

Statement of Deficiencies	(X1) Provider/Supplier/CLIA Identification Number 010006	(X3) Date Survey Completed 04/11/2019
Name of Provider or Supplier North Alabama Medical Center	Street Address, City, State 1701 Veterans Drive, Florence, AL	
For information on the provider's plan to correct this deficiency, please contact the provider or the state survey agency.		

(X4) ID Prefix Tag	Summary Statement of Deficiencies (Each deficiency should be preceded by full regulatory or LSC identifying information)
A0000	A validation survey at the request of Centers for Medicare and Medicaid Services was conducted on 4/11/19. Condition level deficiencies were cited for Physical Environment, 482.41 and standard level deficiencies were cited for the Health Survey. .
A0144	<p>PATIENT RIGHTS: CARE IN SAFE SETTING CFR(s): 482.13(c)(2)</p> <p>The patient has the right to receive care in a safe setting.</p> <p>This STANDARD is not met as evidenced by: Based on review of facility policy and procedure, emergency department (ED) medical records (MR) and interviews, it was determined the ED staff failed to follow their own policy for creating a safe environment in the ED, complete and document patient safety interventions to protect ED patients at risk for self-harm. These deficient practices affected 3 of 3 ED MR's reviewed for patients at risk for self harm and included ED MR's # 7, MR # 13 and MR # 9. This had the potential to negatively affect all patients at risk for self harm who receive care at this facility. Findings include: Facility Policy: Policy/Procedure Title: Suicide Patient Policy # H110.PCS.165 Revised Date: 01/2019 "Scope Team Members Performing: Psychiatrist, Physician, Registered Nurse (RN), Patient Care Assistant, Social Worker Physician Order Requirements: Yes RN's: Assessment and implementation of suicide precautions, evaluation of patient's ongoing risk assessment and needs. MSA's (Medical Service Assistants), PCT's (Patient Care Technician): Collect data and monitor patients Purpose The purpose of this policy is to guide the patient care staff in identification of individuals at risk for suicide and to implement necessary actions toward preventing self harm while under the care of or following discharge from the organization. Policy Guidelines 1. Suicide precautions may be ordered by the patient's physician or may be initiated by the nurse with a</p>

physician's order obtained as soon as possible. a. Depending on the SAD PERSONS SCORE (SAD PERSONS scale is an acronym utilized as a mnemonic device. It was first developed as a clinical assessment tool for medical professionals to determine suicide risk) and Suicide Risk Assessment, a patient admitted with a status for serious self-injurious behavior (or risk of) will be placed on the appropriate suicide precautions. 1. SAD PERSONS Scoring SCORE Requirements 0-4 No suicide risk assessment is required. 5-6 Add the Suicide Precautions Plan of Care, Suicide Risk Assessment: Routine Observations 7-8 Add the Suicide Precautions Plan of Care, Suicide Risk Assessment: Constant Visual Observation 9-or above Add the Suicide Precautions Plan of Care, Suicide Risk Assessment: 1:1 Observation Note: The Emergency Department will add the Suicide Intervention instead of the Suicide Preventions Plan of Care. b. Patients with a history of suicide attempt within the last two weeks should be placed on suicide precautions according to the SAD PERSONS score. c. Patients who verbalize intent to harm themselves or express a suicide plan should be placed on suicide precautions according to their SAD PERSONS score. 2. The continued need for suicide precautions should be re-evaluated every shift and as needed...state the reason for continuing or discontinuing precautions...documented... by the physician. 4. Patients on suicide precautions should be questioned every shift regarding suicide intent and more frequently if a positive response is obtained or if suspicion is high that a patient may attempt suicide. 5. The patient will be closely monitored at all times. Observation levels will be discussed with the attending physician and the observation level will be determined by a physician. Observation levels Definitions Routine Observation-The patient will be checked every 15 minutes by a staff member and every 30 minutes by a registered nurse. Document, as appropriate, in the medical record... Constant Visual Observation-Constant Visual observation is the second level of observation...includes all...components of the routine observation. Additionally, the patient is either observed in a video monitored room or observed at all times by the naked eye. The RN assigned...is responsible to ensure that Constant Visual Observation is in place. The RN documents each shift the continuation of 1:1 observation. 1:1 Observation-1:1 observation is the third level of observation...includes all...components of routine observation. Additionally, a staff member is assigned by the charge nurse to be physically present with this patient at all times. The RN assigned...is responsible to ensure...that 1:1 observation is in progress at all times...documents each shift the continuation of 1:1 observation. 1:1 Sitter Responsibilities-The responsibilities of the caregiver assigned to provide 1:1 observation of a suicidal patient shall include, but not limited to: Observation: Maintains visual observation at all times. Accompanies patient...diagnostic testing... maintains a line of sight...when the patient has a visitor, or uses the bathroom. General Safety Assesses the room environment...remove items...pose...ligature...self harm risk (See Attachment A) 7. A physician's order is required to discharge suicide precautions, with rationale and patient evaluation...in the progress notes. 8. An RN may independently initiate Constant Visual Observations or 1:1 Observation if it is assessed that the patient is at risk to act on suicidal ideations (SI). The physician must be notified immediately....and order...be obtained. Only the physician may discontinue an order for suicide precautions...Constant Visual...or 1:1 Observation. Procedure 1. Obtain physician order for suicide precautions for: b. Patients treated in the Emergency Department (ED) or admitted due to suicide attempt. c. Patients who express intent to harm themselves or demonstrate serious self-injurious behavior. On admission, completed the Suicide Risk Assessment, if indicated by the SAD PERSONS Score. Repeat the Suicide Risk Reassessment every 4 hours, if a positive response is obtained on any of these three questions. Are you currently having internal voices telling you to kill yourself? Are you thinking about killing yourself? Do you have a way to kill yourself available to you? If the response to all three above

questions is NO on the Suicide Risk Reassessment, then repeat...at a minimum of every shift, at least every 12 hours... Initiate the Suicide Plan of Care (This adds all the necessary interventions.) Note: The ED will add the Suicide Intervention instead of the Suicide Preventions Plan of Care. Explain precautions to patient (and family...). Inform...restrictions and rationale... 3. Complete environmental assessment and removal of harmful items (See Attachment A). a. Observe hardware in room. c. Conduct a search...the patient's belonging with a witness at the initiation of suicide precautions. e. All belongings...searches...documented on inventory list. g. Remove any harmful objects...send to the patient's home or include on the Safety Deposit[form to Security... h. Place the patient in paper scrubs...to protect... from self harm. 5. Initiate in Meditech (hospital electronic software) the "Suicide Precautions Order Set". 8. The level of suicide risk precautions will be part of the nurse to nurse hand-off communication..." 1. ED MR # 7 presented to the ED on 1/15/19 at 10:54 AM and discharged on 1/15/19 at 6:57 PM. The chief complaint was hearing voices, anxious. On 1/15/19 at 10:58 AM, the ED RN, triaged the patient, Priority -psych/suicidal patient. Review of the physician's history of present illness completed at 11:10 AM revealed the patient presents complaining of auditory hallucinations and suicidal ideation and voices in his/her head telling her/him to cut themselves. The ED physician documented a depressed mood, mental illness, history of depression, suicide, Schizophrenia, Bipolar and anxiety. There was no physician order for Suicide precaution initiation. At 11:40 AM, the ED RN documented patient reported hearing voices telling me to hurt myself, denies SI but reported past suicide attempt. At 11:48 AM, the RN documented the following suicide risk assessment: Behaviors "NO", for sometimes feel life not worth living and sometimes people would be better off without you. There were 5 additional questions in the Behavior section left blank, not answered. History "YES", for have you had thoughts of hurting yourself and have attempted suicide in the past. There were 4 additional questions in the History section left blank, not answered. Six (6) of 6 questions in the suicide risk assessment section titled, Present Plan were not completed. The Summary section of the Suicide Risk Assessment was not completed. There was no documentation the risk assessment findings was discussed with the physician. The observation level was not completed. The RN documented in the Suicide/Homicide Plan, have you had any thoughts of harming yourself or others? Yes. In addition, the SAD PERSONS Scale documentation completed revealed MR# 7 s's gender and age range with a HX (history) Suicide documented. The SAD Scale Result was 3, No suicide risk assessment is required, for a person with SI and a plan. The SAD PERSONS score failed to identify MR # 7 as at risk for self harm. On 1/15/19 at 11:48, the ED RN documented room clear, patient belongings in brown bag and patient in blue scrubs. At 12:38 PM, the ED RN documented patient "request some kind of medication to calm her/him down and quit hearing these voices". At 1:15 PM, Ativan 1 mg (milligram) by mouth was given. There was no physician order for suicide precautions documented in the medical record. There was no documentation suicide interventions which included an appropriate observation level was identified and implemented for a patient with SI and a plan per policy and procedure. The MR documentation revealed at 6:06 PM the patient reported feeling much better. At 6:30 PM, the physician documented patient ready for discharge and outpatient follow up was arranged for the next day. At 6:56 PM, the patient was discharged with patient instructions on "Anxiety". There was no ED RN documentation a suicide risk reassessment was completed every 4 hours after the initial assessment included positive responses for SI and a plan. In an interview on 4/11/19 at 9:48 AM, Employee Identifier (EI) # 38, CNO (Chief Nursing Officer) confirmed the above findings. 2. ED MR # 13 presented to the ED on 1/16/19 at 10:33 AM. The chief complaint was patient attempted to hang self yesterday with a rope and depression. The ED RN triage documentation at 10:33

AM revealed Priority "3 p-psych/suicidal patient". At 10:41 AM, the ED physician evaluated the patient and documented an attempted suicide yesterday, SI and depression. There was no physician order for suicide precautions initiation. On 1/15/19 at 11:00 AM, the ED RN documented room clear, patient belongings in brown bag and patient in blue scrubs. The Suicide/Homicide documentation revealed thoughts of hanging". The SAD PERSONS scale documentation revealed a history of suicide and psychiatric care, organized /serious attempt. At 11:00 AM, the SAD PERSONS Scale result documented was 4 (no suicide risk assessment required), which was an inaccurate patient assessment. There was no documentation routine, constant or 1:1 observation was completed for a patient at risk for self harm and no documentation suicide precautions were performed for an at risk patient from 11:00 AM to 6:19 PM. There was no documentation suicide risk reassessments every 4 hours was completed by the ED RN. At 6:19 PM, 7:33 PM, 8:35 PM and 10:16 PM, the ED RN documented police at bedside. At 11:07 PM, which was 11 hours later, the ED RN documented the Summary of Suicide risk assessment discussed with MD (medical doctor) and Observation Level 1:1 Staff. However, there was no documentation staff observation 1:1 was performed. The patient was discharged on 1/17/19 at 12:22 AM per emergency medical transport for transport to a psychiatric inpatient facility. During an interview on 4/11/19 at 10:00 AM, EI # 38 confirmed staff failed to follow policy and procedure for the ED patient identified as at risk for self harm including completion of the suicide risk assessment, completion of an appropriate SAD PERSONS score, performing the suicide risk reassessment every 4 hours, identification of the appropriate observation level, initiation of a suicide precaution order set and documentation of all suicide risk precautions completed. 3. ED MR # 9 presented to the ED on 1/21/19 at 1:25 PM. The chief complaint was depression. On 1/15/19 at 1:28 PM, the ED physician evaluated the patient and documented increased depression, anxiety and insomnia with patient reports of " I am at the end of my rope", and denied SI. The exam results were depressed mood, anxious. On 1/15/19 at 1:30 PM, the ED RN, triaged ED MR # 9, Priority 2, depressive disorder. At 1:31 PM, the ED RN documented the "room clear". The SAD PERSONS scale result was 3, depression/hopelessness. There was no documentation the staff implemented safety interventions for a patient at risk of self injurious behavior (major depressive disorder diagnosis) to ensure the patient was kept safe while in the ED. On 1/21/19 at 7:45 PM, the patient was transferred to an inpatient psychiatric facility with the diagnosis of major depressive disorder. There was no physician order for suicide precautions, no appropriate observation level implemented and no suicide reassessment completed per ED RN every 4 hours. In an interview on 4/11/19 at 10:30 AM, EI # 38 confirmed ED staff failed to follow the facility policy and procedure for assessment and implementation of safety precautions for all patients identified at risk for self harm in the ED. During observations of care in the ED on 4/9/19 at 9:20 AM, the surveyors toured the department including "POD D", 3 ED safe rooms designed for use with Behavioral Health (BH) patients in the ED. During the tour, 2 of 3 ED rooms in POD D were occupied with BH patients. One ED door was open, there was a staff sitting outside the door. The other ED room's door was closed with a staff sitting inside the closed door. There was a police officer inside the corridor of POD D. The surveyors observed facility staff performing observation with 2 ED patients within BH POD. In an interview on 4/9/19 at 9:30 AM, EI # 38 reported hospital staff are now assigned to observe at risk ED patients following a recent audit.

A0392

STAFFING AND DELIVERY OF CARE
CFR(s): 482.23(b)

The nursing service must have adequate numbers of licensed registered nurses,

licensed practical (vocational) nurses, and other personnel to provide nursing care to all patients as needed. There must be supervisory and staff personnel for each department or nursing unit to ensure, when needed, the immediate availability of a registered nurse for bedside care of any patient.

This STANDARD is not met as evidenced by:

Based on review of medical records (MR), facility policies and procedures, and interviews, it was determined the facility failed to ensure the staff: a) Obtained and followed the physician's orders for wound care. b) Performed wound assessments and measured wounds per policy. c) Documented specific wound care performed. d) Documented care provided for removal of Central Venous Line (CVL). e) Followed the hospital policy for Tracheostomy (trach) care. f) Followed the hospital policy, performed and documented pain assessments/reassessments in the ED (emergency department). This affected 5 of 22 records reviewed including MR # 20, MR # 19, MR # 9, MR # 18 and MR # 10, and Unsourced Patient # 1, and 4 of 16 ED MR's reviewed which included ED MR's # 16, # 2, # 4, and # 5. This had the potential to negatively affect all patients served by this facility. Findings Include: Policy: Physician Orders, Protocols, Pre-Printed and Standing Orders Policy Number: H110.PCS.105 Date Reviewed: 10/2019 Policy ...Protocols are a specific set of orders developed by physicians or other clinical staff and approved by the medical staff... Procedure ...II. Verbal or Telephone Orders: A. Verbal or telephone orders shall be kept to a minimum and only used in emergent/urgent situations... I. Each verbal or telephone order shall be dated, timed and identified by the names of the individuals who gave and received the order... VIII. Protocols A. Protocols must be initiated by a written, electronic order, or telephone order... B. The protocol order can be initiated before the physician authenticates the order, much like a telephone order. C. After printing off the protocol, document the date, time, and sign off the order... D. The protocol will be placed on the medical record like any physician order... E. The physician will authenticate (sign, date, and time) the use of the protocol, at the next patient visit or electronically, as soon as possible, or by 30 days... Policy: Wound and Skin Care Policy and Procedure Policy Number: H110.PCS.182 Date Reviewed: 11/2018 Policy ...Upon identification of skin breakdown, skin/wound care will be initiated according to the Wound Care Treatment (WCT) Protocol unless otherwise ordered by the physician.. Wound Care Treatment Protocol: Assessment: 1. Assess areas of skin breakdown initially for location, stage, size... Notify the physician and the wound care nurse of any areas of skin breakdown, including rashes. 2. Reassess the areas of skin breakdown at every dressing change and document size and appearance of wound on Wednesdays weekly. If the condition of the patient or wound deteriorates, re-evaluate... Notify the physician and the wound care nurse... Central Venous Catheter (CVC) Dressing Change/Site Care/ Catheter Care/Removal Policy #: H110.PCS.151 Revised Date: 9/2018 Purpose To minimize the risk of the patient acquiring a central line-associated blood stream infection while providing intermediate to long-term venous access... Procedure: V. Removal of Central Line... B. Document in the electronic medical record 1) Patient's response including presence or absence of dyspnea 2) Condition of the site. 3) Confirmed placement of occlusive dressing. Policy/Procedure Title: Suctioning Endotracheal- Tracheostomy Policy # H110.771.046 Revised Date: 12/2015 Procedure: Equipment: e) Sterile Saline- pour bottle... 8... pour normal saline (30-50 cc (cubic centimeters) into the solution container... Policy/Procedure Title: Pain Management Policy # H 110.PCS. 090 Revised Date: 10/2018 Purpose It is the organization's goal to provide patients with pain management in a safe and effective method... Reduce the severity of pain Educate...of the need to report unrelieved pain Enhance the patient's

comfort and satisfaction Policy It is the patient's right to have their pain managed as adequately as can be safely provided...This information is analyzed to make care, treatment, and care decisions. ...Pain Assessment: ...The pain assessment should include...location of pain...Intensity of pain utilizing the appropriate patient pain scale...Description of the pain... Pain scales: 1. Adult Numerical intensity scale 0-10 (with 0 being no pain and 10 being the most severe pain possible)... Pain Intensity... is evaluated as...Severe pain is rated as a pain score of greater than 7. Pain Management Plan 1. A pain management plan is developed based on assessment data...implemented and evaluated for appropriateness and effectiveness. Effectiveness of the pain management plan is determined by the patient's self reported intensity of pain and should be documented... Pain Reassessment: 1. Pain will be reassessed...after each pain intervention 2. Pain will be reassessed after administration of any pain medication within appropriate times based on method of administration and nursing judgement... 1. MR # 20 was admitted to the hospital on 3/21/19 with diagnoses including Left Hip Fracture and Schizoaffective Disorder. Review of the MR revealed an Adult Admission Patient Assessment dated 3/21/19 at 5:48 AM. For the question, "Does pt (patient) have wound" the RN (Registered Nurse) documented, "No." Review of MR revealed the following order dated 3/23/19 at 6:00 AM, "Change dressing L (left) hip (paint with betadine)." There was no documentation the care was performed. Review of the Wound Photography and Staging Documentation Form dated 3/24/19 at 5:30 AM, contained the following information, "Location of Wound: Coccyx; Wound Stage: Type II; Measurements of Wound: 1.75 x 0.75 cm (centimeters)..." There was no depth of wound documented. Review of the RN Adult Shift Assessments dated 3/24/19 at 2:32 PM, 3/24/19 at 7:09 PM, and 3/25/19 at 9:27 AM revealed no documentation of the coccyx wound. There was no documentation the physician was notified of the new wound and there were no orders for wound care in the MR. Review of the Wound Photography and Staging Documentation Form dated 3/27/19 at 4:55 PM revealed the coccyx wound had increased in length to 3 cm and width to 2 cm. There was no depth documented. There was no documentation the physician was notified of the increased size of the wound, according to policy. Review of the RN Adult Shift Assessment dated 3/29/19 at 9:00 PM revealed the RN failed to document the presence of the coccyx wound, or an assessment of the dressing. Review of the Wound Photography and Staging Documentation Form dated 4/4/19 at 5:50 PM revealed the coccyx wound had increased in length to 4 cm and width was 2 cm. There was no depth documented. There was no documentation the physician was notified of the increased size of the wound, according to policy. The surveyor was unable to determine what wound care was provided to the coccyx wound, or the frequency of care provided. An interview was conducted on 4/10/19 at 8:00 AM with Employee Identifier (EI) # 18, RN (Registered Nurse), WCC, (Wound Care Certified), who stated the care for wounds was nurse driven, and there were no protocols or orders for wound care. During an interview conducted on 4/11/19 at 9:51 AM with EI # 34, Director, Risk Management and Compliance, the above findings were confirmed. 34107 2. MR # 19 was admitted to the facility on 4/5/19 for Coronary Heart Disease and possible Coronary Artery Bypass Grafting (CABG). Review of the MR revealed a Central Venous Line (CVL) was placed in surgery. Review of the 4/9/19 flow sheet revealed documentation of, "CVL d/c (discontinued)". Review of the 4/9/19 Skilled Nurse (SN) notes revealed no documentation when /or who removed the CVL, the care provided after the CVL removal, or how the patient tolerated the CVL removal. The surveyor asked, "Who removed the CVL and when?" EI # 23, RN, stated, "The RN taking care of the patient yesterday failed to document." The staff failed to document care provided to the patient per policy. In an interview conducted on 4/10/19, at 9:40 AM, EI # 22, Critical Care Director, confirmed the above findings. 3. MR # 9 was admitted to the facility on

3/29/19 with Acute Respiratory Failure. During an observation of endotracheal suctioning and care of tracheostomy (trach) conducted on 4/9/19 at 2:00 PM, the surveyor observed the EI # 41, RN, open a 1000 milliliter (ml) bottle of Sterile Water. EI # 41 poured the Sterile Water into the trach kit container and then cleaned the trach with the Sterile Water. The RN failed to use Sterile Normal Saline as stated in policy. In an interview conducted on 4/9/19 at 3:25 PM, EI # 22 confirmed the above findings. 30952 4. ED MR # 16 presented to the ED on 4/9/19 at 12:28 PM with a chief complaint back pain and nausea. During an observation of care on 4/9/19 at 1:30 PM, EI # 1, ED RN, administered a narcotic analgesic, Dilaudid 1 mg (milligram) IM (intramuscularly) and anti-emetic (nausea) Phenergan 25 mg IM for complaints of lower back pain, described by the patient as severe pain 9 (1-10 pain scale). The acceptable pain level documented was 3. ED MR # 16 exited the ED on 4/9/19 at 3:51 PM. There was no documentation EI # 1 re-assessed the patient's pain level following the narcotic pain administration. In an interview on 4/11/19 at 10:35 AM, EI # 38, Chief Nursing Officer confirmed the above findings. 5. ED MR # 2 presented to the ED on 4/7/19 at 1:32 PM with a chief complaint shortness of breath 1 week post (after) hysterectomy. On 4/7/19 at 2:45 PM, the ED RN documented Morphine Sulfate (narcotic analgesic) 2 mg IV and Metoclopramide 10 mg IV administered for pain level 10. There was no documentation the ED RN re-assessed the pain level following the narcotic administration. In an interview on 4/11/19 at 10:15 AM, EI # 38 reported the pain re-assessment should have been completed 30 minutes after medication administration. 6. ED MR # 4 presented to the ED on 4/6/19 at 8:26 AM with the chief complaint, wound complications. Review of the ED RN documentation at 8:36 AM revealed the pain evaluation consisted of the following documentation "Are you in pain now?" The documented response was Yes. There was no pain assessment documentation of the present pain level, intensity and pain description. The staff documentation failed to include a complete pain assessment per the facility pain management policy. In an interview on 4/11/19 at 9:48 AM, EI # 38 confirmed the above findings. 7. ED MR # 5 presented to the ED on 3/5/19 at 4:13 PM with the chief complaint documented "cpr" (cardiopulmonary resuscitation). The ED physician documented the patient arrived at the facility intubated and stable. Review of the ED RN documentation at 4:59 PM revealed the pain evaluation consisted of the following documentation "Are you in pain now?" The documented response was Yes. There was no pain assessment documentation of the present pain level, intensity and pain description. The staff documentation failed to include a complete pain assessment per the facility pain management policy. In an interview on 4/11/19 at 10:00 AM, EI # 38 confirmed the above findings. 40119 8. An observation was conducted on 4/9/19 at 12:58 PM to observe EI # 32, Registered Nurse, perform wound care for Unsampled Patient # 1. During the observation, EI # 32 removed the dressing to the Left Lateral Thigh surgical wound, wiped with plain gauze, placed clean gauze over wound, and secured gauze with tape. On 4/11/19 at 10:00 AM the surveyor requested the wound assessment, wound care documentation, and wound care order for the Left Lateral Thigh Surgical wound from EI # 33, Nurse Educator. An interview was conducted on 4/11/19 at 10:44 AM, EI # 33 verbalized there was no documentation of the Left Lateral Thigh assessment or wound care documentation in EI # 32's note and there was no physician's order for wound care to the Left Lateral Thigh. 32470 9. MR # 18 was admitted to the facility on 2/19/19 with an admitting diagnosis of Acute Toxic Metabolic Encephalopathy. Review nurses Adult Admission Patient Assessment documentation dated 2/19/19 revealed patient had a Stage II pressure wound to the right coccyx and a Mepilex dressing was applied. Review of all the physician orders within the MR revealed no order was written for the Mepilex dressing or how often the dressing was to be changed. An interview was conducted on 4/11/19 at 10:00 AM with EI # 35, Registered Nurse, who confirmed no orders were

written for wound care. 10. MR # 10 was admitted to the facility on 4/2/19 with an admitting diagnosis of Necrotic Foot Ulcer. On 4/9/19 at 10:00 AM the surveyor entered the Medical Surgical area with EI # 12, Assistant Administrator, for a chart review of wound patients. Review of the Adult Admission Patient Assessment dated 4/2/19 revealed the patient had a pressure ulcer to the right great toe with no drainage and contained eschar to the wound bed. There was no stage documented to this wound. Review of the medical record in the Electronic Medical Record (EMR) system revealed no documentation pictures were taken of the wound. The surveyor asked EI # 18, RN, wound nurse, about pictures. EI # 18 stated "it is not a pressure wound so no pictures are to be taken. Only pressure ulcers get pictures." The surveyor asked EI # 18 why on admission was it documented as a pressure ulcer and EI # 18 replied "I'm not sure." Further review of the EMR revealed no documentation of wound measurements on admission or during MR #10's stay at the hospital. EI # 18 stated " it was not a pressure ulcer so measurements were not taken" An interview was conducted on 4/9/19 at 11:00 AM with EI # 12. The surveyor explained measurements were not taken on admission. EI # 12 stated " measurements are to be taken on admission.

A0454

CONTENT OF RECORD: ORDERS DATED & SIGNED
CFR(s): 482.24(c)(2)

All orders, including verbal orders, must be dated, timed, and authenticated promptly by the ordering practitioner or by another practitioner who is responsible for the care of the patient only if such a practitioner is acting in accordance with State law, including scope-of-practice laws, hospital policies, and medical staff bylaws, rules, and regulations.

This STANDARD is not met as evidenced by:
Based on review of medical records (MR), facility policy and procedure and interview with administrative staff, it was determined the facility failed to ensure all verbal orders were documented in dated, timed, and authenticated for all inpatient records reviewed. This affected MR # 19, MR # 16, 2 of 22 medical records reviewed and had the potential to negatively affect all patients served by this facility. Findings include:
Policy: Physician Orders, Protocols, Pre-Printed and Standing Orders Policy Number: H110.PCS.105 Date Reviewed: 10/2018 Procedure ...II. Verbal or Telephone Orders:
A. Verbal or telephone orders shall be kept to a minimum and only used in emergent /urgent situations... I. Each verbal or telephone order shall be dated, timed and identified by the names of the individuals who gave and received the order... 1. MR # 19 was admitted to the facility on 4/5/19 for Coronary Heart Disease and possible Coronary Artery Bypass Grafting (CABG). Review of the MR revealed documentation the patient had a Central Venous Line (CVL) placed in surgery. Review of the 4/9/19 flow sheet revealed documentation "CVL d/c (discontinued)" Review of the MR revealed no physician's order or verbal order to remove the CVL. During the record review on 4/10/19, the surveyor asked Employee Identifier (EI) # 23, RN, "When was the CVL removed? EI # 23 stated, "The RN taking care of the patient yesterday failed to document the order." The staff failed to follow facility policy for documenting receipt of physician verbal orders. In an interview conducted on 4/10/19 at 9:40 AM, EI # 22, Critical Care Director, confirmed the above findings. 2. MR # 16 was admitted to the facility on 12/8/18 with Inferior STEMI (ST Elevation Myocardial Infarction), (Per Taber's Medical Dictionary, "Electrical activity of the heart consisting of waves called P,Q, R, S, T and sometimes U). Review of the 12/9/18 Skilled Nurse (SN) notes revealed documentation the patient was placed in Non-

Violent Restraints at 6:50 PM. The staff failed to document physician's verbal order to start restraints on 12/9/18 at 6:50 PM. In an interview conducted on 4/11/19 at 9:55 AM, EI # 36, Health Information Management, confirmed the above findings.

A0620

DIRECTOR OF DIETARY SERVICES

CFR(s): 482.28(a)(1)

The hospital must have a full-time employee who- (i) Serves as director of the food and dietetic services; (ii) Is responsible for daily management of the dietary services; and (iii) Is qualified by experience or training.

This STANDARD is not met as evidenced by:

Based on a tour of the Dietary Department, review of the policy and procedure and interviews with the staff it was determined the Dietary Department failed to follow their policy and procedure and ensure: a). All open food products were sealed and labeled properly. b). All pots and pans were dry prior to stacking on shelf. c). Proper handling of all food items while completing plating. Findings include: Policy Food Preparation, Storage and Service Policy Number: H1 10.801.059 Review Date: 10/20 /18 Purpose: To ensure that all food is stored and served in a manner that is compliant with all applicable regulations. Procedure: All food prepared and served will be handled with clean and sanitary gloves and utensils...Gloves will be changed and hands washed per hand washing policy between tasks. ...Original packaging that has been opened will be labeled with the date it was opened and a use by date that will not exceed the package date. on 4/9/19 at 9:30 AM a tour of the dietary department was conducted. During the tour Employee Identifier (EI) # 11, Dietary Manager and EI # 12, Assistant Administrator, was present. The dry storage area was observed during the tour. While observing the dry storage area the surveyor discovered the following: 1- 4 pound (lb) bag of sugar open with no open date and not sealed properly. 2- 10 lb boxes of graham cracker crumbs in a bag inside each box. Both boxes and the bags were opened and no open date was on the box and the bags were not properly sealed within the box. During the tour the kitchen area the surveyor noticed pots and pans sitting on a shelf. With further inspection of the pots and pans, the pans were wet when stacked. When lifting and separating the pots and pans water ran out from around each one. The surveyor spoke with EI # 11 who stated "the pots and pans are to be completely dry prior to stacking them on the shelf." On 4/9/19 at 11:00 AM the surveyor observed the plating of the food. During the plating of the food the surveyor noticed a bag of dinner rolls and a package of hamburger buns sitting on the counter. Observations conducted revealed after plating the hot food and using utensils and resting hands on the counter EI # 10, Dietary Server, reached into the bag containing dinner rolls with a gloved hand and removed a dinner roll and placed on a plate. Further observations revealed EI # 10 began a new plate and reached in to the bag containing hamburger buns and removed one bun with a gloved hand and placed on a plate. EI # 10 failed to use tongs or remove gloves and sanitize his/her hands and don clean gloves prior to removing the rolls from the bag. The surveyor asked EI # 11 if using a gloved hand was proper protocol for removing the rolls. EI # 11 stated "no it is not tongs should be used." EI # 11 then obtained a pair of tongs and placed on the food line for EI # 10 to use for the rolls. An interview was conducted on 4/9/19 at 11: 35 AM with EI # 11 who confirmed the above mentioned findings.

A0700

PHYSICAL ENVIRONMENT

CFR(s): 482.41

The hospital must be constructed, arranged, and maintained to ensure the safety of the patient, and to provide facilities for diagnosis and treatment and for special hospital services appropriate to the needs of the community.

This CONDITION is not met as evidenced by:

Based on observations during facility tour with hospital staff by the Fire Safety Compliance Officer and staff interviews, it was determined that the facility was not constructed, arranged and maintained to ensure patient safety. This had the potential to negatively affect all patients served by the facility. Findings include: Refer to Life Safety Code violations

A0749

INFECTION CONTROL PROGRAM

CFR(s): 482.42(a)(1)

The infection control officer or officers must develop a system for identifying, reporting, investigating, and controlling infections and communicable diseases of patients and personnel.

This STANDARD is not met as evidenced by:

Based on observations, review of facility policies and procedures, Centers for Disease Control and Prevention (CDC) Frequently Asked Questions (FAQ's) regarding Safe Practices For Medical Injections and interviews with the staff, it was determined the facility failed to ensure the staff: a) Followed the facility policy and procedure for proper hand hygiene and gloving. b) Cleaned the septum of medication vials prior to piercing the vial per CDC guidelines and facility policy. c) Discarded contaminated supplies and maintained clean surfaces in the Operating Room (OR). d) Followed the facility policy for labeling and disposing of spiked Intravenous (IV) fluids and tubing in the OR. e) Disposed of used IV fluids in non-handwashing sinks. f) Followed facility policy for sterile dressing change. g) Cleaned re-useable equipment after use. This did affect MR # 7, MR # 6, MR # 20, MR # 4, Emergency Department (ED) MR # 16, and unsampled patients. This was 4 of 22 MR's with observations, 1 of 1 ED MR observation and unsampled patients and had the potential to negatively affect all patients served by this facility. Findings include: Policy/Procedure: Standard and Transmission Based (Isolation) Policy Revised: 11/2018 1. STANDARD PRECAUTIONS Standard Precautions applies to all persons and assume every person is potentially infected or colonized with an infectious organism ... Components of Standard Precautions include: A. Hand hygiene (refer to Hand Hygiene in Healthcare Setting Policy) ...C. Use of personal protective equipment (PPE) ... 1. Gloves - Always perform HH (hand hygiene prior to donning gloves. Gloves will be used to prevent the contamination of healthcare workers hands ...The following apply to glove use: ...Use gloves if there is a possibility of touching contaminated patient care equipment, environmental surfaces ... Whenever gloves are changed, hand hygiene should be practiced before donning a clean pair of gloves. Gloves are removed before leaving a room and never removed or worn out in the hallways. ...After gloves are removed, hand hygiene must be performed. ... Change gloves between patient contact and mobile equipment contact such as computers. F. Safe Work Practices for Standard Precautions ... Liquid ... waste must be flushed down the sewer system via toilet or flush hopper (never down sink drains) ... Facility Policy: Parenteral Medication Revised Date: 09/2018 Purpose: To provide guidelines for the safe administration of ... parenteral medication. Procedure: 2. Wash or sanitize hands. 3. Prepare the medication as follows: d. Scrub the rubber cap with an alcohol sponge. CDC

Frequently Asked Questions (FAQ's) regarding Safe Practices For Medical Injections "Medication Preparation Questions 1. How should I draw up medications? Parenteral medications should be accessed in an aseptic manner. This includes using a new sterile syringe and sterile needle to draw up medications while preventing contact between the injection materials and the non-sterile environment. Proper hand hygiene should be performed before handling medications and the rubber septum should be disinfected with alcohol prior to piercing it." Facility Policy: Medication Administration Revised Date: 01/2019 Purpose: To establish a practice that promotes safety in the administration of medications. Procedure: K. Procedure for Transferring Patient Medication: 1. The nurse will: b. Narcotics and medications removed from Pyxis (automated dispensing system) will be returned to the automated dispensing system and not be transported with the patient. Facility Policy: Maintenance and Set-Up of Invasive Monitoring and IV sets in the CVOR (Cardiovascular OR) Policy: Members of the Anesthesia Care Team will ensure that all invasive monitoring and IV administration sets are set up according to this policy ensuring patient safety and allow timely interventions on behalf of the patient. Procedure: 1. Transducers and IV administrations sets A. Transducers and IV administration sets that are set up in advance of any surgical procedure will be dated with expiration date 72 hours after initial set up. II. Pre-Spiking of IV Fluid Bags B. Spiked IV fluids are to have the expiration date of 72 hours after initial set up written on the bag. Central Venous Catheter (CVC) Dressing Change/Site Care/ Catheter Care Policy #: H110.PCS.151 Revised Date: 9/2018 Purpose To minimize the risk of the patient acquiring a central line-associated blood stream infection while providing intermediate to long-term venous access... Procedure: B. Process 5. Have patient turn head in direction opposite CVC insertion site and place mask on patient... 7. Carefully remove soiled dressing or tape without pulling on catheter... 8. Discard soiled dressing and gloves in proper receptacle. 11. Open CVC dressing tray... don mask and sterile gloves... Policy/ Procedure Title: ABG (Arterial Blood Gas) Policy #: H110.771.050 Revised Date: 11/2018 2.14 Arterial Puncture/ Radial Artery 5. Locate the radial artery... 6. Cleanse the skin with 70% alcohol. 7. Insert the needle... Manufacturer's Guidelines for Cleaning Revised Date: 07-Mar-17 Cleaning the Analyzer and Downloader Clean the display screen and the case using a gauze pad moisten with Super Sani-Cloth. Wash hands through with soap and water after handling an analyzer or downloader. Exercise universal safety precautions at all times when handling the analyzer, cartridges, and peripherals to prevent exposure to blood-borne pathogens. 1. An observation was conducted by the surveyor and Employee Identifier (EI) # 8, Director of Surgical Services, on 4/9/19 from 10:30 AM to 11:22 AM in OR # 9 on MR # 7 for a Right Femoral Hernia Repair with TAP (Transverse Abdominis Plane) Block and the following was observed: At 10:35 AM EI # 37, Registered Nurse (RN) inserted a foley catheter in MR # 7 and removed his/her gloves without performing hand hygiene. At 10:39 AM EI # 7 applied gloves and began shaving and prepping the right femoral pre surgical site. EI # 7 removed his/her gloves, obtained a chloraprep swab and applied clean gloves without performing hand hygiene as directed per the facility policy. When EI # 7 completed prepping the surgical site, EI # 7 left the OR wearing his/her dirty gloves to "dispose of the chloraprep swab" and upon returning removed his/her gloves without performing hand hygiene. At 10:41 AM EI # 3, Certified Registered Nurse Anesthetist (CRNA), placed a large roll of tape on the IV pole which fell to the floor. EI # 3 retrieved the roll of tape from the floor and placed the contaminated roll of tape on top of his/her clean anesthesia cart which contained labeled IV medications in syringes, thus contaminating the clean area. At 10:46 AM a large blue drape was placed to the upper field for MR # 7. EI # 3 retrieved the contaminated roll of tape, secured the left side of the blue drape to the IV pole and removed his/her gloves without performing hand hygiene. At 10:50 AM EI # 3

applied gloves and retrieved a tube of medication (Lacrilube) from the automated medication dispensing system. EI # 3 failed to perform hand hygiene before applying gloves and entering the automated medication dispensing system as directed per facility policy. EI # 3 then applied the medication to MR # 7's lips and removed his/her gloves without performing hand hygiene. At 10:55 AM EI # 3 applied gloves without performing hand hygiene and retrieved 2 vials of IV medication (Propofol and Neosynephrine). EI # 3 opened the vial's and withdrew the medication into a syringe without cleaning the vial tops with an alcohol sponge as directed per facility policy and CDC guidelines. EI # 3 then removed his/her gloves without performing hand hygiene. At 11:12 AM EI # 2, Physician /Surgeon, completed the procedure and removed his/her gloves and left the OR room without performing hand hygiene. EI # 3 applied gloves and emptied the foley catheter bag containing urine. EI # 3 then removed his/her gloves and began writing on the MR form without performing hand hygiene. At 11:18 AM EI # 5, Scrub Technician, completed preparing MR # 7 for transfer and removed his/her gloves without performing hand hygiene. EI # 4, Scrub Technician, completed preparing contaminated surgical instruments for transfer to central sterile and removed his/her gloves without performing hand hygiene. At 11:22 AM EI # 3 extubated MR # 7 and removed his/her gloves without performing hand hygiene. EI # 3 placed and prepared IV syringe of Fentanyl in his/her front shirt pocket and transported MR # 7 to the recovery room. EI # 3 failed to follow the facility policy of not transporting medications with the patient. 2. An observation was conducted by the surveyor and EI # 8 on 4/9/19 at 11:32 AM in Endoscopy Room # 3 on MR # 6 for an Esophagogastroduodenoscopy (EGD) with Stent Removal. At 11:35 AM EI # 7, Anestheologist, removed his/her gloves and exited the room with the dirty gloves in his/her left hand without performing hand hygiene. At 11:39 AM, wearing the dirty gloves used during the procedure, EI # 17, CRNA, transported MR # 6 down the hallway to the recovery room. EI # 17 failed to remove gloves prior to leaving the room and entering the hallway as directed per the facility policy. EI # 17 then removed his/her gloves and began writing on the MR without performing hand hygiene. 3. During a tour of the two (2) Cardiovascular OR Rooms on 4/9/19 from 1:33 PM to 2:45 PM the surveyor and EI # 8 observed the following: OR # 7: 0.9 % (Percent) Sodium Chloride 1000 cc (cubic centimeters) IV bag x (times) 3 spiked with IV tubing and labeled with a date of 4/4 (4/4/19) and connected to IV pumps, which had been expired per policy for 6 days. OR # 5: Plasma Lyte A 1000 ml (milliliters) x 2 bags spiked and connected to a perfusion pump. There were no labels on the IV bags or tubing indicating the expiration date as directed per the facility policy. 4. An observation was conducted by the surveyor and EI # 8 in the Endoscopy Center on 4/10/19 at 9:05 AM to observe EI # 9, RN, to perform Rapiocide disinfectant testing. EI # 9 completed the test and removed his/her gloves without performing hand hygiene as directed per the facility policy. An interview was conducted on 4/10/19 at 9:25 AM with EI # 8 who confirmed the aforementioned findings and stated the staff failed to follow the facility policies and procedures. 5. At 9:50 AM on 4/10/19 in the Endoscopy Center the surveyor observed 2 discarded bags of IV Normal Saline lying in a sink which had handwashing soak and paper towels on the wall. The surveyor asked EI # 8, if the sink was a clean sink and EI # 8 stated, "Yes". The surveyor then asked EI # 8, if IV fluids should be discarded down a clean sink? EI # 8 stated, "No". An interview was conducted on 4/10/19 at 9:52 AM with EI # 9 who was also present where IV bags used IV bags are usually discarded. EI # 9 stated, "In that sink (clean sink)". 39098 6. MR # 20 was admitted to the hospital on 3/21/19 with diagnoses including Left Hip Fracture and Schizoaffective Disorder. MR # 20 was on contact precautions for ESBL (Extended Spectrum Beta Lactamase) UTI (Urinary Tract Infection). An observation was conducted on 4/10/19 at 9:30 AM to observe wound

care on a stage II pressure ulcer of the coccyx, provided by EI # 19, RN. EI # 18, RN, WCC (Wound Care Certified), was also present and assisted during the wound care. EI # 19 unfastened the patient's adult diaper and discovered the patient had soiled the diaper with feces. EI # 19 removed gown and gloves to leave room to retrieve more diapers. EI # 19 failed to perform hand hygiene after removing gloves. EI # 19 cleaned the patient, then removed the soiled dressing. EI # 19 removed her/his contaminated gloves and donned clean gloves, without first performing hand hygiene. EI # 19 cleansed the wound with Shur-cleans wound cleanser, then patted dry with 4 x 4 gauze. EI # 19 used the back of her/his gloved hand to adjust her/his eye glasses, while measuring the wound. The wound was photographed, then covered with a Mepilex dressing. While wearing the same gloves used for wound care, EI # 19 repositioned the patient and covers, pulled out a wipe from the pack and cleaned the bedside table, and closed the lid on the wipes. Using the dirty wipe folded over, EI # 19 attempted to pick up the pack of wipes off the bed, but dropped them on the floor. EI # 18 picked up the pack of wipes off the floor and placed them on the shelf next to the new wound dressings, without first cleaning the pack. EI # 18 removed her/his gloves following the procedure, and donned clean gloves, without first performing hand hygiene. EI # 18 cleaned the camera, then placed the camera in EI # 19's uniform pocket. During an interview on 4/10/19 at 10:00 AM with EI # 18, the above findings were confirmed. 34107 7. During an observation of medication (med) administration on the Medical/ Surgical unit conducted on 4/9/19 at 11:55 AM the surveyor observed EI # 26 prepare insulin for administration. EI # 26 entered the med room and failed to perform hand hygiene. EI # 26 then removed insulin from the refrigerator, and withdrew 4 units of insulin from the vial. EI # 26 exited the med room and entered an unsampled patient's room where EI # 26 applied gloves and administered the 4 units of insulin to patient's upper left arm. EI # 26 then removed gloves and exited the patient room and failed to perform hand hygiene. The staff failed to perform hand hygiene when entering the med room, before preparing a medication for administration, when entering the patient's room, after glove removal, and before exiting the patient's room per policy. In an interview conducted on 4/9/19 at 12:05 PM, EI # 28, Clinical Coordinator, confirmed the RN failed to perform hand hygiene per policy. 8. During an observation of med administration on the Cardiac Care Unit (CCU) conducted on 4/9/19 at 1:25 PM the surveyor observed EI # 40, RN, enter the med room, place their work cell phone on the Pyxis machine, obtain intravenous (IV) Merrium 500 milligram (mg)/250 milliliter (ml) bag from the Pyxis. EI # 40 then proceeded to patient room with IV med and cell phone in hand. EI # 40 entered the patient room placed the work cell phone on the med cart in the patient's room, applied gloves and hung the IV med. EI # 40 failed to perform hand hygiene when entering the med room, before obtaining medication from Pyxis and clean cell phone before placing on cart in patient room. After EI # 40 completed care, removed the dirty work cell phone from the cart and left the patient room, returned to med room and placed the dirty cell phone on the counter and failed to clean the work cell phone. In an interview conducted on 4/9/19 at 2:30 PM, EI # 22 confirmed the staff failed to perform hand hygiene, and clean the dirty cell phone from med room, patient room and back to med room. 9. During an observation of a CVC dressing change on the CCU unit conducted on 4/10/19 at 9:10 AM with EI # 23, Registered Nurse, the surveyor observed EI # 23 apply hand sanitizer and rub hands together for 8 seconds. EI # 23 hands were still wet when she tried to apply the gloves. EI # 23 instructed MR # 4 to turn his/her head away from the CVC dressing. The patient stated, "I don't know what she said." The patient's family present in the room, stated, "He/she is very hard of hearing." EI # 23 failed to place a mask on MR # 4 per policy. EI # 23 removed the old transparent dressing and left the dirty Biopatch and stat-lock device. EI # 23 applied

sterile gloves and then removed the old Biopatch disc and stat-lock device at the insertion site with sterile gloves and then continued to perform the dressing change with the contaminated gloves. The staff failed to follow the sterile CVC dressing policy. In an interview conducted on 4/11/19 at 10:20 AM, EI # 38, Chief Nursing Officer, confirmed the staff failed to follow facility policy. 10. On 4/10/19 at 11:45 AM the surveyor observed EI # 25, Respiratory Therapist Technician, obtain an Arterial Blood Gas (ABG) specimen from an unsampled patient in the Emergency Department (ED) using i-STAT machine (hand held ABG analyzer). EI # 23 cleaned the left radial area with an alcohol pad and then touched cleaned site several more times before actually performing the stick. During the procedure EI # 23 changed gloves several times using hand sanitizer for 5 to 12 seconds her hands were not dry before replacing gloves. EI # 23 placed the i-STAT machine on the patient's bed and then to the supply cart. EI # 23 completed patient care removed gloves and washed hands with soap and water and then picked up the dirty i-STAT machine from the supply cart with ungloved hands and carried it to the nurse's station and placed the dirty i-STAT machine on the docking station. EI # 21, Ancillary Support Director, was present during the observations on 4/10/19 at 11:45 AM and confirmed the above findings at the time of the observations. 30952 11. During a tour of the (ED) Emergency Department on 4/9/19 at 9:20 AM, the surveyors observed EI # 39, ED RN, in the medication room obtaining patient supplies. EI # 39 retrieved one bag of intravenous (IV) solution and one package of IV tubing from the cabinet. EI # 39 dropped the IV tubing package on the floor then reached down and retrieved the tubing package from the floor. EI # 39 opened the tubing package and inserted the IV line into the IV solution bag in preparation for patient use. EI # 39 failed to perform hand hygiene after retrieving supplies from the floor and before preparing IV solution for patient use. On 4/10/19 at 2:30 PM, EI # 33, Nurse Educator, present during the observation, confirmed the above finding. 12. At 1:30 PM in the ED, EI # 1, ED RN removed the needle from a prepared syringe which contained Dilaudid injectable, then transferred the Dilaudid into another syringe in order to mix Phenergan for intramuscular injection for ED MR # 16. EI # 1 failed to clean the septum of the original syringe vial with alcohol prior to insertion of the needle. In an interview on 4/11/19 at 8:20 AM, EI # 43, Infection Preventionist confirmed staff failed to follow facility infection control practices. 32470 13. An observation was conducted on 4/10/19 at 8:20 AM at the Wound Care Center. EI # 13, RN, entered exam room # 4 to speak with the patient and EI # 14, physician, entered the room. After washing hands EI # 14 completed a debridement on the patient's foot. Once complete EI # 14 removed gloves and exited the room without washing or sanitizing hands. At 8:25 AM EI # 16 entered exam room # 4 to wrap the patient's foot after the debridement. EI # 16 obtained supplies needed and donned gloves. EI # 16 failed to sanitize hands prior to donning gloves. EI # 16 completed the wound care. An interview was conducted at 8:30 AM with EI # 12, Assistant Administrator, who confirmed the above mentioned findings. 14. An observation was conducted on 4/10/19 at 8:45 AM to 9:00 AM at the Wound Care Center. EI # 13, RN, and EI # 14 entered exam room # 8. After washing hands EI # 14 donned gloves, plugged in the observation lamp and turned on, examined the patient's (unsampled patient) foot using the same gloves used to plug in and turn on the lamp. EI # 14 then began the debridement of the foot using the same gloves. When complete EI # 14 removed gloves and exited the room and failed to wash or sanitize hands prior to exiting. At 9:00 EI # 16, RN, entered exam room # 8. EI # 16 sanitized hands and donned gloves and removed the dressing to the foot. When complete EI # 16 removed gloves, obtained a roll of tape, donned clean gloves and failed to sanitize hands prior to donning gloves and applied a prism dressing to the wound bed. EI # 16 then prepped the foot and leg for a cast. After completing the wrapping of the leg EI # 16 removed gloves and donned a clean

pair of gloves and failed to sanitize hands. EI # 16 then wrapped the foot and leg with padding for the cast. EI # 16 removed gloves, donned clean gloves and failed to sanitize hands. At 9:20 AM EI # 14 entered exam room # 8 and donned gloves and gown and failed to wash or sanitize hands. EI #14 applied the cast to the foot and leg, removed the gown and gloves and exited the room. EI # 14 failed to wash or sanitize hands prior to leaving the exam room and went directly into the dictation room. An interview was conducted on 4/10/19 at 9:30 AM with EI # 12, who confirmed the above mentioned findings. 40119 15. An observation was conducted on 4/9/19 at 12:58 PM to observe EI # 32, Registered Nurse, administer IV (intravenous) medication and perform wound care to an unsampled patient. EI # 32 donned gloves without hand hygiene EI # 32 prepared syringe of Ketoralac 30 mg/ml 1 ml on the desktop surface of the computer without cleaning the computer surface prior to the preparation of medication. EI # 32 administered the IV Ketoralac without removing gloves and performing hand hygiene. EI # 32 removed gloves, performed hand hygiene at the patient's bathroom sink, then used bare hand to turn the sink faucet off. EI # 32 donned gloves, removed bandage to the patient's left lateral thigh with bloody drainage present on the bandage, removed gloves, and donned clean gloves without performing hand hygiene. EI # 32 placed gauze over left lateral thigh wound, secured with tape, removed gloves, obtained patient lunch tray and gave tray to another facility staff member without performing hand hygiene. An interview was conducted with EI # 33, who confirmed the above findings.

A0806

DISCHARGE PLANNING NEEDS ASSESSMENT
CFR(s): 482.43(b)(1), (3), (4)

(1) The hospital must provide a discharge planning evaluation to the patients identified in paragraph (a) of this section, and to other patients upon the patient's request, the request of a person acting on the patient's behalf, or the request of the physician. (3) - The discharge planning evaluation must include an evaluation of the likelihood of a patient needing post-hospital services and of the availability of the services. (4) - The discharge planning evaluation must include an evaluation of the likelihood of a patient's capacity for self-care or of the possibility of the patient being cared for in the environment from which he or she entered the hospital.

This STANDARD is not met as evidenced by:
Based on review of medical records (MR) and interview with administrative staff, it was determined the facility failed to ensure patient admitted with home health services were discharged with same services for 1 of 1 home health discharge records reviewed. This affected MR # 16 and had the potential to negatively affect all patients served by this facility. Findings include: 1. MR # 16 was admitted on 12/8/18 with the diagnosis of Inferior STEMI (ST Elevation Myocardial Infarction), (Per Taber's Medical Dictionary, "Electrical activity of the heart consisting of waves called P,Q, R,S, T and sometimes U) and discharged on 12/11/18 to self care with family. Review of the Adult Admission Patient Assessment completed on 12/8/18 at 3:15 PM by the Registered Nurse (RN) revealed documentation prior to admission to hospital MR # 16 was receiving the following services in the home: Home Health Nurse, Home Health Aide, Oxygen Therapy, and Respiratory Therapy and requested to have the services continued on discharge. Review of the Case Management Follow-Up Assessment notes dated 12/10/18, 12/11/18, and 12/12/18 revealed no documentation of home health contact or referral. Review of 12/31/18 Nurse Note revealed documentation, "Spoke with patient by phone. He/she states XXXX Home Health is seeing her currently..." The facility failed to ensure home health services were offered

	<p>or continued on discharge from the facility. In an interview conducted on 4/11/19 at 9:55 AM, Employee Identifier # 36, Health Information Manager, confirmed the facility failed to contact home health agency to ensure services were resumed.</p>
E0000	<p>Based on the validation survey conducted on 4/9/19 to 4/11/19, the facility was found to be in substantial compliance with the Centers of Medicare /Medicaid Services requirements for Emergency Preparedness.</p>
K0000	<p>This STANDARD is not met as evidenced by: . K3 Building: 0202 K6 Plan Approval: 1965/1974/1978 K7 Survey Under: 2012 Existing K8 BUSINESS Generator: One Diesel, Kohler 400 kW (installed 2000) FACP: Faraday MPC-2000 (installed 2000) Locking Devices: None Smoke Detection: Partial (in Wound Care) Type of Structure: 1965/1974/1978 single story with a partial basement protected ordinary, Type III(211). The facility has a partial automatic sprinkler system. During a routine validation survey conducted on this date, the facility was found not in compliance with 42 CFR 482.41 as evidenced by the following deficiencies of NFPA 101 Life Safety Code (LSC) and codes referenced by the LSC, as observed by the LSC Surveyors while accompanied by the facility maintenance personnel. .</p>
K0211	<p>Means of Egress - General CFR(s): NFPA 101</p> <p>Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1</p> <p>This STANDARD is not met as evidenced by: . Based on observation and interview, the facility failed to maintain the means of egress per the requirements of: 2012 NFPA 101, 39.2.1, and 7.2.2.4.1.1 This deficiency could affect 10 occupants. Findings include: On 04/11/2019, during a tour of the facility from 08:00 am to 12:30 pm, the surveyor observed a ramp with a broken outside handrail in the means of egress by Room 420 exit. The right handrail could not be of use to occupants because it was leaning approximately 45 degrees outwards from the ramp. A member of the maintenance staff was present when this deficiency was identified. .</p>
K0343	<p>Fire Alarm System - Notification CFR(s): NFPA 101</p> <p>Fire Alarm - Notification 2012 NEW Positive alarm sequence in accordance with 9.6.3.4 are permitted. Occupant notification is provided automatically in accordance with 9.6.3 by audible and visual signals. In critical care areas, visual alarms are sufficient. The fire alarm system transmits the alarm automatically to notify emergency forces in the event of a fire. Annunciation and annunciation zoning for fire alarm and sprinklers shall be provided by audible and visual indicators and zones shall not be larger than 22,500 square feet per zone. 18.3.4.3 through 18.3.4.3.3, 9.6.4</p>

	<p>This STANDARD is not met as evidenced by: . Based on observation and interview, the facility failed to ensure the visual function of the notification devices for the fire alarm was per the requirements of: 2012 NFPA 101, 18.3.4.3.1, and 9.6.3.5 2010 NFPA 72, 10.10.2 Findings include: On 04/10/2018, during a tour of the facility from 6:00 pm to 10:00 pm, the surveyor observed fire alarm visual notification devices continued to function after the signal deactivation means was actuated. A member of the maintenance staff was present when this deficiency was identified. .</p>
<p>K0345</p>	<p>Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101</p> <p>Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72</p> <p>This STANDARD is not met as evidenced by: . Based on review of documentation and interview, the facility failed to maintain the smoke detectors per the requirements of: 2012 NFPA 101, 4.6.12.3, 4.6.12.4, and 9.6.1.3 2010 NFPA 72, 14.4.5.3.2 This deficiency could affect all occupants. Findings include: On 04/11/2019, during a tour of the facility from 8:00 am to 12:30 pm, the facility failed to provide documentation that a smoke detector sensitivity test was completed within the past two years. A member of the maintenance staff was present when this deficiency was identified. .</p>
<p>K0351</p>	<p>Sprinkler System - Installation CFR(s): NFPA 101</p> <p>Sprinkler System - Installation 2012 NEW Buildings are to be protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state and local regulations prohibit sprinklers. Listed quick-response or listed residential sprinklers are used throughout smoke compartments with patient sleeping rooms. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed six square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 18.3.5.1, 18.3.5.4, 18.3.5.5, 18.3.5.6, 9.7, 9.7.1.1(1), 18.3.5.10</p> <p>This STANDARD is not met as evidenced by: . Based on observation and interview, the facility failed to ensure the automatic sprinkler system was per the requirements of: 2012 NFPA 101, 18.3.5.1, 18.3.5.4, and 9.7.1.1 (1) 2010 NFPA 13, 8.5.6.1 Findings include: On 04/09/2019, during a tour of the facility from 1:00 pm to 4:15 pm, the surveyor observed boxes of kitchen food and supplies were stored within 18 inches of the automatic sprinkler heads in the</p>

following locations: 1. The kitchen walk in cooler 2. The kitchen walk in freezer 3. The Dry Storage Room A member of the maintenance staff was present when this deficiency was identified. .

K0353

Sprinkler System - Maintenance and Testing
CFR(s): NFPA 101

Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25

This STANDARD is not met as evidenced by:
. Based on observation and interview, the facility failed to maintain the automatic sprinkler system per the requirements of: 2012 NFPA 101, 18.3.5.1, and 9.7.5 2011 NFPA 25, 5.2.4.1, and 5.2.2.2 Findings include: 1. On 04/09/2019, during a tour of the facility from 1:00 pm to 4:15 pm, the facility failed to provide documentation for the monthly inspections on the wet sprinkler system gauges. 2. On 04/10/2019, during a tour of the facility from 8:00 am to 2:00 pm, the surveyor observed an HVAC supply air duct resting on the automatic sprinkler system pipes above ceiling near the Education Work Room and Room 1C191. A member of the maintenance staff was present when this deficiency was identified. . 39327

K0372

Subdivision of Building Spaces - Smoke Barrie
CFR(s): NFPA 101

Subdivision of Building Spaces - Smoke Barrier Construction 2012 NEW Smoke barriers shall be constructed to provide at least a one hour fire resistance rating and constructed in accordance with 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations of fully ducted HVAC systems. 18.3.7.3, 18.3.7.4, 18.3.7.5, 8.3 Describe any mechanical smoke control system in REMARKS.

This STANDARD is not met as evidenced by:
. Based on observation and interview, the facility failed to maintain smoke barriers that would provide at least a half hour fire resistance rating and restrict the movement of smoke per the requirements of: 2012 NFPA 101, 18.3.7.3, 8.5.1, and 8.5.6.2 Findings include: On 04/09/2019, during a tour of the facility from 1:00 pm to 4:15 pm, the surveyor observed the following in smoke barriers above the ceiling on the Third Floor: 1. An unsealed penetration of approximately 2 inches at the entrance to the Baby Wing 2. An unsealed penetration around the HVAC duct on Wing 3100 above the doors A member of the maintenance staff was present when this deficiency was identified.