| DEPARTMEN Centers for M | IT OF HEALTH AND HUMAN edicare and Medicaid Services | SERVICES | | | AH FORM APPROVED OMB NO. 0938-0391 |
|----------------------------|---|--|------------------------|--|---|
| STATEMENT | OF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUF IDENTIFICATION | ON NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED 03/02/2005 |
| | OVIDER OR SUPPLIER DUNDATION HOSPITAL | _ – Santa Clara | STREET ADDI | RESS, CITY, STATE, ZIP CODE 900 KIELY BLVD Santa Clara, Ca 9509 | 50 |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT O DEFICIENCY MUST BE REGULATORY OR I INFORM | PRECEDED BY FULL SC IDENTIFYING | CH ID PREFIX TAG | PROVIDER'S PLAN OF CORRECT! (EACH CORRECTIVE ACTION SHOU! CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | LD BE COMPLETION DATE |
| A000 | INITIAL COMMENTS The following reflects to Department of Health Separated validation survives: Representing the Department of the Department of Health Services: Glenn Koike, Evaluator Nurse; Brenda Ryan, Health Fourse; Michael Bennett, M.D., and Magda Gabali, Pharm. Consultant. | Services during a ey. Intriment of Health Health Facilities acilities Evaluator Medical Consulta | A000 | APPROPRIATE DEFICIENCY) SAN JOSE APR 0 7 2005 LICENSING & CERTIFICATION DIVISION | |
| A141 | 482.21 QUALITY ASSI PERFORMANCE IMPI The hospital must dever maintain an effective, of wide, data-driven quality performance improvem. The hospital's governing that the program reflect the hospital's organization of the program reflect involves all hospital deservices (including those under contract or arrant focuses on indicators in health outcomes and the reduction of medical error the hospital must main demonstrate evidence for review by CMS. This condition is not medicated in the program of | elop, implement an ongoing, hospital- ty assessment and nent program. In body must ensure the complexity of the complexity and the complexity and the complexity of the compl | re of ed | | |
| • | Based on record review the hospital failed to im maintain an effective q and performance impro | plement and uality assessment | · | | |

Page 1 of 21

| rthem California | nente Nort | Kaiser Perman | | | • | والمؤثوا الا |
|--|---|---|---------------------|---|---|--------------------------|
| AH ORM APPROVED AB NO. 0938-0391 | | | | | IT OF HEALTH AND HUMAN edicare and Medicaid Services | |
| DATE SURVEY COMPLETED 03/02/2005 | C | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | | (X1) PROVIDER/SUPPLI IDENTIFICATION N | STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPL AND PLAN OF CORRECTION IDENTIFICATION | |
| |)50 | ESS, CITY, STATE, ZIP CODE 900 KIELY BLVD SANTA CLARA, CA 950 | REET ADDR | ST | OVIDER OR SUPPLIER DUNDATION HOSPITAL | |
| (X5) COMPLETION DATE | JLD BE | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THI APPROPRIATE DEFICIENCY) | ID PREFIX TAG | PRECEDED BY FULL LSC IDENTIFYING | SUMMARY STATEMENT O DEFICIENCY MUST BE REGULATORY OR I INFORM | (X4) ID PREFIX TAG |
| | Santa cal cody is on and cove ent sk The ety o the the vely lity of | The quality assessment and performance improvement progat Kaiser Foundation Hospital S Clara is governed by the Medic Executive Committee. This bo responsible for reviewing the performance of the organization recommending actions to improvare. Activities related to paties afety are overseen by the Risi Management/Patient Safety Committee and this includes oversight of significant events. Risk Management/Patient Safet Committee reports regularly to Medical Executive Committee, ensures that leadership is activity involved in evaluating the qualicare. Upon review of the program the following improvements were initiated. | A141 | ovement plan in for unusual events, in and safety of is dependent on the quality and risk events. I verage daily census of 22 patient charts 2, 33 and 34) had ispital's criteria for the rogram to improve if patients and to is. The hospital failed gram as identified in: In a failure to | Findings include: The hospital's quality a performance and imprincluded data collection that affected the health patients. The plan was 'immediate' reporting to department for these of the hospital had an average and patients. Four of the reviewed (Patients 1, 2 events that met the hospital imprevent medical errors to implement this program. | A141 |
| 03/07/05 | dership neeting ekly.) ss of e d any nis he Risk | Actions: The Significant Event Manage Team (SEMT), a hospital lead group that reviews adverse outcomes has increased its m frequency from monthly to we The purpose of this team is to monitor and evaluate timelines reporting, thoroughness of the investigations and recommen- necessary improvements. Th team will reports up through th Management/Patient Safety Committee and then to the Me Executive Committee. | | | | |

Page 2 of 21

Responsible Person: Assistant Chief of Staff - Medical

| | IT OF HEALTH AND HUMAN ledicare and Medicaid Service | | | | | | AH ORM APPROVED 18 NO. 0938-0391 |
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| STATEMENT | OF DEFICIENCIES OF CORRECTION | | | | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | 1 | DATE SURVEY COMPLETED 03/02/2005 |
| | ROVIDER OR SUPPLIER OUNDATION HOSPITA | | П | REET ADDR | ESS, CITY, STATE, ZIP CODE 900 KIELY BLVD SANTA CLARA, CA 950 | 50 | |
| (X4) ID PREFIX TAG | | | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | LD BE | (X5) COMPLETION DATE |
| A141 | | | | A141 | Legal Chief of Quality Assistant Administrator Quality Service Director of Risk and Patient Sa | | |
| | | | | | Monitoring A weekly report is generated w provides data on the timeliness UOR reporting. This report will reviewed weekly by the SEMT monthly by Risk Management/Patient Safety Committee. Both the Performa Improvement Committee and Medical Executive Committees provide oversight for these rep and take necessary improvement action as warranted. | of be and ance will orts | On-going |
| | See A 145, regarding Quality/Risk departm compromised patient | ent of medical ever | | | The Significant Event (SE) Pol (AD.19.03) includes a requirent for significant events to be repimmediately to the Director of Management, Director of Qual the Administrator-on-call. Uporeview of these cases the folloactions were initiated: | nent orted Risk ity or on | al |
| | | | | | Actions: E-mail communication was se physicians and managers reemphasizing the immediate reporting requirements delined the Significant Event Policy. | | 03/01/05 & 03/16/05 respectively |
| | | | | | Inservices were initiated for managers on both the UOR a significant event reporting pro- | | 03/15/05- 04/22/05 |

FORM CMS - 2567 (09-92)

Page 3 of 21

| Kaiser Permanente | Northern California |
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| | 4/7/05 |

| | IT OF HEALTH AND HUMAN edicare and Medicaid Service | | | | FORM APPROVED OMB NO. 0938-0391 |
|--------------------------|--|--|-------------------------|---|--|
| | OF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUI IDENTIFICATION 0500 | ON NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED 03/02/2005 |
| | ROVIDER OR SUPPLIER DUNDATION HOSPITA | AL – Santa Clara | STREET ADDR | ESS, CITY, STATE, ZIP CODE 900 KIELY BLVD SANTA CLARA, CA 950 | 50 |
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| A141 | | | A141 | At these inservices, the manag- were provided "tip" sheets outling staff responsibility for reporting tip sheets are tools that are used the managers for educating partical care and ancillary staff. Staff inservices will be completed by 04/22/05. In addition, the hospital has take action to enhance the following New Employee Orientation was revised to include requirements UOR reporting. New physician orientation has revised to include the new | ning The ed by tient on on one of the control of t |
| | | | | requirements for UOR and SE reporting. Resident orientation will be rev to include the new requiremen UOR and SE reporting. Responsible Person: | ts for |
| | | | | Assistant Chief of Staff - Medic Legal Director of Risk and Patient State Department Managers Monitoring Process: | afety |
| | | | | Timeliness of UOR submissio reviewed by the Quality Depar | tment. |
| | | | | Managers will receive monthly reports showing compliance w timeliness of UOR submission March data will be received or 30. | rith 04/30/05 n. |
| | | | | The Director of Risk Manager Patient Safety or the Risk Coordinator will review this da weekly. The Risk | |

Page 4 of 21

4/7/05 FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 Centers for Medicare and Medicaid Services (CMS) (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CL1A STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: A. BUILDING AND PLAN OF CORRECTION 03/02/2005 B. WING... 050071 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 900 KIELY BLVD KAISER FOUNDATION HOSPITAL - Santa Clara SANTA CLARA, CA 95050 PROVIDER'S PLAN OF CORRECTION (X5)SUMMARY STATEMENT OF DEFICIENCIES (EACH) ID (X4) ID COMPLÉTION (EACH CORRECTIVE ACTION SHOULD BE PREFIX DEFICIENCY MUST BE PRECEDED BY FULL PREFIX CROSS-REFERENCED TO THE DATE REGULATORY OR LSC IDENTIFYING TAG TAG APPROPRIATE DEFICIENCY) INFORMATION Management/Patient Safety A142 A142 Committee will monitor the results of these reports on an on-going basis. Data will be reported up to the Performance Improvement 482.21(a) PROGRAM SCOPE Committee and necessary action will be taken as warranted. 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: Please refer to response for A141 on See A145, regarding the notification to the page 3. Quality/Risk department of medical events that compromised patients health. 482.21(a)(2) PROGRAM SCOPE A145 A145 The hospital must measure, analyze, and track quality indicators, including adverse

FORM CMS - 2567 (09-92)

Page 5 of 21

patient events, and other aspects of

performance that assess processes of care,

| | | | | | | | AH |
|--------------------------|--|---|-------------------|---------------------|--|---------------|---|
| | T OF HEALTH AND HUMAN edicare and Medicald Services | | | | | | RM APPROVED 3 NO. 0938-0391 |
| | OF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUI IDENTIFICATIO 0500 | UN NÇ | | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING |) C | ATE SURVEY COMPLETED 13/02/2005 |
| | OVIDER OR SUPPLIER DUNDATION HOSPITAL | L – Santa Clara | STR | EET ADDRE | ESS, CITY, STATE, ZIP CODE 900 KIELY BLVD SANTA CLARA, CA 9505 | 50 | |
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| A145 | hospital services and o | perations. | | A145 | | | , ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, |
| | This standard is not m Based on observation, document review, the implement its own pro- measuring, analyzing, patient events that ass care for 4 of 22 patient 34) reviewed. Finding | interviews, and hospital failed to cedures for and tracking adverses processes of trecords (1, 2, 33 | rse | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| A145 | 1. Patient 1 was a 64 admitted to the hospit at 4:51 pm on 12/24/0 complaint of "vision of was accompanied by stated that Patient 1 warticulating words. He physician at 4:53 pm, screening examination | al's emergency roo 4 with a chief nanges". The patie his wife, who furth as having a hard t was seen by the and the medical | ent er iime | A145 | The hospital investigated this cand the results of this review woresented to the SEMT, Risk Management/Patient Safety and Medical Executive Committees Recommendations and correct actions included the following: | ere nd the | De la |
| | 5:02 pm. Initially, the "Stroke". | diagnosis was tha | t of | | Actions: tPA Administration Policy (PC: was revised. | 20.08)∠ | 02/06/05 |
| | The physician discuss (tissue plasminogen a promotes bleeding an clots, with the patient both consented to its | activator), a drug the d dissolves blood and his wife. The use. The order wa | nat y as | | This policy revision included an additional safeguard requiring Pharmacy department to mix t within the required timeframe. | the | 02/06/05 |
| | written at 6:55 pm, and dose was 67.5 mg; te administered as a bol 60.25 mg, to be given Patient 1's primary nu | n percent (6.75) to us over 1 minute a over 59 minutes. | be ed | | If time constraints prevent the Pharmacy department from mitPA, the drug will be mixed by registered nurses in either the | ixing | 02/06/05 |

FORM CMS - 2567 (09-92)

Page 6 of 21

| enters for N | Medicare and Medicaid Service | | | | OMB NO. 0938-039 |
|--|--|---|--|---|---|
| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUP AND PLAN OF CORRECTION IDENTIFICATIO 05007 | | N NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED 03/02/2005 | |
| | ROVIDER OR SUPPLIER OUNDATION HOSPITA | | | EESS, CITY, STATE, ZIP CODE 900 KIELY BLVD SANTA CLARA, CA 950 | 50 |
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| A145 | premixed 100 mg of the bottle to an intravigave the 6.75 mg. both programmed the puring, over 59 minutes, infusion process, Nuibreak, turning care of to the medication bei was asked by relief Cattend another patier of Patient 1. While under the care patient received an omedication tPA and swhile in the intensive According to adminis a report on he evening (Friday night) suspect of medication may have Quality/Risk manage report until 1/10/05, safter Nurse C wrote to Due to the time lagoroccurred and when it prevented Quality/Risk further investigating determine if measure taken to prevent a result of the time lagoroccurred and when it prevented Quality/Risk manage report until 1/10/10 measure taken to prevent a result of the time lagoroccurred and when it prevented Quality/Risk manage report until 1/10/10 measure taken to prevent a result of the time lagoroccurred and when it prevented Quality/Risk manage report until 1/10/10 measure taken to prevent a result of the time lagoroccurred and when it prevented Quality/Risk manage report until 1/10/10 measure taken to prevent a result of the time lagoroccurred and when it prevented Quality/Risk manage report until 1/10/10 measure taken to prevent a result of the time lagoroccurred and when it prevented Quality/Risk manage report until 1/10/10 measure taken to prevented Quality/Risk manage report until 1/10/10 measure taken to prevented Quality/Risk manage report until 1/10/10 measure taken to prevented Quality/Risk manage report until 1/10/10 measure taken to prevented Quality/Risk manage report until 1/10/10 measure taken to prevented Quality/Risk manage report until 1/10/10 measure taken to prevented Quality/Risk manage report until 1/10/10 measure taken to prevented Quality/Risk manage report until 1/10/10 measure taken to prevented Quality/Risk manage report until 1/10/10 measure taken to prevented Quality/Risk manage report until 1/10/10 measure taken to prevented tak | enous infusion pumplus over 1 minute, the period to administer the 6. Sometime during the see A went on her over to Nurse B. Priod of Charge Nurse C to at while she took care of Nurse C, the verdose of the subsequently expired care unit on 12/26/0 stration, Nurse C making of December 24th ting that an overdose ave caused the death ment did not get the seventeen days (17) the incident report. If when the event twas reported, sk management from the accident to es could have been | en 50 ne B 4. | Emergency Department or the A verification checklist was cre- requiring two nurses to verify a document the order, amount of mixed, amount to be administe and amount to be discarded. A Clinical Nurse Specialist from Quality Department will review nursing checklist retrospectivel. Emergency department staff we educated on the revised tPA paprocedures and the above che Intensive Care Unit staff was inserviced on the revised tPA paprocedures and the above che Responsible Party. Emergency Department Nursin Director ICU Manager Pharmacy Director ICU Manager Pharmacy Director Monitoring: Each time tPA is administered process will be reviewed retrospectively by the Pharmacy Director or his designee. Resulthis review will be communicated monthly to Pharmacy, the Emergency Department and the Intensive Care Unit. Pharmacy Therapeutics Committee as we to the Medical Executive Committee as with the theory oversight of this process and will take necessary action warranted. These committees will also has | ICU. ated and tPA red of the the y. as olicy, cklist. olicy, cklist. olicy, cklist. olicy, cklist. of ed the ey & ell as nittee ess as |

| DEPARTME Centers for N | NT OF HEALTH AND HUMAN Medicare and Medicaid Services | SERVICES (CMS) | | | | AH ORM APPROVED MB NO. 0938-039 |
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| | ROVIDER OR SUPPLIER OUNDATION HOSPITAL | | | RESS, CITY, STATE, ZIP CODE 900 KIELY BLVD SANTA CLARA, CA 9505 | 50 | |
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| A145 | admitted to the hospital an outpatient clinic with difficulties. He was additional floor for further care. Of 11/01/04, at 10:30 am, an order to keep the pasty mouth) as he was he eating. | respiratory mitted to a medical on the morning of the physician wrote atient NPO (nothing | | The hospital thoroughly investig this case. The findings were presented to SEMT, the Risk Management Patient Safety Executive and the Medical Exec Committee. The following actio were initiated: | utive | |
| | At 6:00 pm, Staff E retr | leved the patient's | | A ations. | | Be |
| | lunch tray from the unit began feeding the patic physician's order not to anything by mouth. At | ent despite the give the patient | | Actions: Dietary Heat & Serve Policy (IX. has been revised. The changes this policy include the following: | | 04/05/05 |
| | called the licensed nurs was having difficulty bro nurse entered the room patient unresponsive w | se stating the patier eathing. When the n, she found the | nt | Dietary aides must verify fee status of each patient with the patient's nurse or charge nu- before tray delivery. | hat | 02/26/05 |
| | 40's. The patient expire error at 7:30 pm. | ed as a result of thi | \$ | All Adult Medical Surgical un are prohibited from storing to for NPO patients in the | nits rays | 02/01/05 |
| | When the nurse question what happened, the sta | oned Staff E as to | | refrigerator on the unit. This change in practice was | | 02/18/05 |
| | responded by saying it was feeding the patient an incident report and gassistant unit manager. | occurred while he The nurse wrote gave it to her | | communicated to nursing an dietary staff during the week 02/14/05 and 02/21/05. | nd. | & 02/25/05 respectively |
| | manager was interview pm. and stated he rece the event and began to incident. He forwarded Quality/Risk management | ed on 3/2/05 at 3:00 ived the report afte investigate the the report to | 0 | Actions also included specific coaching and re-educating the assistant-manager who did not immediately report the case. | | 3/1/05 |
| | hospital's internal mail : Manager stated she ne report and did not know | system. The Risk ver received the of the event until | | Responsible Person: Assistant Administrator for Patie Care Services | ent | |
| | 11/06/04, five days after physician on the unit as the unit to look at Patier was no explanation give | ked if she was on nt 2's death. There en s to why | | Director of Adult Services Managers of Adult Services Manager of Nutrition Services | | |
| | Quality/Risk manageme report. | ent did not get the | | Monitoring Dietary department will conduct audits to ensure that trays for Ni patients are not present in the refrigerators. At least 30 spot cher month will be conducted for | PO iecks | 07/15/05 |

| | IT OF HEALTH AND HUMAN edicare and Medicaid Services | | | | | | AH ORM APPROVED 4B NO. 0938-0391 |
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| | OVIDER OR SUPPLIER DUNDATION HÖSPITAL | _ – Santa Clara | STR | REET ADDRI | ESS, CITY, STATE, ZIP CODE 900 KIELY BLVD SANTA CLARA, CA 950 | 50 | |
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| A145 | | • | | A145 | period of 3 months. The data wireported monthly to the Risk Management/Patient Safety Committee and necessary improvement action will be take warranted. Further monitoring with determined based on compliance. | n as vill be | |
| | 3. Patient 33 was a 63 admitted on 2/12/05 fo and shortness of breat diagnosed with a suspiner lower left leg. On 2 Patient 33 was treated infusion of TPA (tissue activator). TPA is a thickney used for dissolvin was infused at 1 mg/hr pm until 2/13/05 at 4:0 33 was noted to be "underesponding to commandeviated to left", and 'opt (Patient) on TPA and changes in mental starmedication that inhibits The most common conadministration of TPA bleeding. Additional ause include: Stroke, in hemorrhage, and arrhy and Comparisons). Opatient 33 was lying on floor West Intensive Chad a flat-affect, her eight was not responsive standing at her bedsid. | r complaints of country in the patient was ected blood clot in 2/12/05 at 4:00 pm with a continuous plasminogen rombolytic agent (ag blood clots). TP. from 2/12/05 4:00 0 am, when Patien responsive". The physician's note and heparin with acutius". Heparin is a blood from clottin in plication of the and heparin is diverse events of Theracranial ythmias (Drug Faction 3/1/05 at 10:00 and her bed on the 6 th are Unit. The Patie yes were open, but it to her husband e. the Pharmacy ed about the | S . A A) at a ses te g. PA ts m, ent | | This case reviewed and was determined not to be a significal event, but rather an adverse driverence of the current ADR reportance of the current ADR reportance emphasizes concurrent collection, and review by Pharmacists. ADR information reported through the ADR hotling Pyxis Antidote Removal Information and e Codes. Although this ADI was documented and followed the clinical pharmacist, it had not been the practice for clinical pharmacists to call the ADR hot The following improvements has 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 insert Effective 03/01/05, all ADRs identified by the clinical pharmatical ensure timely and complete reporting. Responsible Party: Pharmacy Director Monitoring: Quick Track system will be use | ug rting t data is ne, ation, R by ot ttine. vices. | 03/01/05 04/07/05 |

| IT OF HEALTH AND HUMAN | | | | AH FORM APPROVED OMB NO. 0938-0391 |
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| DEFICIENCY MUST BE REGULATORY OR | PRECEDED BY FULL LSC IDENTIFYING | | (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE | LD BE COMPLETION DATE |
| stroke was due to TPA had it been reported at ADR pharmacist reviet 2005 ADR reported an report or an investigati suspected stroke. On the hospital's Risk Ma said if an ADR resulter potential harm", it was to report the ADR "now Management Departm". The hospital's policy a "Adverse Drug Reactil last revised on 8/04) s was to be reported an Occurrence Report" w purpose of the ADR p comprehensive prograsurveillance to identify prevent untoward drug By 3/1/05, Patient 33's occurred on 2/13/05 a be due to the infusion had not been reported the Risk Management. | and heparin, and investigated. The wed the February and did not locate a son of Patient 33's 3/1/05 at 5:30 pm, nagement Director d in "harm, or the hospital's policy" to the Risk ment for investigation and procedures for on" (index # PC.01 specified that any Add an "Unusual yould be initiated. To olicy was to "provided of hospital-wided, evaluate, report ag experiences." Is stroke, which and was suspected of TPA and heparit department, which the stroke in the parity of the partment, which and investigated it department, which | ey on. .01 DR The ie a e and to in, by | weekly on an on-going basis an follow-up will be conducted with managers whose staff are not reporting ADRs in a timely man Oversight of ADR process occumentally by the Pharmacy & | ner. |
| supplies for Patient 3- Patient 34 was an 84 admitted on 1/31/05 f and dehydration. The diagnosed with CMV herpes esophagitis (v On 1/31/05 at 6:30 pr initiated on ganciclov | 4 were inspected. year old male or painful swallowing patient was (cytomegalovirus) riral throat infection n, Patient 34 was ir 285mg IV | ng | reaction. As in the case of pat #33, the clinical pharmacists we involved with the review of medications ordered for this part Actions as a result of the case review include: Actions: | eent vere atient. 03/01/05 |
| | SOLIDER OR SUPPLIER OUNDATION HOSPITAL SUMMARY STATEMENT OF DEFICIENCY MUST BE REGULATORY OR INFORM Program and if Patient stroke was due to TPA had it been reported at ADR pharmacist review 2005 ADR reported ar report or an investigati suspected stroke. On the hospital's Risk Masaid if an ADR resulter potential harm", it was to report the ADR "now Management Departm. The hospital's policy a "Adverse Drug Reactil last revised on 8/04) swas to be reported an Occurrence Report" where the ADR prograsurveillance to identify prevent untoward drug by 3/1/05, Patient 33's occurred on 2/13/05 and be due to the infusion had not been reported the Risk Management was not in accordance and procedures. 4. On 3/1/05 at 11:05 for and dehydration. The diagnosed with CMV herpes esophagitis (v. On 1/31/05 at 6:30 printitated on ganciclov (intravenously) every | OF DEFICIENCIES F CORRECTION OF DEFICIENCIES F CORRECTION (X1) PROVIDER/SUR IDENTIFICATION OSOOT ROVIDER OR SUPPLIER OUNDATION HOSPITAL — Santa Clara SUMMARY STATEMENT OF DEFICIENCIES (EA DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION program and if Patient 33's suspected stroke was due to TPA and heparin, and had it been reported and investigated. TI 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 polic 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 last revised on 8/04) specified that any A was to be reported and an "Unusual Occurrence Report" would be initiated. Purpose of the ADR policy was to "provic comprehensive program of hospital-wide surveillance to identify, evaluate, report a prevent untoward drug experiences." By 3/1/05, Patient 33's stroke, which occurred on 2/13/05 and was suspected be due to the infusion of TPA and hepari had not been reported and investigated if the Risk Management department, which was not in accordance with hospital polic and procedures. 4. On 3/1/05 at 11:00 am, the medicati supplies for Patient 34 were inspected. Patient 34 was an 84 year old male admitted on 1/31/05 for painful swallowin and dehydration. The patient was diagnosed with CMV (cytomegalovirus) | CONTRECTION COVIDER OR SUPPLIER CONTRECTION STREET ADDR COVIDER OR SUPPLIER CONTRECTION COVIDER OR SUPPLIER COVIDER OR SUPPLIER CONTRECTION COVIDER OR SUPPLIER COLOR OR SUPPLIER COLOR OR SUPPLIER COLOR OR SUPPLIER COLOR OR SUPPLIER COMPRETION COLOR OR SUPPLIER CORD OR SUPPLIER COLOR OR | Addisoid Sancies (CMS) OF DEPICIENCIES F CORRECTION (X1) PROVIDER/SUPPLIER OSO071 ROVIDER OR SUPPLIER OUNDATION HOSPITAL - Santa Clara SUMMARY STATEMENT OF DEPICIENCIES (EACH DEPICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION 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 space in did not locate a report or an investigation of Patient 33's suspected stroke. On 3/1/05 at 5:30 pm, had not been reported and in Chusual Coccurrence 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 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 maile: admitted on 1/31/05 for painful swallowing and dehydration. The patient was diagnosed with CMV (cytomegalovirus) herpes sepophagitis (viral throat infection). On 1/31/05 at 6:30 pm, Patient 34 was initiated on ganciclovir 285mg IV (intravenously) every 12 hours, and |

FORM CMS - 2567 (09-92)

Page 10 of 21

| DEPARTME Centers for A | NT OF HEALTH AND HUMAN Medicare and Medicald Service | N SERVICES | | | AH FORM APPROVED OMB NO. 0938-0391 |
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| A145 | Ganciclovir is an antive Ceftazidime is an antive Ceftazidime is an antive Ceftazidime is an antive ceft include thrombocytop number of platelets in life-threatening. Patient 34's platelet of 1/31/05 125 K/ul (fact 140–400K/ul with K=1/2/1/05 gagnoiclovir of 140mg IV every 24 hoc 2/2/05 80 K/ul 2/3/05 66 K/ul 2/3/05 66 K/ul 2/5/05 ganciclovir 450mg started 2/8/05 36 K/ul 2/10/05 28 K/ul 2/10/05 28 K/ul 2/10/05 295 K/ul Patient 34's medical refollowing progress not a. A 2/7/05 physician "thrombocytopenia (lo secondary to ganciclow valganciclovir orally". b. A 2/10/05 physician decreased plt (plateled Ganciclovir". On 3/1/05 at 11:20 ampharmacist was aware adverse reaction (through Ganciclovir was aware adverse reaction (through Ganciclovi | riral agent. biotic. Potential fects of ganciclovir enia (decreased the blood) and can ount was as follows: ility normal range wa 000) lose was decreased ours. scontinued, and orally twice daily encord included the tes: n's note stating w platelet count) wa vir" and to vir" and start en's note that ets) was secondary to the interviewed ur e of Patient 34's embocytopenia) due which was identified in | as to | and importance of timeliness of reporting were provided to the Pharmacy. Responsible Party: Pharmacy Director Monitoring: Quick Track system will be used 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. | er. |
| | On 3/1/05 at 3:15 pm, | the Pharmacy | | Although this ADR was documen | ted |

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| A145 | Director was interview hospital's Adverse Dri program and if Patient thrombocytopenia sust ganciclovir had been investigated. The ADI reviewed the February and did not locate a reinvestigation of Patient thrombocytopenia. On the Pharmacy Director pharmacist who said is Patient 34's suspected reaction (thrombocytopenia of the facility's Risk man if an ADR resulted in harm", it was the hospithe ADR "now" to the Department for investigated by the Risk department, which was with hospital policies and programment policies and policies and policies and policies and programment policies and | red about the ug Reactions (ADR) t 34's spected due to reported and R pharmacist / 2005 ADR reports report or an t 34's n 3/1/05 at 3:40 pm, r contacted the ICU's she had not reported d adverse drug penia) subsequent to n 3/1/05 at 5:30 pm, agement Director sa harm, or potential oital's policy to report Quality Assurance igation. thrombocytopenia, //05 and was the infusion of | o , id | and followed by the clinical pharmacist, it had not been the practice for clinical pharmacists call the ADR hotline. Actions: Effective 03/01/05, all ADRs identified by the clinical pharma are called into the ADR hotline ensure timely and complete reporting. Responsible Party: Pharmacy Director Monitoring: Quick Track system will be use monitor timeliness of reporting ADRs. Reports will be generate weekly on an on-going basis ar follow-up will be conducted with managers whose staff is not reporting ADRs in a timely man Oversight of ADR process occumentally by the Pharmacy & Therapeutics Committee and the Medication Error Improvement Committee. | d to 03/01/05 to 04/12/05 & on-going ad ad aner. |

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| Contract for Medicine and Medical Services (CISS) AND PLAN OF CORRECTION NAME OF PROVIDER CR SUPPLIER KAISER FOUNDATION HOSPITAL - Santa Clara NAME OF PROVIDER CR SUPPLIER KAISER FOUNDATION HOSPITAL - Santa Clara (24) ID PREPK TAG SUMMARY STATEMENT OF DEPULISHOES (EACH PREPK) TAG SUMMARY STATEMENT OF DEPULISHOES (EACH PREPK) TAG SUMMARY STATEMENT OF DEPULISHOES (EACH PREPK) REGULATORY OR LSG IGNITITY INFO MICROARTION AND A 208 A 208 DEPOLIPS AND HOSE CORRECTION AND A 482 23(c) PREPARATION AND AND AND ADDRESS, CTY, STATE, ZIP CODE SANTA CLARA, CA 9505 SANTA CLARA, CA 9505 COMPLETION PREPK, TAG A 208 APPROPRIATE DEPICIENCY) A 208 DEPOLIPS PLAN OF CORRECTION AND APPROPRIATE DEPICIENCY) A 208 DIVIDING AND ADDRESS, CTY, STATE, ZIP CODE SANTA CLARA, CA 9505 COMPLETION PREPK, TAG APPROPRIATE DEPICIENCY) A 208 APPROPRIATE DEPICIENCY A 208 A 208 APPROPRIATE DEPICIENCY A 208 A 208 APPROPRIATE DEPICIENCY A 208 A 208 APROPRIATE DEPICIENCY A 208 A 208 APPROPRIATE DEPICIENCY A 208 A 208 A 208 Influsion policy and practice were reviewed and the following inprovements have been iniliated: include reviewed and the following inprovements have been iniliated: include reviewed and the following inprovements have been iniliated: include reviewed and the following inprovements have been iniliated: include reviewed to the following intravenous (IV) antibion son. Patient 32's "Vital signs and I (Intake) & O (Output) Record documented DGLR IV fluid was influenced by the following adjusting a set of 30milyr 227/O4 evening shift (1 pm - 7 am) = 1000ml for a rate of 60milyr 227/O4 evening shift (1 pm - 7 am) = 240ml | DEPARTMEN | T OF HEALTH AND HUMAN | SERVICES | 11 | | AH FORM APPROVED |
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| 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 standards 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 5 ¹⁰ 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's "Vital signs and I (intake) & O (output) Record" documented DisLR IV fluid was infused as follows: 2/27/04 night shift (11 pm - 7 am) = 1000ml for a rate of 50ml/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 2/28/04 night shift (11 pm - 7 am) = 240ml for a rate of 30ml/hr 2/28/04 night shift (11 pm - 7 am) = 240ml for a rate of 30ml/hr 2/28/04 night shift (11 pm - 7 am) = 240ml for a rate of 30ml/hr 2/28/04 night shift (11 pm - 7 am) = 240ml for a rate of 30ml/hr 2/28/04 night shift (11 pm - 7 am) = 240ml for a rate of 30ml/hr 2/28/04 night shift (11 pm - 7 am) = 240ml for a rate of 30ml/hr 2/28/04 night shift (11 pm - 7 am) = 240ml for a rate of 30ml/hr 2/28/04 night shift (11 pm - 7 am) = 240ml for a rate of 30ml/hr 2/28/04 night shift (11 pm - 7 am) = 240ml for a rate of 30ml/hr 2/28/04 night shift (11 pm - 7 am) = 240ml for a rate of 30ml/hr 2/28/04 night shift (11 pm - 7 am) = 240ml for a rate of 30ml/hr 2/28/04 night shift (11 pm - 7 am) = 240ml for a rate of 30ml/hr 2/28/04 night shift (11 pm - 7 am) = 240ml for a rate of 30ml/hr 2/28/04 night shift (11 pm - 7 am) = 240ml fo | PREFIX | DEFICIENCY MUST BE PRECEDED BY FU REGULATORY OR LSC IDENTIFYING | | . PREFIX. | (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE | LD BE COMPLÉTION |
| Patient 32's record documented a 2/28/05 Monitoring: | A 208 | Drugs and biologicals rand administered in ac Federal and State laws practitioner or practition the patient's care as sp§482.12(c), and accept practice. This standard s not me Based on observation, and staff interview, the provide medications in physician's orders and of practice. Findings include: 1. On 2/28/05 at 12:2 of the 5 TH Floor Post-Prevealed Patient 32 waintravenous (IV) antibio caesarian section. Patroom and had a continudextrose 5% in Lactate intravenous fluids infus 30ml/hr. Patient 32 sacut off the dextrose (IV) Patient 32's "Vital signs (output) Record" docur was infused as follows: 2/27/04 night shift (11p for a rate of 125ml/hr 2/27/04 day shift (7 am a rate of 56ml/hr 2/27/04 evening shift (3 240ml for a rate of 30ml/hr for a rate of 30ml/hr | inust be prepared cordance with the orders of the ners responsible for pecified under ted standards of the accordance with accordance with accordance with accepted standards of the first subsequent to accordance with accepted standards of the first subsequent to accordance with accepted standards of the first subsequent to accordance with accepted standards of the first subsequent to a first s | or ds on t o a o a o uid ml | reviewed and the following improvements have been initiate Actions: General Infusing Policy (PC 05.09.08) has been and revised include TKO rates which will be until a specific rate order is writt Nursing staff will be educated or revised policy and practice by Nursing Managers and Nursing Educators and the importance or reviewing orders prior to infusing adjusting rates. Responsible Party: Assistant Administrator for Patie Care Services Nursing Directors Nursing Managers | od: 04/06/05 to used en. 04/25/05 of g or |

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| 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". | | i | 70 open medical records will be reviewed weekly for compliance policy requirements and adherer to physician orders for 3 months nursing managers, assistant managers and charge nurses. Results will be reported monthly the Performance Improvement Committee and Medical Executive Committee and actions will be tales warranted. Future monitoring be based on compliance. | to re ken | |
| | Patient 32's medical r Patient 32's IV infusion the morning of 2/27/0 accordance with the p | n rate was decrease 5 which was not in | ed | Practice was reviewed and discussed with individual nurse. Nurse was counseled by departr manager. Responsible Party: Department Manager Monitoring: Refer to plan above | 02/28/05 nent |
| | 2. Patient 1, a 64 ye admitted to the hospit at 4:51 pm on 12/24/0 complaint of "vision of was accompanied by stated that Patient 1 v articulating words. He physician who wrote a administer 67.5 mg of (6.75) to be administer minute and 60.25 mg minutes. Patient 1's particulating words and premixed 100 mg of the bottle to an intraversal to an intraversal to a programmed the pummg, over 59 minutes. | cal's emergency roor 24 with a chief changes". The patier his wife, who further was having a hard tir e was seen by the an order at 6:55 pm, f TPA; ten percent ered as a bolus over to be given over 59 orimary nurse (Nurse of TPA and connecte enous infusion pump us over 1 minute, the up to administer the | nt to 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 | Please refer to response for A14 page 6. | 5 on |

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| A208 | infusion process, Nurse break, turning care ove to the medication being was asked by Relief Cl attend another patient of Patient 1. | r to Nurse B. Prior g completed, Nurse harge Nurse C to | В | | | • |
| | After the 60 minute information in the pump alar staff the preset amount Nurse C responded to it off. She saw that sor remained in the bottle a another nurse (Nurse C rest (approximately 32. patient more TPA than ordered. | m sounded to alert to fTPA had infused the alarm and turned me medication and with the help of the manning the sound with the help of the full and with the help of the full and the full a | d. ed | | | |
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| | | • | | | | |
| A215 | 482.23(c)(4) PREPARA ADMINISTRATION OF | ATION AND DRUGS | A215 | | | |
| | There must be a hospit reporting transfusion redrug reactions, and error of drugs. This standard was not Based on documentatic although the hospital hereporting adverse drug | eactions, adverse ors in administration met as evidenced b on and interview, as a procedure for reactions and error | py: | | | |
| | in administration of dru implement these proce include: | gs, staff failed to | | | | |

AH FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 Contors for Medicare and Medicaid Services (CMS) (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CL1A STATEMENT OF DEFICIENCIES COMPLETED **IDENTIFICATION NUMBER:** A. BUILDING_ AND PLAN OF CORRECTION 03/02/2005 B. WING 050071 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 900 KIELY BLVD KAISER FOUNDATION HOSPITAL — Santa Clara SANTA CLARA, CA 95050 PROVIDER'S PLAN OF CORRECTION (X5)SUMMARY STATEMENT OF DEFICIENCIES (EACH (X4) ID 1D COMPLÉTION (EACH CORRECTIVE ACTION SHOULD BE PREFIX PRÉFIX DEFICIENCY MUST BE PRECEDED BY FULL CROSS-REFERENCED TO THE DATE REGULATORY OR LSC IDENTIFYING TAG TAG APPROPRIATE DEFICIENCY) INFORMATION Please refer to response for A145 on A215 administration of a medication that did not A215 follow hospital procedure and the failure to page 9. investigate and report an adverse drug reaction in accordance with hospital policy and procedures. A252 482.25(b) DELIVERY OF SERVICES A252 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: The General Infusing Policy On 2/28/05 at 11:15 am, the inspection of (PC.05.09.08) has been reviewed the central pharmacy revealed an order for and the following actions have been Patient 31 for intravenous (IV) Dextrose 5% in Lactated Ringer's solution (D5LR) with 20 taken: units of oxytocin to be infused at a rate of 125ml/hr. The label printed by the Actions: Policy has been revised to include pharmacy to be placed on the IV bag 04/04/05 the rate or "as directed" rates for specified the infusion rate to be "UD" (as large volume fluids and medications directed), but did not include the ordered that are titrated. This is consistent rate of infusion of 125ml/hr. with current hospital practice. The Pharmacy Director said all labels Policy will be approved by the printed in the pharmacy and placed on bags 04/24/05 & of IV fluid did not include specific infusion Pharmacy & Therapeutics 04/12/05 Committee and Nursing Policy & rates. The Pharmacy Director said nursing respectively staff may be changing infusion rates, so the Procedure Committee. Page 16 of 21 FORM CMS - 2567 (09-92)

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ΑĤ FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0939-0391 Centers for Medicare and Medicald Services (CMS) STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CL1A (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION COMPLETED **IDENTIFICATION NUMBER:** A. BUILDING. B. WING 03/02/2005 050071 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 SUMMARY STATEMENT OF DEFICIENCIES (EACH ΙĐ PROVIDER'S PLAN OF CORRECTION (X5)PRÉFIX COMPLETION DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE TAG REGULATORY OR LSC IDENTIFYING DATE TAG INFORMATION APPROPRIATE DEFICIENCY) A252 infusion rate specified in physician's orders 04/30/05 A252 Pharmacy and Nursing staff are would not be entered in the pharmacy being educated on revised policy and change in practice by the computer or in the infusion rate on the label of the IV bag. Pharmacy Director and Nursing Managers, respectively. The hospital's policy and procedures on "IV Administration: General Infusing Policy" Responsible Party: Pharmacy Director (index # 05.09.08 last revised 8/04) specified "Labeling of IV infusion bags or Assistant Administrator for Patient bottles should include: Care Services Patient's name, medical number, room Monitoring: number, drug name and amount, solution and volume, preparation date, rate of 30 labels/week for 4 weeks will be 07/15/05 infusion." The label on Patient 31's D5LR reviewed by Pharmacy. Data will be IV bag did not include an infusion rate. reported to the Pharmacy and which was not in accordance with hospital Therapeutics and Performance procedures. Improvement Committee, Future monitoring will be based on compliance. A452 482.55 EMERGENCY SERVICES A452 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: FORM CMS - 2567 (09-92) Page 17 of 21

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| | ROVIDER OR SUPPLIER OUNDATION HOSPIT | 'AL – Santa Clara | STREET ADD | RESS, CITY, STATE, ZIP CODE 900 KIELY BLVD SANTA CLARA, CA 950 | 50 |
| (X4) ID PREFIX TAG | DEFICIENCY MUST I | T OF DEFICIENCIES (EAG BE PRECEDED BY FULL R LSC IDENTIFYING RMATION | CH ID PREFIX TAG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | LD BE COMPLÉTION DATE |
| 1. See A145 regarding Patient 1 who was admitted to the hospital's emergency roon 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; Subsect 2.3.3.10.4 states, "Staff subtracts the todose from 100 mg (vial contains 100mg 100 ml) and withdraws and discards appropriate amount: i.e. if total dose is sing, then discard 10 ml from vial." The policy further sates under Subsection 2.3.3.10.3, the maximum dose that may administered in 9.mg. Nursing staff did not follow this policy for mixing the TPA. After mixing the TPA a water, the entire contents 100 mg, and the ordered dose 67.5 mg, was administered to Patient 1. | | ital's emergency roor spital policy for mixing e medication TPA fedication and IV 0.05.20.03; Subsection taff subtracts the total vial contains 100mg in ws and discards i.e. if total dose is 90 ml from vial." The under Subsection mum dose that may be g. I follow this policy for er mixing the TPA and tents 100 mg, and note 5 mg, was | n g n l n | Please refer to response for A1 page 6 | 45 on |
| | month old who was room on 3/1/05 for a was recorded in the taken orally. The emdid not have a policy temperatures. The highest department policy st | ng Patient 3, an 11 seen in the emergence fever. The temperate patient's chart as bei nergency department of for the taking of infa nospital's pediatric tated that temperature ally for infants under 1 | ure ng nt | Actions: The Emergency department ha adopted Age-related Considera Pediatric and Geriatric Policy (ED.03.03.03) for monitoring in temperature. Currently, temperatures for infants under age of one will be taken rectally unless contraindicated. Emergency department staff winserviced on the policy and chin practice. | fant the v. 03/02/05 |
| | 3 - 2567 (09-92) | | | In addition, American Academy Pediatrics guidelines and other evidence-based recommendat will be reviewed and policy and procedures will be revised, if indicated. Staff will be re-trained the changes in practice by managers. | ions |

| 12.4 | | | | | | 4/7/05 |
|--------------------------|---|---|-------------|---|-----|--------------------------------------|
| | T OF HEALTH AND HUMA | | | | | AH RM APPROVED 3 NO. 0938-0391 |
| STATEMENT AND PLAN C | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SU IDENTIFICATION 0500 | ON NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | i c | ATE SURVEY COMPLETED 3/02/2005 |
| | ROVIDER OR SUPPLIER OUNDATION HOSPIT | AL – Santa Clara | STREET ADDR | RESS, CITY, STATE, ZIP CODE 900 KIELY BLVD SANTA CLARA, CA 9505 | 50 | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (I DEFICIENCY MUST BE PRECEDED BY FU REGULATORY OR LSC IDENTIFYING INFORMATION | | | PROVIDER'S PLAN OF CORRECTION | | (X5) COMPLETION DATE |
| A452 | | | A452 | Responsible Party: Emergency Department Nursing Director Emergency Department Medica Directors Monitoring: 25% of infant charts will be monitored weekly for three mon by the Emergency Department management. Results will be reported to Performance Improvement Committee month and improvement action will be taken as warranted. Future monitoring will be based on compliance. | ths | 07/15/05 |
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| 10.10 | жжа ли ма манали жазана на т | | | | | 4/705 AH |
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| | IT OF HEALTH AND HUM adjeste and Medicald Serv | | | | | ORM APPROVED IB NO. 0938-0391 |
| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SU AND PLAN OF CORRECTION (X1) PROVIDER/SU (DENTIFICATION (DENTIFICATIO | | ON NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | | ATE SURVEY COMPLETED 03/02/2005 | |
| | ROVIDER OR SUPPLIER OUNDATION HOSPIT | TAL - Santa Clara | STREET ADDR | ESS, CITY, STATE, ZIP CODE 900 KIELY BLVD SANTA CLARA, CA 950 | 50 | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EA DEFICIENCY MUST BE PRÉCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION | | ACH ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION | | (X5) COMPLETION DATE |
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| | | | | | | |
| A455 | 482.55(A)(2) ORGA DIRECTION | ANIZATION AND | A455 | | | |
| | departments of the This Standard is no Based on interview four emergency roof found that in 1 of 4 records, the emergency | ot met as evidenced to and documentation, om patient records, it (Patient 3) patient gency department fails a that was consistent | oy: in was | Please refer to response for A page 18. | 452 on | |
| | 8:10a.m., by his pa "fever." The infant nurse (Nurse F) what infant's temperatur nurse was interview a.m., and stated he temperature using When the emerger | ergency room on 3/1/0 arents for a complaint was seen by the triag ho documented the re was taken orally. To wed on 3/1/05 at 9:00 | of le he | | | |

FORM CMS - 2567 (09-92)

Page 20 of 21

| | Medicaro and Medicald Service | | | | | MB NO. 0988-039 |
|---|--|--|------------------------|---|------|--|
| 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 |
| | ROVIDER OR SUPPLIER OUNDATION HOSPITA | L - Santa Clara | STREET ADDR | RESS, CITY, STATE, ZIP CODE 900 KIELY BLVD SANTA CLARA, CA 95 | 050 | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EAC DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION | | CH 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, n provided. On 3/1/05 at was made to the hospi review of their policy st temperatures are taken year of age. The emer- follow this policy. | :10:00 a.m., a visit ital's pediatric unit. / tated that rectal n for infants under 1 | 1 | | | |