although proctoring is a part of the process to assure that quality physicians serve on its medical staff, an entire host of activities act as a check and balance to ensure that the most competent and experienced medical staff provide care to patients. Other processes to ensure that all Hospital medical staff are competent were not explored by the surveyors but should be mentioned. The Hospital ensures initial competence for all newly appointed medical staff in a variety of ways. The Hospital has an extensive process for verifying the credentials of initial applicants, as documented both in the Professional Staff Bylaws, Article B and in its credentialing policies and procedures. Each practitioner's file includes documentation of education, training, licensure, past and current practice, and liability history.		

ID Prefix TAG	Providers' Plan of Correction	Lead and Completion Date	
A043	Practitioners are also required to submit evidence to substantiate their request for privileges specific to their practice; e.g. surgeons must provide evidence of cases performed in training or in recent practice at facilities where their affiliation is verified to be in "good-standing". Residency training program directors are asked to verify competence as are peers of the practitioner. Once a practitioner has been granted privileges, a physician member of the hospital clinical department is assigned to provide proctoring and assist with orientation as needed.		
	The proctoring process, which includes medical review, is conducted within the initial 12 months of medical staff membership as required in the Bylaws. No practitioner is advanced from provisional staff status until proctoring has been completed. In addition to the initial evaluation period (Provisional Staff status), the practitioner is also subject to the quality department's ongoing monitoring process, as is every practitioner with hospital privileges, regardless of their length of service on the medical staff.		
	Described below is the redesigned proctoring process, with clear lines of escalation for noncompliance with requirements for proctoring. This process meets the intent of the Bylaws.		
	The surveyor reviewed a list of 90 physician files for evidence of proctoring, not 50 as stated in the report. The number of files without proctoring on file was 45 at the time of the survey. Therefore, the number should have been based on 45 of 90, not 45 of 50 as alleged in the Statement of		
	Immediate measures initiated during the validation survey in October, 2007 include: 1. Reduction of number of physicians with no proctoring in file from 45 out of 90 to 5 as of January 16, 2008. A report on these physicians'	10/18/07	
	proctoring status will be presented at the February, 2008 Credentialing and Privileging (C&P) Committee for review and action. 2. Beginning 10/18/07, a new monitoring process to oversee timely completion of proctoring was implemented. It entails sending monthly updates of progress on proctoring to the Chief of Staff and Assistant Administrator Quality and Safety (AAQS). These updates are reflective of each month's current proctoring activities and include practitioners that are newly appointed to the	02/05/08 10/18/07 and ongoing	

PRINTED: 12/11/200 FORM APPROVEI OMB NO. 0938-039

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING B. WING 050710 10/25/2007 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 7300 NORTH FRESNO ST KAISER FOUNDATION HOSPITAL - FRESNO **FRESNO, CA 93720** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X4) ID (X5)COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) A 043 Continued From page 1 A 043 2. The hospital failed to ensure that the medical staff was accountable to the governing body for Refer to attached pages the quality of care provided to two of 23 patients 2a through 2f (Patient 1 and 2) when: a. Physician A failed to provide quality of care to two patients during delivery. b. The hospital failed to implement their quality of care policies and procedures. (A49) 3. The hospital failed to ensure the governing body verified one of the criteria for selection to the Refer to attached page medical staff was competency when: a. There 3a was no objective evidence of current and timely proctoring in three of 35 credentialing files reviewed. b. Forty five of 50 provisional physicians were not completely and/or timely proctored. (A50) 4. The hospital failed to ensure the governing body appointed a chief executive officer who was Refer to attached page responsible for managing the hospital when 4a Physician A was not held accountable to follow High Risk Rounds with Perinatologist administrative guidelines. (A 57) The cumulative effect of these systemic practices resulted in the failure of the hospital to deliver statutorily mandated compliance with the A048: Governing Body-Medical Staff Leads: Condition of Participation: Governing Body, CFR AAQS. §482.12 Quality The surveyor reviewed a list of 90 physician files A 048 482.12(a)(4) MEDICAL STAFF - BYLAWS AND A 048 Chief for evidence of proctoring, not 50 as stated in the BULES report. The number of files without proctoring on file was 45 at the time of the survey. Therefore, the The governing body must approve medical staff number should have been based on 45 of 90, not bylaws and other medical staff rules and 45 of 50 as alleged in the Statement of regulations. Deficiencies Please refer to Proctoring process as outlined in A043(1).

D Prefix TAG	Providers' Plan of Correction	Lead and Completion Date	
A043 (2)	A043(2): Patients 1 and 2	Leads:	
	The following demonstrates that the Medical Staff is accountable to the Governing Body and that the peer review actions taken in the cases of Patient 1	AAQS, Quality Chief, Quality Director, Assistant	
	and Patient 2 were consistent with the Professional Staff Bylaws and legal requirements that were applicable at the time of the incidents described in this Statement of Deficiency.	Administrator Patient Care Services (AAPCS)	
	2(a). The cases identified for this Validation Survey occurred in 2004 and 2005.		
	All "significant events" are investigated-through department (system process) review, peer review, or both. The department managers and supervisors assist in the investigation and the formulation and implementation of necessary action plans. The review of "significant events" is the accountability of the Risk Management Committee, a multi-disciplinary group of directors, physicians and hospital senior leaders. This committee reviews the findings of the investigation and recommends corrective action plans. The MEC reviews a monthly report of "significant events" submitted by the Chief of Risk, who is a member of the MEC. Individual practitioner	£.	
	concerns are addressed through peer review. The MEC also reviews system issues relevant to patient quality of care and patient safety. Risk management data is reported to the Governing Body through established reporting mechanisms.		
	Listed below is a summary of actions performed by the Hospital and Medical Staff at the time the Quality Department was notified of the cases involving Patient 1 and Patient 2. Each of these cases triggered peer review. Each case, with peer review findings, was reported to the MEC action in 2004 (Patient 1) and 2005 (Patient 2).		
	Patient 1 Case (January, 2004): 1. Perinatal Peer Review occurred 02/12/2004, 06/24/2004, 07/28/2004. 2. Peer Review Follow-up to MEC 9/22/2004, 12/07/2004, 12/15/2004.	7/28/04 12/15/04	
	Patient 2 Case April, 2005: 1. Reported to Risk Management and identified as a "significant event". Reported to Hospital Leadership team with concurrent referral to Risk Management Committee and Peer Review.	4/22/05	

ID Prefix TAG	Providers' Plan of Correction	Lead and	
1010 (0)	2 Post Cours Archeis (BOA)	Completion Date	
A043 (2)	Root Cause Analysis (RCA) completed by Risk	5/19/05	
	Department on 5/19/05 with recommended actions		
	implemented through 12/2005. The surveyor		
	reviewed the RCA documentation and commented		
	on the good work accomplished in follow-up to the		
	event involving Patient 2.		
	3. On-call roster responsibilities of Physician A	05/25/05	
		05/25/05	
	ceased.		
	4. Perinatal Patient Safety Project Committee	03/01/05	
	(PPSC) was implemented in 03/01/2005.	through	
	Multidisciplinary group consisting of staff,	10/05	
	physicians and departmental managers. During		
	meetings held from 03/05 through 10/05, issues		
	addressed included but were not limited to: Chain		
	of Command policy reviewed and revised,		
	Perinatal Department and Neonatal escalation		
	algorithms developed and implemented CRAD		
	algorithms developed and implemented, SBAR		
100	communication and Human Factor training		
	completed.		
	5. 05/27/05 - Communications from Department	05/27/05	
	Manager, Nursing Executive, and Interim OB Chief	1 1 1 2 B 12	
	to all staff and physicians educating on Patient	1 3 2	
	Advocacy and Chain of Command, enforcement of		
	the Perinatal Department Escalation Algorithm and		
	Request for a Perinatology Consult.		
	6. Perinatal Peer Review Meetings occurred on	7/12/05	
	5/25/2005, 6/09/2005, 7/12/2005.	1112103	
		7/00/05	
	7. Peer Review Follow-up to MEC 7/20/2005 and	7/26/05	
	07/26/2005.		
	8. Fetal Heart Monitor "Train the Trainer" for both		
	physicians and RN staff completed in July. 2005.	07/05	
	9. Critical Events Training focusing on	T	
	communications and team effectiveness for staff		
	and physicians completed in 10/05.		
	10. Audited all deliveries which required use of a	10/05	
	vacuum delivery system for six months after event	10,00	
	in 2005 – no other injury events of this type		
	occurred during this review period.		
	11. Staff received re-education on reporting	10/01/07	
	medical errors via the December 11.	10/31/05	
	medical errors via the Responsible Reporting		
	Form (RRFs) or through the OOPS line from		
	06/05 through 11/05 at staff meetings.		
	12. Vacuum Assisted Delivery Policy revised and	11/05	
	education completed by 11/05.		
	13. The current OB inpatient chief was designated	11/05	
	by the Interim Department Chief to lead	11/03	
	performance improvement activities with		
	departmental manager in 2005 (Alea acress		
	departmental manager in 2005 (Also serves as one		
	of the co-chairs of Perinatal Service Performance		
	Improvement Committee).		
	14. Departmental Structure Standards updated	12/06	
	12/06. Section 2(F) – Consultation of Medical Staff		
	outlines responsibilities of consulting and on-call		
	physicians.		

ID Prefix TAG	Providers' Plan of Correction	Lead and Completion Date	
A043 (2)	 15. A new Vacuum Assisted Delivery Perinatal Services Policy revised, effective 03/07. Staff educated on revisions. 16. Physician A's privileges amended and approved by MEC and Kaiser Foundation Hospital Board 4/24/2007. Reports of restriction were made to the Medical Board of California and the National Practitioner Data Bank as required by Professional Staff Bylaws and legal requirements. 	03/07	
	In 2007, the following activities have occurred for staff and physicians to strengthen their knowledge of their responsibilities for reporting and escalating quality of care issues. These activities reflect the Medical Staff and Hospital's ongoing responsibility for assessment and reassessment of quality and peer review processes:	01/07 and ongoing	
	Peer Review: a. 06/01/07 through 11/30/07 – education to all physicians and administrative leaders on revised Peer Review process implemented 08/07.	11/30/07	
	b. 08/06/2007 Revised Peer Review process implemented. This is to ensure the appropriate level of corrective action is developed and	08/06/07	
	reconciled against the medical decision-making and/or conduct issues identified. 2. Critical Events Training – 10/23/07 through 10/25/07 (This was scheduled prior to the	10/25/07	
	Validation Survey). Perinatal staff and physicians participated with primary goal of improving communication and team effectiveness. Exercises included training on emergency delivery		
	techniques. 3. Highly Reliable Surgical Team (HRST)	08/07 and	
	program implemented in 08/07 - Perinatal	ongoing	
	Services physicians and staff participating. Primary goals: Implement standardized communication techniques in every OR, every procedure, every day.	11/30/07	
	4. Responsible Reporting Forms (RRF). Training and reporting of quality concerns and/or medical errors. Staff are continually re-educated on the	Ongoing	
	importance of reporting medical errors and/or quality of care concerns via RRF reporting tools or utilizing the OOPS line for a verbal message. Data indicators, such as shift, care provider, outcomes,		
	human factors, etc., are entered and tracked in the Risk database. Trends are reviewed, analyzed and presented to the Operations Performance Improvement Committee (OPIC) and MEC for		
	review and action at least 4 times a year.		

ID Prefix TAG	Providers' Plan of Correction	Lead and Completion Date	
A043 (2)	 Significant Event education and reporting (including SB 1301, 1312). Education to physicians occurred 5/24/07 and 8/2/097 for SB 1301/1312 reporting guidelines. Additional education to staff at leadership, departmental and staff huddles to increase awareness for reporting requirements. Significant Event report presented at MEC each month by Chief of Risk Management. CME presentations – sample topics: Peer Review Training (6/26/07, 6/29/07, 7/31/07, 9/12/07, 10/17/07, 11/28/07) Patient Provider Interaction (3/15/07, 10/11/07, 10/18/07), Language Services to Support Quality Care 	08/02/07 and ongoing ongoing	
	(4/20/07), Safety Training (5/18/07, 5/25/07, 6/8/07), EMTALA annual review (8/10/07), Hospital Reporting Requirements (5/24/07, 8/2/07).		
	2.(b) The Hospital's Quality Program assesses and continuously improves the care and services the Hospital delivers to patients. The Hospital has a systematic, integrated approach to planning, designing, measuring, assessing, and improving the quality of care and services provided to patients. Performance improvement activities are prioritized by using criteria that include but are not limited to: Clinical Quality, Service and Access, Patient Safety, Risk Management, Performance Gaps, and High Volume Diagnoses and Procedures. Participation in performance	ongoing	
	improvement activities is multidisciplinary. Prior to July, 2007, the Quality Program held meetings one day a month (Quality Day) with a problem-focused agenda that involved the review of specific quality indicators on a rotating basis. Quality workgroups were assigned if system issues were recognized that required action.		
	Beginning July, 2007, the Quality Program was redesigned to enhance processes to identify system issues and provide corrective actions that could impact a variety of hospital departments on a more continuous basis. The Quality Program reports to the Operations Performance Improvement Committee (OPIC) which includes Hospital leadership and Medical Staff leaders. The OPIC reports its actions and recommendations directly to the MEC on a monthly basis. The MEC is accountable for reporting its activity to the Board through existing reporting mechanisms.	07/07 and ongoing	
	As part of the Quality Program, the Quality Department staff completes an annual evaluation		

ID Prefix TAG	Providers' Plan of Correction	Lead and Completion Date	
A043 (2)	of the previous year's Quality Program work plan and identifies areas of focus for the upcoming year.		
	The Hospital offered to present the information described above with the surveyors during the October visit - the surveyors' schedules did not allow the opportunity for the Hospital to present the information at that time.		
	Additional information about the redesigned Quality Program process is described below.		
	Beginning in August, 2007, the Quality Program oversees the work of three service line performance improvement committees that report to the Operations Performance Improvement Committee (OPIC), a multi-disciplinary committee which includes Hospital leadership and Medical Staff Leaders. OPIC reports monthly on quality activities to the MEC. The three service line committees are: 1) Perinatal Service Line Performance Improvement Committee; 2) Surgical Service Line Performance Improvement Committee; 3) Medical Service Line Performance Improvement Committee.	08/07	
	and maintain effective and efficient operational systems to ensure patient safety and quality improvement.		
	Each of the service committees has defined quality indicators and areas of focus with action plans developed and implemented. Data are assessed for compliance and quality improvement. Results of action plans are tracked and reported to leadership to ensure the Hospital's quality goals are being met. If barriers to compliance in implementing action plans cannot be resolved by the service line committee, the issue is referred to OPIC for resolution.		
	The Quality Program utilizes a variety of sources for monitoring hospital performance and identification of areas for improvement, including but not limited to: concurrent observational audits, medical record review, retrospective audits, patient care indicators, incident reports, infection control reports, and survey and/or complaint feedback from patients, staff and physicians. The program's assessment process is designed to secure information about patient outcomes, hospital		

ID Prefix TAG	Providers' Plan of Correction	Lead and Completion Date	
A043 (2)	practice patterns, and quality of care performance. The information is evaluated and analyzed to drive efforts to improve patient care by: 1) determining if quality indicators are being met and sustained; 2) identifying barriers impacting performance improvement if quality indicators are not being met; 3) determining what corrective actions need to occur to resolve issues and improve patient care outcomes if system issues exist and; 4) sharing best practices among the service lines to achieve quality goals.		
	67 States		

D Prefix TAG		
A043 (3)	A043(3) Selection Criteria for Competency	Leads:
	Please refer to Proctoring process as outlined in A043(1).	AAQS, Quality Chief
	Evidence of proctoring or of plan for completion of proctoring/verification of initial competency is present in every physician's credentials file.	
	The surveyor reviewed a list of 90 physician files for evidence of proctoring, not 50 as stated in the report. The number of files without proctoring on file was 45 at the time of the survey. Therefore, the number should have been based on 45 of 90, not 45 of 50 as alleged in the Statement of Deficiencies.	
	*	
	##** 5	4
		\$4

ID Prefix TAG	Providers' Plan of Correction	Lead and Completion Date	
A043 (4)	A043(4) Hospital Chief Executive Officer	Leads: AAQS,	
	The Hospital disputes this finding.	Quality Chief	
	There has been a Hospital Administrator since KFH Fresno commenced hospital operations in February 28, 1995. The current Hospital Administrator was appointed by the Board effective August 1, 2005. The Hospital Administrator is responsible for managing the Hospital.	08/01/05	
	The "High Risk Rounds with the Perinatologist" memo is neither a Hospital or Medical Staff policy nor guideline as identified by the surveyor in the Statement of Deficiencies. The memo did not describe, nor was related to, the practitioner's privileges. The memo did not require notice, review or approval by the Hospital Administrator. Such a physician-to-physician memo does not require discussion with or the involvement of the Hospital Administrator.		
	The memo from the Interim Chief of the Department to the practitioner explained the process that the nursing staff should use to contact the practitioner for orders and consultative		
	services. The physician did not fail to make rounds as alleged in the Statement of Deficiencies because no such rounds with the Clinical Nurse Specialist were required as a condition of his practice.		

PRINTED: 12/11/20 FORM APPROVI OMB NO. 0938-03

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION				(X2) MULTIPLE CONSTRUCTION A. BUILDING		SURVEY
		050710	B. WING	3	10/	25/2007
	PROVIDER OR SUPPLIER	TAL - FRESNO		STREET ADDRESS, CITY, STATE, ZIP C 7300 NORTH FRESNO ST FRESNO, CA 93720	ODE	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETIO DATE
A 048	Based on staff inter document review; the medical staff op bylaws, rules and reapproved by the gorprovisional physicial set forth in the Bylaw credential files revision incomplete as set for failed to conduct applaced patients at a care that was not in staff bylaws and me regulations. Findings: On 10/18/07 at 4:45 Physician D and Physician D and Phyof the 50 provisional the medical staff rosevidence of proctoric credential (met certa They both also state process was not in a set forth in the The Staff for Kaiser Four and Physician E staff proctoring process of assessment of complete staff or the Bylaw documentation under evaluation shall be for the staff of the staff or the Bylaw documentation shall be for the staff of the staff or the Bylaw documentation shall be for the staff of the staff or the Bylaw documentation shall be for the staff of the st	s not met as evidenced by: views and administrative ne hospital failed to verify that rerated under the medical staff regulations that had been verning body when: 45 of 50 ns proctoring was not done as ws, and three out of 35 rewed were inadequate and/or orth in the Bylaws when they praisals. These failures potential risk of receiving accordance with the medical adical staff rules and p.m., during an interview with residence with the medical adical staff rules and p.m., during an interview with residence with the process and that the current proctoring accordance with the process and that the current proctoring accordance with the process and that the current red that th	A 04	18		
	set forth in the Bylav documentation unde evaluation shall be funless extended by	vs. The Bylaws contained or Section H-2 that "the initial				

Event ID: U88J11

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES				OMB NO	<u>0. 0938-03</u>
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ILDING	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		050710	B. WI	NG	-	10/25/2007	
	PROVIDER OR SUPPLIER FOUNDATION HOSP	ITAL - FRESNO		73	EET ADDRESS, CITY, STATE, ZIP CO 00 NORTH FRESNO ST RESNO, CA 93720		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
A 048	year upon a determined protocol contained regarding time frame	ge 3 nination of good cause. The of the hospital's proctoring similar documentation les that were not followed.	A)48			
	"The Bylaws of the Foundation Hospital stated on page 57, Bylaws, the Profess Rules and Regulation desirable for the protection the Hospital. B. Earpolicies and proced practice. They shall and Rules and Regulation for the Hospital and Rules and Regulation for the Hospital for t	Professional Staff for Kaiser I" was reviewed. The Bylaws I-1, "A. In addition to these ional Staff shall adopt such ons as may be necessary or oper delivery of health care in ch department may establish ures for its specialized be consistent with the Bylaws ulations of the Professional ubject to the approval of the					
	for Kaiser Foundation C 4, "To qualify for the Professional State Perform a sufficient sufficient patient care or another communicating to permit the the applicant's current privileges, whether responding to the sufficient sufficie	plaws of the Professional Staff on Hospital states on page 6, and continue membership on of a practitioner must: It number of cases, and have be contact within the Hospital of the hospital or health care Professional Staff to assess and competency for all clinical equested or already granted, of initial evaluation and ed in Section H-2."					
	Foundation Hospital page 38, D-3, " Chie shall provide for gen medical care of Hos be an ex officio mem	rofessional Statt for Kaiser contained documentation on of of Staff. The Chief of Staff eral supervision of the pital patients. He or she shall of the pital perform such duties as					

PHINTED: 12/11/20 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVI CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-03 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: AND PLAN OF CORRECTION COMPLETED A. BUILDING B. WING 050710 10/25/2007 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 7300 NORTH FRESNO ST KAISER FOUNDATION HOSPITAL - FRESNO FRESNO, CA 93720 SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETIC (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) A 048 Continued From page 4 A 048 the Professional Staff or the Executive Committee shall designate. He or she shall appoint with Executive Committee approval, the chairpersons and committee members of all standing and special Professional Staff committees, except where otherwise provided by these Bylaws and Rules and Regulations. He or she shall act in coordination and cooperation with the Hospital Administration in matters of mutual concern within the hospital. He or she shall represent the views, policies, needs and grievances of the Professional Staff to the Hospital Administrator and the Board of Directors. He or she shall impart the policies of the Board of Directors to the Professional Staff in professional and public relations. The Chief of Staff shall supervise enforcement of these Bylaws and Rules and Regulations." On 10/22/07 at 8:00 a.m. during an interview with Staff I and Administrator H. Staff I produced a Summary of Progress on Proctoring dated 10/25/07 which established that 45 out of 50 provisional physicians had no documented evidence of current and timely proctoring in their credential files. Both Staff I and Administrator H stated that the proctoring was not being done as set forth in the The Bylaws of the Professional Staff for Kaiser Foundation Hospital. Staff I and Administrator H stated that the current proctoring process that was in use could not be found within the Bylaws. Both Staff I and Administrator H stated during the interview that the physician in chief, the chief operating officer of the hospital, members of the Executive Committee, and members of the Credentials and Privileges

Committee were aware of the fact that proctoring was not being done as set forth in the the Bylaws. They were also aware of the fact that the current

		AND HUMAN SERVICES & MEDICAID SERVICES			FOF	ED: 12/11/200 RM APPROVEI O. 0938-039
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		MULTIPLE CONSTRUCTION	(X3) DATE	SURVEY
		050710	B. WI	NG	10	/25/2007
	PROVIDER OR SUPPLIER FOUNDATION HOSPI	TAL - FRESNO		STREET ADDRESS, CITY, STATE, ZIP CO 7300 NORTH FRESNO ST FRESNO, CA 93720		. 20, 200,
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		SHOULD BE	(X5) COMPLETION DATE
A 048	ран при	that was in use could not be	AC	048		
A 049	Physician F stated h Credentials and Priv he was aware of the proctoring was not b The Bylaws of the P Foundation Hospital the fact that the curr was in use could not He stated that the D hospital who were re	•	A 0-	49		
		must ensure that the medical o the governing body for the ed to patients.		A049: Governing Body-Medical S The Statement of Deficiencies should identified Physician A as the cited polysician B. Please refer to "A043(2) Patients above.	ıld have hysician, not	Leads: AAQS, Quality Chief, AAPCS
	Based on staff intervidocument review, the that the medinal staff governing body for the two of 23 patients (Patients). Physician B failed	not met as evidenced by: ew and administrative hospital failed to ensure was accountable to the e quality of care provided to atient 1 and 2) when: to provide quality of care to elivery which caused harm to		1. Physician A's privileges were res MEC and the restriction was subseq approved by the Board 04/27/2007. restriction were made to the Medical California and the National Practition 2. The Hospital and Medical Staff de accountability to the Board for quality implementing the following policies: a) Chain of Command policy b) LDRP Escalation Algorithm guide c) Vacuum Assisted Delivery policy	Reports of the Reports of the I Board of her Data Bank, emonstrate y of care by	04/27/07

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		050710	B. WIN	۱G		10/2	25/2007
NAME OF P	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
KAISER	FOUNDATION HOSP	ITAL - FRESNO			300 NORTH FRESNO ST RESNO, CA 93720	E	2 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
A 049	Continued From pa	age 6	Α (049		- ALEXANDE - FE	
	care policies and p				Please refer to "A043(2) Patients 1 above for corrective actions taken incident described in 2005 in the Sta Deficiencies.	after the	
	outcomes. Findings:	d in negative health care			The surveyor reviewed the Root Cause (RCA) documentation and commented work accomplished in follow-up to this involving Patient 2.	on the good	
	interviewed. Physic for ten years. Qual judgment were iden was asked to improphysician A only go Physician B stated have problems, but to reorganize the wiinstead of dealing we Physician B stated reviewed the delive when the baby died was a "significant de "competency". Phydepartment reviewed twin babies in 2005 pronounced dead 2 found it to be a "Ser should only occur of with "adverse action stated that the quality Physician A for Pati unacceptable. Physician A's poor	sician B stated that Physician			Involving Fatient 2.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		050710	B. WIN	IG	10/25/2007	
	PROVIDER OR SUPPLIER FOUNDATION HOSP	TAL - FRESNO		STREET ADDRESS, CITY, STATE, ZIP C 7300 NORTH FRESNO ST FRESNO, CA 93720	ODE	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
A 049	listen. Physician B is governing body did 2005 about the qual Physician A. On 10/23/07 at 3:10 conducted with Staff Physician A for tension complaints from the as early as 1998 to stated that these lets Executive (NE) at the refer issues to admisstaff. Staff 1 was a Physician A delivere and Patient 2 in 200 there were quality of care Physician A prostated that the polici (Conflict Resolution) was not followed who not addressed and ras a supervisor, she Physician A lashed Patient 2's baby was the nurse that he "O in the room during the formation of the Neinstated that Physician extraction policy and use the vacuum extraction policy and use the vacuum extraction of the Neinback on call two day stated there was a Linear transport of the Neinback on call two day stated there was a Linear transport of the Neinback on call two day stated there was a Linear transport of the Neinback on call two day stated there was a Linear transport of the Neinback on call two day stated there was a Linear transport of the Neinback on call two day stated there was a Linear transport of the Neinback on call two day stated there was a Linear transport of the Neinback on call two day stated there was a Linear transport of the Neinback on call two daystated there was a Linear transport of the Neinback on call two daystated there was a Linear transport of the Neinback on call two daystated there was a Linear transport of the Neinback on call two daystated there was a Linear transport of the Neinback on call two daystated there was a Linear transport of the Neinback on call two daystated there was a Linear transport of the Neinback on call two daystated there was a Linear transport of the Neinback on call two daystated there was a Linear transport of the Neinback on call two daystated there was a Linear transport of the Neinback on call two daystated there was a Linear transport of the Neinback of	nad no knowledge that the anything between 2004 and lity of care provided by I p.m., an interview was f 1. Staff 1 worked with years. There were letters of staff regarding Physician A the present time. Staff 1 ters were sent to the Nurse te time. The NE's job was to nistration and the medical supervisor during the time of care to Patient 1 in 2004 to 15. Staff 1 was aware that if care issue regarding the evided to both patients. Staff 1 titled "Chain of Command" in effect in 2004 and 2005 ten quality of care issues were resolved. Staff 1 stated that the was told by staff that the was told by staff that the policy of the evacuum extraction delivery told Staff 1 that Physician A told only gave a gentle pull. "Staff 1 in A violated the vacuum extraction delivery told Staff 1 that Physician A told on at the end. "Staff 1 in A violated the vacuum extraction delivery told Staff 1 that Physician A told on the end. "Staff 1 in A violated the vacuum extraction delivery told Staff 1 that Physician A told on the end. "Staff 1 in A violated the vacuum extraction delivery told Staff 1 that Physician A told on the end. "Staff 1 in A violated the vacuum extraction delivery told Staff 1 that Physician A told on the end. "Staff 1 in A violated the vacuum extraction delivery told Staff 1 that Physician A told on the end of the	Α 0	149		

CENTE	RS FOR MEDICARI	E & MEDICAID SERVICES			OMB NO. 0938-03		
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		050710	B. WING		10/3	25/2007	
NAME OF F	PROVIDER OR SUPPLIER		STRE	EET ADDRESS, CITY, STATE, ZIP (.0/2007	
KAISER	FOUNDATION HOSP	ITAL - FRESNO		000 NORTH FRESNO ST RESNO, CA 93720			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
A 049	rules) in place in 20 were delivered. Staduring Patient 2's devent" as set forth taking too long" and inappropriate. After with Patient 1 and 2 feedback given aboaddressed Physicial 2. The QA program quality of care policimplemented: a. On 10/23/07, the Resolution) effective reviewed. The policimplemented: 1. When a problem staff involved along care providers would 2. If the staff were the unit management assist. 3. The unit management assist. 4. If the unit management in the problem is staff to problem in the problem in	2005 when Patient 2's twins off 1 stated that staff present delivery "did not escalate the in the Algorithm when "it was d the "vacuum pulls" were the incidents during delivery 2, Staff 1 stated there was no but any effort that "Quality"	A 049				
	situation and assist 6. If the nursing sup- resolve the problem executive would be the problem continu- hospital administrate medical staff call res	ervisor would then assess the in solving the problem. Dervisor was not able to the service director or nurse contacted for assistance. If ed to be unresolved, the property would be contacted. A source was available for to only be called by the					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1.	LDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		050710	B. WIN	B. WING			25/2007
	PROVIDER OR SUPPLIER	ITAL - FRESNO		CODE			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG		PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	ON SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
A 049	nursing supervisor The procedure was administration and address and resolv Physician A's behathe deliveries of Pathey were identified b. On 10/2307, the Recovery Postpartinguideline effective inguideline contained 1. For clinical pract Vocational Nurse/F was to confer with Specialist (CNS). 2. Then the Medicabe contacted. 3. Then then the cobe contacted. 4. Then Obstetricate to be contacted. 5. Then if the nursite the RN was to go unthe Assistant Physic Administrator on-cabe. Before the OB Cobirector could be consulted. The Algorithm was delivery of Patient 2 during Patient 2's deevent" as set forth in the color of the contact of the consulted.	or On-Call administrator. In not followed when the medical staff failed to be problems regarding avior and competency during attent 1 and 2's babies when defended and the problems reviewed. The ladocumentation as follows: In 2005 was reviewed. The ladocumentation as follows: In 2005	AO	149			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDI	TIPLE CONSTRUCTION NG	COMPL	(X3) DATE SURVEY COMPLETED	
	PROVIDER OR SUPPLIER			REET ADDRESS, CITY, STATE, ZIP CODE 7300 NORTH FRESNO ST FRESNO, CA 93720		25/2007	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
A 049	policy dated March purpose was to claprocedure and cor assisted deliveries of the vacuum was 1. If progress was contraction. 2. If the extractor (disconnected) 3 ti 3. If 20 to 30 minuty. The policy was not was not made with hours elapsed between vacuum until delivere to the fetal scalp at On 10/25/07 at 8:5 conducted with Adradministrator G an aware of the incide there was complete room, prolonged laprogression to a ceguidance for an escuere also aware of Patient 2's twin delicomplete disorder in prolonged vacuum non-viable twin, an procedures that we about Physician A vappropriately and/oeffectively.	ne Vacuum Assisted Delivery n of 2004 was reviewed. The arify indications of use, atraindications of vacuum . When to discontinue the use is as follows: not being made with each becomes disengaged mes. tes elapsed without success. of fetal scalp was observed. being followed when progress each contraction, over two ween the start of the use of the ery, and when injury was noted	A 049				
7. 000							

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 12/11/200 FORM APPROVEI

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			OMB NO	0. 0938-03
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT	TIPLE CONSTRUCTION	(X3) DATE S COMPL	SURVEY
		050710	B. WING _		10/2	25/2007
NAME OF P	ROVIDER OR SUPPLIER			REET ADDRESS, CITY, STATE, ZIP CODE	=	
KAISER	FOUNDATION HOSP	ITAL - FRESNO	- 1	7300 NORTH FRESNO ST FRESNO, CA 93720		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETI DATE
A 050	This STANDARD is Based on staff interreviews, and admin hospital failed to veensured that criteria medical staff membranes be based on control there was no decurrent and timely pfailed to conduct ap 2. 45 of 50 provision completely and/or times and the care from members. Findings: 1. On 10/18/07 at 33 reviewed with Staff	y must ensure that criteria for dual character, competence, e, and judgement. s not met as evidenced by: views, credentialing file istrative document review; the rify that the governing body a for selection of both new pers and selection of current pers for continued membership competence when: dentialing files were reviewed occumented evidence of proctoring when the hospital praisals.		A050: Governing Body-Medical State of 90 ph for evidence of proctoring, not 50 as report. The number of files without p file was 45 at the time of the survey. number should have been based on 45 of 50 as alleged in the Statement of Deficiencies. The CMS Conditions of Participation Hospitals do not require the performa proctoring. The CoP require that the has a process to assess the competer medical staff members. The Medical accountable to the hospital governing assuring that there is a process for as medical staff members' competencies. Fresno Professional Staff Bylaws whice approved by the Hospital Governing Englineate such processes including the for proctoring in Section H-2. The Hospital continues to maintain an active medical competent in specialty and subspecial provided to its patients. As stated above, Section H-2 of the Processure that quality physicians serve or staff, an entire host of activities act as balance to ensure that a competent and medical staff provides care to patients. Refer to A043(1) Proctoring Process additional information. The Hospital continues to ensure that selection of both new medical staff memselection of current m	ysician files stated in the roctoring on Therefore, the 45 of 90, not of (CoP) for not of (CoP) for not of Medical Staff not of Staff is body for sessment of the KFH of were Body, e requirement spital has and all staff that is the services on its medical a check and in dexperience is. sfor criteria for embers and	Leads: AAQS, Quality Chief

OLIVIE	TIO TOTT WILD TO ATT	a MEDICAID SERVICES			OIVID INC). <u>0938-</u> 0
	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIED IDENTIFICATION N		(X2) MUL [*] A. BUILDI	TIPLE CONSTRUCTION	(X3) DATE :	
		050710	B. WING		10/2	25/2007
NAME OF F	PROVIDER OR SUPPLIER		ST	REST ADDRESS, CITY, STATE, ZIP CO		
KAISER	FOUNDATION HOSP	ITAL - FRESNO		7300 NORTH FRESNO ST FRESNO, CA 93720		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLET DATE
	On 10/18/07, the B for Kaiser Foundatic C 4, "To qualify for the Professional St Perform a sufficient sufficient patient care or another communicating to permit the applicant's current privileges, whether including completion proctoring as specification of 50 provisional phroster had no object their credential files. On 10/18/07 at 4:45 Physician D and Phof the 50 provisional staff roster had no opproctoring in their credential files. Foundation Hospital current process did of competency in a total physician D and Phof the 50 provisional staff roster had no opproctoring in their credential files. Foundation Hospital current process did of competency in a total physician D and Phof the Bylaws. On 10/19/07 at 4:50 administrative document substitute of the process on Proctor The document substitute of the professional physician	ylaws of the Professional Staff on Hospital states on page 6, r and continue membership on aff a practitioner must: at number of cases, and have are contact within the Hospital hity hospital or health care a Professional Staff to assess ent competency for all clinical requested or already granted, in of initial evaluation and fied in Section H-2." 34 p.m., Staff I stated that 45 hysicians on the medical staff tive evidence of proctoring in the process on the medical staff that the process set forth in The sional Staff for Kaiser. They both stated that the not allow for the assessment timely manner as set forth in p.m., Staff I provided an ment titled "Summary of ing" which was reviewed. It is that the shot and	A 050			

CENTE	HO FUN MEDICANE	& MEDICAID SERVICES				UI	AIR IAC	<u>. 0938-03</u>
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		050710	B. WIN	IG _		10/25/2007		
NAME OF F	PROVIDER OR SUPPLIER				EET ADDRESS, CITY, STATE, ZIP C	ODE		
KAISER	FOUNDATION HOSPI	TAL - FRESNO			RESNO, CA 93720			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRE REGULATORY OR LSC IDENTIFYING INFORMATION) TA						D BE COMPLE	
	On 10/22/07 at 8:00 Staff I and Adminis Bylaws of the Profe Foundation Hospita 10/18/07. The Bylaw out of a total of 50 p documented eviden proctoring in their or contained documen "the initial evaluation (1) year, unless exter Privileges Committed up to one year upon cause." The gener proctoring protocol or regarding time frame extended an addition followed. Both Staff that the proctoring where the the Bylaw H stated that the cur was in use could not Both Staff I and Adminterview that the phoperating officer of the Executive Committee Credentials and Privaware of the fact that done as set forth in the Bylaws. On 10/22/07 at 8:05 interviewed. Physici Credentials and Privas aware of the fact was not being done as set forth in the Bylaws.	a.m. during an interview with trator H, Staff I produced The ssional Staff for Kaiser I and these were reviewed on a sestablished the fact that 45 provisional physicians had no oce of current and timely redential files. (The Bylaws tation under Section H-2 that in shall be for a period of one ended by the Credentials and refor an additional period of a determination of good all provisions of the hospital's contained documentation reso of one year that could be nall year that were not I and Administrator H stated was not being done as set ws. Staff I and Administrator rent proctoring process that the befound within the Bylaws. Ininistrator H stated during the ysician in chief, the chief he hospital, members of the eand members of the ileges Committee were the tractoring was not being the Bylaws and they were set that the current proctoring use could not be found within the Ileges Committee. Physician act that the current proctoring as set forth in the The Bylaws	AO	50				
		taff for Kaiser Foundation						

OLIVIL	TIOT OF WILDION IL	& MEDICAID SERVICES			OND NO	J. 0936-0 ₀	
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUIL	JLTIPLE CONSTRUCTION DING		X3) DATE SURVEY COMPLETED	
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NAME OF F	PROVIDER OR SUPPLIER		. :	STREET ADDRESS, CITY, STATE, ZIP COL	DE		
KAISER	FOUNDATION HOSP	TAL - FRESNO		7300 NORTH FRESNO ST FRESNO, CA 93720			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE ADEFICIENCY)	SHOULD BE	(X5) COMPLETI DATE	
A 050	current proctoring not be found within stated that the Dep hospital who were r	so aware of the fact that the process that was in use could the Bylaws. Physician Fartment chiefs within the esponsible for the proctoring appropriate committees were	A 05	50			
A 057	482.12(b) CHIEF E	XECUTIVE OFFICER must appoint a chief o is responsible for managing	A 05	A057: Governing Body-Medical S Refer to Information in A043(4) He Executive Officer. The Hospital disputes this finding.		Leads: AAQS, Quality Chief	
	Based on staff inter document review, the governing body approfficer who was resphospital in 2007 who accountable to follow Risk Rounds with Poplaced patients at rismanaged health care Findings: On 10/23/07 the Hig Perinatologist guidel (reviewing) time was a.m., Monday throught to notify the Birthing rounding. Upon arm			There has been a Hospital Administration commenced hospital operation February 28, 1995. The current Hospital Administrator was appointed by the languist 1, 2005. The Hospital Administrator was appointed by the languist 1, 2005. The Hospital Administrator was appointed by the Interpretation of Periodical Administrator was related to the practical privileges. The memo did not require review or approval by the Hospital Administrator. The memo from the Interim Chief of the tothe practitioner explained the procenursing staff should use to contact the for orders and consultative services. In the did not fail to make rounds as alleged statement of Deficiencies because not staff should use to contact the for orders and consultative services.	ons in spital Board effective histrator is al. Inatologist al. In the spital all al. In the spital all al. In the spital a	08/01/05	

CENTE	HS FUH MEDICAH	E & MEDICAID SERVICES			OWR NC	<u>). 0938-03</u>
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	3	050710	B. WING _		10/2	25/2007
NAME OF	PROVIDER OR SUPPLIER			REET ADDRESS, CITY, STATE, ZIP C	ODE	
KAISER	FOUNDATION HOSE	PITAL - FRESNO		7300 NORTH FRESNO ST FRESNO, CA 93720		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETI DATE
	On 10/23/07 at 3:3 A did not consister a.m., did not consister a.m., did not consister a.m., did not consistently contact sconsistently contact Staff 3 stated Perin Delivery Recovery reviewing policies a reviewing and update delivery, complete plan of care for the updating new prace monthly for the Per Staff 3 stated Physicand procedures. Sinot intermittently repatients prior to de a comprehensive in patient's clinical redid not update new twice monthly. On 10/24/07 at 8:30 Administrator G was administrative guide with Perinatologist" ensure the perinata make rounds with Pstated acknowledge and that the high risplace. Administrato Physician A had be risk rounds guidelin vice president/area the responsible indi Medical Staff and g G went on to say the Management) was the Management of the state of the say the Management of the say the Management) was the Management of the same state of the say the Management of the same say the Management) was the Management of the same say the say t	age 15 10 p.m., Staff 3 stated Physician atly arrive on the unit at 8:30 stently make his presence staff 3 or Staff 1, and did not be the (Medical Doctor) MD. Inatology activities with Labor Postpartum (LDRP) included: and procedures, routinely ating complicated patients prior eting a comprehensive medical patient's clinical record, and procedures and changes twice string a comprehensive medical patient Safety Project. Initial Patient Safety	A 057	with the Clinical Nurse Specialist a condition of his practice.	were required as	

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI	IPLE CONSTRUCTION	(X3) DATE S COMPL	
		050710	B. WING _	21.	10/2	25/2007
	PROVIDER OR SUPPLIER FOUNDATION HOSP	TAL - FRESNO	. 7	REET ADDRESS, CITY, STATE, ZIP (300 NORTH FRESNO ST FRESNO, CA 93720	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
A 057	directly through the Performance Improphysician A was no rounds guideline. A Staff K should have individual within the information directly Administrator G achexcuse for not being non-compliance wit guideline. On 10/24/07 at 9:05 Physician C and Ad that they were the represented Medica respectively. They was a high risk rounput in place to ensure specialist could make saw consult patiena.m., Monday through Fri Administrator G agree have such guideline Physician A comply guideline without exaministrator G replate fact that Physiciathe high risk rounds brought to their atternon-compliance represented to the gof medical staff to be waccountable to the gof medical care proverse.	Quality Assurance vement (QAPI) process that in-compliant with the high risk dministrator G stated that is been the responsible administration to convey that to the governing body. In the high risk rounds informed of Physician A is in the high risk rounds in a.m., during an interview with ministrator G, both stated esponsible individuals who all Staff and governing body, both acknowledged that there are the perinatal clinical nurse are rounds with Physician A as ents from 8:30 a.m. to 9:30 and it was important to so, and it was important that with the high risk rounds beet that they were unaware of an A was non-compliant with guidelines when it was intion. Physician C and and that Physician C and that Phy	A 057			

PRINTED: 12/11/200 FORM APPROVE OMB NO. 0938-039

CENTE	RS FOR MEDICARI	E & MEDICAID SERVICES			OIVID INC). 0936-0	
STATEMEN"	TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
1 10		050710	B. WING		10/:	25/2007	
	PROVIDER OR SUPPLIER	PITAL - FRESNO		REET ADDRESS, CITY, STATE, ZIP COD 7300 NORTH FRESNO ST FRESNO, CA 93720	ÞΕ		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLET DATE	
A 263	On 10/24/07 at 9: Staff K acknowledge individual within the have known about with the high risk reacknowledged being within the administ conveyed directly to Physician A was not rounds guideline. excuse for not contregarding Physician high risk rounds guideline. excuse for not contregarding Physician high risk rounds guideline. excuse for not contregarding Physician high risk rounds guideline. excuse for not contregarding Physician high risk rounds guideline. Excuse for not contregarding Physician high risk rounds guideline. The hospital must reduct the program reflect hospital's organization hospital's organization hospital department those services furn arrangement); and to improved health and reduction of metal the hospital must reduction.	15 a.m., during an interview, ged being the responsible e administration who should Physician A's non-compliance ounds guideline. Staff K also ng the responsible individual ration who should have to Administrator G that con-compliant with the high risk Staff K stated that there was no veying the information an A's non-compliance with the uideline to Administrator G. develop, implement and ve, ongoing, hospital-wide, assessment and performance ram. erning body must ensure that its the complexity of the tion and services; involves all into and services (including iished under contract or focuses on indicators related outcomes and the prevention	A 263		ta driven, nt and Program since it 1995. The Identified in Tag is do not rective QAPI In, the Hospital Idement to rective care. In monitoring in tifies, riate vements to	Leads: AAQS, Quality Chief	
				Statement of Deficiencies are as follo			

Event ID: U88J11

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ULTIPL LDING			(X3) DATE SURVEY COMPLETED	
		050710	B. WI	NG		10/	25/2007	
	PROVIDER OR SUPPLIER			730	ET ADDRESS, CITY, STATE, ZIP CODE NO NORTH FRESNO ST ESNO, CA 93720			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOTH CROSS-REFERENCED TO THE APPROPRIES OF THE APP	OULD BE	(X5) COMPLE DATE	
A 263			AZ	T P M cc M M go fo cc B G in H is pr	A263-1: The CMS CoP for Hospitals do not require the performance of proctoring. The CoP require the Medical Staff to have a process to assess the competence of medical staff members. The Medical Staff is accountable to the hospital governing body for assuring that there is a process for assessment of medical staff members' competencies. The KFH Fresno Professional Staff Bylaws, which were approved by the Hospital Governing Body, delineate such processes including the requirement for proctoring in Section H-2. The Hospital has an active medical staff that is competent in specialty and subspecialty services provided to its patients. Please refer to "A043(1) Proctoring Process" as outlined above.			
	two of 23 patients 3. Refer to A50. T governing board u criteria for selectio there was no object	the quality of care provided to (Patient 1 and 2). The hospital failed to ensure the sed competence as one of the n to the medical staff when cive evidence of current and n three out of 35 credentialing		PI	263 – 2: lease refer to "A043(2) Patients 1 an utlined above. 263-3:	d 2" as	Leads: AAQS, Quality Chief, AAPCS Leads: AAQS,	
	files reviewed. 4. Refer to A57. T governing body ap officer who was rehospital when Physical Physica	he hospital failed to ensure the pointed a chief executive sponsible for managing the sician A was not held t following the administrative		AZ PI	lease refer to "A043(1) Proctoring Proutlined above. 263 – 4: lease refer to "A043(4) Chief Execution outlined above.		Quality Chief Leads: AAQS, Quality Chief	

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	ILDING	PLE CONSTRUCTION	(X3) DATE	
		050710	B. WII	NG		10/	25/2007
	PROVIDER OR SUPPLIER FOUNDATION HOSPI	TAL - FRESNO		73	EET ADDRESS, CITY, STATE, ZIP COD 100 NORTH FRESNO ST RESNO, CA 93720		- 4
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	SHOULD BE	(X5) COMPLETIC DATE
A 263	guideline titled "High Perinatologist." 5. The hospital faile program requirement Assessment and Pe (QAPI) Program was Once the QA program concern with Physic failed to provide evic resolved in two of 23 The QA program failed		A	263	Refer to attached page 263(5) a		
	which showed meas indicators for which t would improve health failed to look at the o	d to have a QAPI program urable improvement there was evidence that it noutcomes when the hospital care given to two out of 23 and 2) with a quality view.			Refer to attached page 263(6) a		
	which showed meas indicators for which t would improve health reduce medical error	here was evidence that it n outcomes and identify and s when an effective process ative outcomes was not put in			Refer to attached page 263(7) a		
	body (or organized grassumed full legal au operation of the hosp administrative official accountable for ensu program for quality in	d to ensure its governing roup or individual who althority and responsibility for sital), medical staff, and s were responsible and ring that an on-going approvement was defined, aintained when Physician A			Refer to attached page 263(8) a		

D Prefix TAG	Providers' Plan of Correction	Lead and Completion Date		
A263 (5)	A263-5: The Hospital has, and has always had, an effective, ongoing, hospital-wide, data driven, legally compliant Quality Assessment and Performance Improvement (QAPI) Program since it began operations on February 28, 1995.	Leads: AAQS, Quality Chief, Quality Director		
	As part of its' ongoing QAPI Program, the Hospital monitors for opportunities for improvement to enhance patient safety and quality of care. Because of the processes in place for monitoring in the QAPI Program, the Hospital identifies, investigates and implements appropriate corrective actions and process improvements to enhance patient care and safety.			
	In 2005, the Hospital QAPI Program identified and addressed the alleged concerns. The cases identified occurred in 2004 and 2005.	05/19/05		
	Physician A's privileges were restricted by MEC and the restriction was approved by the Board 4/24/2007. Reports of restriction were made to the Medical Board of California and the National Practitioner Data Bank as required by Professional Staff Bylaws and legal requirements.	04/24/07		
	Please refer to "A043(2) Patients 1 and 2" as outlined above for further details related to the Hospital's response.			

ID Prefix TAG	Providers' Plan of Correction	Lead and Completion Date		
A263 (6)	A263 – 6: The Hospital has an effective, ongoing, hospital-wide, data driven, legally compliant Quality Assessment and Performance Improvement (QAPI) Program since it began operations on February 28, 1995. The alleged events or	Leads: AAQS, Quality Chief, Quality Director		
	problems identified in the Statement of Deficiencies do not indicate that the Hospital has an ineffective QAPI Program.			
	As part of its ongoing QAPI Program, the Hospital monitors for opportunities for improvement to enhance patient safety and quality of care. Because of the processes in place for monitoring in the QAPI Program, the Hospital identifies, investigates, and implements appropriate corrective actions and process improvements to enhance patient care and safety. The Hospital's QAPI process enables the root cause analysis and response to ensure improvements in patient quality of care and patient safety.			
	Please refer to "A043(2) Patients 1 and 2" as outlined above for further details related to the Hospital's response.			
	COlor.			

ID Prefix TAG	Providers' Plan of Correction	Lead and Completion Date
A263 (7)	A263 – 7: The Hospital has, and has always had, an effective, ongoing, hospital-wide, data driven, legally compliant Quality Assessment and Performance Improvement (QAPI) Program that identifies and reduces medical errors and includes an effective process of notification of negative outcomes. See "A266: Risk Management Process" as outlined below.	Leads: AAQS, Quality Chief, Risk Director
	E. C.	4

D Prefix TAG	Providers' Plan of Correction	Lead and Completion Date		
A263 (8)	A263 - 8:	Leads:		
		AAQS,		
	The Hospital disputes this finding.	Quality Chief		
	The "High Risk Rounds with the Perinatologist"			
	memo is neither a hospital or medical staff policy			
	nor guideline as identified by the surveyor in the			
	Statement of Deficiencies. The memo did not describe, nor was related to, the practitioner's			
	privileges. This physician-to-physician memo was			
	not a policy or guideline.			
	The memo from the chief of the department to the			
	practitioner explained the process that the nursing			
	staff should use to contact the practitioner for orders or consultative services. The physician did			
	not fail to make rounds as alleged in the Statement			
	of Deficiencies because no such rounds with the			
	Clinical Nurse Specialist were required as a			
	condition of the exercise of the practitioner's clinical privileges.			
	privileges.			
		1921		

PRINTED: 12/11/200 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVE CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 050710 10/25/2007 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 7300 NORTH FRESNO ST KAISER FOUNDATION HOSPITAL - FRESNO **FRESNO, CA 93720** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETION PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) A 263 Continued From page 20 A 263 did not follow the administrative guideline titled "High Risk Rounds with Perinatologist." (A310) The hospital failed to ensure its governing body Refer to attached page (or organized group or individual who assumed 263(9) a full legal authority and responsibility for operation of the hospital), medical staff, and administrative officials were responsible and accountable forverifying that an on-going program for patient safety included: the reduction of medical errors, was defined, and was implemented and maintained when Physician A did not follow the High Risk Rounds with Perinatologist guideline. (A311)A263 - 10: 10. Refer to A340. The hospital failed to ensure Leads: AAQS. the medical staff conducted appraisals of its Please refer to "A043(1) Proctoring Process" as Quality members when 45 of 50 provisional physicians Chief outlined above. were not proctored according to the Bylaws. A263 - 11: Leads: 11. Refer to A347. The hospital failed to ensure AAQS. the medical staff was well organized and Although proctoring is a part of the process to Quality accountable to the governing body for the quality Chief assure that quality physicians serve on its medical of the medical care provided to the patients when staff, an entire host of activities act as a check and 45 of 50 provisional physicians were not balance to ensure that a competent and proctored according to the Bylaws. experienced medical staff provides care to patients. 12. Refer to A951. The hospital failed to provide Please refer to "A043(1) Proctoring Process" as surgical services consistent with needs and outlined above. resources. The hospital failed to have policies

The cumulative effect of these systemic problems

Event ID: U88J11

governing surgical care which were designed to

standards of medical practice and patient care

when the Chain of Command (Conflict

were not followed by Physician A.

ensure the achievement and maintenance of high

Resolution), Labor Delivery Recovery Postpartum

(LDRP), and Vacuum Assisted Delivery policies

A263 - 12

outlined below.

See response to "A951: Surgical Services" as

Leads:

AAQS.

Quality

AAPCS

Chief.

D Prefix TAG	Providers' Plan of Correction	Lead and Completion Date		
A263 (9)	A263 -9:	Leads:		
		AAQS,		
	The Hospital has, and has always had, an	Quality		
	effective, ongoing, hospital-wide, data driven,	Chief		
	benefitye, origonity, riospital-wide, data drivers,			
	legally compliant Quality Assessment and			
	Performance Improvement (QAPI) Program that			
	identifies and reduces medical errors and includes			
	an effective patient safety processes.			
	The Hospital disputes this finding and the			
	allegation that the Hospital fails to maintain an			
	ongoing program for patient safety that includes			
	processes for the reduction of medical errors.			
	The William Diet Designed with the Designate legist"			
	The "High Risk Rounds with the Perinatologist"			
	memo is neither a hospital or medical staff policy	5 5 5 5 5 5 T		
	nor guideline as identified by the surveyor in the			
	Statement of Deficiencies. The memo did not			
	describe, nor was related to, the practitioner's			
	privileges.			
	The memo from the Interim Chief of the department	2 2 2		
	to the practitioner explained the process that the			
	nursing staff should use to contact the practitioner			
	for orders or consultative services. The physician			
	tid and fall to make rounds as alleged in the	0 79		
	did not fail to make rounds as alleged in the			
	Statement of Deficiencies because no such rounds			
	with the Clinical Nurse Specialist were required as			
	a condition of his practice			
	Please refer to "A043(2) Patients 1 and 2" and			
	A266: Risk Management Process as outlined			
	above for further details related to the			
	Hospital's response.			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1, ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING			SURVEY LETED	
		050710	B. WI	1G	37	10/:	25/2007
	PROVIDER OR SUPPLIER	TAL - FRESNO		730	ET ADDRESS, CITY, STATE, ZIP CODE 00 NORTH FRESNO ST ESNO, CA 93720		2072007
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A 264		ed patients at risk for medical	A 2	264			white.
	errors and unsafe prindings:	atient care practices.					
	interviewed. Physic for ten years. Quali judgment were iden was asked to improre Physician A only gore Physician B stated thave problems, but to reorganize the whinstead of dealing we Physician B stated the reviewed the deliver when the baby died was a "significant de "competency". Physician B stated the reviewed the deliver when the baby died was a "significant de "competency". Physician to be a "Sen should only occur or with "adverse action stated that the qualite Physician A for Patie unacceptable. Physician A for Patie unacceptable physician A for Patie unacceptable. Physician A for Patie unacceptable physician A for Patie una	hat the quality department y of Patient 1's baby in 2004 months later, and found there eviation" in Physician A's sician B stated the quality d the delivery of Patient 2's when the second twin was minutes after birth, and tinel Event" (an indicator that a rare basis in a hospital) " (caused harm). Physician B y of care delivered by ent 1 in 2004 was ician B stated that Physician cal skills were poor. The quality of care delivered by ent 2 in 2005 was also lician B stated he was					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 050710		1, ,	ILDING	LE CONSTRUCTION	COMPLETE		
NAME OF PROVIDER OR SUPPLIER			STRE	ET ADDRESS, CITY, STATE, ZIP CODE		5/2007	
KAISER	FOUNDATION HOSPI	TAL - FRESNO		730	00 NORTH FRESNO ST RESNO, CA 93720	1 19 21 21	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE
A 264	quality of care provided on 10/23/07 at 3:10 conducted with Staff Physician A for ten complaints from the as early as 1998 to stated that these let Executive (NE) at the refer issues to admiss the staff. Staff 1 was a Physician A delivered and Patient 2 in 200 there were quality of care Physician A prestated that the policies (Conflict Resolution was not followed with Physician A were not Staff 1 stated that a by staff that Physician A told the gentle pull." Staff in extraction delivery of that Physician A "pure end." Staff 1 stated vacuum extraction prontinuing to use the 2's second twin beyon Obstetrical doctor work of Patient 2's twins in issue was brought to in call two days after there was a Labor D (LDRP) Escalation A in 2005 when Patient 2005 when 2005	ded by Physician A. I p.m., an interview was if 1. Staff 1 worked with years. There were letters of a staff regarding Physician A the present time. Staff 1 ters were sent to the Nurse ne time. The NE's job was to inistration and the medical a supervisor during the time ed care to Patient 1 in 2004 by titled "Chain of Command of the covided to both patients. Staff 1 by titled "Chain of Command of the covided to both patients. Staff 1 by titled "Chain of Command of the covided to both patients. Staff 1 by titled "Chain of Command of the covided and a lashed out at the nursery of the covided to be solved. The covided the covided was born dead. The room during the vacuum of Patient 2 in 2005 told Staff 1 and the covided with a jerk motion at the distribution of the covided with a jerk motion at the distribution of Patient was a vacuum extractor on Patient of the covided was a vacuum extractor on Patient of the covided was a vacuum extractor on Patient of the covided was a vacuum extractor on Patient of the covided was a vacuum extractor on Patient of the covided was a vacuum extractor on Patient of the covided was a vacuum extractor on Patient of the covided was a vacuum extractor on Patient of the covided was a vacuum extractor on Patient of the covided was a vacuum extractor on Patient of the covided was a vacuum extractor on Patient of the covided was a vacuum extractor on Patient of the covided with a perk motion at the covided was a vacuum extractor on Patient of the covided was a vacuum extractor on Patient of the covided was a vacuum extractor on Patient of the covided was a vacuum extractor on Patient of the covided was a vacuum extractor on Patient of the covided was a vacuum extractor on Patient of the covided was a vacuum extractor on Patient of the covided was a vacuum extractor on Patient of the covided was a vacuum extractor on Patient of the covided was a vacuum extractor on Patient of the covided was a vacuum extractor on Patient of the covided was a vacuum extractor on Patient of the covided was a	AZ	264			

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	TIO T OTT MEDIOTIT	L & MILDIO/ ND OLITATOLO			OIVID IVC	7. 0300-00
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULT	IPLE CONSTRUCTION	(X3) DATE S	
		050710 B. WING			10/:	25/2007
	PROVIDER OR SUPPLIER	PITAL - FRESNO	7	REET ADDRESS, CITY, STATE, ZIP CO 300 NORTH FRESNO ST FRESNO, CA 93720		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	COMPLETIC DATE
A 264	Twin B delivery "difor the in the Algor long" and the "vacia After the incidents and 2, Staff 1 state given about any eff Physician A. 2. The QA program quality of care policimplemented: a. On 10/23/07, the Resolution) effective reviewed. The policimplemented: 1. When a problem staff involved along care providers wou 2. If the staff were the unit management assist. 3. The unit management assist. 3. The unit management assist. 4. If the unit management assist. 5. The nursing sup situation and assist 6. If the nursing sure executive would be the problem continue hospital administration.	d not escalate the event" as set ithm when "it was taking too num pulls" were inappropriate. during delivery with Patient 1 and there was no feedback fort that "Quality" addressed in failed to ensure the following cles and procedures were: Chain of Command (Conflict re in 2004 and 2005 was cry contained documentation in was identified on the unit, the patient the physicians and other lid work towards resolution. Unable to resolve the issue, and team would be contacted to rement staff would then assess esist in solving the problem. It is solving the problem of the nursing supervisor would rervisor would then assess the in solving the problem. The previsor was not able to the intervisor was not able to the contacted for assistance. If the document is a variable for would be contacted. A source was available for	A 264	DEFICIENCY		
		to only be called by the or On-Call administrator.				

PRINTED: 12/11/200 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVE CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 050710 10/25/2007 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 7300 NORTH FRESNO ST KAISER FOUNDATION HOSPITAL - FRESNO FRESNO, CA 93720 SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX COMPLETION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) A 264 Continued From page 25 A 264 The procedure was not followed when administration and the medical staff failed to address and resolve problems regarding Physician A's behavior and competency during the deliveries of Patient 1 and 2's babies when they were identified. b. On 10/2307, the "LDRP (Labor Delivery Recovery Postpartum) Escalation Algorithm" quideline effective in 2005 was reviewed. The quideline contained documentation as follows: 1. For clinical practice issues, the Licensed Vocational Nurse/Registered Nurse (LVN/RN) was to confer with peers and or the Clinical Nurse Specialist (CNS). 2. Then the Medical Doctor (MD) on-call was to be contacted. 3. Then then the consult with back-up MD was to be contacted. 4. Then Obstetrical (OB) Nursing Manager was to be contacted. Then if the nursing manager was unavailable. the RN was to go upward to the OB Chief and to the Assistant Physician In Chief (APIC) or MD Administrator on-call. 6. Before the OB Chief was notified, the Service Director could be notified and the Perinatologist could be consulted as needed. The Algorithm was not followed during the delivery of Patient 2's twins when staff present during Patient 2's delivery "did not escalate the event" as set forth in the Algorithm when too much time elapsed between vacuum pulls and delivery, and the vacuum pulls were inappropriate.

c. On 10/23/07, The Vacuum Assisted Delivery

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 050710 NAME OF PROVIDER OR SUPPLIER KAISER FOUNDATION HOSPITAL - FRESNO			(X2) MU A. BUIL	ULTIPLE CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		050710	B. WIN	IG	_ 10/	25/2007
			STREET ADDRESS, CITY, STATE, 7300 NORTH FRESNO ST FRESNO, CA 93720		0/25/2007	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	COMPLETIC DATE
A 264	policy dated March purpose was to cla procedure and comassisted deliveries. of the vacuum was 1. If progress was contraction. 2. If the extractor by (disconnected) 3 tir 3. If 20 to 30 minut 4. If trauma (injury) The policy was not was not made with hours elapsed between vacuum until delivered to the fetal scalp at the fetal scalp a	of 2004 was reviewed. The rify indications of use, traindications of vacuum When to discontinue the use as follows: not being made with each recomes disengaged res. res elapsed without success, of fetal scalp was observed. The being followed when progress each contraction, over two reen the start of the use of the ry, and when injury was noted birth. In a.m., an interview was reinistrator G and Physician C. It is a proposed to the ry were at in 2004 with Patient 1 where disorder in the operating	A 2	64		
A 265	482.21(a)(1) QAPI H	HEALTH OUTCOMES	A 26	5		

OLIVILLI OI VII WILDIONIL & WIL	EDICAID SERVICES			OMB NO	<u>0. 0938-03</u>
	PROVIDER/SUPPLIER/CLIA DENTIFICATION NUMBER:	(X2) MU A. BUILI	ILTIPLE CONSTRUCTION DING	(X3) DATE COMPI	SURVEY
050710		B. WING	3	10/	25/2007
NAME OF PROVIDER OR SUPPLIER KAISER FOUNDATION HOSPITAL -	FRESNO	\$	STREET ADDRESS, CITY, STATE, ZIP COD 7300 NORTH FRESNO ST FRESNO, CA 93720		
(X4) ID SUMMARY STATEMEN PREFIX (EACH DEFICIENCY MUST TAG REGULATORY OR LSC IDEN	BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
A 265 Continued From page 27 an ongoing program that improvement in indicators evidence that it will improve evidence that it will improve administrative document of ailed to have an ongoing Performance Improvement showed measurable improvement areas for which there were program would improve he the hospital failed to look a of 23 patients (Patient 1 aview. These failures resucare outcomes for two pates. On 10/23/07 at 9:30 a.m., part of the Quality Assurar interviewed. Physician B for ten years. Quality issur judgment were identified in was asked to improve. Physician A only got upset Physician B stated that Physician B stated that Physician B stated that the reviewed the delivery of Patients and the physician B stated that the reviewed the delivery of Patients and the physician B stated that the reviewed the delivery of Patients and Pa	shows measurable of for which there is we health outcomes. The tas evidenced by: and clinical and review, the hospital Quality Assessment at (QAPI) Program that overment in indicators in the evidence that a realth outcomes when the care given to two and 2) with a quality alted in negative health ients (Patient 1 and 2). Physician B who was not (QA) team was worked with Physician A res regarding poor a 2004 and Physician A res regarding poor a 2004 and Physician A residence of the system of the continued to overning body choose ality department deficiencies." quality department	A 26	A265: Quality and PI The Hospital has, and has always hat effective, ongoing, hospital-wide, dat legally compliant Quality Assessmen Performance Improvement (QAPI) Pubegan operations on February 28, 18 the alleged events or problems identify Statement of Deficiencies indicates at the Hospital to sustain an effective Quality of Because of the processes in place for the QAPI Program, the Hospital ident investigates and implements appropriactions and process improvements to patient care and safety. The Hospital process enables the root cause analytic response to ensure improvements in professional care and patient safety. Please refer to "A043(2) Patients 1 and outlined above for further details response.	ta driven, at and rogram since it and rogram since it apps. None of ified in the an inability of API Program. If the Hospital ement to care. If monitoring in ifies, ate corrective enhance is QAPI sis and patient quality	Leads: AAQS, Quality Chief, Quality Director, Risk Director

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 050710				(X2) MULTIPLE CONSTRUCTION A. BUILDING		SURVEY
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NAME OF PROVIDER OR SUPPLIER KAISER FOUNDATION HOSPITAL - FRESNO				STREET ADDRESS, CITY, STATE, ZIP C 7300 NORTH FRESNO ST FRESNO, CA 93720		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	COMPLETIO DATE
A 265	there was a "signif A's "competency" Physician B stated reviewed the delive 2005 because the dead 22 minutes a "Sentinel Event" (a occur on a rare bate action" (caused hat the quality of care Patient 1 in 2004 with stated that Physicial were poor. Physicial were poor. Physicial delivered by Physician governing body did 2005 about the quality poor obstetrical skip to listen. Physician governing body did 2005 about the quality physician A. On 10/23/07 at 9:3 responsible for the was interviewed. For the was interviewed. For the was interviewed. For the was interviewed at Patient 1's would have been ustated that the quality physician A was unphysician A was unphysician D stated was aware of that woor judgment and	icant deviation" in Physician from the standard of practice. Ithe quality department very of Patient 2's twin babies in second twin was pronounced after birth, and found it to be a un indicator that should only sis in a hospital) with "adverse arm). Physician B stated that delivered by Physician A for vas unacceptable. Physician B an A's general Obstetrical skills cian B stated the quality of care cian A for Patient 2 in 2005 able. Physician B was alarmed an A's poor judgement and allis, but management refused B had no knowledge that the lanything between 2004 and allity of care provided by 5 a.m., Physician D who was oversight of the QA committee Physician D was not working of Patient 1's baby, but sian D stated that "if a general allogical (OBGYN) physician is fetal monitoring strip, it nacceptable." Physician D ity of care delivered by acceptable and that the laskills were not acceptable. It skills were not acceptable.	A 26	15		
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		(X2) MULTIPLE CONSTRUCTION A. BUILDING		SURVEY LETED
		050710	B. WII	NG	3.5	10/	25/2007
	PROVIDER OR SUPPLIER	ITAL - FRESNO		730	EET ADDRESS, CITY, STATE, ZIP (00 NORTH FRESNO ST RESNO, CA 93720	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	ON SHOULD BE HE APPROPRIATE	COMPLETION DATE
	On 10/23/07 at 3:10 conducted with Staf Physician A for ten complaints from the as early as 1998 to stated that these let Executive (NE) at the refer issues to admist staff. Staff 1 was a Physician A delivered and Patient 2 in 2000 there were quality of care Physician A prostated that the policy (Conflict Resolution) was not followed who and addressed and ras a supervisor, she Physician A lashed of Patient 2's baby was the nurse that he "O in the room during the format of Patient 2 in 2005 "pulled with a jerk most that Physician extraction policy and use the vacuum extraction policy and use the vacuum extraction of the NE in back on call two days stated there was a Le Postpartum (LDRP) rules) in place in 2000 was delivered. Staff during Patient 2's de event" as set for the	op.m., an interview was ff 1. Staff 1 worked with years. There were letters of e staff regarding Physician A the present time. Staff 1 tters were sent to the Nurse he time. The NE's job was to inistration and the medical a supervisor during the time ed care to Patient 1 in 2004 05. Staff 1 was aware that of care issue regarding the ovided to both patients. Staff 1 by titled "Chain of Command)" in effect in 2004 and 2005 hen quality of care issues were resolved. Staff 1 stated that e was told by staff that out at the nursery nurse after s born dead. Physician A told only gave a gentle pull." Staff the vacuum extraction delivery told Staff 1 that Physician A notion at the end. " Staff 1 in A violated the vacuum d procedure by continuing to ractor on Patient 2's baby her Obstetrical doctor would very of Patient 2's twins in care issue was brought to the mmediately. Physician A was a safter the incident. Staff 1 cabor Delivery Recovery Escalation Algorithm (set 05 when Patient 2's twin baby 1 stated that staff present elivery "did not escalate the in the Algorithm when "it was the "vacuum pulls" were	A	265			

DEPAR	TMENT OF HEALTH	HAND HUMAN SERVICES			PRINTE	D: 12/11/200
CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			OMB NO	M APPROVE 0. 0938-039
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 050710		(X2) MULTIF	LE CONSTRUCTION	(X3) DATE :	SURVEY	
		B. WING		10/	25/2007	
NAME OF F	PROVIDER OR SUPPLIER		STRE	ET ADDRESS, CITY, STATE, ZIP CO		20/2001
KAISER	FOUNDATION HOSPI	TAL - FRESNO	730	00 NORTH FRESNO ST ESNO, CA 93720		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
A 265	inappropriate. After with Patient 1 and 2	the incidents during delivery , Staff 1 stated there was no ut any effort that "Quality"	A 265			
	conducted with Adm They were aware of 1's delivery in 2004 disorder in the opera with an untimely prosection, and no guide concerns. They were the delivery of Patient complete disorder in prolonged vacuum en non-viable second to Recovery Postpartur Algorithm guideline of C stated that there were Review and a Facility identified Sentinel Exscores of 1, 2, or 3) to based on criteria. To Physician A was adhupon him. When asked in Physician A was not making it difficult for violation of the guidel aware. Physician A was not making it difficult for violation of the guidel aware. Physician A was not making it difficult for violation of the guidel aware. Physician A was not making it difficult for violation of the guidel aware. Physician A was not making it difficult for violation of the guidel aware. Physician A was not making it difficult for violations. Medical sephysicians. Medical sephysicians. Medical sephysician C and Gove Administrator G were	there half of the time, was the nurses, and was in lines, he said he was not was given guidelines to follow ands (reviews) on high risk e plan of care was staff, the patients and other				

PRINTED: 12/11/2007

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 A. BUILDING (X3) DATE SURVEY COMPLETED

	050710		B. WING		10/25/2007	
	PROVIDER OR SUPPLIER FOUNDATION HOSPI	TAL - FRESNO		REET ADDRESS, CITY, STATE, ZIP CODE 7300 NORTH FRESNO ST FRESNO, CA 93720	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL IC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPROFICE OF THE APPROPROPROPROPROPERT OF THE APPROPROPROPROPERT OF THE APPROPROPROPERT OF THE APPROPROPROPERT OF THE APPROPROPERT OF THE APPROPROPERT OF THE APPROPROPERT OF THE APPROPROPERT OF T	D BE COMPLETION	
A 265	Perinatologist guidel There was no docum program was monito improvements and ir	nented evidence the QA pring measurable andicators in areas for which	A 265			
A 266	health outcomes. 482.21(a)(1) QAPI M The program must in an ongoing program improvement in indice	that a program would improve IEDICAL ERRORS Include, but not be limited to, that shows measurable ators for which there is dentify and reduce medical	A 266	A266: Quality and PI The cases cited in the Statement of Deficie occurred in 2004 and 2005. The Hospital has, and has always had, an effective, ongoing, hospital-wide, data drive legally compliant Quality Assessment and Performance Improvement (QAPI) Program identifies and reduces medical errors and in an effective process of notification of negatioutcomes.	Chief, Risk Director, Quality Director	
	Based on staff interviand administrative do failed to ensure there Assessment Perform Program that showed indicators in areas for that a program would errors when an effect negative outcomes we patient safety for 2 of (Patient 1 and 2). The death of 2 patients. Findings: 1. On 10/23/07 at 1:0	not met as evidenced by: ew, clinical record review, becument review; the hospital was an ongoing Quality ance Improvement (QAPI) measurable improvement which there were evidence identify and reduce medical ive process of notification of as not put in place to ensure 23 patients reviewed ese failures resulted in the 0 p.m., Patient 1's clinical Patient 1 was admitted with		The Quality Program is accountable to the Mathe oversight of quality reviews and actions remedy issues, either systemic or specific to department or individual, and reporting its fir to OPIC and MEC on an ongoing basis. The Hospital respectfully disagrees with the surveyors' statement that the hospital did no quality mechanisms in place at the time these events occurred and that the lack of this prodiffectly resulted in the death of these two paraburing the survey, the surveyors had access review the peer reviews conducted in 2004 at 2005. The actions taken as a result of the pereview substantiates the effectiveness of the Hospital's QAPI Program. The surveyors were aware that Physician A's privileges were rest by the MEC and the restriction was approved the Board on 4/24/2007. Reports of the restriction	to a a a a a a a a a a a a a a a a a a a	

PRINTED: 12/11/2007 FORM APPROVED OMB NO. 0938-0391

OLIVIE	TO TOTT WILD TO ALLE	A MEDIONID CENTRICES	-			CIVID INC	. 0336-033
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		050710	B. WI	NG _		10/2	5/2007
NAME OF	PROVIDER OR SUPPLIER			STE	REET ADDRESS, CITY, STATE, ZIP CODE		
KAISER	FOUNDATION HOSPI	TAL - FRESNO		1	300 NORTH FRESNO ST FRESNO, CA 93720		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREF TAG		PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
A 266	Continued From parterm (about three polyhydramnios (and the fetus in pregnarthospital's labor and 1/28/04 at 4:15 p.m. contractions (uterus Her contractions (uterus Her contractions we 60 to 70 seconds, howere 154, and her influid surrounding the was started on a druterine contractions drug, Patient 1 contractions drug, Patient 1 contractions with a baselin decelerations (a slowed at Patient 1 to 170 with late decelerations and position of the part tones with a baselin decelerations and positions arrived at Patient 1's 8:00 p.m., Patient 1 centimeters (a measinches), and "late decelerations", and "late decele	ge 32 e weeks early) labor and n excess of fluid surrounding ncy) for observation to the delivery department on . with complaints of uterine squeezes) since 1:30 p.m ere 2 to 4 minutes apart lasting er babies' fetal heart tones nembranes (bag encasing e fetus) were intact. Patient 1 ug that inhibited preterm at 4:25 p.m. In spite of the inued to have contractions. In dated 1/28/04 at 6:09 p.m. tation of contractions five g 50 seconds, fetal heart e of 150 to 180 with late wing of the heart rate in lons) and variability (changes effect the status of the t 7:00 p.m., contractions were apart lasting 50 to 60 eart tones with a baseline of rations and poor variability. It is second, and fetal aseline of 150 to 170 with late or variability. Physician A bedside to evaluate her at was dilated 1 to 2 urement that is similar to celerations were noted with		266	DEFICIENCY)	ifornia and required by uirements. s outlined e if regarding policies and ans to ufety. ages the element process puraged to es as timely and artment. It care are ty for peer Risk Hotline of calls that ally, the ompliance, ocerns or wents within	
	p.m., the drug to stop discontinued. At 8:2 minutes apart lasting tones with a baseline decelerations occurri	0 p.m., contractions were 5 50 seconds, and fetal heart			significant event policy, are investigated department review, peer review or both. determine if system issues are present w referred by to Risk Management for addition investigation.	Reviews hich are	

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CENTE	RS FOR MEDICARE	& MEDICAID SERVICES				OMB MO	7. 0938-03	
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI A. BUIL		TIPLE CONSTRUCTION		X3) DATE SURVEY COMPLETED	
		050710	B. WIN	IG_		10/2	25/2007	
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE			
KAISER	FOUNDATION HOSP	TAL - FRESNO			RESNO, CA 93720		,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	x	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	COMPLETION DATE	
A 266	minutes apart lasting tone baseline was after each contracting Patient 1's membra at 11:00 p.m., and a were two minutes at the fetal heart tone decelerations after variability. At 11:40 nursing care of Pating regarding the fetal regarding the fetal regarding strip indicelerations to Phymonitoring strip indicelerations and pwas taken to the opsection at 1:03 a.m. progress was from 10:00 p.m. to four coesarean section at Report). The fetal blood flow to the planourished the fetus poor neurological (nindicated by poor varient 1 delivered hand the reasons for distress according to Physicial report. On 10/23/07 1:30 p. conducted with Staffor Patient 1 at 11:44 comfortable with the not good variability aprogressing", and variability aprogressing applications are applications and a manufacture and a	ng 60 seconds, and fetal heart 150 with late decelerations on and poor variability. The seconds are artificially ruptured at 11:08 p.m. contractions part lasting 60 seconds and baseline was 150 with late each contraction and poor p.m., Staff 2 took over the ent 1. Staff 2 voiced concerns monitoring strip and the late	A 2		System issues may also be identified dipeer review process. Any system issued determined to have a high potential for injury to patients are referred to Risk M for additional investigation and reporting Department Managers and Supervisors enlisted to assist in the investigation are formulation and implementation of the The review of significant events is the accountability of the Risk Management a multi-disciplinary group of directors, phospital senior leaders. The committee findings after the investigation and reacconsensus on necessary corrective act including any reporting requirements. committee reports monthly to the MEC is accountable for reporting risk manage to the Board through existing reporting mechanisms.	es serious anagement g. s are nd action plan. t Committee, physicians, a reviews the ch tivities, This . The MEC		

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		050710	B. WING		10/25	5/2007	
	F PROVIDER OR SUPPLIER	ITAL - FRESNO	73	EET ADDRESS, CITY, STATE, ZIP C 00 NORTH FRESNO ST RESNO, CA 93720	CODE		
PREFI TAG	X (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	ON SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
A 26	Patient 1 had a nor a slow progression Staff who were in cesarean section to "stressed". Staff 2 hounding nurses at to chart. On 10/24/07 at 2:00	age 34 n-reassuring monitor strip and of labor for over two hours. the operating room during the old Staff 2 conditions were stated Physician A was feer delivery, telling them how 0 p.m., an interview was ff 3. Staff 3 stated that a fetal	A 266				
	monitor strip with lathe placenta was not the baby needed to monitor strip nurses variability which was nervous system of baby was compens deficiency). Staff 3 the birth of Patient been escalated an place for Chain of C that was not followed was a "violation of c of practice" in the cato Patient 1 during it	ate decelerations indicated that be decelerations indicated that be getting enough oxygen and be delivered. On the fetal is would also look at the sa reflection of the autonomic the baby and indicated the ating (making up for a stated that the incident with 1's baby in 2004 "should have do that there was a policy in command/Conflict Resolution and. Staff 3 stated that there common sense and standard are delivered by Physician Coner babies' delivery in 2004.					
	Resolution) effective reviewed. The policy under Procedure: 1. When a problem staff involved along care providers would 2. If the staff were to the problem in the staff were to the staff were	nain of Command (Conflict e in 2004 and 2005 was by contained documentation was identified on the unit, the with the physicians and other d work towards resolution. unable to resolve the issue, at team would be contacted to					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED		
		050710	B. WIN	VG		10	10/25/2007	
NAME OF PROVIDER OR KAISER FOUNDATION		TAL - FRESNO		730	ET ADDRESS, CITY, STATE, ZIP (DO NORTH FRESNO ST ESNO, CA 93720		2001	
PREFIX (EACH I	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI TAG		PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
the situation 4. If the unresolve the be contact 5. The nursituation and 6. If the nuresolve the executive with the problem hospital admedical state assistance nursing support of the delivery identified. On 10/25/0 conducted Administrate aware of the there was conformed and progression guidance for the conducted of the conduct	t manage on and as nit manage on and as nit manage of problem ed. sing super of assist ursing super problem evould be no continue ministrate of and the continue was ion and the dresolve of Patier of Patier of Patier of Patier of and e incident of a cession and the complete of a cession and the continue of a cession in the	ge 35 ment staff would then assess sist in solving the problem. Hement staff was unable to the nursing supervisor would be ervisor would then assess the in solving the problem. He problem to the service director or nurse contacted for assistance. If the details to be unresolved, the problem to every available for the only be called by the problems regarding the medical staff failed to problems regarding that I baby when they were the solving the problems of the problems of the problems regarding that I baby when they were the solving that I baby when they were the solving that I baby when they were the solving that I where the solving that I where the solving to problems regarding that I where the solving that I where the solving that I where the solving to Discharge Summary written that I was admitted to the that I was admitted to the that I weeks and uncontrolled.	A 2	266				

FORM APPROVED OMB NO. 0938-0391

CENTERS FOR MEDICARE & MEDICAID SERVICES					OWR VC). 0938-03 <u>9</u>	
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	ULTIP	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	20	050710	B. WI	NG		10/2	25/2007
NAME OF	PROVIDER OR SUPPLIER			STRE	ET ADDRESS, CITY, STATE, ZIP CODE		
KAISER	FOUNDATION HOSP	TAL - FRESNO			00 NORTH FRESNO ST ESNO, CA 93720		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPROPRIED OF T	ULD BE	(X5) COMPLETION DATE
A 266	Continued From pa	ge 36	Α:	266		6	
	Patient 1 progresse 10:15 p.m. and 0 st was taken to the op double set up for tw	s for induction (causing labor). d to complete dilatation at ation (ready for delivery) and erating room at 10:25 p.m. for in vaginal delivery. Twin A					
	4/21/05 with Apgar Twin A, Twin B was "good" fetal heart ra membranes (bag er	al delivery at 10:43 p.m. on scores of 9. After delivery of vertex (head down) with a te. Active rupture of neasing fluid surrounding the					
-8 a	The head was at +1 head in the cavity for Patient 1's labor wa After waiting for 40 were tried at 10:58 p	and clear fluid was noted. station (the level of the fetal armed by the bones of the hip). s assisted by medication. minutes, vacuum extractions o.m. to accelerate delivery. to pop-off (vacuum pops off					
	when pressure excemade. The fetal here Two more vacuum a down to +3 station. more time due to make one push and no post 12:22 a.m Twin B	beds the minimum) were ad came down to +2 station. attempts and the head came. The vacuum was applied one aternal exhaustion, and with p-off, Twin B was delivered at was very pale, had Apgars of itated for 20 minutes, and			4.		
	expired at 12:42 a.m extraction was attem was high at +1 static extractions were atte Summary contained had a good fetal headelivery, but after derate and did not respectively. See the documentation that the extraction was attempted to the extraction of the extraction was attempted to	n. on 4/22/05. Vacuum Inpted when the fetal head Inp. A total of five vacuum Impted. The Clinical Implementation that "Baby Intrate up to the time of Ilivery did not have a heart Implementation on the time of the cord contained Implementation on the time of time of the time of time					
	(take hold), and the engaged was at 11:2	B p.m. but did not engage next vacuum extraction that 24 p.m After four effective were attempted. Patient 1					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		050710	B. WING		10/2	5/2007	
	PROVIDER OR SUPPLIER FOUNDATION HOSPI	TAL - FRESNO	7:	REET ADDRESS, CITY, STATE, ZIP CO 300 NORTH FRESNO ST RESNO, CA 93720	DDE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
	was prepared for a a.m After prepara 12:18 a.m., one mo attempted and Twin a.m Twin B was p An autopsy (exam twas done on 4/22/0 contained documen examination was of at term with edema scalp (skin on the hwith normal abdomin heart. The Autopsy for gestational age, posterior fossa and disruption cervical socciput-C1 or cervical conducted with Staff care of Patient 2 at stated that the Patie were "good" until the Staff 6 stated that or that resulted in the dwas on his hands an rough. Staff 6 stated dead, and Physician everyone else saying stated that Physician them what to chart. Swas written up before was nothing done abhard to work with Phat the nurses, harass listen to them. Staff in the surgical room in the	cesarean section at 12:09 tion for at cesarean section at re vacuum extraction was B was delivered at 12:22 ronounced dead at 12:42 a.m. o determine cause of death) 7. The Autopsy report tation that the external a normally formed male fetus of the left eye region and ead). The infant was pale nal organs and a normal report findings were "Large and sub-dural blood in spinal cord and moderate pinal cord, consistent with al vertebral body separation." p.m., an interview was 6. Staff 6 took over nursing 11:30 p.m. on 4/21/05. Staff 6 at 2's Twin B fetal heart tones a last vacuum extraction. In the last vacuum extraction delivery of Twin B, Physician A and knees and pulled and was at that the baby was born A was angry and yelled at git was their fault. Staff 6 a A harassed others and told staff 6 stated that Physician A et this and after, and there yelled sed them, and would not 6 stated there was no control	A 266				
	On 10/22/01 at 0.40	a.iii. aii ii ilei view was					

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	AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN B. WING	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
	PROVIDER OR SUPPLIER	050710 PITAL - FRESNO	STR	REET ADDRESS, CITY, STATE, ZI 300 NORTH FRESNO ST RESNO, CA 93720		25/2007	
(X4) ID PREFIX TAG			ID PREFIX TAG			(X5) COMPLETIO DATE	
A 266	conducted with Sta analysis of the inci Overview SE 05-00 documentation tha	off 4 regarding the hospitals' dent with Patient 2. The D4-SV contained there was a concern with cting infant at delivery; lack of	A 266				
	conducted with Starespiratory care in midnight on 4/22/05 behind Physician A 9 stated the fetal helimits up to the last stated Physician A the vacuum extract	0 p. m., an interview was ff 9. Staff 9 took over the operating room at 12:00 5. Staff 9 was positioned near Patient 2's left leg. Staff eart tones were within normal vacuum extraction. Staff 9 had to "reach high up" to place or in the beginning. Staff 9 v was born "white as a sheet."					
	conducted with Star supervisor, she was lashed out at the nubaby was born dead that he "Only gave a room during the vac Patient 2 in 2005 to "pulled with a jerk me stated that Physicia extraction policy and use the vacuum ext beyond what any oth have. After the delimate attention of the NE is back on call two day stated there was a LP ostpartum (LDRP) rules) in place in 2004.	op.m., an interview was if 1. Staff 1 stated that as a stold by staff that Physician A bursery nurse after Patient 2's id. Physician A told the nurse a gentle pull." Staff in the cum extraction delivery of id Staff 1 that Physician A notion at the end. "Staff 1 in A violated the vacuum id procedure by continuing to ractor on Patient 2's baby ner Obstetrical doctor would very of Patient 2's twins in care issue was brought to the immediately. Physician A was after the incident. Staff 1 in abor Delivery Recovery Escalation Algorithm (set in 55 when Patient 2's twin baby 1 stated that staff present					

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ULTIPLE CONSTRUCTION LDING		(X3) DATE SURVEY COMPLETED	
		050710	B. WIN	NG	10/:	25/2007	
	PROVIDER OR SUPPLIER	ITAL - FRESNO		STREET ADDRESS, CITY, STATE 7300 NORTH FRESNO ST FRESNO, CA 93720			
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A 266	during Patient 2's devent" as set for the taking too long" and inappropriate. After with Patient 1 and 2 feedback given aboaddressed Physicia	elivery "did not escalate the e in the Algorithm when "it was d the "vacuum pulls" were the incidents during delivery 2. Staff 1 stated there was no out any effort that "Quality" n A.	A 2	266			
	conducted with State care in the operating when Patient 2's Twistated that Physicial in the operating roo "technique method extraction) was forcultimately separated a "nuchal (neck) coland that was why the come down". Staff ready for a cesareal listen. Staff 5 stated he promised Patient stated "we are going Physician A harasses staff what they shou 5 to chart that there B. On 10/24/07 at 2:30	if 5. Staff 5 took over nursing groom the night of 4/22/05 vin B was delivered. Staff 5 in A screamed and mumbled in. Staff 5 stated that the of the last one (vacuum eful, adamant, and rough and if the spinal cord." Twin B had are daround the neck one time, the babies head would not a sked if Physician A was a section, and he did not if Physician A had stated that if 2 a vaginal delivery and if to do this." Staff 5 stated if Staff when charting and told lid say. Physician A told Staff was gentle suction on Twin in p.m., an administrative onducted. The hospital's					
	policy for vaginal del extraction that transi was requested. Staff there were no policie						
	On 10/24/07, the Ch	ain of Command (Conflict					

	& MEDICAID SERVICES		_		ONID INC	<i>).</i> 0938-035	
TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1. '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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PROVIDER OR SUPPLIER			STRE	ET ADDRESS, CITY, STATE, ZIP CO			
FOUNDATION HOSPI	TAL - FRESNO						
(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREF		(EACH CORRECTIVE ACTION	SHOULD BE	COMPLETION DATE	
Continued From pa	ge 40	A 2	266				
						. "	
	cy contained documentation						
under Procedure:							
staff involved along care providers would 2. If the staff were the unit management assist. 3. The unit management the situation and as 4. If the unit management the situation and as 4. If the unit management the contacted. 5. The nursing supposituation and assist 6. If the nursing supposituation and assist 6. If the nursing supposituation and assist 6. If the problem executive would be the problem continuation that the problem continuation that the problem continuation that the problem continuation that is a sistance but was a sistance b	with the physicians and other d work towards resolution. Unable to resolve the issue, int team would be contacted to ement staff would then assess sist in solving the problem. It is a proper would then assess the in solving the problem. It is always a pervisor would then assess the in solving the problem. It is always a pervisor was not able to the service director or nurse contacted for assistance. If ed to be unresolved, the provided be contacted. A source was available for to only be called by the						
The procedure was administration and the address and resolved Physician A's behave the delivery of Patient were identified. On 10/2407, the "LD Postpartum) Escalar effective in 2005 was contained document.	not followed when he medical staff failed to problems regarding vior and competency during ht 2's twins in 2005 when they PRP (Labor Delivery Recovery tion Algorithm" guideline s reviewed. The guideline tation as follows:						
֡֡֜֜֜֜֜֜֜֜֜֜֜֜֜֜֜֜֜֜֜֜֜֜֜֜֜֜֜֜֜֜֜֜֜֜֜	PROVIDER OR SUPPLIER FOUNDATION HOSPI SUMMARY STA (EACH DEFICIENCY REGULATORY OR LE Continued From pa Resolution) effective reviewed. The polic under Procedure: 1. When a problem staff involved along care providers woul 2. If the staff were in the unit management assist. 3. The unit manage the situation and assist. 4. If the unit manage resolve the problem be contacted. 5. The nursing sup- situation and assist 6. If the nursing sup- situation and assist 6. If the nursing sup- situation and assist 6. If the problem executive would be the problem continu hospital administration medical staff call resolve the problem executive would be the problem continu hospital administration medical staff call resolve the problem executive would be the problem continu hospital administration medical staff call resolve assistance but was nursing supervisor of The procedure was administration and the address and resolve Physician A's behave the delivery of Patien were identified. On 10/2407, the "LD Postpartum) Escalat effective in 2005 was contained document	PROVIDER OR SUPPLIER FOUNDATION HOSPITAL - FRESNO SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 40 Resolution) effective in 2004 and 2005 was reviewed. The policy contained documentation under Procedure: 1. When a problem was identified on the unit, the staff involved along with the physicians and other care providers would work towards resolution. 2. If the staff were unable to resolve the issue, the unit management team would be contacted to assist. 3. The unit management staff would then assess the situation and assist in solving the problem. 4. If the unit management staff was unable to resolve the problem, the nursing supervisor would be contacted. 5. The nursing supervisor would then assess the situation and assist in solving the problem. 6. If the nursing supervisor was not able to resolve the problem, the service director or nurse executive would be contacted for assistance. If the problem continued to be unresolved, the hospital administrator would be contacted. A medical staff call resource was available for assistance but was to only be called by the nursing supervisor or On-Call administrator. The procedure was not followed when administration and the medical staff failed to address and resolve problems regarding Physician A's behavior and competency during the delivery of Patient 2's twins in 2005 when they	PROVIDER OR SUPPLIER FOUNDATION HOSPITAL - FRESNO SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 40 Resolution) effective in 2004 and 2005 was reviewed. The policy contained documentation under Procedure: 1. When a problem was identified on the unit, the staff involved along with the physicians and other care providers would work towards resolution. 2. If the staff were unable to resolve the issue, the unit management staff would then assess the situation and assist in solving the problem. 4. If the unit management staff was unable to resolve the problem, the nursing supervisor would be contacted. 5. The nursing supervisor would then assess the situation and assist in solving the problem. 6. If the nursing supervisor was not able to resolve the problem, the service director or nurse executive would be contacted for assistance. If the problem continued to be unresolved, the hospital administrator would be contacted. A medical staff call resource was available for assistance but was to only be called by the nursing supervisor or On-Call administrator. The procedure was not followed when administration and the medical staff failed to address and resolve problems regarding Physician A's behavior and competency during the delivery of Patient 2's twins in 2005 when they were identified. On 10/2407, the "LDRP (Labor Delivery Recovery Postpartum) Escalation Algorithm" guideline effective in 2005 was reviewed. The guideline contained documentation as follows:	PROVIDER OR SUPPLIER FOUNDATION HOSPITAL - FRESNO SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 40 Resolution) effective in 2004 and 2005 was reviewed. The policy contained documentation under Procedure: 1. When a problem was identified on the unit, the staff involved along with the physicians and other care providers would work towards resolution. 2. If the staff were unable to resolve the issue, the unit management staff would then assess the situation and assist in solving the problem. 4. If the unit management staff was unable to resolve the problem, the nursing supervisor would be contacted. 5. The nursing supervisor would then assess the situation and assist in solving the problem. 6. If the nursing supervisor was not able to resolve the problem, the service director or nurse executive would be contacted for assistance. If the problem continued to be unresolved, the hospital administrator would be contacted. A medical staff call resource was available for assistance but was to only be called by the nursing supervisor or On-Call administrator. The procedure was not followed when administration and the medical staff failed to address and resolve problems regarding Physician A's behavior and competency during the delivery of Patient 2's twins in 2005 when they were identified. On 10/2407, the "LDRP (Labor Delivery Recovery Postpartum) Escalation Algorithm" guideline effective in 2005 was reviewed. The guideline contained documentation as follows:	PROVIDER OR SUPPLIER FOUNDATION HOSPITAL - FRESNO SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REQULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 40 Resolution) effective in 2004 and 2005 was reviewed. The policy contained documentation under Procedure: 1. When a problem was identified on the unit, the staff involved along with the physicians and other care providers would work towards resolution. 2. If the staff were unable to resolve the issue, the unit management staff was unable to resolve the problem. 4. If the unit management staff was unable to resolve the problem, the nursing supervisor would be contacted. 5. The nursing supervisor was not able to resolve the problem, the service director or urse executive would be contacted. 6. If the nursing supervisor would then assess the situation and assist in solving the problem. 6. If the problem continued to be unresolved, the hospital administrator would be contacted. A medical staff call resource was available for assistance but was to only be called by the nursing supervisor Or-Call administrator. The procedure was not followed when administrator would be contacted. A medical staff call resource was available for assistance but was to only be called by the nursing supervisor or Or-Call administrator. The procedure was not followed when administrator and competency during the delivery of Patient 2's twins in 2005 when they were identified. On 10/2407, the "LDRP (Labor Delivery Recovery Postpartum) Escalation Algorithm" guideline effective in 2005 was reviewed. The guideline contained documentation as follows:	PROVIDER OR SUPPLIER FOUNDATION HOSPITAL - FRESNO SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCIES OF TRESNO, CA 93720) SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCIES OF TRESNO, CA 93720) SUMMARY STATEMENT OF DEFICIENCIES OF TRESNO, CA 93720 SUMMARY STATEMENT OF DEFICIENCIES OF TRESNO, CA 93720 CONTINUED FROM DEFICIENCIES OF THE PROCEDED BY SPULL PREFIX TAG (EACH DEPRICENTE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) CONTINUED FROM BY A 266 Resolution) effective in 2004 and 2005 was reviewed. The policy contained documentation under Procedure: 1. When a problem was identified on the unit, the staff involved along with the physicians and other care providers would work towards resolution. 2. If the staff were unable to resolve the issue, the unit management staff would then assess the situation and assist in solving the problem. 4. If the unit management staff would then assess the situation and assist in solving the problem. 5. The nursing supervisor would then assess the situation and assist in solving the problem. 6. If the nursing supervisor would then assess the situation and assist in solving the problem. 7. The problem continued to be unresolved, the hospital administrator would be contacted. A medical staff call resource was available for assistance, if the problem continued to be unresolved, the hospital administrator would be called by the nursing supervisor or On-Call administrator. The procedure was not followed when administration and the medical staff failed to address and resolve problems regarding Physician A's behavior and competency during the delivery of Patient 2's twins in 2005 when they were identified. On 10/2407, the "LDRP (Labor Delivery Recovery Postparturn) Escalation Algorithm" guideline effective in 2005 was reviewed. The guideline contained documentation as follows:	

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	PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: A. BUILDI		LTIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED		
		050710	B. WING		10/:	25/2007
	PROVIDER OR SUPPLIER FOUNDATION HOSPI	ITAL - FRESNO		TREET ADDRESS, CITY, STATE, ZIP CODE 7300 NORTH FRESNO ST FRESNO, CA 93720		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
A 266	Vocational Nurse/ F was to confer with p Specialist (CNS). 2. Then the Medicabe contacted. 3. Then then the cobe contacted. 4. Then Obstetrical to be contacted. 5. Then if the nursing the RN was to go up the Assistant Physical Administrator on-cale. Before the OB Cobirector could be not could be consulted at The Algorithm was redelivery of Patient 2's deevent" as set forth in much time elapsed if delivery, and the vaccinappropriate. On 10/24/07, The Vaccinappropriate. On 10/24/07, The Vaccinappropriate. On 10/24/07, The Vaccinappropriate. On 10/24/07, The Vaccinappropriate. If progress was not clarify procedure and contraction. If progress was not contraction. If the extractor be (disconnected) 3 tim 3. If 20 to 30 minute	Registered Nurse (LVN/RN) peers and or the Clinical Nurse al Doctor (MD) on-call was to consult with back-up MD was to al (OB) Nursing Manager was ing manager was unavailable, pward to the OB Chief and to cian In Chief (APIC) or MD all, chief was notified, the Service otified and the Perinatologist as needed. not followed during the as twins when staff present elivery "did not escalate the anthe Algorithm when too between vacuum pulls and cuum pulls were facuum Assisted Delivery of 2004 was reviewed. The lify indications of use, raindications of vacuum The procedure as to when to of the vacuum was as not being made with each ecomes disengaged	A 266	3		

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CLIVIL	NO FOR WEDICAN	A MEDICAID SERVICES			OMBIN	<i>J.</i> 0938-039	
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) ML A. BUIL	ULTIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
	, * .	050710	B. WING	3	10/	25/2007	
	PROVIDER OR SUPPLIER	ITAL - FRESNO		STREET ADDRESS, CITY, STATE, ZIP CODE 7300 NORTH FRESNO ST FRESNO, CA 93720		•	
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A 266	The policy was not was not made with hours elapsed betw	being followed when progress each contraction, over two reen the start of the use of the ry, and when injury was noted	A 26	36			
A 310	to the fetal scalp at On 10/25/07 at 8:50 conducted with Adn Administrator G and aware of the incider twins where there w operating room, a p delivery of a non-via policies and proced when concerns abo communicated appl and resolved effecti 482.21(e)(1) EXECT The hospital's gover group or individual w authority and respon hospital), medical st officials are respons ensuring that an one	birth. Dia.m., an interview was ministrator G and Physician C. In Physician C stated they were not in 2005 with Patient 2's was complete disorder in the rolonged vacuum extraction while twin, and quality of care were that were not followed by the physician A were not copriately and/or addressed wely. JTIVE RESPONSIBILITIES who assumes full legal who assumes full legal insibility for operations of the aff, and administrative ible and accountable for going program for quality	A 31	A310: Quality and PI The Hospital disputes this finding. The "High Risk Rounds with the Perinal memo is neither a hospital or medical s nor guideline as identified by the survey Statement of Deficiencies. The memo describe, nor was related to, the practiti	taff policy or in the	Leads: AAQS, Quality Chief	
	maintained. This STANDARD is Based on staff interv	ned, implemented, and not met as evidenced by: iews and administrative ie hospital failed to ensure medical staff, and		privileges. This physician-to-physician not a guideline. The memo from the Interim Chief of the to the practitioner explained the process nursing staff should use to contact the process for orders or consultative services. The did not fail to make rounds as alleged in Statement of Deficiencies because no su with the Clinical Nurse Specialist were real condition of the exercise of the practitic clinical privileges.	department that the ractitioner physician the uch rounds		

PRINTED: 12/11/200 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVE CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 050710 10/25/2007 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 7300 NORTH FRESNO ST KAISER FOUNDATION HOSPITAL - FRESNO **FRESNO, CA 93720** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLÉTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) DATE TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) A 310 Continued From page 43 A 310 administrative officials were responsible and accountable for ensuring that an ongoing program for quality improvement was defined, implemented and maintained when the guideline titled "High Risk Rounds with Perinatologist" was not followed. This failure placed patients at risk for negative health care outcomes. Findings: On 10/24/07 at 8:30 a.m., Administrator G (senior vice president/area manager) was shown a copy of the high risk rounds (reviews) guideline that had been put in place to ensure the perinatal clinical nurse specialist could make rounds with Physician A, and they were reviewed. Administrator G was aware of what it represented and acknowledged that the policy had been put in place. Administrator G did not know that Physician A had been non-compliant with the policy. Administrator G stated that Staff K (Director Quality Management) was the responsible individual within the administration who should have known directly that Physician A was non-compliant with the high risk rounds policy. Administrator G went on to state that Staff K should have been the responsible individual within the administration to convey that information directly to administration. Administrator G acknowledged that was no excuse for not being informed of Physician A's non-compliance with the high risk rounds guideline.

During an interview with Physician C (physician in

chief) and Administrator G (senior vice president/area manager) on 10/24/07 at 9:05 a.m., both stated that they were the responsible

		AND HUMAN SERVICES & MEDICAID SERVICES				FOR	D: 12/11/2007 M APPROVEC D: 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			SURVEY LETED	
	r	050710	B. WI	NG		10/	25/2007
NAME OF PROVIDER OR SUPPLIER KAISER FOUNDATION HOSPITAL - FRESNO				73	EET ADDRESS, CITY, STATE, ZIP CODE 100 NORTH FRESNO ST RESNO, CA 93720		
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A 310	individuals who reprigoverning body, respacknowledged that the guideline that had be perinatal clinical nurrounds with Physicial patients from 8:30 athrough Friday. Both Administrator G agree have such a policy a Physician A comply exception. Both Phy G replied that they we Physician A was non rounds guidelines whattention. They both non-compliance reprimedical staff to be we accountable to the goof medical care provious of medical care provious from the responsible indiving administration who start Physician A's non-corrounds guideline. Start Start Start Physician A's non-corrounds guideline. Start Physician A's non-corrounds guideline. Start Physician A's non-corrounds guideline. Start Physician A's non-corrounds guideline with the high risk rounds administration who start Physic with the high risk rounds guideline to Administration who start Physic with the high risk rounds guideline to Administration who start Physic with the high risk rounds guideline to Administration who start Physic with the high risk rounds guideline to Administration who start Physic with the high risk rounds guideline to Administration who start Physic with the high risk rounds guideline to Administration who start Physic with the high risk rounds guideline to Administration who start Physic with the high risk rounds guideline to Administration who start Physic with the high risk rounds guideline to Administration who start Physic with the high risk rounds guideline to Administration who start Physic with the high risk rounds guideline to Administration who start Physic with the high risk rounds guideline to Administration who start Physic with the high risk rounds guideline to Administration who start Physic with the physic with the high risk rounds guideline to Administration who start Physic with the high risk rounds guideline to Administration who start Physic with the high risk rounds guideline to Administration who start Physic with the physic with	esented Medical Staff and pectively. They both here was a high risk rounds een put in place to ensure the se specialist could make an A as he saw consult and to 9:30 a.m., Monday an Physician C and eed that it was important to end it was important that with the policy without sician C and Administrator ere unaware of the fact that compliant with the High Risk en it was brought to their stated that Physician A's esented a failure of the ell organized and overning body for the quality ded to the patients. a.m., Staff K (Director ell) acknowledged that she was dual within the enould have known about empliance with the high risk aff K also acknowledged that ble individual within the enould have conveyed directly enior vice president/area and A was non-compliant and squideline. Staff K ere was no excuse for not ation regarding Physician A's the high risk rounds ator G (senior vice	A 31	1			
A 311	482.21(e)(1) EXECUT	IVE RESPONSIBILITIES	A 31	1		:	

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD	TIPLE CONSTRUCTION	(X3) DATE S			
050710			B. WING		10/2	25/2007		
NAME OF PROVIDER OR SUPPLIER KAISER FOUNDATION HOSPITAL - FRESNO			s	TREET ADDRESS, CITY, STATE, ZIP CODE 7300 NORTH FRESNO ST FRESNO, CA 93720				
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A 311 Continued From page 45 The hospital's governing body (or organized group or individual who assumes full legal authority and responsibility for operations of the hospital), medical staff, and administrative officials are responsible and accountable for ensuring that an ongoing program for patient safety, including the reduction of medical errors, is defined, implemented and maintained.		A 31	A311: Quality and PI The Hospital has, and has always had, effective, ongoing, hospital-wide, data legally compliant Quality Assessment a Performance Improvement (QAPI) Projection identifies and reduces medical errors a an effective patient safety processes.	driven, and gram that nd includes				
	Based on interview a review, the hospital governing body, mer officials were responsantly including that an one safety, including the was defined, implement the guideline titled "herinatologist" was replaced patients at rist and placed the safet Findings: On 10/23/07 at 3:30 with Staff 3 (perinate stated that Physician with all the policies with all the policies with facility. Staff 3 st Physician A was non rounds guideline that ensure the perinatal	dical staff, and administrative asible and accountable for poing program for patient reduction of medical errors tented and maintained when High Risk Rounds with not followed. This failure sk of increased medical errors		The Hospital disputes this finding and tallegation that the Hospital fails to main ongoing program for patient safety that processes for the reduction of medical. The "High Risk Rounds with the Perina memo is neither a hospital or medical shor guideline as identified by the survey Statement of Deficiencies. The memo describe, nor was related to, the practitiprivileges. The memo from the Interim Chief of the to the practitioner explained the process nursing staff should use to contact the process or consultative services. The did not fail to make rounds as alleged in Statement of Deficiencies because no swith the Clinical Nurse Specialist were racondition of his practice Please refer to "A043(2) Patients 1 and A266: Risk Management Process as a above for further details related to the Hospital's response.	ntain an includes errors. tologist" taff policy yor in the did not ioner's department is that the practitioner physician in the uch rounds equired as			

PRINTED: 12/11/200 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVE CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 050710 10/25/2007 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 7300 NORTH FRESNO ST KAISER FOUNDATION HOSPITAL - FRESNO FRESNO, CA 93720 SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) A 311 Continued From page 46 A 311 patients from 8:30 a.m. to 9:30 a.m. Monday through Friday. Staff stated that Physician A would not notify the birthing center when he was not rounding. In addition on days when he would be rounding, he would not contact the nursing team prior to beginning his rounds as directed in the high risk rounds guideline. Staff 3 stated that Physician A's non-compliance was a serious and significant problem with potential negative impact on the care of his consult patients. Staff 3 also specifically spoke to Physician A's non-compliance with his other assigned perinatology activities within the birthing center. Staff 3 stated that all policies and procedures for review, research, and approval were to be reviewed by Physician A with no more than a one week turn around time. Staff 3 went on to say that Physician A was compliant only intermittently with regard to his policy and procedure review responsibilities. On 10/23/07, the guideline titled "High Risk Rounds with Perinatologist" dated 4/12/06 were reviewed. Rounding (reviewing) time was to be from 8:30 a.m. to 9:30 a.m. Monday through Friday. Physician A was to notify the Birthing Center on the days he was not rounding. Upon arrival to the unit, Physician A was to contact Staff 1 or Staff 3 and contact the Medical Doctor (MD) on call. On 10/24/07 at 9:00 a.m., during an interview with Physician C (physician in chief) and Administrator G (senior vice president/area manager) both stated that they were the responsible individuals who represented Medical Staff and governing body, respectively. They both acknowledged that

there was a high risk rounds guideline that had been put in place to ensure the perinatal clinical

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILD	DING	(X3) DATE SURVEY COMPLETED		
		050710	B. WING	3	10/	25/2007
	NAME OF PROVIDER OR SUPPLIER KAISER FOUNDATION HOSPITAL - FRESNO			STREET ADDRESS, CITY, STATE, ZIP C 7300 NORTH FRESNO ST FRESNO, CA 93720		
(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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	TIVE ACTION SHOULD BE CED TO THE APPROPRIATE	
A 311	Continued From page 47 nurse specialist could make rounds with Physician A as he saw consult patients from 8:30 a.m. to 9:30 a.m. Monday through Friday. Both Physician C and Administrator G agreed that it was important to have such a policy and it was important that Physician A comply with the policy without exception. Both Physician C and Administrator G replied that they were unaware of the fact that Physician A was non-compliant with the rounding policy when it was brought to their attention. Both Physician C and Administrator G replied that they were unaware of the fact that Physician A was non-compliant with his assigned reviews of policies and procedures when it was brought to their attention. They both stated that Physician A's non-compliance represented a failure of the medical staff to ensure that an ongoing program for patient safety, including the reduction of medical errors was defined,		A 31			
A 338	The hospital must he staff that operates us governing body and of care provided to pure the company of the hospital failed to staff that operates us governing body and organized medical staff.	ave an organized medical under bylaws approved by the lis responsible for the quality patients by the hospital. Is not met as evidenced by: record and document review, have a organized medical under bylaws approved by the the hospital failed to have an staff that is responsible for the ded to patients by the	A 338	A338 (1-3) Organized Medical St Since its opening in February 1995 has had a single organized medical operates under its Bylaws which at the Governing Body. The Medical compliance with the Conditions of evidenced by: (1) it conducts period	5, the hospital al staff that re approved by Staff is in Participation as	Leads: AAQS, Quality Chief, Quality Director, AAPCS

	THE POST WILDION	IL & WILDIOAID OLITAIOLO			OMB M	<u>0. 0938-039</u>
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MU A. BUILE	ILTIPLE CONSTRUCTION DING	(X3) DATE COMP	SURVEY	
	050710 B. WING				10	/25/2007
NAME OF	PROVIDER OR SUPPLIER		8	STREET ADDRESS, CITY, STATE, ZIP COD		
KAISER	R FOUNDATION HOSE	PITAL - FRESNO		7300 NORTH FRESNO ST FRESNO, CA 93720		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORE	RECTION	(X5)
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A 338	8 Continued From page 48		A 33	its members as a condition of exerciprivileges in the Hospital; (2) it is accomplished.	sing clinical	
	Findings:			the Governing body for physician-dicare and (3) it enforces its Profession	riven quality of	
	1 The failure of t	the hospital to ensure the		Bylaws.		
		ucted appraisals of its		The CMS Conditions of Participation	(CoP) for	
		o documented evidence of		Hospitals do not require the perform	ance of	
		50 credentialing files. (A 340)		proctoring. The CoP require that the has processes to assess the compet	Medical Staff	
	2 The failure of th	e Hospital to ensure the		medical staff members. The Medical	Staff is	
1	medical staff was			accountable to the Hospital Governir	ig Body for	
1	accountable to the	governing body for the quality		assuring that there is a process for a medical staff members' competencie	ssessment of	
-		provided to the patients when		Fresno Professional Staff Bylaws wh	ich were	
		uct appraisals of their members sional physicians were not		approved by the Hospital Governing	Body	
		ospital Bylaws. (A347)		delineate such processes including the for proctoring in Section H-2. The Ho	spital has an	
**	medical staff enforce	e Hospital to ensure the		active medical staff that is competent and subspecialty services provided to	in specialty its patients.	
		es when 45 of 50 provisional t proctored per the hospital		Refer to attached pages		
1 kg	bylaws. (A353)	productor por tito troopital		338 a through 338 c		
0.8	The cumulative offe	set of those systemic prostices				(II)
76.5	resulted in the failur	ect of these systemic practices re of the hospital to deliver				
1	statutorily mandated	d compliance with the				
	Condition of Particip 482.22	pation: Medical staff, CR §				
four common and a first first		CAL STAFF PERIODIC	A 340	A340: Medical Staff		Leads:
	APPRAISALS	AL OTALT I ELLOSIO	7 0-10	See "A338 Organized Medical Staff"	"tlined	AAQS, Quality
	The sure stant at the se			above.	_as outlined	Chief
	The medical staff medical staf	ust periodically conduct		<u></u>		
	appraisais or is mer	nbers.		The surveyor reviewed a list of 90 phy	sician files	1-3
				for evidence of proctoring, not 50 as st report. The number of files without pro-	ated in the	
				file was 45 at the time of the survey. T	herefore the	
			-	number should have been based on 45	5 of 90, not	
			ľ	45 of 50 as alleged in the Statement of		
			- 1	Deficiencies.		

ID Prefix TAG	Providers' Plan of Correction	Lead and Completion Date
A338	Although proctoring is a part of the process to assure that qualified physicians serve on its medical staff, an entire host of activities act as a check and balance to ensure that a competent and experienced medical staff provides care to patients. The Hospital assures that criteria for appointment of new medical staff members and reappointment of current medical staff members include an assessment of each individual's professional conduct, competence, character, training, experience and judgment. Proctoring is one of the	
	mechanisms that the Medical Staff uses in conducting appraisals of its members. Proctoring has been redesigned (see A043(1) Proctoring Process as outlined above).	
	Evidence of proctoring or plan for completion of proctoring/verification of initial competency will be present in every practitioner's Medical Staff file.	
	Process for New Staff Members: The Hospital has an extensive process for verifying the competency and qualifications of initial	
	applicants, as documented both in the Professional Staff Bylaws, Article B and in its credentialing policies and procedures. Each practitioner's file includes but is not limited to documentation and verification of education, training, licensure, past	
	and current practice, and liability history. Practitioners are also required to submit evidence to substantiate their request for privileges specific to their practice; e.g. surgeons must provide	Sec. 1
	evidence of cases performed in training or in recent practice at facilities where their affiliation is verified to be in good-standing. Residency Training Program Directors are asked to verify applicants'	
	competence. Once a practitioner has been granted privileges, a member of the department is assigned to provide orientation to the medical staff and to observe his/her practice. To enhance the	
	documentation of this process, a proctoring plan and related forms will be implemented and maintained in the practitioners' medical staff file.	
	Actual proctoring and medical record review are conducted within the initial 12 month evaluation period as required in Bylaws Section H-2. No practitioner is advanced from provisional staff status until proctoring has been completed. Should the practitioner not have had a sufficient volume of cases to meet the proctoring	

ID Prefix TAG	Providers' Plan of Correction	ection Lead and Completion Date		
A338	requirement that practitioner's provisional staff status can be extended only for an additional 12 month period. The practitioner must complete proctoring and other conditions of provisional staff status in that additional time frame to remain on the medical staff.			
	During the initial evaluation period, the practitioner is also subject to the quality department's ongoing process. All Medical Staff members, regardless of length of service on the Medical Staff, are subject to this continuous quality appraisal process. Each department has quality indicators which set minimum thresholds for evaluation of competence. Practitioners who do not meet those minimums are subject to a focused peer review which could result in adverse action up to and including revocation of privileges.			
	Process for Continued Membership: Continual evaluation is conducted on all practitioners in accordance with Policy P.15.00 "Provider Profiling and Peer Review and Evaluation of LIP Performance". A summary of performance is provided during bi-annual reappointment as required by the Professional Staff Bylaws, Article B-3 and its credentialing policies and procedures. This summary includes data on complaints, grievances, member satisfaction, mortality rates, admissions, length of stay, inpatient avoidable days, and other areas relating to utilization, medical record review and suspension history, infection rate, transfusion rate, and peer review. Information is again obtained for each practitioner relevant to licensure, practice during the previous two years at our own and other facilities, input from peers, and liability claims. Case volume is compared against requirements for privileges requested to ensure that there is a sufficient number performed to maintain competence. When there is not a sufficient number, the practitioner is not permitted to exercise those privileges until he or she can demonstrate the requisite competence in accordance with Medical Staff requirements. Information collected both for initial appointment and reappointment is reviewed and evaluated by the Chief of the appropriate department or			
	specialty, who makes a recommendation to the C&P Committee, which consists of active staff members representing the various areas of practice. The committee's recommendation is then			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 050710		(X2) MULTII A. BUILDING	PLE CONSTRUCTION	(X3) DATE S COMPL		
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NAME OF PROVIDER OR SUPPLIER KAISER FOUNDATION HOSPITAL - FRESNO			73	EET ADDRESS, CITY, STATE, ZIP C 300 NORTH FRESNO ST RESNO, CA 93720		
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	Based on staff inter document review, the medical staff or members when the evidence of proctor files. This failure renot being reviewed Findings: On 10/18/07, the B for Kaiser Foundation C 4, "To qualify for the Professional St. Perform a sufficient patient care or another communicating to permit the the applicant's curre privileges, whether including completion proctoring as specifically proctoring as specifically proctoring consisting practices and/or proctor professional Star Regulations and hos privileges shall be ebased on criteria estand approved by the Committee. This recommittee.	is not met as evidenced by: erview and administrative the hospital failed to ensure onducted appraisals of its ere was no documented ring in 45 of 50 credentialing esulted in physician practice	A 340			

OLIVILITO I OITIV	ILDIO/ II IL	a mediarno del triono					CIVID IVO	. 0000 00
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			_	(X3) DATE SURVEY COMPLETED	
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Departmeresponsible proctoring compliant Committee shall be for extended Committee year upon initial eval Failure to shall be grand/or climent be sull 10/18/07 staff I, she provisional had no obcredential On 10/18/Physicians objective of files. They proctoring the process Profession Hospital. process dicompeten The Bylaw Foundatio On 10/22/0	and/or other the cole for process was set forting son the me evidence of the evidence o	er organizations. The per designee shall be caused and shall submit and other evidence of Credentials and Privileges approval. The initial evaluation of one (1) year, unless additional period of up to one ation of a good cause. The all not exceed two (2) years. Ally complete initial evaluation of termination of membership ages. Such termination shall wiew under Section B-5." In., during an interview with the the vast majority of the 50 and on the medical staff roster idence of proctoring in their in the 50 provisional edical staff roster had no of proctoring in their exact that the current was not in accordance with in the The Bylaws of the or Kaiser Foundation stated that the current was for the assessment of ely manner as set forth in rofessional Staff for Kaiser	A3	340				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MU A. BUIL	JLTIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED		
		050710	B. WIN	G	10/2	10/25/2007	
	PROVIDER OR SUPPLIER FOUNDATION HOSP	ITAL - FRESNO		STREET ADDRESS, CITY, STATE, ZIP C 7300 NORTH FRESNO ST FRESNO, CA 93720			
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A 340	documentation which out of a total of 50 probjective evidence proctoring in their conditions and their conditions are professional Staff for They both conceder process that was in the Bylaws. Both Stated during the interpretation of the Chief operating of the Creek members of the C	ch established the fact that 45 provisional physicians had no of current and timely redential files. Both Staff I and ted that the proctoring was not both in the The Bylaws of the process of the fact that the current proctoring use could not be found within aff I and Administrator Herview that physician in chief, pofficer of the hospital, ecutive Committee, and indentials and Privileges are of the fact that proctoring as set forth in the the Bylaws. The fact that the current that was in use could not be	A 34	10			
	Physician F, he state the Credentials and stated he was aware proctoring was not be The Bylaws of the P Foundation Hospital also aware of the factorious the Bylaws. He state within the hospital will proctoring and report committees were not bylaws. 482.22(b) MEDICAL The medical staff mulaccountable to the general staff mulaccountable and staff mulaccountable.	a.m., during an interview with ed that he was a member of Privileges Committee. He of the fact that the current reing done as set forth in the rofessional Staff for Kaiser. Physician F stated he was set that the current proctoring use could not be found within d that the Department chiefs no were responsible for the ting to the appropriate t in compliance with the the STAFF ACCOUNTABILITY ast be well organized and overning body for the quality	A 347				
		provided to the patients.					

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	ATEMENT OF DEFICIENCIES ID PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUI	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE COME	E SURVEY PLETED 0/25/2007	
	PROVIDER OR SUPPLIER FOUNDATION HOSP	ITAL - FRESNO		73	REET ADDRESS; CITY, STATE, ZIP COD 300 NORTH FRESNO ST RESNO, CA 93720	T ADDRESS; CITY, STATE, ZIP CODE NORTH FRESNO ST		
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A 347	The medical staff mapproved by the go If the medical staff majority of the membe doctors of medical. The responsibility for the medical staff majority dual doctor of when permitted by staff.	nust be organized in a manner verning body. has an executive committee, a bers of the committee must		347				
	Based on interview a hospital failed to enswell organized and a body for the quality of to the patients. This for not getting care to quality. Findings: During an interview of H on 10/22/07 at 8:0 documentation which	and document review, the sure the medical staff was accountable to the governing of the medical care provided failure placed patients at risk hat was driven by physician with Staff I and Administrator 0 a.m., Staff I produced a established the fact that 45 dovisional physicians had no		TI B CC m gc fo cc By Gc	The Medical Staff is accountable to the Body for physician-driven quality of cathe Conditions of Participation require fedical Staff have processes to assess ompetence of medical staff members nedical staff is accountable to the host overning body for assuring that there or assessment of medical staff members of medical staff members of the process of the KFH Fresno Professions, which were approved by the Foverning Body, delineates such proceduding the requirement for proctoring	e that the ss the s. The spital e is a process ers' essional Staff Hospital esses	Leads: AAQS, Quality Chief	

PRINTED: 12/11/20 FORM APPROVI OMB NO. 0938-03

CENTE	RS FOR MEDICAR	E & MEDICAID SERVICES			OMB NO	. 0938-03
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE S COMPLE	
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	PROVIDER OR SUPPLIER	ITAL - FRESNO	S	TREST ALDRESS, CITY, STATE, ZIP C 7300 NORTH FRESNO ST FRESNO, CA 93720		
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A 347	proctoring in their of Administrator H state being done as set in Professional Staff Hospital. They both proctoring process found within the By Administrator H state the physician in chirof the hospital, mer Committee, and m Privileges Committee and m Privileges Committee and the current proctoric could not be found Staff I went on to seen to the appropriate deficient proctoric could not be found Staff I went on to seen to the appropriate deficient proctoric could not be found Staff I went on to seen to the appropriate deficient proctoric could not be found Staff I went on to seen to the appropriate deficient proctoric could not be found Staff I went on to seen to the appropriate deficient proctoric could not be found Staff I went on to seen to the appropriate deficient proctoric could not be found Staff I went on to seen to the appropriate deficient proctoric could not be found Staff I went on to seen to the appropriate deficient proctoric could not be found Staff I went on to seen to the appropriate deficient proctoric could not be found Staff I went on to seen to the appropriate deficient proctoric could not be found Staff I went on to seen to the appropriate deficient proctoric could not be found Staff I went on to seen to the appropriate deficient proctoric could not be found Staff I went on to seen to the appropriate deficient proctoric could not be found Staff I went on to seen to the appropriate deficient proctoric could not be found staff I went on to seen to the appropriate deficient proctoric could not be found staff. I went on the staff I went on t	of current and timely credential files. Both Staff I and ated that the proctoring was not forth in the The Bylaws of the for Kaiser Foundation histated that the current that was in use could not be laws. Both Staff I and ated during the interview that eff, the chief operating officer embers of the Executive embers of the Credentials and see were aware of the fact that being done as set forth in the ealso aware of the fact that and process that was in use	A 34	H-2. The CMS Conditions of Part Hospitals do not explicitly require of proctoring. Although proctoring is a part of the assure that quality physicians served that a compete experienced medical staff provided the hospital assures that criterianew medical staff members and recurrent medical staff members and recurrent medical staff members included, competence, character, experience and judgment. Proctomechanisms that the Medical Staff conducting appraisals of its members included monitoring reports related practitioner's proctoring status whimonthly from C&P Committee to the further evidence of the MEC's accessuring that quality of care provided evaluated in a systematic and considered the process.	the performance the process to the process t	

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CLIVIE	TIOT OF MEDICAL	L & MEDICAID SETTICES			OIVID IVC	7. 0930-00
	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MU A. BUIL	ULTIPLE CONSTRUCTION DING	(X3) DATE S	
		050710	B. WING	G	10/2	25/2007
	PROVIDER OR SUPPLIER FOUNDATION HOS			STREET ADDRESS, CITY, STATE 7300 NORTH FRESNO ST FRESNO, CA 93720		
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A 347	Continued From p	age 54	A 34	47		
		with the "The Bylaws of the				
	Hospital." He were Department chiefs proctoring and rep stated there was a at different levels a	for Kaiser Foundation int on to state that the individual is were overwhelmed with their corting responsibilities. He also in abdication of responsibilities among Department chiefs, key ars and the members of the attion.				
	chief) and Administ president/area mana.m., both stated to individuals who reproduced in the lack of prostore that the lack of medical staff to accountable to the of medical care prostore that the lack of medical care prostore that the lack of the lack o	with Physician C (physician in trator G (senior vice mager) on 10/24/07 at 9:00 that they were the responsible presented Medical Staff and spectively. They both stated ctoring for 45 out of a total of sicians represented a failure of be well organized and governing body for the quality by				
	Executive Committ proctoring issue. For complexity of this is appropriately escal responsible individual body.	ee members to address the urther she stated that the full ssue had not been directly and lated to her attention as the ual representing governing				
A 353	482.22(c) MEDICA	L STAFF BYLAWS	A 353	3		
	The medical staff medical staf	nust adopt and enforce bylaws onsibilities.				

PRINTED: 12/11/20 DEPARTMENT OF HEALTH AND HUMAN SERVICES. FORM APPROV CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-03 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 050710 10/25/2007 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 7300 NORTH FRESNO ST KAISER FOUNDATION HOSPITAL - FRESNO **FRESNO, CA 93720** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETIC TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) A 353 Continued From page 55 A 353 A353: Medical Staff Leads: This STANDARD is not met as evidenced by: AAQS. Based on staff interview and administrative Refer to A043(1) Proctoring Process as outlined Quality document review, the hospital failed to ensure above. Chief the medical staff enforced bylaws to carry out its responsibilities when 45 of 50 provisional Proctoring has been redesigned to assure the physicians were not proctored per the hospital Medical Staff's compliance with its Professional Bylaws. This failure placed patients at risk of not Staff Bylaws, and in particular in those provisions receiving quality patient care. of the Bylaws related to assessing the competence of provisional staff members. Findings: The surveyor reviewed a list of 90 physician files On 10/22/07 at 8:00 a.m., Staff I produced a for evidence of proctoring, not 50 as stated in the Summary of Progress on Proctoring dated report. The number of files without proctoring on 10/25/07 that directly related to the flow of file was 45 at the time of the survey. Therefore, the information regarding non-compliance with the number should have been based on 45 of 90, not proctoring and credentialing process. Staff 1 45 of 50 as alleged in the Statement of stated that as medical staff services supervisor Deficiencies she presented reports on proctoring progress and non-compliance on a monthly basis to the Credentials & Privileges Committee, Staff I stated that after the Credentials & Privileges Committee was notified, the appropriate Department chairs were notified regarding the deficient proctoring of provisional physicians. Staff I went on to say that it was the responsibility of the Credentials & Privileges Committee as well as the Executive committee to work with the department chairs as a means of ensuring their cooperation regarding progress on proctoring. Staff I produced objective documentation which substantiated the appropriate individuals had been notified in a timely manner however had not cooperated as requested. The Bylaws contained documentation under Section H-2 that "the initial evaluation shall be for a period of one (1) year. unless extended by the Credentials and Privileges

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This STANDARD is not met as evidenced by:

Based on staff interview, clinical record review.

and administrative document review; the hospital

failed to ensure surgical services were consistent

Consistent with that review is a summary of followup actions that occurred immediately after the event involving Patient 2 to re-educate the clinical staff and medical staff of the policies and their

respective accountability to comply with the

policies. Ongoing education continues through

nursing forums, patient care team meetings and

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	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) ML	ULT) DATE S	URVEY
	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL			COMPL	
		050710	B. WIN	G		10/2	25/2007
NAME OF F	PROVIDER OR SUPPLIER			STF	REET ADDRESS, CITY, STATE, ZIP CODE		
KAISER	FOUNDATION HOSP	ITAL - FRESNO			300 NORTH FRESNO ST		
				F	RESNO, CA 93720		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETI DATE
	(Patient 1 & 2). Poli were not designed a maintenance of high practice when there for the transition fro surgical intervention risk for delayed surgical intervention risk for delayed surgical intervention risk for delayed surgical intervention. 1. On 10/23/07 at 1 record was reviewed preterm (about three polyhydramnios (and the fetus in pregnant hospital's labor and 1/28/04 at 4:15 p.m. contractions (uterus Her contractions (uterus Her contractions we 60 to 70 seconds, howere 154, and her might full discontinuity, and her might full discontinuity, Patient 1 continuity, Patient 1 continu	cies governing surgical care to assure the achievement and in standards of medical was no policy and procedure in a vaginal delivery to in. This placed the patients at gical interventions. :00 p.m., Patient 1's clinical delivery department on with complaints of uterine squeezes) since 1:30 p.m re 2 to 4 minutes apart lasting or babies' fetal heart tones in the delivery department on with complaints of uterine squeezes) since 1:30 p.m re 2 to 4 minutes apart lasting or babies' fetal heart tones in the delivery department on with complaints of uterine squeezes) were intact. Patient 1 in get that inhibited preterm at 4:25 p.m. In spite of the nued to have contractions. In dated 1/28/04 at 6:09 p.m. ation of contractions five the status of the the status of the reconstructions were of the status of the reconstructions were of the p.m., contractions were	A 9	7771188 CC 88 P	1. A Root Cause Analysis (RCA) was performatter the event on 05/19/2005. During that R review of Chain of Command policy, the LDR Escalation Log Algorithm, and Vacuum Assis Delivery policy were all reviewed with the state 2. Perinatal Patient Safety Project Committee (PPSC) implemented in 03/01/2005. Multidisciplinary group consisting of staff, physicians and departmental managers. Dur meetings held from 03/05 through 10/05, issue addressed included but were not limited to: Of Command policy reviewed and revised, LD and Neonatal escalation algorithms developed and implemented SBAR communication and Human Factor training completed. 3. Critical Events Training for staff completed 10/05 (focus communications, team effectiveness). 4. Vacuum Assisted Delivery Policy revised a education completed by 11/05. 5. The current OB inpatient chief was designated by the Interim Department Chief to lead performance improvement activities with departmental manager in 2005 (Also serves as of the co-chairs of Perinatal Service Performance mprovement Committee). 5. Perinatology Algorithm for consultation requests amended and distributed to physician and staff. 7. Departmental Structure Standards updated 2/06. Section 2(F) — Consultation of Medical Staff outlines responsibilities of consulting and all physicians. 6. Vacuum Assisted Delivery Perinatal Service Performs and Staff outlines responsibilities of consulting and all physicians. 6. Vacuum Assisted Delivery Perinatal Service Performs and Staff outlines responsibilities of consulting and all physicians.	RCA, RP sted aff. see uring ues Chain DRP sed d in and sated as one ance uns d l d on-	05/19/05 03/01/05 ongoing 10/05 11/05 07/06 12/06 03/07 and ongoing
	170 with late deceler At 8:04 p.m., contrac	ations and poor variability. tions were three to four for 50 seconds, and fetal		9 p	when to proceed to C-Section. Education initiated in 03/07 for staff and hysicians on new Vacuum Assisted Delivery evice implemented in 05/07. Device is handle		03/07 and ongoing

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD	LTIPLE CONSTRUCTION DING	(X3) DATE SI COMPLE	
		050710	B. WING		10/2	5/2007
	PROVIDER OR SUPPLIER FOUNDATION HOSP	ITAL - FRESNO	s	TREET ADDRESS, CITY, STATE, ZIP CODE 7300 NORTH FRESNO ST FRESNO, CA 93720		
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A 951	decelerations and parrived at Patient 1	paseline of 150 to 170 with late poor variability. Physician A is bedside to evaluate her at	A 95	of Command and escalation process at Care Team meetings.	t Patient	06/01/07
	inches), and "late d uterine contractions p.m., the drug to sto discontinued. At 8: minutes apart lastin tones with a baselin decelerations occur variability. At 10:18	surement that is similar to eccelerations were noted with by Physician A. At 8:05 pp preterm labor was 20 p.m., contractions were 5 g 50 seconds, and fetal heart e of 170 with late ring consistently, and poor p.m., contractions were two		In 2007, the following activities have on staff and physicians regarding responsi reporting and escalating quality of care 1. Critical Events Training – 10/23/07 to 10/25/07(was scheduled prior to the Va Survey occurring). Perinatal staff and participated with primary goal of improve communication and team effectiveness. exercises which involved emergency deduring training.	ibilities for issues: hrough lidation physicians ing Had	10/25/07
	tone baseline was 1 after each contraction 1's membranes wer p.m., and at 11:08 p	g 60 seconds, and fetal heart 50 with late decelerations on and poor variability. Patient e artificially ruptured at 11:00 o.m. contractions were two g 60 seconds and the fetal		2. Highly Reliable Surgical Team (HRS program implemented in 08/07 – Perinal Services physicans and staff participatin goals: Implement standardized commur techniques in every OR, Every proceduriday.	tal gg. Primary nication e, Every	08/07 and ongoing
	decelerations after evariability. At 11:40 nursing care of Patie regarding the fetal medecelerations to Phymonitoring strip indicated decelerations and powas taken to the operation at 1:03 a.m.	each contraction and poor p.m., Staff 2 took over the ent 1. Staff 2 voiced concerns nonitoring strip and the late vician A. The fetal cated consistent late por variability until Patient 1 erating room for a cesarean on 1/29/04. Patient 1's labor one to two centimeters at		3. Responsible Reporting Forms (RRF) and reporting of quality concerns and/or errors. Staff are continually re-educated importance of reporting medical errors ar quality of care concerns via RRF reportin utilizing the Oops line for a verbal messal indicators, such as shift, care provider, or human factors, etc., are entered and track the Risk database. Trends are reviewed, analyzed and presented to OPIC and ME review and action minimally 4 times a year	medical on the nd/or ng tools or ge. Data utcomes, ked in C for	ongoing
	cesarean section at Report). The fetal in blood flow to the place nourished the fetus) poor neurological (ne indicated by poor var Patient 2's baby was	1:03 a.m. (per the Operative monitor strip indicated poor centa (mothers' organ that by late decelerations and ervous system) status as riability for three hours. delivered by cesarean ons for the cesarean section		4. Significant Event education and report (including SB 1301, 1312). Education to physicians occurred 5/24/07 and 8/2/097 (1301/1312 reporting guidelines. Additional education to staff at leadership, departments staff huddles to increase awareness for refrequirements. Staff expected to follow Sig Event Reporting policy. Significant Event presented at MEC each month by Chief of	for SB al ntal and porting inficant	5/24//07 an ngoing

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the incident with the birth of Patient 1's baby in 2004 "should have been escalated" and that there

Command/Conflict Resolution that was not followed. Staff 3 stated that there was a "violation of common sense and standard of practice" in the care delivered by Physician C to Patient 1 during her babies' delivery in 2004. Patient 1's baby died

was a policy in place for Chain of

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		050710	B. WII	NG _		10/25/2007	
	PROVIDER OR SUPPLIER	TAL - FRESNO		7:	REET ADDRESS, CITY, STATE, ZIP COI 300 NORTH FRESNO ST FRESNO, CA 93720	DE	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	72000	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETIC DATE
	months later after g On 10/24/07, the Ch Resolution) effective reviewed. The policy under Procedure: 1. When a problem staff involved along care providers would 2. If the staff were us the unit management assist. 3. The unit manage the situation and assist. 4. If the unit manage resolve the problem, be contacted. 5. The nursing supe situation and assist if 6. If the nursing supe situation and assist if 6. If the nursing supe resolve the problem, executive would be of the problem continue hospital administration medical staff call res assistance but was to nursing supervisor of The procedure was re administration and the address and resolve Physician A's behavi the delivery of Patien identified. On 10/25/07 at 8:50 a conducted with Admin	nain of Command (Conflict in 2004 and 2005 was by contained documentation) was identified on the unit, the with the physicians and other diwork towards resolution. Inable to resolve the issue, in team would be contacted to ment staff would then assess sist in solving the problem. In the nursing supervisor would be revisor would then assess the in solving the problem. In the service director or nurse contacted for assistance. If the service director or nurse contacted for assistance. If the dot of the unresolved, the in would be contacted. A cource was available for confly be called by the conformal administrator. In the followed when the medical staff failed to problems regarding or and competency during the laby when they were the a.m., an interview was instrator G and Physician C.	A	951			
,	Administrator G and I	Physician C stated they were					

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S FOR MEDICARE	& MEDICAID SERVICES			OMB NO	<u>). 0938-03</u>
OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE S COMPL	
	050710	B. WING _	-A	10/2	25/2007
ROVIDER OR SUPPLIER	ITAL - FRESNO	7	300 NORTH FRESNO ST	Œ	
			HESNO, CA 93720		
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION	SHOULD BE	(X5) COMPLETIC DATE
aware of the incide there was complete room, prolonged lal progression to a ce	nt in 2004 with Patient 1 where disorder in the operating bor with an untimely sarean section, and no	A 951			
record was reviewed documentation in the py Physician A, Pat thospital on 4/21/05 diagnosis of twins a gestational diabetes Patient 1 progresse 10:15 p.m. and 0 stays taken to the optoble set up for two was a normal vaginal (21/05 with Apgar second) fetal heart rangembranes (bag eretus) was performe the head was at +1 tead in the cavity for each of the pressure exception at 10:58 performed to the push and no pot the push and on, and was for and 0, and was for and 0, and was and pot the push and on and on and was and on and on and was and the push and on and on and was and the push and the	d. According to the Discharge Summary written tient 2 was admitted to the at 11:50 a.m. with the at 37 weeks and uncontrolled of for induction (causing labor). If the complete dilatation at attention (ready for delivery) and the erating room at 10:25 p.m. for in vaginal delivery. Twin A all delivery at 10:43 p.m. on scores of 9. After delivery of vertex (head down) with a te. Active rupture of the erating fluid surrounding the dilatation and clear fluid was noted. In station (the level of the fetal remed by the bones of the hip). It is assisted by medication. In initiation, wacuum extractions of the minimum were ad came down to +2 station. In the				
	CONTINUED FROM PARTICIPATION AND PROVIDER OR SUPPLIER COUNDATION HOSP SUMMARY STA (EACH DEFICIENCY REGULATORY OR LETTER CONTINUED FROM PARTICIPATION FROM PARTICIPATION FROM PARTICIPATION FROM PARTICIPATION FROM PARTICIPATION PROVIDED TO THE PARTICIPATION PARTICIPATION PROVIDED TO THE PARTICIPATION PARTICIPATION PROVIDED TO THE PARTICIPATION PARTICIP	OF DEFICIENCIES F CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 050710	OF DEFICIENCIES CORRECTION (X1) PROVIDER SUPPLIER DOUNDATION HOSPITAL - FRESNO SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 61 aware of the incident in 2004 with Patient 1 where there was complete disorder in the operating room, prolonged labor with an untimely progression to a cesarean section, and no guidance for an escalation of concerns. 2. On 10/18/07 at 2:00 p.m., Patient 2's clinical record was reviewed. According to documentation in the Discharge Summary written by Physician A, Patient 2 was admitted to the pospital on 4/21/05 at 11:50 a.m. with the diagnosis of twins at 37 weeks and uncontrolled destational diabetes for induction (causing labor). Patient 1 progressed to complete dilatation at 10:15 p.m. and 0 station (ready for delivery) and vas taken to the operating room at 10:25 p.m. for induction set up for twin vaginal delivery. Twin A vas a normal vaginal delivery at 10:43 p.m. on 1/21/05 with Apgar scores of 9. After delivery of 5 win A, Twin B was vertex (head down) with a good "fetal heart rate. Active rupture of 9 nembranes (bag encasing fluid surrounding the 10 per 10 p	OCOMPACTION (X1) PROVIDER SUPPLIER (X2) MULTIPLE CONSTRUCTION A, BUILDING B, WING STREET ADDRESS, CITY, STATE, ZIP COL 7300 NORTH FRESNO ST FRESNO, CA 93720 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEPOLIENCY MUST BE PRECEDED BY FULL REQULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 61 aware of the incident in 2004 with Patient 1 where there was complete disorder in the operating from prolonged labor with an untimely progression to a cesarean section, and no guidance for an escalation of concerns. 2. On 10/18/07 at 2:00 p.m., Patient 2's clinical record was reviewed. According to documentation in the Discharge Summary written by Physician A, Patient 2 was admitted to the indignosis of fwins at 37 weeks and uncontrolled gestational diabetes for induction (causing labor). Patient 1 progressed to complete dilatation at 10:15 p.m. and 0 station (ready for delivery) and was taken to the operating room at 10:25 p.m. for louble set up for twin vaginal delivery. Twin A was a normal vaginal delivery at 10:43 p.m. on 12/105 with Apgar scores of 9. After delivery of win A, Twin B was vertex (head down) with a good fetal heart rate. Active rupture of membranes (bag encasing fluid surrounding the etus) was performed and clear fluid was noted. The head was at +1 station (the level of the fetal ead in the cavity formed by the bones of the hip). Tatient 1's labor was assisted by medication. If the waiting for 40 minutes, vacuum extractions rere tried at 10:58 p.m. to accelerate delivery, we attempts with no pop-off (vacuum pops off hen pressure exceeds the minimum) were nade. The fetal head came down to +2 station. We more vacuum attempts and the head came down to +3 station. The vacuum was applied one to the public and no pop-off, Twin B was very pale, had Appars 10 and 0, and was resuscitated for 20 minutes and expired at 12:242 a.m. on 4/22/05. Vacuum	OF DEPICIENCIES (X1) PROVIDER OR SUPPLIER OSO710 STREET ADDRESS, CITY, STATE, 2IP CODE TOUNDATION HOSPITAL - FRESNO SUMMARY STATEMENT OF DEPICIENCIES (EACH DEPICIENCY MIST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 61 Warring of the incident in 2004 with Patient 1 where there was complete disorder in the operating room, prolonged labor with an untimely progression to a cesarean section, and no guidance for an escalation of concerns. 2. On 10/18/07 at 2:00 p.m., Patient 2's clinical record was reviewed. According to documentation in the Discharge Summary written by Physician A, Patient 2 was admitted to this lidighosis of twins at 37 weeks and uncontrolled pestational diabetes for induction (causing labor). Patient 1 progressed to complete dilatation at 10:15 p.m. and 0 station (ready for delivery) and was taken to the operating room at 10:25 p.m. for touble set up for twin vaginal delivery at 10:43 p.m. on 12/1/05 with Apgar scores of 9. After delivery of win A, Twin B was vertex (head down) with a good' fetal heart rate. Active rupture of membranes (bag encasing fluid surrounding the etus) was performed and clear fluid was noted. The head was at +1 station (the level of the fetal ead in the cavity formed by the bones of the hip), ratient 1's labor was assisted by medication, fiter waiting for 40 minutes, vacuum extractions ere tried at 10:38 p.m. to accelerate delivery, we attempts with no pop-off (vacuum pops off when pressure exceeds the minimum) were noted. The results with no pop-off (vacuum pops off when pressure exceeds the minimum) were noted the development of the station. The vacuum was applied one nore time due to maternal exhaustion, and with ne push and no pop-off, Twin B was delivered 1:12:22 a.m Twin B was very pale, had Apgars 0 and 0, and was resuscitated for 20 minutes developed the process of the proces

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were "good" until the last vacuum extraction. Staff 6 stated that on the last vacuum extraction that resulted in the delivery of Twin B, Physician A was on his hands and knees and pulled and was rough. Staff 6 stated that the baby was born

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILD		(X3) DATE SURVEY COMPLETED	
		050710	B. WING			
	PROVIDER OR SUPPLIER	ITAL - FRESNO	STREET ADDRESS, CITY, STATE, ZIP CO 7300 NORTH FRESNO ST FRESNO, CA 93720		DE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	dead, and Physicial everyone else sayir stated that Physicial them what to chart. was written up before was nothing done a hard to work with Plat the nurses, haras listen to them. Staff in the surgical room. On 10/22/07 at 8:40 conducted with Staff analysis of the incide Overview SE 05-00-documentation that "technique in extract teamwork, commun." On 10/23/07 at 3:10 conducted with Staff supervisor, she was lashed out at the nurbaby was born dead that he "Only gave a room during the vac Patient 2 in 2005 told "pulled with a jerk m stated that Physician extraction policy and use the vacuum extreme beyond what any oth have. After the delive 2004, the quality of cattention of the NE in back on call two days stated there was a Le Postpartum (LDRP)	n A was angry and yelled at ng it was their fault. Staff 6 in A harassed others and told Staff 6 stated that Physician A re this and after, and there bout it. Staff 6 stated it was hysician A because he yelled seed them, and would not of 6 stated there was no control during the delivery. I a.m. an interview was of 4 regarding the hospitals' ent with Patient 2. The	A 95	1		

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 12/11/20 FORM APPROVE OMB NO. 0938-03

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			OMB NO. 0938-03
STATEMEN	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		050710	B. WING		10/25/2007
	ROVIDER OR SUPPLIER	ITAL - FRESNO	S	TREET ADDRESS, CITY, STATE, ZIP COI 7300 NORTH FRESNO ST FRESNO, CA 93720	DE
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE COMPLETI
A 951	during Patient 2's devent" as set for the taking too long" and inappropriate. After in the operating root stated there was no	ige 64 f 1 stated that staff present elivery "did not escalate the e in the Algorithm when "it was d the "vacuum pulls" were the incidents during delivery om of Patient 2's twins, Staff 1 of feedback given about any addressed Physician A's	A 95	1	
	conducted with Starcare in the operatin when Patient 2's Tw stated that Physicia in the operating roo "technique method extraction) was forcultimately separated a "nuchal (neck) co and that was why the come down". Staff ready for a cesarea listen. Staff 5 states he promised Patien stated "we are going Physician A harasse staff what they should be conducted with Staff policy for vaginal de extraction that trans was requested. Staff	5 p.m., an interview was if 5. Staff 5 took over nursing g room the night of 4/22/05 win B was delivered. Staff 5 in A screamed and mumbled in. Staff 5 stated that the of the last one (vacuum reful, adamant, and rough and id the spinal cord." Twin B had rd around the neck one time, re babies head would not 5 asked if Physician A was in section, and he did not id Physician A had stated that it 2 a vaginal delivery and ig to do this." Staff 5 stated and staff when charting and told and say. Physician A told Staff if was gentle suction on Twin p.m., an interview was if 1 and Staff 3. The hospital's liveries with vacuum ition into cesarean sections if 1 and Staff 3 stated that res regarding vaginal deliveries			

PRINTED: 12/11/200 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVE OMB NO. 0938-039 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING B. WING 050710 10/25/2007 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 7300 NORTH FRESNO ST KAISER FOUNDATION HOSPITAL - FRESNO FRESNO, CA 93720 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X4) ID COMPLETION (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) A 951 Continued From page 65 A 951 cesarean section. On 10/24/07, the policy titled "Chain of Command (Conflict Resolution)" effective in 2004 and 2005 was reviewed. The policy contained documentation under Procedure: 1. When a problem was identified on the unit, the staff involved along with the physicians and other care providers would work towards resolution. 2. If the staff were unable to resolve the issue. the unit management team would be contacted to assist. 3. The unit management staff would then assess the situation and assist in solving the problem. 4. If the unit management staff was unable to resolve the problem, the nursing supervisor would be contacted. 5. The nursing supervisor would then assess the situation and assist in solving the problem. 6. If the nursing supervisor was not able to resolve the problem, the service director or nurse executive would be contacted for assistance. If the problem continued to be unresolved, the hospital administrator would be contacted. A medical staff call resource was available for assistance but was to only be called by the nursing supervisor or On-Call administrator. The procedure was not followed when administration and the medical staff failed to address and resolve problems regarding Physician A's behavior and competency during the delivery in the operating room of Patient 2's twins in 2005 when they were identified.

On 10/2407, the "LDRP (Labor Delivery Recovery Postpartum) Escalation Algorithm" guideline effective in 2005 was reviewed. The guideline

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NAME OF PROVIDER OR SUPPLIER KAISER FOUNDATION HOSPITAL - FRESNO (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION): A 951 Continued From page 66 contained documentation as follows: 1. For clinical practice issues, the Licensed Vocational Nurse/ Registered Nurse (LVN/RN) STREET ADDRESS, CITY, STATE, ZIP CODE 7300 NORTH FRESNO ST FRESNO, CA 93720 DPREFIX (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) A 951 Continued From page 66 A 951 Contained documentation as follows:	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) A 951 Continued From page 66 contained documentation as follows: 1. For clinical practice issues, the Licensed Vocational Nurse/ Registered Nurse (LVN/RN)			050710	B. WI	1G		10	/25/2007
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) A 951 Continued From page 66 contained documentation as follows: 1. For clinical practice issues, the Licensed Vocational Nurse/ Registered Nurse (LVN/RN)		14 187	ITAL - FRESNO		730	00 NORTH FRESNO ST	DE	
1. For clinical practice issues, the Licensed Vocational Nurse/ Registered Nurse (LVN/RN)	PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	SHOULD BE	(X5) COMPLETIC DATE
was to confer with peers and or the Clinical Nurse Specialist (CNS). 2. Then the Medical Doctor (MD) on-call was to be contacted. 3. Then then the consult with back-up MD was to be contacted. 4. Then Obstetrical (OB) Nursing Manager was to be contacted. 5. Then if the nursing manager was unavailable, the RN was to go upward to the OB Chief and to the Assistant Physician In Chief (APIC) or MD Administrator on-call. 6. Before the OB Chief was notified, the Service Director could be notified and the Perinatologist could be consulted as needed. The Algorithm was not followed during the delivery of Patient 2's twins when staff present during Patient 2's delivery "ciid not escalate the event" as set forth in the Algorithm when too much time elapsed between vacuum pulls and delivery, the vacuum pulls were inappropriate, and there was complete disorder in the delivery/operating room. On 10/24/07, The Vacuum Assisted Delivery policy dated March of 2004 was reviewed. The purpose was to clarify indications of use, procedure and contraindications of vacuum assisted deliveries. The procedure as to when to discontinue the use of the vacuum was as follows: 1. If progress was not being made with each contraction.		1. For clinical practi Vocational Nurse/F was to confer with p Specialist (CNS). 2. Then the Medica be contacted. 3. Then then the co be contacted. 4. Then Obstetrical to be contacted. 5. Then if the nursi the RN was to go up the Assistant Physic Administrator on-ca 6. Before the OB C Director could be no could be consulted a The Algorithm was r delivery of Patient 2's de event" as set forth in much time elapsed if delivery, the vacuum and there was comp delivery/operating ro On 10/24/07, The Va policy dated March of purpose was to clarif procedure and contra assisted deliveries. discontinue the use of follows: 1. If progress was no	ce issues, the Licensed Registered Nurse (LVN/RN) beers and or the Clinical Nurse al Doctor (MD) on-call was to consult with back-up MD was to (OB) Nursing Manager was an an anger was unavailable, bward to the OB Chief and to clian In Chief (APIC) or MD III, whier was notified, the Service of the Algorithm when too between vacuum pulls and in pulls were inappropriate, blete disorder in the form. Cacuum Assisted Delivery of 2004 was reviewed. The findications of use, aindications of vacuum The procedure as to when to of the vacuum was as	AS)51			

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		050710	B. WING		10/	25/2007
	PROVIDER OR SUPPLIER FOUNDATION HOSP	ITAL - FRESNO	7	REET ADDRESS, CITY, STATE, ZIP O 7300 NORTH FRESNO ST FRESNO, CA 93720	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	ON SHOULD BE E APPROPRIATE	(X5) COMPLETIC DATE
A 951	2. If the extractor be (disconnected) 3 tird 3. If 20 to 30 minut 4. If trauma (injury) The policy was not was not made with hours elapsed betwork vacuum until deliver inappropriate, and vertical scalp at birth. On 10/25/07 at 8:50 conducted with Administrator G and aware of the incident twins where there we operating room, a prodelivery of a non-via policies and procedu when concerns about the concerns are concerns about the concerns are concerns about the concerns are concerns about the concerns and concerns are concerns about the concerns are concerns and concerns are concer	pecomes disengaged mes. The ses elapsed without success. The scalp was observed. The scalp was observe	A 951			