

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/07/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 050516	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/04/2024
NAME OF PROVIDER OR SUPPLIER MERCY SAN JUAN MEDICAL CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 6501 COYLE AVE CARMICHAEL, CA 95608		
(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 000	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health during a complaint validation survey conducted on 9/30/2024 through 10/4/2024 for CMS Control #CA00918214, #CA00914497, and #CA00916965. The investigation was limited to the specific complaints investigated and authorized conditions of participation, and does not represent the findings of a full inspection of the hospital. The census on date of entry was 367 and the sample size was 27.	A 000			
A 043	GOVERNING BODY CFR(s): 482.12 There must be an effective governing body that is legally responsible for the conduct of the hospital. If a hospital does not have an organized governing body, the persons legally responsible for the conduct of the hospital must carry out the functions specified in this part that pertain to the governing body ... This CONDITION is not met as evidenced by: Based on interview, and document review, the hospital failed to ensure an effective governing body legally responsible for the conduct of the hospital for a census of 367 patients out of a hospital bed capacity of 384 when: A. The hospital failed to ensure the services of the Regional Morgue Office complied with regulations and facility policies and procedures related to family notification of patient death, timely completion of death certificates, and	A 043		11/25/24	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
		11/13/2024

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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A 043	Continued From page 1 processing of patient remains for a sample of three out of 61 hospital deceased patients (Patient 2, Patient 3, Patient 4) stored at an off-site morgue. Refer to A-0083. These failures contributed to ongoing delays in processing death certificates, lack of family notification of patient deaths, and prolonged storage of patient bodies in an off-site morgue, which had the potential to result in family distress over the perception of patients missing for prolonged periods of time when in fact they were deceased and in storage; On 10/4/2024, the off-site morgue had 61 patient remains from the hospital, 11 patient remains from deaths in 2022, 15 patient remains from deaths in 2023, and 19 patient remains from deaths in the first half of 2024. The cumulative effect of these systemic problems resulted in the inability of the hospital to comply with the statutorily mandated Condition of Participation for Governing Body.	A 043			
A 083	CONTRACTED SERVICES CFR(s): 482.12(e) The governing body must be responsible for services furnished in the hospital whether or not they are furnished under contracts. The governing body must ensure that a contractor of services (including one for shared services and joint ventures) furnishes services that permit the hospital to comply with all applicable conditions of participation and standards for the contracted services. This STANDARD is not met as evidenced by: Based on interview and document review, the	A 083		11/25/24	

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A 083	<p>Continued From page 2</p> <p>hospital failed to demonstrate the governing body was responsible for services furnished by the Regional Morgue Office (RMO), in the Greater Sacramento Division (GSD), for a sample of three out of 61 deceased patients (Patient 2, Patient 3, and Patient 4) stored in an off-site morgue at time of survey. The Regional Morgue Office failed to:</p> <ol style="list-style-type: none"> 1. Notify the families of Patient 2, Patient 3, and Patient 4 of their deaths, and complete death certificates per regulatory requirements, 2. Resolve a known back-log of 61 deceased patients stored in an off-site morgue according to the GSD Laboratory Morgue Policy and Procedure. <p>These failures resulted in a delay in completion of death certificates, in notification to families of patient deaths, and in handling the patients' bodies after death. These failures had the potential to prolong distress and grief for families.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. During a review of a log kept by the RMO of patient remains in an off-site morgue, the log indicated: <ol style="list-style-type: none"> a. Patient 2 died on 10/3/2022, family had not been found as of 9/5/2024 per the Public Administrator (PA), the death certificate had not been completed, and Patient 2's remains continued to be stored at the off-site morgue; b. Patient 3 died on 10/21/2022, on 5/23/2024 the PA spoke with Patient 3's family member who requested disposal of remains under county indigent (suffering from extreme poverty) plan, 	A 083			

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A 083	<p>Continued From page 3</p> <p>the death certificate had not been completed, and Patient 3's remains continue to be stored at the off-site morgue; and</p> <p>c. Patient 4 died on 12/28/2022, a note indicated Spanish interpreter needed to proceed, the death certificate had not been completed, and Patient 4's remains continue to be stored at the off-site morgue.</p> <p>During an interview on 10/1/2024 at 1:15 p.m. with the Sacramento Market Leader of Laboratory Services: Lab, Cardiopulmonary, & Rehabilitation (SMLLSLCR), SMLLSLCR stated the RMO was responsible for making three attempts to contact family once patient remains left the local hospital. SMLLSLCR stated there was no expected time frame for the contact attempts. SMLLSLCR stated, until recently there was no log to track the attempts. SMLLSLCR stated, if the process fails to yield results, the case should be forwarded to the County Public Administrator, who would attempt to find family, and if none could be found after a diligent search, contact the coroner to pick up the body. SMLLSLCR stated, the Office of the Coroner would attempt to contact family if known family could not be reached. SMLLSLCR stated, records of referrals to the PA and the Coroner's Office had not been kept until recently. SMLLSLCR could not provide documented evidence of referrals to the PA or Coroner.</p> <p>During an interview on 10/2/2024 at 10:20 a.m. with Chairman of the Community Board (CCB) responsible for both the Community Board and the Quality Committee of the Community Board (QCCB), CCB stated the Community Board was comprised of the Chiefs of Staff and Presidents of the hospitals in the GSD, which included four</p>	A 083			

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A 083	<p>Continued From page 4</p> <p>hospitals. The Community Board reviewed reports from the QCCB Committee. CCB stated they were not aware of prior hospital regulatory violations for failure to process patient remains.</p> <p>During review of the Community Board Meeting minutes for the period of January 2024 to August 2024 meetings, the minutes did not reference any concerns regarding processing patient remains. There was no information regarding untimely completion of death certificates or lack of notification of next of kin of the death of a patient.</p> <p>2. During an interview on 10/2/2024 at 1:05 p.m. with Supervisor of Lab Support Services (SLSS), SLSS stated she was aware the RMO was failing to timely process patient remains and complete death certificate worksheets beginning in April 2023. SLSS stated, initially she tried to help more with the process in addition to her clinical laboratory duties. SLSS stated the backlog continued; she reported it to the Regional Laboratory Director and Hospital President (HP) in September 2023. SLSS stated "It went nowhere." SLSS stated no log or documents were kept for the Morgue processes until April 2024.</p> <p>During an interview on 10/3/2024 at 3 p.m. with the Regional Director of Laboratory Services (RDLS), RDLS stated he had been aware of the RMO backlog shortly after starting his role three months ago.</p> <p>During an interview on 10/3/2024 at 3:35 p.m. with the Chief Operating Officer (COO), the COO stated he started in his role three and half months ago and the lab reports to him. He was not aware of the back-log of processing human remains within RMO until it was a news story, in August</p>	A 083			

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A 083	Continued From page 5 2024. COO stated resolving the issues became a priority then. During an interview on 10/3/2024 at 4:15 p.m. with the Hospital President (HP), the HP stated he was legally responsible for all hospital services. HP stated he reports to a GSD Hospital President, but the Healthcare Organization Governing Body had delegated the responsibility of hospital services to him. HP stated he was aware of the failures of the RMO to timely process patient remains and complete the death certificate worksheets in September 2023. HP referred the issues to the GSD President in September 2023. HP stated the GSD President and legal department were working to resolve the issue. HP stated he had not received, nor asked for any updates on solutions. When asked to explain this lack of oversight, HP stated the problem would be addressed at the divisional level; HP stated, "It is not my scope." HP stated he was not aware of the failure to notify families. HP stated, "We assumed the remains being stored did not have families." HP explained the patient populations at the hospital included high numbers of homeless persons. HP stated he never reported the backlog of patient remains processing or family notifications to the Community Board. HP stated that National Board is only notified of regional issues from the Community Board. HP stated "I'm legally and morally responsible for those in the morgue". HP stated he was not aware of previous facility regulatory violations and plans of correction for failure to notify families of patient deaths. HP stated the previous QD notified him that all plans of corrections were completed. HP stated the previous plans of corrections did not have ongoing monitoring. HP stated QD does not have	A 083			

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A 083	Continued From page 6 a direct line of reporting to him. In a concurrent interview and document review of the GSD Laboratory Morgue Policy and Procedure, approved 3/1/2022, with the SLSS on 10/3/2024 at 1 p.m., the document indicated processes for handling abandoned bodies and bodies with no next of kin. The document indicated the RMO should contact the public administrator and coroner when family could not be reached, or found, or the next of kin did not have resources to cremate or bury the body. The SLSS stated there was no documented evidence these agencies were contacted for assistance. In a document review of the Patient Safety Program Annual Summary and Evaluation for Fiscal Year 2023, which details categories of adverse events reported during the year, any regulatory findings, and active and completed plans of correction, submitted September 2023 to the Community Board, the document did not include documentation of the gaps in patient notification, death certificate processing according to legal requirements, or delay in handling patient remains. In a concurrent interview and record review of the newly created log of patient remains in off-site morgue storage, last updated 10/3/2024, with the QD on 10/3/2024 at 4:45 p.m., the QD confirmed the log indicated 11 bodies have been in storage since 2022, 15 bodies have been in storage since 2023, and 19 bodies have remained in storage from 1/1/2024 to 6/30/2024. The log indicated there were 61 patient remains in the off-site morgue on 10/3/2024.	A 083			
A 263	QAPI	A 263		11/25/24	

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A 263	<p>Continued From page 7 CFR(s): 482.21</p> <p>The hospital must develop, implement and maintain an effective, ongoing, hospital-wide, data-driven quality assessment and performance improvement program.</p> <p>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.</p> <p>The hospital must maintain and demonstrate evidence of its QAPI program for review by CMS.</p> <p>This CONDITION is not met as evidenced by: Based on observation, interview and document review, the hospital failed to develop, implement, and maintain an effective, ongoing, hospital-wide, data-driven quality assessment and performance improvement (QAPI) program that reflected the complexity of the hospital's organization and services for a census of 367 patients in a hospital bed capacity of 384, as evidenced by:</p> <p>A. The hospital QAPI program failed to show documented evidence of data collected to track performance and to ensure improvements were sustained for two plans of correction for regulatory violations related in part to family notification of patient death and processing of the bodies of deceased patients, and the implementation of a process change for central venous catheter (a thin flexible tube that is</p>	A 263		

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A 263	Continued From page 8 inserted into a vein and guided into a large vein above the right side of the heart) removal. Refer to A0283. These failures resulted in regulatory noncompliance with QAPI standards and resulted in missed opportunities for improvement andf ongoing failures. The cumulative effect of these systemic problems resulted in the inability of the Hospital to comply with the statutorily mandated Condition of Participation for QAPI.	A 263			
A 283	QUALITY IMPROVEMENT ACTIVITIES CFR(s): 482.21(b)(2)(ii), (c)(1), (c)(3) (b) Program Data (2) [The hospital must use the data collected to -] (ii) Identify opportunities for improvement and changes that will lead to improvement. (c) Program Activities (1) The hospital must set priorities for its performance improvement activities that-- (i) Focus on high-risk, high-volume, or problem-prone areas; (ii) Consider the incidence, prevalence, and severity of problems in those areas; and (iii) Affect health outcomes, patient safety, and quality of care. (3) The hospital must take actions aimed at performance improvement and, after implementing those actions, the hospital must measure its success, and track performance to ensure that improvements are sustained.	A 283		11/25/24	

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A 283	Continued From page 9 This STANDARD is not met as evidenced by: Based on observation, interviews, and record reviews, the hospital Quality Assessment and Performance Improvement (QAPI) Program failed to show documented evidence of data collected to track performance and to ensure improvements were sustained when there was no documented evidence of implementation and completion for: 1. The Plan of Correction (POC, an action plan submitted by a hospital to a State Agency to correct a cited regulatory violation) for intake CA00511685, dated April 2022, indicated plans to educate staff regarding accuracy of family contact information in chart, timely notification of death to next of kin by physician and physician's timely completion of deceased patient's charts including the summary of hospital course and discharge summary. Additionally, the Quality Program Manager (QPM) was responsible for verification through chart audits and providing semiannual reporting of audit for integration into the QAPI process. The timeframe indicated on the POC stated "reporting will continue until four consecutive audit results are 100% excluding months with no cases". 2. The POC for intake CA00747251, dated July 2023, indicated the development of an education module for the Pathology (study of disease) Laboratory and Administrative Nursing Supervisor staff covering the steps to take after the death of a patient to ensure dignity and respect, following federal and state regulatory requirements and including responsible staff tasks. This POC would be verified by Quality and Patient Safety Program	A 283			

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A 283	<p>Continued From page 10 Manager (QPSPM) with chart audits meeting measurable goals until "three consecutive months of goal performance was achieved".</p> <p>3. A performance improvement project, dated 6/8/2023, identified by the Quality Management Committee (QMC) as a targeted area for improvement, focused on the removal of central venous catheters (CVC, a thin flexible tube that is inserted into a vein and guided into a large vein above the right side of the heart) prior to transfer to lower level of care (intensive care unit to medical or surgical units) to reduce the risk of CVC related patient adverse events.</p> <p>These failures resulted in regulatory noncompliance with QAPI standards and resulted in missed opportunities for improvement.</p> <p>Findings:</p> <ol style="list-style-type: none"> During a review of the POC for intake CA00511685, dated April 2022, the POC included the following corrective actions, in part: <ol style="list-style-type: none"> Education provided to medical staff on contacting and documenting family notification of death. Department managers provided education to hospital staff about the importance of accuracy of information in the medical record, including contact numbers. Developed an auditing and reporting process to evaluate the accuracy of telephone numbers listed as contacts in the medical record. Scheduled semiannual reporting and of audit results to the QMC of the medical staff for integration into the established QAPI process. During a review of the POC for intake 	A 283			

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A 283	<p>Continued From page 11</p> <p>CA00747251, dated July 2023, the POC included the following corrective actions, in part:</p> <p>a. Development of an education module for Pathology Laboratory and Administrative Nursing Supervisors to include at time of death the patient will be cared for with dignity and respect, in accordance with federal and state regulatory requirements, the location of Notifications of Death Form, the documentation of deceased patient in morgue logbook and identify who is provided access to the morgue.</p> <p>b. Retrospective chart audits performed by QPSM to verified that patients were deposited in the morgue with the appropriate documentation. This audit was to continue until 3 consecutive months of goal performance of 100% compliance was achieved.</p> <p>During a review of the hospital QAPI plans, dated fiscal year 2023 and fiscal year 2024, the QAPI plans did not include any documented evidence of implementation of corrective actions identified in the POCs or evidence of tracking of performance improvement.</p> <p>During a concurrent interview and record review on 10/1/24, at 11:05 a.m., with the Quality Director (QD), the QD was provided a copy of the POCs for intakes CA00511685 and CA00747251. After reviewing the POCs, the QD stated, "I am not familiar with these POCs ...will research ...these were before I started and there was no handoff to me [from previous staff]".</p> <p>During an interview on 10/3/24, at 1:20 p.m., with the QD, the QD stated, "I have not been able to locate data for either POC". The QD stated, "No one was working on these [POCs], there is no data to provide implementation and tracking." The</p>	A 283			

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A 283	<p>Continued From page 12</p> <p>QD confirmed there was no documented evidence the interventions in the POCs, that were dated April 2022 and July 2023 respectively, were monitored for success and sustained compliance per hospital QAPI plan and regulatory requirements.</p> <p>3. During an interview on 10/3/24, at 11:45 a.m., with Critical Care Nurse Educator (CCNE), the CCNE stated, they are working on a performance improvement project (PIP) to remove CVC before the patient is transferred to the medical or surgical floor. The CCNE stated, starting in February of 2023, the QMC started to investigate CVC line removal before transfer to a lower level of care as a quality indicator. The CCNE stated the nursing staff had been educated via Pathways (an online learning module the hospital utilizes to educate nurses) to a new vascular (vein) access policy, which included a skills module for vascular access care and removal. This module was assigned on 3/9/23 with a due date of 4/30/23. When asked about how many patients were being sent to the medical/surgical floor with CVC for this PIP the CCNE stated, "We are not tracking the data."</p> <p>During a review of QMC minutes, dated June 2023, the QMC indicated the need to remove CVCs prior to transfer to a lower level of care.</p> <p>During a concurrent observation and interview of the 5C Trauma medical surgical and telemetry (continuous monitoring of heart activity) unit, on 10/3/24, at 10:20 a.m., with the QD, the QD stated the unit was focused on monthly report cards (an infographic that is posted on a bulletin board for all staff to see). The only PIP that was observed posted in the unit was for patient falls.</p>	A 283			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 050516	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/04/2024
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A 283	Continued From page 13 The QD stated that she did not see evidence of a PIP for CVC removal.	A 283			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
OMB NO. 0938-0391

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A 043	Continued From page 1 processing of patient remains for a sample of three out of 61 hospital deceased patients (Patient 2, Patient 3, Patient 4) stored at an off-site morgue. Refer to A-0083. These failures contributed to ongoing delays in processing death certificates, lack of family notification of patient deaths, and prolonged storage of patient bodies in an off-site morgue, which had the potential to result in family distress over the perception of patients missing for prolonged periods of time when in fact they were deceased and in storage; On 10/4/2024, the off-site morgue had 61 patient remains from the hospital, 11 patient remains from deaths in 2022, 15 patient remains from deaths in 2023, and 19 patient remains from deaths in the first half of 2024.	A 043	In order to evaluate this plan for effectiveness and to integrate this plan into the quality assurance system, escalation of the tracker to the Community Board of Directors will be monitored on a per meeting basis until 100% compliance is obtained for 4 consecutive meetings, and biannually thereafter. Numerator equals the number of Community Board of Directors meetings the tracker was presented at. Denominator equals the number of Community Board of Directors meetings to date. Responsible Person: Director of Quality To immediately correct CFR(s): 482.12(e), regarding the governing body's responsibility for services furnished in the hospital, the Community Board of Directors: <ul style="list-style-type: none"> Were informed of the events noted in this CMS investigation regarding the Regional Morgue Office (RMO) services. Will be updated on the process improvement work and process changes being implemented by the Greater Sacramento Division (GSD) hospitals. These process improvements include documentation by RMO of at least 3 next of kin notification attempts if, upon transfer to the RMO, the next of kin has not been reachable by the hospital prior to transfer to RMO, timely initiation of the death certificate processes upon transfer of the body defined as within 2 business days of death, as well as the current and ongoing status updates of the remains at the off-site morgue. 	Beginning 11/14/2024
A 083	CONTRACTED SERVICES CFR(s): 482.12(e) The cumulative effect of these systemic problems resulted in the inability of the hospital to comply with the statutorily mandated Condition of Participation for Governing Body. The governing body must be responsible for services furnished in the hospital whether or not they are furnished under contracts. The governing body must ensure that a contractor of services (including one for shared services and joint ventures) furnishes services that permit the hospital to comply with all applicable conditions of participation and standards for the contracted services. This STANDARD is not met as evidenced by: Based on interview and document review, the	A 083	Additionally, the back-log of deceased patients stored at the off-site morgue were reviewed and added to the tracking process implemented for all deceased patients. Responsible Person: Hospital President/CEO	08/20/2024 11/21/2024 10/04/2024

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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A 083	<p>Continued From page 2</p> <p>hospital failed to demonstrate the governing body was responsible for services furnished by the Regional Morgue Office (RMO), in the Greater Sacramento Division (GSD), for a sample of three out of 61 deceased patients (Patient 2, Patient 3, and Patient 4) stored in an off-site morgue at time of survey. The Regional Morgue Office failed to:</p> <ol style="list-style-type: none"> 1. Notify the families of Patient 2, Patient 3, and Patient 4 of their deaths, and complete death certificates per regulatory requirements, 2. Resolve a known back-log of 61 deceased patients stored in an off-site morgue according to the GSD Laboratory Morgue Policy and Procedure. <p>These failures resulted in a delay in completion of death certificates, in notification to families of patient deaths, and in handling the patients' bodies after death. These failures had the potential to prolong distress and grief for families.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. During a review of a log kept by the RMO of patient remains in an off-site morgue, the log indicated: <ol style="list-style-type: none"> a. Patient 2 died on 10/3/2022, family had not been found as of 9/5/2024 per the Public Administrator (PA), the death certificate had not been completed, and Patient 2's remains continued to be stored at the off-site morgue; b. Patient 3 died on 10/21/2022, on 5/23/2024 the PA spoke with Patient 3's family member who requested disposal of remains under county indigent (suffering from extreme poverty) plan, 	A 083	<p>To ensure the deficient practice does not recur, the RMO service will be held accountable for the following metrics and will be reported to the Community Board of Directors monthly:</p> <ul style="list-style-type: none"> • Timeliness of Death Certificate Completion (not to exceed 8 days per State law) • Timelines of body being transferred to preferred mortuary within 8 days of death • Timeliness of Next of Kin Notification (not to exceed 8 days) • Number of bodies at RMO >90 days (goal less that 25%) <p>An annual evaluation of RMO services will be presented to the Community Board of Directors for evaluation of the quality of service.</p> <p>Responsible Person: Reported to the Director of Quality by RMO Director of Laboratory</p> <p>As part of the new next of kin notification process, HIPAA compliant scripting for voicemails has been created. This scripting includes the caller leaving a local number for the next of kin to call back. A log will track the date of death, date and time message left, name of the deceased patient and the name of the person who was attempted to be reached. The Administrative Nurse Manager (ANS) can then reference this tracker when/if the next of kin calls back and ensure the correct information on the final disposition and location of the decedent is communicated. This does not change RMO's process of next of kin notification.</p> <p>Responsible Person: VP/Chief Nursing Executive</p>	<p>Tracking beginning 11/6/2024</p> <p>Process started 11/14/2024</p> <p>Education to be completed 11/22/24 and implemented 11/25/24</p>
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CENTERS FOR MEDICARE & MEDICAID SERVICES

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A 083	<p>Continued From page 3</p> <p>the death certificate had not been completed, and Patient 3's remains continue to be stored at the off-site morgue; and</p> <p>c. Patient 4 died on 12/28/2022, a note indicated Spanish interpreter needed to proceed, the death certificate had not been completed, and Patient 4's remains continue to be stored at the off-site morgue.</p> <p>During an interview on 10/1/2024 at 1:15 p.m. with the Sacramento Market Leader of Laboratory Services: Lab, Cardiopulmonary, & Rehabilitation (SMLLSLCR), SMLLSLCR stated the RMO was responsible for making three attempts to contact family once patient remains left the local hospital. SMLLSLCR stated there was no expected time frame for the contact attempts. SMLLSLCR stated, until recently there was no log to track the attempts. SMLLSLCR stated, if the process fails to yield results, the case should be forwarded to the County Public Administrator, who would attempt to find family, and if none could be found after a diligent search, contact the coroner to pick up the body. SMLLSLCR stated, the Office of the Coroner would attempt to contact family if known family could not be reached. SMLLSLCR stated, records of referrals to the PA and the Coroner's Office had not been kept until recently. SMLLSLCR could not provide documented evidence of referrals to the PA or Coroner.</p> <p>During an interview on 10/2/2024 at 10:20 a.m. with Chairman of the Community Board (CCB) responsible for both the Community Board and the Quality Committee of the Community Board (QCCB), CCB stated the Community Board was comprised of the Chiefs of Staff and Presidents of the hospitals in the GSD, which included four</p>	A 083	<p>In order to evaluate this plan for effectiveness and to integrate this plan into the quality assurance system, compliance with timeliness of next of kin notifications, timeliness of completed death certificates and the length of stay of each body in the offsite morgue will be monitored on a monthly basis until 95% compliance for each metric is achieved for 4 consecutive months and annually thereafter.</p> <ul style="list-style-type: none"> • Timeliness of Death Certificate: Numerator equals the number of hospital deceased patients overseen by RMO for at least 8 day whose death certificate was completed within 8 days of death / Denominator equals the number of hospital deceased patients transferred from hospital to RMO that remain at RMO for at least 8 days. • Timeliness of Next of Kin notification: Numerator equals number of hospital deceased patients, with known next of kin, overseen by RMO, whose next of kin are notified within 8 days / Denominator equals the number of hospital deceased patients, with known next of kin, overseen by RMO • Number of bodies at RMO >90 days (goal less than 25%): Numerator equals number of bodies remaining at RMO >90 days over a rolling 3 months / Denominator equals number of bodies sent to RMO over the same rolling 3 month period. The report will also detail out the length of stay for each body remaining at PML >90 days. <p>Responsible Person: Reported to the Director of Quality by RMO Director of Laboratory</p>	<p>Tracking to begin 11/06/2024</p> <p>Tracking to begin 11/06/2024</p> <p>Tracking to begin 11/18/2024</p> <p>Beginning 11/14/2024</p>	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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A 083	<p>Continued From page 5</p> <p>2024. COO stated resolving the issues became a priority then.</p> <p>During an interview on 10/3/2024 at 4:15 p.m. with the Hospital President (HP), the HP stated he was legally responsible for all hospital services. HP stated he reports to a GSD Hospital President, but the Healthcare Organization Governing Body had delegated the responsibility of hospital services to him. HP stated he was aware of the failures of the RMO to timely process patient remains and complete the death certificate worksheets in September 2023. HP referred the issues to the GSD President in September 2023. HP stated the GSD President and legal department were working to resolve the issue. HP stated he had not received, nor asked for any updates on solutions. When asked to explain this lack of oversight, HP stated the problem would be addressed at the divisional level; HP stated, "It is not my scope." HP stated he was not aware of the failure to notify families. HP stated, "We assumed the remains being stored did not have families." HP explained the patient populations at the hospital included high numbers of homeless persons. HP stated he never reported the backlog of patient remains processing or family notifications to the Community Board. HP stated that National Board is only notified of regional issues from the Community Board. HP stated "I'm legally and morally responsible for those in the morgue". HP stated he was not aware of previous facility regulatory violations and plans of correction for failure to notify families of patient deaths. HP stated the previous QD notified him that all plans of corrections were completed. HP stated the previous plans of corrections did not have ongoing monitoring. HP stated QD does not have</p>	A 083	<p>In order to evaluate this plan for effectiveness and to integrate this plan into the quality assurance system, escalation of the tracker to the Community Board of Directors will be monitored on a per meeting basis until 100% compliance is obtained for 4 consecutive meetings, and biannually checked thereafter. Numerator equals the number of Community Board of Directors meetings the tracker was presented at. Denominator equals the number of Community Board of Directors meetings to date.</p> <p>Responsible Person: Director of Quality</p> <p>To immediately correct Quality Improvement Activities CFR(s): 482.21(b)(2)(ii), (c)(1), (c)(3), and ensure the deficient practice does not recur the Quality Department created a tracker of all State self reported events, as well as regulatory and complaint surveys, that did not meet the statute and were substantiated and regulatory violations were cited dating back to 2021. This tracker includes a summary title of the event, CA number for reference, party responsible for the monitoring of the PoC metrics, details of the accepted PoC monitoring metrics, indication if compliance has been met, then if not yet met, the monitoring start date and metric tracking will be completed. Those events without evidence of noted compliance will be audited to validate the current state. If compliance is not met, metrics will be reinstated. The tracker will be maintained on an ongoing basis with all active and new events, and reported on a per meeting basis to the Quality Management Committee (QMC), Quality Community Board meeting, and Community Board of Directors meeting. The focus of the report is to provide a summary of current compliance and action taken if not meeting compliance. This reporting structure will ensure timely communication to the Community Board of Directors for effective oversight of the hospital.</p>	Beginning 11/11/2024

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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A 083	<p>Continued From page 6 a direct line of reporting to him.</p> <p>In a concurrent interview and document review of the GSD Laboratory Morgue Policy and Procedure, approved 3/1/2022, with the SLSS on 10/3/2024 at 1 p.m., the document indicated processes for handling abandoned bodies and bodies with no next of kin. The document indicated the RMO should contact the public administrator and coroner when family could not be reached, or found, or the next of kin did not have resources to cremate or bury the body. The SLSS stated there was no documented evidence these agencies were contacted for assistance.</p> <p>In a document review of the Patient Safety Program Annual Summary and Evaluation for Fiscal Year 2023, which details categories of adverse events reported during the year, any regulatory findings, and active and completed plans of correction, submitted September 2023 to the Community Board, the document did not include documentation of the gaps in patient notification, death certificate processing according to legal requirements, or delay in handling patient remains.</p> <p>In a concurrent interview and record review of the newly created log of patient remains in off-site morgue storage, last updated 10/3/2024, with the QD on 10/3/2024 at 4:45 p.m., the QD confirmed the log indicated 11 bodies have been in storage since 2022, 15 bodies have been in storage since 2023, and 19 bodies have remained in storage from 1/1/2024 to 6/30/2024. The log indicated there were 61 patient remains in the off-site morgue on 10/3/2024.</p>	A 083	<p>In order to evaluate this plan for effectiveness and to integrate this plan into the quality assurance system, escalation of the tracker to the Community Board of Directors will be monitored on a per meeting basis until 100% compliance is obtained for 4 consecutive meetings, and biannually checked thereafter. Numerator equals the number of Community Board of Directors meetings the tracker was presented at. Denominator equals the number of Community Board of Directors meetings to date.</p> <p>Responsible Person: Director of Quality</p> <p>Additionally, to correct and ensure the deficient practice related to the focus on removal of central venous catheters, the Critical Care team will be reeducating critical care nurses on the importance of necessity evaluation for central lines. Education will be assigned to all ICU registered nurses (RN) via Pathways. Effective 11/11/2024, prior to transferring out of the ICUs, each patient with a central line (excluding cardiac surgery patients) will have the "Review of Central Line Necessity Prior to transfer to med/surg/tele floor" completed. If a necessity indicator is not met, the RN will discuss removal with the provider. These forms will be submitted to the Manager for review, tracking and trending for potential PI work.</p> <p>Responsible Person: Senior Director of Critical Care</p> <p>In order to evaluate this plan for effectiveness and to integrate this plan into the quality assurance system, ICUs will monitor the number of patients transferring out of the ICUs to a med/surg/tele unit with a central line (excluding cardiac surgery patients). The goal is 95% of the patients transferring out of the ICUs to a med/surg/tele unit with a central line (excluding PICCs) will have an approved indication for use. The data will be monitored on a monthly basis until compliance is achieved and sustained for four (4) consecutive months.</p> <p>Responsible Person: VP Chief Nursing Officer</p>	
A 263	QAPI	A 263		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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A 263	<p>Continued From page 7 CFR(s): 482.21</p> <p>The hospital must develop, implement and maintain an effective, ongoing, hospital-wide, data-driven quality assessment and performance improvement program.</p> <p>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.</p> <p>The hospital must maintain and demonstrate evidence of its QAPI program for review by CMS.</p> <p>This CONDITION is not met as evidenced by: Based on observation, interview and document review, the hospital failed to develop, implement, and maintain an effective, ongoing, hospital-wide, data-driven quality assessment and performance improvement (QAPI) program that reflected the complexity of the hospital's organization and services for a census of 367 patients in a hospital bed capacity of 384, as evidenced by:</p> <p>A. The hospital QAPI program failed to show documented evidence of data collected to track performance and to ensure improvements were sustained for two plans of correction for regulatory violations related in part to family notification of patient death and processing of the bodies of deceased patients, and the implementation of a process change for central venous catheter (a thin flexible tube that is</p>	A 263		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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A 263	Continued From page 8 inserted into a vein and guided into a large vein above the right side of the heart) removal. Refer to A0283. These failures resulted in regulatory noncompliance with QAPI standards and resulted in missed opportunities for improvement and ongoing failures. The cumulative effect of these systemic problems resulted in the inability of the Hospital to comply with the statutorily mandated Condition of Participation for QAPI.	A 263		
A 283	QUALITY IMPROVEMENT ACTIVITIES CFR(s): 482.21(b)(2)(ii), (c)(1), (c)(3) (b) Program Data (2) [The hospital must use the data collected to -] (ii) Identify opportunities for improvement and changes that will lead to improvement. (c) Program Activities (1) The hospital must set priorities for its performance improvement activities that-- (i) Focus on high-risk, high-volume, or problem-prone areas; (ii) Consider the incidence, prevalence, and severity of problems in those areas; and (iii) Affect health outcomes, patient safety, and quality of care. (3) The hospital must take actions aimed at performance improvement and, after implementing those actions, the hospital must measure its success, and track performance to ensure that improvements are sustained.	A 283		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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A 283	<p>Continued From page 9</p> <p>This STANDARD is not met as evidenced by: Based on observation, interviews, and record reviews, the hospital Quality Assessment and Performance Improvement (QAPI) Program failed to show documented evidence of data collected to track performance and to ensure improvements were sustained when there was no documented evidence of implementation and completion for:</p> <p>1. The Plan of Correction (POC, an action plan submitted by a hospital to a State Agency to correct a cited regulatory violation) for intake CA00511685, dated April 2022, indicated plans to educate staff regarding accuracy of family contact information in chart, timely notification of death to next of kin by physician and physician's timely completion of deceased patient's charts including the summary of hospital course and discharge summary. Additionally, the Quality Program Manager (QPM) was responsible for verification through chart audits and providing semiannual reporting of audit for integration into the QAPI process. The timeframe indicated on the POC stated "reporting will continue until four consecutive audit results are 100% excluding months with no cases".</p> <p>2. The POC for intake CA00747251, dated July 2023, indicated the development of an education module for the Pathology (study of disease) Laboratory and Administrative Nursing Supervisor staff covering the steps to take after the death of a patient to ensure dignity and respect, following federal and state regulatory requirements and including responsible staff tasks. This POC would be verified by Quality and Patient Safety Program</p>	A 283		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 050516	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/04/2024
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NAME OF PROVIDER OR SUPPLIER MERCY SAN JUAN MEDICAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 6501 COYLE AVE CARMICHAEL, CA 95608
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A 283	<p>Continued From page 10</p> <p>Manager (QPSPM) with chart audits meeting measurable goals until "three consecutive months of goal performance was achieved".</p> <p>3. A performance improvement project, dated 6/8/2023, identified by the Quality Management Committee (QMC) as a targeted area for improvement, focused on the removal of central venous catheters (CVC, a thin flexible tube that is inserted into a vein and guided into a large vein above the right side of the heart) prior to transfer to lower level of care (intensive care unit to medical or surgical units) to reduce the risk of CVC related patient adverse events.</p> <p>These failures resulted in regulatory noncompliance with QAPI standards and resulted in missed opportunities for improvement.</p> <p>Findings:</p> <p>1. During a review of the POC for intake CA00511685, dated April 2022, the POC included the following corrective actions, in part:</p> <ul style="list-style-type: none"> a. Education provided to medical staff on contacting and documenting family notification of death. b. Department managers provided education to hospital staff about the importance of accuracy of information in the medical record, including contact numbers. c. Developed an auditing and reporting process to evaluate the accuracy of telephone numbers listed as contacts in the medical record. d. Scheduled semiannual reporting and of audit results to the QMC of the medical staff for integration into the established QAPI process. <p>2. During a review of the POC for intake</p>	A 283		
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A 283	<p>Continued From page 11</p> <p>CA00747251, dated July 2023, the POC included the following corrective actions, in part:</p> <p>a. Development of an education module for Pathology Laboratory and Administrative Nursing Supervisors to include at time of death the patient will be cared for with dignity and respect, in accordance with federal and state regulatory requirements, the location of Notifications of Death Form, the documentation of deceased patient in morgue logbook and identify who is provided access to the morgue.</p> <p>b. Retrospective chart audits performed by QPSM to verified that patients were deposited in the morgue with the appropriate documentation. This audit was to continue until 3 consecutive months of goal performance of 100% compliance was achieved.</p> <p>During a review of the hospital QAPI plans, dated fiscal year 2023 and fiscal year 2024, the QAPI plans did not include any documented evidence of implementation of corrective actions identified in the POCs or evidence of tracking of performance improvement.</p> <p>During a concurrent interview and record review on 10/1/24, at 11:05 a.m., with the Quality Director (QD), the QD was provided a copy of the POCs for intakes CA00511685 and CA00747251. After reviewing the POCs, the QD stated, "I am not familiar with these POCs ...will research ...these were before I started and there was no handoff to me [from previous staff]".</p> <p>During an interview on 10/3/24, at 1:20 p.m., with the QD, the QD stated, "I have not been able to locate data for either POC". The QD stated, "No one was working on these [POCs], there is no data to provide implementation and tracking." The</p>	A 283		

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NAME OF PROVIDER OR SUPPLIER MERCY SAN JUAN MEDICAL CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 6501 COYLE AVE CARMICHAEL, CA 95608		
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A 283	<p>Continued From page 12</p> <p>QD confirmed there was no documented evidence the interventions in the POCs, that were dated April 2022 and July 2023 respectively, were monitored for success and sustained compliance per hospital QAPI plan and regulatory requirements.</p> <p>3. During an interview on 10/3/24, at 11:45 a.m., with Critical Care Nurse Educator (CCNE), the CCNE stated, they are working on a performance improvement project (PIP) to remove CVC before the patient is transferred to the medical or surgical floor. The CCNE stated, starting in February of 2023, the QMC started to investigate CVC line removal before transfer to a lower level of care as a quality indicator. The CCNE stated the nursing staff had been educated via Pathways (an online learning module the hospital utilizes to educate nurses) to a new vascular (vein) access policy, which included a skills module for vascular access care and removal. This module was assigned on 3/9/23 with a due date of 4/30/23. When asked about how many patients were being sent to the medical/surgical floor with CVC for this PIP the CCNE stated, "We are not tracking the data."</p> <p>During a review of QMC minutes, dated June 2023, the QMC indicated the need to remove CVCs prior to transfer to a lower level of care.</p> <p>During a concurrent observation and interview of the 5C Trauma medical surgical and telemetry (continuous monitoring of heart activity) unit, on 10/3/24, at 10:20 a.m., with the QD, the QD stated the unit was focused on monthly report cards (an infographic that is posted on a bulletin board for all staff to see). The only PIP that was observed posted in the unit was for patient falls.</p>	A 283			

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A 283	Continued From page 13 The QD stated that she did not see evidence of a PIP for CVC removal.	A 283		
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{A 000}	<p>INITIAL COMMENTS</p> <p>The following reflects the findings of the California Department of Public Health during a federal complaint validation revisit survey for complaint number CA00912399.</p> <p>The sample size was 21.</p> <p>The facility was found to be in substantial compliance with 42 CFR, Part 482.23 Nursing Services Condition of Participation for Hospitals, effective October 4, 2024.</p>	{A 000}		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.