DEPARTMENT OF HEALTH AND HUMAN SERVICES Centers for Medicare and Medicaid Services (CMS)		AH FORM APPROVED OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CL1A IDENTIFICATION NUMBER: 050071	(X2) MULTIPLE CONSTRUCTION A. BUILDING_____ B. WING_____	(X3) DATE SURVEY COMPLETED **03/02/2005**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KAISER FOUNDATION HOSPITAL – Santa Clara	**900 KIELY BLVD SANTA CLARA, CA 95050**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A000	INITIAL COMMENTS The following reflects the findings of the Department of Health Services during a Federal validation survey. Representing the Department of Health Services: Glenn Koike, Health Facilities Evaluator Nurse; Brenda Ryan, Health Facilities Evaluator Nurse; Michael Bennett, M.D.., Medical Consultant; and Magda Gabali, Pharm.D., Pharmacist Consultant.	A000	STATE DEPARTMENT OF HEALTH SERVICES SAN JOSE APR 0 7 2005 LICENSING & CERTIFICATION DIVISION	
A141	482.21 QUALITY ASSESSMENT & PERFORMANCE IMPROVEMENT The hospital must develop, implement and maintain an effective, ongoing, hospital-wide, data-driven quality assessment and performance improvement program. The hospital's governing body must ensure that the program reflects the complexity of the hospital's organization and services; involves all hospital departments and services (including those services furnished under contract or arrangement); and focuses on indicators related to improved health outcomes and the prevention and reduction of medical errors. The hospital must maintain and demonstrate evidence of its QAPI program for review by CMS. This condition is not met as evidenced by: Based on record review and staff interview, the hospital failed to implement and maintain an effective quality assessment and performance improvement plan.	A141		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare and Medicaid Services (CMS)

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CL1A IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	050071	A. BUILDING _____ B. WING _____	03/02/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KAISER FOUNDATION HOSPITAL – Santa Clara	**900 KIELY BLVD SANTA CLARA, CA 95050**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A141	Findings include: The hospital's quality assessment and performance and improvement plan included data collection for unusual events, that affected the health and safety of patients. The plan was dependent on 'immediate' reporting to the quality and risk department for these events. The hospital had an average daily census of 230 patients. Four of 22 patient charts reviewed (Patients 1, 2, 33 and 34) had events that met the hospital's criteria for the quality improvement program to improve the health outcomes of patients and to prevent medical errors. The hospital failed to implement this program as identified in: See A 142 the hospital's failure to implement the hospital-wide quality program.	A141	The quality assessment and performance improvement program at Kaiser Foundation Hospital Santa Clara is governed by the Medical Executive Committee. This body is responsible for reviewing the performance of the organization and recommending actions to improve care. Activities related to patient safety are overseen by the Risk Management/Patient Safety Committee and this includes oversight of significant events. The Risk Management/Patient Safety Committee reports regularly to the Medical Executive Committee, which ensures that leadership is actively involved in evaluating the quality of care. Upon review of the program the following improvements were initiated. Actions: The Significant Event Management Team (SEMT), a hospital leadership group that reviews adverse outcomes has increased its meeting frequency from monthly to weekly. The purpose of this team is to monitor and evaluate timeliness of reporting, thoroughness of the investigations and recommend any necessary improvements. This team will reports up through the Risk Management/Patient Safety Committee and then to the Medical Executive Committee. Responsible Person: Assistant Chief of Staff - Medical	03/07/05

DEPARTMENT OF HEALTH AND HUMAN SERVICES Centers for Medicare and Medicaid Services (CMS)			AH FORM APPROVED OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CL1A IDENTIFICATION NUMBER: 050071	(X2) MULTIPLE CONSTRUCTION A. BUILDING_____ B. WING_____	(X3) DATE SURVEY COMPLETED **03/02/2005**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KAISER FOUNDATION HOSPITAL – Santa Clara	**900 KIELY BLVD SANTA CLARA, CA 95050**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A141		A141	Legal Chief of Quality Assistant Administrator Quality & Service Director of Risk and Patient Safety	
			<u>Monitoring</u> A weekly report is generated which provides data on the timeliness of UOR reporting. This report will be reviewed weekly by the SEMT and monthly by Risk Management/Patient Safety Committee. Both the Performance Improvement Committee and Medical Executive Committees will provide oversight for these reports and take necessary improvement action as warranted.	On-going
	See A 145, regarding the notification to the Quality/Risk department of medical events compromised patients health.		The Significant Event (SE) Policy (AD.19.03) includes a requirement for significant events to be reported immediately to the Director of Risk Management, Director of Quality or the Administrator-on-call. Upon review of these cases the following actions were initiated:	
			<u>Actions:</u> E-mail communication was sent to physicians and managers re-emphasizing the immediate reporting requirements delineated in the Significant Event Policy.	03/01/05 & 03/16/05 respectively
			Inservices were initiated for managers on both the UOR and significant event reporting process.	03/15/05-04/22/05

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare and Medicaid Services (CMS)

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	050071	A. BUILDING _____ B. WING _____	03/02/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KAISER FOUNDATION HOSPITAL – Santa Clara	900 KIELY BLVD SANTA CLARA, CA 95050

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A141		A141	At these inservices, the managers were provided "tip" sheets outlining staff responsibility for reporting. The tip sheets are tools that are used by the managers for educating patient care and ancillary staff. Staff inservices will be completed by 04/22/05.	
			In addition, the hospital has taken action to enhance the following: New Employee Orientation was revised to include requirements for UOR reporting.	03/15/05
			New physician orientation has been revised to include the new requirements for UOR and SE reporting.	04/01/05
			Resident orientation will be revised to include the new requirements for UOR and SE reporting.	07/01/05
			Responsible Person: Assistant Chief of Staff - Medical Legal Director of Risk and Patient Safety Department Managers	
			Monitoring Process: Timeliness of UOR submission was reviewed by the Quality Department.	03/01/05
			Managers will receive monthly reports showing compliance with timeliness of UOR submission. March data will be received on April 30.	04/30/05
			The Director of Risk Management & Patient Safety or the Risk Coordinator will review this data weekly. The Risk	04/04/05

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare and Medicaid Services (CMS)

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CL1A IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	050071	A. BUILDING _____ B. WING _____	03/02/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KAISER FOUNDATION HOSPITAL – Santa Clara	**900 KIELY BLVD SANTA CLARA, CA 95050**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A142	482.21(a) PROGRAM SCOPE The hospital must ensure that specific program scope requirements are met. This standard is not met as evidenced by: Based on observation, interviews and document review, the hospital failed to ensure that requirement's for the institution's quality program were met. Findings include: See A145, regarding the notification to the Quality/Risk department of medical events that compromised patients health.	A142	Management/Patient Safety Committee will monitor the results of these reports on an on-going basis. Data will be reported up to the Performance Improvement Committee and necessary action will be taken as warranted. Please refer to response for A141 on page 3.	
A145	482.21(a)(2) PROGRAM SCOPE The hospital must measure, analyze, and track quality indicators, including adverse patient events, and other aspects of performance that assess processes of care,	A145		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare and Medicaid Services (CMS)

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CL1A IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	050071	A. BUILDING _____ B. WING _____	03/02/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KAISER FOUNDATION HOSPITAL – Santa Clara	**900 KIELY BLVD SANTA CLARA, CA 95050**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A145	hospital services and operations. This standard is not met as evidenced by: Based on observation, interviews, and document review, the hospital failed to implement its own procedures for measuring, analyzing, and tracking adverse patient events that assess processes of care for 4 of 22 patient records (1, 2, 33 and 34) reviewed. Findings include:	A145		
A145	1. Patient 1 was a 64 year old male admitted to the hospital's emergency room at 4:51 pm on 12/24/04 with a chief complaint of "vision changes". The patient was accompanied by his wife, who further stated that Patient 1 was having a hard time articulating words. He was seen by the physician at 4:53 pm, and the medical screening examination was completed at 5:02 pm. Initially, the diagnosis was that of "Stroke". The physician discussed the use of tPA (tissue plasminogen activator), a drug that promotes bleeding and dissolves blood clots, with the patient and his wife. They both consented to its use. The order was written at 6:55 pm, and the calculated total dose was 67.5 mg; ten percent (6.75) to be administered as a bolus over 1 minute and 60.25 mg, to be given over 59 minutes. Patient 1's primary nurse (Nurse A)	A145	The hospital investigated this case and the results of this review were presented to the SEMT, Risk Management/Patient Safety and the Medical Executive Committees. Recommendations and corrective actions included the following: Actions: tPA Administration Policy (PC.20.08) was revised. This policy revision included an additional safeguard requiring the Pharmacy department to mix tPA within the required timeframe. If time constraints prevent the Pharmacy department from mixing tPA, the drug will be mixed by registered nurses in either the	02/06/05 02/06/05 02/06/05

DEPARTMENT OF HEALTH AND HUMAN SERVICES Centers for Medicare and Medicaid Services (CMS)		AH FORM APPROVED OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CL1A IDENTIFICATION NUMBER: 050071	(X2) MULTIPLE CONSTRUCTION A. BUILDING_____ B. WING_____	(X3) DATE SURVEY COMPLETED **03/02/2005**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KAISER FOUNDATION HOSPITAL – Santa Clara	**900 KIELY BLVD SANTA CLARA, CA 95050**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A145	premixed 100 mg of TPA and connected the bottle to an intravenous infusion pump, gave the 6.75 mg. bolus over 1 minute, then programmed the pump to administer the 60 mg. over 59 minutes. Sometime during the infusion process, Nurse A went on her break, turning care over to Nurse B. Prior to the medication being completed, Nurse B was asked by relief Charge Nurse C to attend another patient while she took care of Patient 1. While under the care of Nurse C, the patient received an overdose of the medication tPA and subsequently expired while in the intensive care unit on 12/26/04. According to administration, Nurse C made a report on he evening of December 24th (Friday night) suspecting that an overdose of medication may have caused the death. Quality/Risk management did not get the report until 1/10/05, seventeen days (17) after Nurse C wrote the incident report. Due to the time lag of when the event occurred and when it was reported, prevented Quality/Risk management from further investigating the accident to determine if measures could have been taken to prevent a recurrence. 2. Patient 2 was a 77 year old male,	A145	Emergency Department or the ICU. A verification checklist was created requiring two nurses to verify and document the order, amount of tPA mixed, amount to be administered and amount to be discarded. A Clinical Nurse Specialist from the Quality Department will review the nursing checklist retrospectively. Emergency department staff was educated on the revised tPA policy, procedures and the above checklist. Intensive Care Unit staff was inserviced on the revised tPA policy, procedures and the above checklist. Responsible Party: Emergency Department Nursing Director ICU Manager Pharmacy Director Monitoring: Each time tPA is administered, the process will be reviewed retrospectively by the Pharmacy Director or his designee. Results of this review will be communicated monthly to Pharmacy, the Emergency Department and the Intensive Care Unit. Pharmacy & Therapeutics Committee as well as to the Medical Executive Committee will have oversight of this process and will take necessary action as warranted. These committees will also have oversight of improvement actions.	03/21/05 02/06/05 02/11/05 02/06/05

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare and Medicaid Services (CMS)

AH
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CL1A IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	050071	A. BUILDING _____ B. WING _____	03/02/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KAISER FOUNDATION HOSPITAL – Santa Clara	900 KIELY BLVD SANTA CLARA, CA 95050

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A145	admitted to the hospital on 10/28/04 from an outpatient clinic with respiratory difficulties. He was admitted to a medical floor for further care. On the morning of 11/01/04, at 10:30 am, the physician wrote an order to keep the patient NPO (nothing by mouth) as he was having difficulty with eating. At 6:00 pm, Staff E retrieved the patient's lunch tray from the unit refrigerator and began feeding the patient despite the physician's order not to give the patient anything by mouth. At 6:30 pm, Staff E called the licensed nurse stating the patient was having difficulty breathing. When the nurse entered the room, she found the patient unresponsive with his SP02 in the 40's. The patient expired as a result of this error at 7:30 pm. When the nurse questioned Staff E as to what happened, the staff member responded by saying it occurred while he was feeding the patient. The nurse wrote an incident report and gave it to her assistant unit manager. The assistant unit manager was interviewed on 3/2/05 at 3:00 pm. and stated he received the report after the event and began to investigate the incident. He forwarded the report to Quality/Risk management through the hospital's internal mail system. The Risk Manager stated she never received the report and did not know of the event until 11/06/04, five days after the event, when a physician on the unit asked if she was on the unit to look at Patient 2's death. There was no explanation given s to why Quality/Risk management did not get the report.	A145	The hospital thoroughly investigated this case. The findings were presented to SEMT, the Risk Management Patient Safety Executive and the Medical Executive Committee. The following actions were initiated: Actions: Dietary Heat & Serve Policy (IX.L) has been revised. The changes in this policy include the following: • Dietary aides must verify feeding status of each patient with that patient's nurse or charge nurse before tray delivery. • All Adult Medical Surgical units are prohibited from storing trays for NPO patients in the refrigerator on the unit. • This change in practice was communicated to nursing and dietary staff during the weeks of 02/14/05 and 02/21/05. Actions also included specific coaching and re-educating the assistant-manager who did not immediately report the case. Responsible Person: Assistant Administrator for Patient Care Services Director of Adult Services Managers of Adult Services Manager of Nutrition Services Monitoring Dietary department will conduct audits to ensure that trays for NPO patients are not present in the refrigerators. At least 30 spot checks per month will be conducted for a	04/05/05 02/26/05 02/01/05 02/18/05 & 02/25/05 respectively 3/1/05 07/15/05

DEPARTMENT OF HEALTH AND HUMAN SERVICES Centers for Medicare and Medicaid Services (CMS)		AH FORM APPROVED OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CL1A IDENTIFICATION NUMBER: 050071	(X2) MULTIPLE CONSTRUCTION A. BUILDING_____ B. WING_____	(X3) DATE SURVEY COMPLETED **03/02/2005**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KAISER FOUNDATION HOSPITAL – Santa Clara	**900 KIELY BLVD SANTA CLARA, CA 95050**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A145		A145	period of 3 months. The data will be reported monthly to the Risk Management/Patient Safety Committee and necessary improvement action will be taken as warranted. Further monitoring will be determined based on compliance.	
	3. Patient 33 was a 63 year old female admitted on 2/12/05 for complaints of cough and shortness of breath. The patient was diagnosed with a suspected blood clot in her lower left leg. On 2/12/05 at 4:00 pm, Patient 33 was treated with a continuous infusion of TPA (tissue plasminogen activator). TPA is a thrombolytic agent (a drug used for dissolving blood clots). TPA was infused at 1 mg/hr from 2/12/05 4:00 pm until 2/13/05 at 4:00 am, when Patient 33 was noted to be "unresponsive". At 2/13/05 4:500 pm, the physician's note documented that Patient 33 was "not responding to commands, non-verbal, eyes deviated to left", and 'concern for bleed as pt (Patient) on TPA and heparin with acute changes in mental status". Heparin is a medication that inhibits blood from clotting. The most common complication of the administration of TPA and heparin is bleeding. Additional adverse events of TPA use include: Stroke, intracranial hemorrhage, and arrhythmias (Drug Facts and Comparisons). On 3/1/05 at 10:00 am, Patient 33 was lying on her bed on the 6th floor West Intensive Care Unit. The Patient had a flat-affect, her eyes were open, but she was not responsive to her husband standing at her bedside. On 3/1/05 at 3:15 pm, the Pharmacy Director was interviewed about the hospital's Adverse Drug Reactions (ADR)		This case reviewed and was determined not to be a significant event, but rather an adverse drug reaction. The current ADR reporting practice emphasizes concurrent data collection, and review by Pharmacists. ADR information is reported through the ADR hotline, Pyxis Antidote Removal Information, and e Codes. Although this ADR was documented and followed by the clinical pharmacist, it had not been the practice for clinical pharmacists to call the ADR hotline. The following improvements have been initiated: Actions: The ADR policy (PC.01.01) and UOR (AD.21.01) Reporting Policies were reviewed with the Pharmacy staff through staff meetings and one on one inservices. Effective 03/01/05, all ADRs identified by the clinical pharmacists are called into the ADR hotline to ensure timely and complete reporting. Responsible Party: Pharmacy Director Monitoring: Quick Track system will be used to	03/01/05- 04/07/05 03/01/05

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare and Medicaid Services (CMS)

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CL1A IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	050071	A. BUILDING _____ B. WING _____	03/02/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KAISER FOUNDATION HOSPITAL – Santa Clara	**900 KIELY BLVD SANTA CLARA, CA 95050**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A145	program and if Patient 33's suspected stroke was due to TPA and heparin, and had it been reported and investigated. The ADR pharmacist reviewed the February 2005 ADR reported and did not locate a report or an investigation of Patient 33's suspected stroke. On 3/1/05 at 5:30 pm, the hospital's Risk Management Director said if an ADR resulted in "harm, or potential harm", it was the hospital's policy to report the ADR "now" to the Risk Management Department for investigation. The hospital's policy and procedures for "Adverse Drug Reaction" (index # PC.01.01 last revised on 8/04) specified that any ADR was to be reported and an "Unusual Occurrence Report" would be initiated. The purpose of the ADR policy was to "provide a comprehensive program of hospital-wide surveillance to identify, evaluate, report and prevent untoward drug experiences." By 3/1/05, Patient 33's stroke, which occurred on 2/13/05 and was suspected to be due to the infusion of TPA and heparin, had not been reported and investigated by the Risk Management department, which was not in accordance with hospital policies and procedures. 4. On 3/1/05 at 11:00 am, the medication supplies for Patient 34 were inspected. Patient 34 was an 84 year old male admitted on 1/31/05 for painful swallowing and dehydration. The patient was diagnosed with CMV (cytomegalovirus) herpes esophagitis (viral throat infection). On 1/31/05 at 6:30 pm, Patient 34 was initiated on ganciclovir 285mg IV (intravenously) every 12 hours, and ceftazidime 1gm IV every 8 hours.	A145	monitor timeliness of reporting ADRs. Reports will be generated weekly on an on-going basis and follow-up will be conducted with managers whose staff are not reporting ADRs in a timely manner. Oversight of ADR process occurs monthly by the Pharmacy & Therapeutics Committee and the Medication Error Improvement Committee. This case was reviewed and determined to be an adverse drug reaction. As in the case of patient #33, the clinical pharmacists were involved with the review of medications ordered for this patient. Actions as a result of the case review include: Actions: Inservices on ADR reporting policy	04/12/05 & on-going 03/01/05

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare and Medicaid Services (CMS)

AH
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CL1A IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	050071	A. BUILDING_____ B. WING_____	03/02/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KAISER FOUNDATION HOSPITAL – Santa Clara	**900 KIELY BLVD SANTA CLARA, CA 95050**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A145	Ganciclovir is an antiviral agent. Ceftazidime is an antibiotic. Potential significant adverse effects of ganciclovir include thrombocytopenia (decreased number of platelets in the blood) and can be life-threatening. Patient 34's platelet count was as follows: 1/31/05 125 K/ul (facility normal range was 140-400K/ul with K=1000) 2/1/05 gaqnciclovir dose was decreased to 140mg IV every 24 hours. 2/2/05 80 K/ul 2/3/05 66 K/ul 2/5/05 64 K/ul 2/7/05 ganciclovir discontinued, and valganciclovir 450mg orally twice daily started 2/8/05 36 K/ul 2/10/05 28 K/ul 2/14/05 50 K/ul; valganciclovir dose decreased to 450mg daily 3/1/05 295 K/ul Patient 34's medical record included the following progress notes: a. A 2/7/05 physician's note stating "thrombocytopenia (low platelet count) was secondary to ganciclovir" and to "discontinue ganciclovir" and start "valganciclovir orally". b. A 2/10/05 physician's note that 'decreased plt (platelets) was secondary to Ganciclovir". On 3/1/05 at 11:20 am, the interviewed unit pharmacist was aware of Patient 34's adverse reaction (thrombocytopenia) due to the drug Ganciclovir which was identified by Patient 34's medical team on 2/2/05. On 3/1/05 at 3:15 pm, the Pharmacy	A145	and importance of timeliness of reporting were provided to the Pharmacy. <u>Responsible Party:</u> Pharmacy Director <u>Monitoring:</u> Quick Track system will be used to monitor timeliness of reporting ADRs. Reports will be generated weekly on an on-going basis and follow-up will be conducted with managers whose staff is not reporting ADRs in a timely manner. Oversight of ADR process occurs monthly by the Pharmacy & Therapeutics Committee and the Medication Error Improvement Committee. Although this ADR was documented	BF 04/12/05 & on-going

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare and Medicaid Services (CMS)

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CL1A IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	050071	A. BUILDING_____ B. WING_____	03/02/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KAISER FOUNDATION HOSPITAL – Santa Clara	**900 KIELY BLVD SANTA CLARA, CA 95050**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A145	Director was interviewed about the hospital's Adverse Drug Reactions (ADR) program and if Patient 34's thrombocytopenia suspected due to ganciclovir had been reported and investigated. The ADR pharmacist reviewed the February 2005 ADR reports and did not locate a report or an investigation of Patient 34's thrombocytopenia. On 3/1/05 at 3:40 pm, the Pharmacy Director contacted the ICU's pharmacist who said she had not reported Patient 34's suspected adverse drug reaction (thrombocytopenia) subsequent to ganciclovir therapy. On 3/1/05 at 5:30 pm, the facility's Risk management Director said if an ADR resulted in 'harm, or potential harm", it was the hospital's policy to report the ADR "now" to the Quality Assurance Department for investigation. By 3/1/05,Patient 34"s thrombocytopenia, which occurred on 2/2/05 and was suspected to be due to the infusion of ganciclovir, had not been reported and investigated by the Risk Management department, which was not in accordance with hospital policies and procedures.	A145	and followed by the clinical pharmacist, it had not been the practice for clinical pharmacists to call the ADR hotline. Actions: Effective 03/01/05, all ADRs identified by the clinical pharmacists are called into the ADR hotline to ensure timely and complete reporting. Responsible Party: Pharmacy Director Monitoring: Quick Track system will be used to monitor timeliness of reporting ADRs. Reports will be generated weekly on an on-going basis and follow-up will be conducted with managers whose staff is not reporting ADRs in a timely manner. Oversight of ADR process occurs monthly by the Pharmacy & Therapeutics Committee and the Medication Error Improvement Committee.	03/01/05 04/12/05 & on-going

DEPARTMENT OF HEALTH AND HUMAN SERVICES Centers for Medicare and Medicaid Services (CMS)		AH FORM APPROVED OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CL1A IDENTIFICATION NUMBER: 050071	(X2) MULTIPLE CONSTRUCTION A. BUILDING_____ B. WING_____	(X3) DATE SURVEY COMPLETED **03/02/2005**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KAISER FOUNDATION HOSPITAL – Santa Clara	**900 KIELY BLVD SANTA CLARA, CA 95050**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 208	482.23(c) PREPARATION AND ADMINISTRATION OF DRUGS Drugs and biologicals must be prepared and administered in accordance with Federal and State laws, the orders of the practitioner or practitioners responsible for the patient's care as specified under §482.12(c), and accepted standards of practice. This standard s not met as evidenced by: Based on observation, document review and staff interview, the hospital failed to provide medications in accordance with physician's orders and accepted standards of practice. Findings include: 1. On 2/28/05 at 12:25PM, the inspection of the 5TH Floor Post-Partum Nursing Unit revealed Patient 32 was receiving intravenous (IV) antibiotics subsequent to a caesarian section. Patient 32 was in her room and had a continuous infusion of dextrose 5% in Lactated Ringer's (D5 LR) intravenous fluids infusing at a rate of 30ml/hr. Patient 32 said "they're going to cut off the dextrose (IV infusion) soon." Patient 32's "Vital signs and I (intake) & O (output) Record" documented D5LR IV fluid was infused as follows: 2/27/04 night shift (11pm – 7 am) = 1000ml for a rate of 125ml/hr 2/27/04 day shift (7 am – 3 pm) = 450ml for a rate of 56ml/hr 2/27/04 evening shift (3 pm – 11 pm) = 240ml for a rate of 30ml/hr 2/28/04 night shift (11 pm – 7 am) = 240ml for a rate of 30ml/hr Patient 32's record documented a 2/28/05	A 208	Infusion policy and practice were reviewed and the following improvements have been initiated: Actions: General Infusing Policy (PC 05.09.08) has been and revised to include TKO rates which will be used until a specific rate order is written. Nursing staff will be educated on the revised policy and practice by Nursing Managers and Nursing Educators and the importance of reviewing orders prior to infusing or adjusting rates. Responsible Party: Assistant Administrator for Patient Care Services Nursing Directors Nursing Managers Nursing Educators Monitoring:	04/06/05 04/25/05

DEPARTMENT OF HEALTH AND HUMAN SERVICES Centers for Medicare and Medicaid Services (CMS)		AH FORM APPROVED OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CL1A IDENTIFICATION NUMBER: 050071	(X2) MULTIPLE CONSTRUCTION A. BUILDING_____ B. WING_____	(X3) DATE SURVEY COMPLETED **03/02/2005**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KAISER FOUNDATION HOSPITAL – Santa Clara	**900 KIELY BLVD SANTA CLARA, CA 95050**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A208	8:00 am physician's order to decrease the IV fluid rate from 125ml to TKO (to keep open). Nursing staff said IV fluid would be infused at a rate of 30-50ml/hr when ordered as "TKO".	A208	70 open medical records will be reviewed weekly for compliance with policy requirements and adherence to physician orders for 3 months by nursing managers, assistant managers and charge nurses. Results will be reported monthly to the Performance Improvement Committee and Medical Executive Committee and actions will be taken as warranted. Future monitoring will be based on compliance.	07/25/05
	Patient 32's medical record documented Patient 32's IV infusion rate was decreased the morning of 2/27/05 which was not in accordance with the physician's orders.		Practice was reviewed and discussed with individual nurse. Nurse was counseled by department manager. Responsible Party: Department Manager Monitoring: Refer to plan above	02/28/05
	2. Patient 1, a 64 year old male, was admitted to the hospital's emergency room at 4:51 pm on 12/24/04 with a chief complaint of "vision changes". The patient was accompanied by his wife, who further stated that Patient 1 was having a hard time articulating words. He was seen by the physician who wrote an order at 6:55 pm, to administer 67.5 mg of TPA; ten percent (6.75) to be administered as a bolus over 1 minute and 60.25 mg, to be given over 59 minutes. Patient 1's primary nurse (Nurse A) premixed 100 mg of TPA and connected the bottle to an intravenous infusion pump, gave the 6.75 mg bolus over 1 minute, then programmed the pump to administer the 60 mg. over 59 minutes. Sometime during the		Please refer to response for A145 on page 6.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare and Medicaid Services (CMS)

AH
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CL1A IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	050071	A. BUILDING _____ B. WING _____	03/02/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KAISER FOUNDATION HOSPITAL – Santa Clara	900 KIELY BLVD SANTA CLARA, CA 95050

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A208	infusion process, Nurse A went on her break, turning care over to Nurse B. Prior to the medication being completed, Nurse B was asked by Relief Charge Nurse C to attend another patient while she took care of Patient 1. After the 60 minute infusion time had elapsed, the pump alarm sounded to alert staff the preset amount of TPA had infused. Nurse C responded to the alarm and turned it off. She saw that some medication remained in the bottle and with the help of another nurse (Nurse D) administered the rest (approximately 32.5 mg) thus giving the patient more TPA than the physician ordered.	A208		
A215	482.23(c)(4) PREPARATION AND ADMINISTRATION OF DRUGS There must be a hospital procedure for reporting transfusion reactions, adverse drug reactions, and errors in administration of drugs. This standard was not met as evidenced by: Based on documentation and interview, although the hospital has a procedure for reporting adverse drug reactions and errors in administration of drugs, staff failed to implement these procedures. Findings include: See A 145 regarding the error in	A215		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare and Medicaid Services (CMS)

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CL1A IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	050071	A. BUILDING _____ B. WING _____	03/02/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KAISER FOUNDATION HOSPITAL – Santa Clara	900 KIELY BLVD SANTA CLARA, CA 95050

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A215	administration of a medication that did not follow hospital procedure and the failure to investigate and report an adverse drug reaction in accordance with hospital policy and procedures.	A215	Please refer to response for A145 on page 9.	
A252	482.25(b) DELIVERY OF SERVICES In order to provide patient safety, drugs and biologicals must be controlled and distributed in accordance with applicable standards of practice, consistent with Federal and State law. This Standard was not met as evidenced by: Based on observation, document review, and staff interviews, the hospital failed to provide patient safety by ensuring all drugs and biologicals were controlled and distributed in accordance with applicable standards of practice. Findings include: On 2/28/05 at 11:15 am, the inspection of the central pharmacy revealed an order for Patient 31 for intravenous (IV) Dextrose 5% in Lactated Ringer's solution (D5LR) with 20 units of oxytocin to be infused at a rate of 125ml/hr. The label printed by the pharmacy to be placed on the IV bag specified the infusion rate to be "UD" (as directed), but did not include the ordered rate of infusion of 125ml/hr. The Pharmacy Director said all labels printed in the pharmacy and placed on bags of IV fluid did not include specific infusion rates. The Pharmacy Director said nursing staff may be changing infusion rates, so the	A252	The General Infusing Policy (PC.05.09.08) has been reviewed and the following actions have been taken: Actions: Policy has been revised to include the rate or "as directed" rates for large volume fluids and medications that are titrated. This is consistent with current hospital practice. Policy will be approved by the Pharmacy & Therapeutics Committee and Nursing Policy & Procedure Committee.	04/04/05 04/24/05 & 04/12/05 respectively

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare and Medicaid Services (CMS)

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CL1A IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	050071	A. BUILDING_____ B. WING_____	03/02/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KAISER FOUNDATION HOSPITAL – Santa Clara	**900 KIELY BLVD SANTA CLARA, CA 95050**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A252	infusion rate specified in physician's orders would not be entered in the pharmacy computer or in the infusion rate on the label of the IV bag. The hospital's policy and procedures on "IV Administration: General Infusing Policy" (index # 05.09.08 last revised 8/04) specified "Labeling of IV infusion bags or bottles should include: Patient's name, medical number, room number, drug name and amount, solution and volume, preparation date, rate of infusion." The label on Patient 31's D5LR IV bag did not include an infusion rate, which was not in accordance with hospital procedures.	A252	Pharmacy and Nursing staff are being educated on revised policy and change in practice by the Pharmacy Director and Nursing Managers, respectively. Responsible Party: Pharmacy Director Assistant Administrator for Patient Care Services Monitoring: 30 labels/week for 4 weeks will be reviewed by Pharmacy. Data will be reported to the Pharmacy and Therapeutics and Performance Improvement Committee. Future monitoring will be based on compliance.	04/30/05 07/15/05
A452	482.55 EMERGENCY SERVICES The hospital must meet the emergency needs of patients in accordance with acceptable standards of practice. This Condition is not met as evidenced by: Based on documentation in 2 of 5 emergency room records reviewed (Patients 1 and 3) and staff interview, the hospital did not meet the emergency standards for patient care in accordance with their own policy. Findings include:	A452		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare and Medicaid Services (CMS)

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CL1A IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	050071	A. BUILDING_____ B. WING_____	03/02/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KAISER FOUNDATION HOSPITAL – Santa Clara	**900 KIELY BLVD SANTA CLARA, CA 95050**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A452	1. See A145 regarding Patient 1 who was admitted to the hospital's emergency room on 12/24/04. The hospital policy for mixing and administering the medication TPA under the policy of Medication and IV therapy, Section: ED.05.20.03; Subsection 2.3.3.10.4 states, "Staff subtracts the total dose from 100 mg (vial contains 100mg in 100 ml) and withdraws and discards appropriate amount: i.e. if total dose is 90 mg, then discard 10 ml from vial." The policy further sates under Subsection 2.3.3.10.3, the maximum dose that may be administered in 9.mg. Nursing staff did not follow this policy for mixing the TPA. After mixing the TPA and water, the entire contents 100 mg, and not the ordered dose 67.5 mg, was administered to Patient 1. 2.See A 455 regarding Patient 3, an 11 month old who was seen in the emergency room on 3/1/05 for a fever. The temperature was recorded in the patient's chart as being taken orally. The emergency department did not have a policy for the taking of infant temperatures. The hospital's pediatric department policy stated that temperatures are to be taken rectally for infants under 1 year of age.	A452	Please refer to response for A145 on page 6 Actions: The Emergency department has adopted Age-related Considerations, Pediatric and Geriatric Policy (ED.03.03.03) for monitoring infant temperature. Currently, temperatures for infants under the age of one will be taken rectally, unless contraindicated. Emergency department staff was inserviced on the policy and change in practice. In addition, American Academy of Pediatrics guidelines and other evidence-based recommendations will be reviewed and policy and procedures will be revised, if indicated. Staff will be re-trained on the changes in practice by managers.	03/01/05 03/02/05 05/01/05

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare and Medicaid Services (CMS)

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CL1A IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	050071	A. BUILDING _____ B. WING _____	03/02/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KAISER FOUNDATION HOSPITAL – Santa Clara	**900 KIELY BLVD SANTA CLARA, CA 95050**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A452		A452	Responsible Party: Emergency Department Nursing Director Emergency Department Medical Directors Monitoring: 25% of infant charts will be monitored weekly for three months by the Emergency Department management. Results will be reported to Performance Improvement Committee monthly and improvement action will be taken as warranted. Future monitoring will be based on compliance.	07/15/05

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare and Medicaid Services (CMS)

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CL1A IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	050071	A. BUILDING _____ B. WING _____	03/02/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KAISER FOUNDATION HOSPITAL – Santa Clara	900 KIELY BLVD SANTA CLARA, CA 95050

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A455	482.55(A)(2) ORGANIZATION AND DIRECTION The services must be integrated with other departments of the hospital. This Standard is not met as evidenced by: Based on interview and documentation, in four emergency room patient records, it was found that in 1 of 4 (Patient 3) patient records, the emergency department failed to provide a service that was consistent with another department of the hospital. Findings include: Patient 3 was an 11 month old infant brought to the emergency room on 3/1/05 at 8:10a.m., by his parents for a complaint of "fever." The infant was seen by the triage nurse (Nurse F) who documented the infant's temperature was taken orally. The nurse was interviewed on 3/1/05 at 9:00 a.m., and stated he took the infant's temperature using an oral thermometer. When the emergency room nurse manager was asked for their policy on taking an	A455	Please refer to response for A452 on page 18.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES Centers for Medicare and Medicaid Services (CMS)		AH FORM APPROVED OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CL1A IDENTIFICATION NUMBER: 050071	(X2) MULTIPLE CONSTRUCTION A. BUILDING_____ B. WING_____	(X3) DATE SURVEY COMPLETED **03/02/2005**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KAISER FOUNDATION HOSPITAL – Santa Clara	**900 KIELY BLVD SANTA CLARA, CA 95050**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A455	infant's temperature, none could be provided. On 3/1/05 at 10:00 a.m., a visit was made to the hospital's pediatric unit. A review of their policy stated that rectal temperatures are taken for infants under 1 year of age. The emergency room did not follow this policy.	A455		