Statement of Deficiencies	**(X1) Provider/Supplier/CLIA Identification Number**	**(X3) Date Survey Completed**
	670031	01/12/2012
Name of Provider or Supplier	**Street Address, City, State**	
St Luke's Patients Medical Center	4600 East Sam Houston Parkway South, Pasadena, TX	

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	Note: The CMS-2567L is an official, legal document. All information must remain unchanged except for entering the plan of correction, correction dates, and the signature space. If information is inadvertently changed by the provider, you should notify the state Survey Agency. If the AS notices any discrepancy in the information related to the deficiency citation (s), the AS will report this occurrence to the Dallas Regional Office. The Regional Office will make a referral of possible fraud to the Office of the Inspector General (DOING). ********** An unannounced visit was made to this hospital to conduct a recertification survey and licensure inspection. An entrance conference was held on 01/10/2012 with administrative personnel. The reason for the survey and the requirements under which the survey would be conducted were explained. An exit conference was held on 01/12/2012. The facility's administrative staff present were notified of the outcome of the survey and opportunity given to provide explanation and evidence. Deficiencies were cited based on the survey. The facility is in compliance with Cop 42 CFR part 482 and the State Licensing rules 25 Texas Administrative Code Chapter 133 as surveyed this day. Glossary : Bicarbonate solution: nonpyrogenic, hypertonic solution of Sodium Bicarbonate (NaHCO3) in water. CMS: Center for Medicare Services Endoscopy: is a procedure that lets your doctor look inside your body. It uses an instrument called an endoscope, or scope for short. ER: emergency room Hemodialysis : Hemodialysis: A medical procedure that uses a special machine (a dialysis machine) to filter waste products and water from the blood . Iodosorb Jell : is a wound gel that inhibits bacterial growth as it absorbs exudate. Specially formulated for use on wet, exudating ulcers Lasix :a drug used to treat excessive fluid accumulation and swelling (edema) of the body Levaquin: a drug used to treat infections of the sinuses, skin, lungs, ears, airways, bones, and joints Morphine: is a narcotic pain reliever used to treat moderate to severe pain Protonix: is used to treat gastroesophageal reflux disease (GERD), a condition in which backward flow of acid from the stomach causes heartburn and possible injury of the esophagus (the tube between the throat and stomach). Pyxis

	machine: is a medication dispensing machine used in hospitals Xenaderm:a protective ointment used to treat certain types of wounds or ulcers of the skin.
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 observation, interview and, record review the facility (a) Failed to have a dietary director who is a full time employee of the hospital; (b) Failed to enforce its food and supply storage policy# B006 and; (c) Failed to ensure Dietary equipment were routinely cleaned. Findings: During observation on 1/11/12 at 8:15 am in the Dietary Suite at the facility Staff # 14N presented herself as the Director of Dietary Services and had been working in that capacity since July 2011. According to the staff she was a full time employee of a contract agency (MMS) and that all the dietary staff were employee of that contract agency. Staff # 14N further stated she reports directly to the Regional Director Operations at MMS however, if she had problems at the facility she would also discuss them with the facility ' s Chief Executive Officer (CEO). Review of the facility 's current dietary policy manual revealed the entire operation and day to day management of the dietary department was conducted by employee of the contract agency MMS. There was no facility employee designated to oversee the operations of the dietary department. During an interview on 1/11/12 at 2:00 pm with Staff #28 B, Chief Nursing Officer (CNO) She stated there was no hospital employee with direct oversight of the Dietary Department. Review of Personnel file for Staff # 14 N revealed she was hired as Dietary Director since July 2011. The Job description summary stated the following information: " Direct the operation of Food & Nutrition Services. Performs a variety of duties including the planning, and supervision of special functions, maintaining cash control, payroll records, hiring and training of personnel. Ensure customer satisfaction and good public relations are achieved through the safe and efficient uses of resources. " Observation on 1/11/12 at 8: 25 am in the dry storage room in the dietary suite revealed multiple food items that were opened and were not stored in a manner to prevent contamination. There were opened bags of pasta wrapped in saran wrap with the edges open; there were several opened packages of pasta, cornbread mix, and walnuts that had no wrappings and was not placed in covered containers. Further observation on 1/11/12 at 8: 40 am in the dietary suite revealed a food rack with multiple shelves stocked with prepared pastry to be baked had visible build up of dust webs on the bars of the shelves. There was heavy build up of dust webs on the dish washing machine, dust particles in corners of the floor. A dish cart in the clean dish room with clean glass ware, had visible dust and particles on the shelves of the cart. The cart was heavily stained with a whitish substance giving the appearance of a very dirty cart. These findings were also observed by Staff # N14 (Dietary Director) who was present at the time of the observation. During an interview on 1/11/12 at 9:45 am with Staff # N14 regarding the observation she stated the matter would be addressed with the dietary staff. Review of the facility's food supply storage procedure # B006 dated 3/11 gave the following information: 'Policies: All food , non-food items and supplies used in food preparation shall be stored in such a manner as to

	maintain the safety and wholesomeness of the food for human consumption. Store foods in their original packages. Foods that must be opened must be stored in NSF (National Sanitation Foundation) approved containers that have tight fitting lids."
A0654	UTILIZATION REVIEW COMMITTEE CFR(s): 482.30(b) A UR committee consisting of two or more practitioners must carry out the UR function. At least two of the members of the committee must be doctors of medicine or osteopathy. The other members may be any of the other types of practitioners specified in 482.12(c)(1). (1) Except as specified in paragraphs (b)(2) and (3) of this section, the UR committee must be one of the following: (i) A staff committee of the institution; (ii) A group outside the institution-- (A) Established by the local medical society and some or all of the hospitals in the locality; or (B) Established in a manner approved by CMS. (2) If, because of the small size of the institution, it is impracticable to have a properly functioning staff committee, the UR committee must be established as specified in paragraph (b)(1)(ii) of this section. (3) The committee or group's reviews may not be conducted by any individual who-- (i) Has a direct financial interest (for example, an ownership interest) in that hospital; or (ii) Was professionally involved in the care of the patient whose case is being reviewed. This STANDARD is not met as evidenced by: Based on interview and record review, the Hospital failed to ensure the Utilization Review Committee consisted of at least two physician practitioners in 2010 and 2011. Findings include: Record review of the facility's Utilization Review committee meeting minute sign-in sheets revealed only one physician participated in the following meetings: February 25, 2010 April 22, 2010 September 8, 2010 August 25, 2011 October 27, 2011 The Chief Financial Officer stated 1/12/12 at 9:35 a.m. that he was not aware of the requirement by CMS that two physicians are required to participate in the Utilization Review committee process. Record review of a hospital policy titled "Utilization Review Management Plan" dated 11/2011 stated "Composition of the Utilization Review (UR) Committee: A Utilization Review committee consisting of two or more practitioners must carry out the UR function."
A0701	MAINTENANCE OF PHYSICAL PLANT CFR(s): 482.41(a) The condition of the physical plant and the overall hospital environment must be developed and maintained in such a manner that the safety and well-being of patients are assured. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the Hospital failed to maintain a clean environment. Heavy dust / lint was observed in the emergency room, cardiac Cath lab, and the surgical suite area. Findings include: Initial tour 1/10/12 at 9:40 a.m. revealed heavy dust / lint build up (1/8 inch) as follows: Emergency Room: -ER treatment room #1 had heavy dust / lint build-up on two over-head lights used for suturing. Cardiac Cath Lab: -Treatment room #9 had heavy dust / lint build-up on top of the wall mounted cardiac monitor, the wall mounted TV, and the bottom of the stretcher. -Cath Lab room had heavy dust / lint build up on top of a surgical light, bottom of two IV poles, top of the wall mounted x-ray viewing box, the arms of the

	Ergo-light, the base of the x-ray C-arm, and the Cath lab patient table. Surgical Suite Area: -Operating room soiled utility room had heavy dust / lint build-up on the ceiling ventilation vent -Medication room had heavy dust / lint build-up on top of the Pyxis medication machine and on top of a refrigerator -Janitor closet had heavy dust / lint build-up on the ceiling ventilation vent -Operating room sub-sterile areas A, B, and C had heavy dust / lint build-up on top of the blanket warmers -Pre-operative holding area room #'s 1, 2, 3, and 4 had heavy dust / lint build-up of top of the wall mounted cardiac monitors, bottom of the stretchers, and on top of a supply cart -Endoscopy Room #3 used for eye procedures had heavy dust / lint build-up on top of two overhead surgical lights and on top of a surgical cabinet. -Endoscopy storage cabinet for scopes had heavy dust / lint build up on top of the cabinet -Recover room had a stretcher that was used of "eye" patients that had heavy dust / lint build-up on the bottom of the stretcher -Step down recovery unit had heavy dust / lint build-up on top of the wall mounted cardiac monitors in room #'s 11, 12, 13, 14, 15, 16, 17, 18, and 19. Also the bottom of the stretchers had heavy dust / lint build-up. During an interview on 01/10/2012 with the the operating room nurse manager (ID# 25Y) she acknowledged that the nursing staff is responsible for cleaning the Cath lab, the surgical suite area, and the recovery room. Record review of a policy titled "Cleaning of Non-Critical Portable Patient Care Equipment" dated 11/2011 stated "Purpose: Reusable non-cortical portable patient care equipment have the potential of becoming contaminated with microorganisms. Proper cleaning and decontamination of the equipment reduces the risk of transmission of pathogens between patient. Procedures: Thoroughly wipe down equipment with a clean cloth saturated with approved cleaning solution..." 17028 Room # 106 During observation rounds on the unit on 1/10 /12 at 10:15 am A patient reported that when she was taken to her room on the evening of 1/9/12 the bed was made up but there were spots of blood on the side rail and on the bar at the base of the bed (orthopedic bed). The patient stated her sister cleaned it off and reported to a staff that came in and cleaned the area. Observation on the afternoon of 1/10/12 at 2:15 pm on the surgical unit reveal the following information: Room # 106 was cleaned following a patient discharge. Inspection of the room revealed the floor was cleaned and the bed in the room was made. Further observation in the room revealed there was dust particles on the base of the bed, on the rail beneath the mattress, and in the crevasses. There was visible dust on the bed supports , and a brown looking splatter at the base of a side rail. Staff # 30 D that was present at the inspection stated a patient was discharged from the room about two hours prior and the room was cleaned and ready for a new patient. The Staff had removed the sheets and rolled back the mattress for the inspection. During an interview on 1/10/12 at 2:35 pm with Staff # 31 E, (house keeping staff that cleaned the room) she stated all areas in the room should be dusted and wet wiped with a sanitizer after a patient is discharged from the room. She inspected the room and stated the room would be re- cleaned. Review of the facility's policy/procedure for cleaning patient rooms revealed the following information: 'Dust all ledges, blinds, overhead lights, vents and doors. Disinfect bed rails, frame, mattress, headboard, footboard and under frame."
A0749	INFECTION CONTROL OFFICER RESPONSIBILITIES 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 observation, interview and record review, facility failed to maintain a sanitary environment in that facility ' s nursing staff failed to wear gloves, wash hand and maintain infection control practices when providing direct care and administering medication to patient's ; failed to clean droplet of blood from used equipment and failed to ensure expired supplies were not available for use in patient care areas in 6 of 32 sampled patients. #s 1, 7, 15, 16, 29, 32 Findings: Review of the facility's current policy and procedure on Medication therapy # PHA136 directed staff as follows: " Medication administration will be in compliance with infection control guidelines (standard Precautions) " Standard Precaution " Assume that every person is potentially infected or colonized with an organism that could be transmitted in the healthcare setting and apply the following infection control practices during the delivery of health care: During the delivery of healthcare, avoid unnecessary touching of surfaces in close proximity to the patient to prevent both contamination of clean hands from environmental surfaces and transmission of pathogens from contaminated hands to surfaces. Wear disposable medical examination gloves for providing direct patient care. Wear gloves when it is reasonably anticipated that contact with blood or potentially infectious materials, mucous membrane, non intact skin or potentially contaminated intact skin (e.g. of a patient incontinent of stool or urine could occur.) Perform Hand hygiene before direct contact with patients, After removing gloves. " Patient #15 On 01/ 11/2012 at 7:20 a. m. registered nurse (5 E) was observed in the room of patient # 15. Observation at that time revealed the patient ' s chart was stored on top of the dirty linen cart stored in the patient ' s room. The cart was holding a yellow bag containing soiled linen. Registered nurse (5 E) picked up the chart from off the soiled linen cart and returned it to the chart rack at the nurses ' station. Registered nurse (5 E) did not clean the contaminated chart or wash her hand after touching the soiled linen cart. She then proceeded to make a telephone call at the nurse station. On 01/11/2012 at 7:24 a.m. the surveyor informed registered nurse (5 E) that she the surveyor had observed her with the patient ' s chart stored on the dirty linen cart and that she had not cleaned the chart or wash her hands after handling potentially contaminated items. Registered Nurse (5 E) stated " You can't do that? " Patient # 7 On 01/11 /2012 at 7:30 a.m. registered nurse (7 G) was observed in the room of patient # 7. Observation at that time revealed registered nurse (7 G) picked up soiled linen stored on top of the dirty linen cart and placed them in a yellow bag. Registered nurse (7 G) was not wearing gloves when handling the soiled linen and did not wash or cleansed her hands after handling the soiled linen. She then placed her contaminated hand in her pocket and retrieved a marker which she used to write on the board in the patient ' s room. After writing on the board, she returned the contaminated marker to her pocket, picked up the clip board in the room, along with containers from the patient ' s bedside table. The nurse opened the door with her contaminated hands then walked to the nurses ' station where she placed the items on the nurses ' station and in the garbage. On 01/11/2012 at 7:36 a.m. during an interview with registered nurse (7 G) the surveyor informed the nurse that she the surveyor had observed her handled soiled linen with her ungloved hands and that she the nurse did not wash her hands after handling the contaminated linen. Registered nurse (7 G) stated " I am sorry. " Patient #16 On 01/11/2012 at 8:00 a.m. registered nurse # 6F was observed at the bedside of patient #16 administering oral and intravenous medication to the patient. On entering the patient ' s room registered nurse (6F) pulled a dirty linen cart that was located in the patient ' s room. The cart was holding dirty linen in a yellow bag. She then placed a packet containing patient #16 ' s home medication on top of the dirty linen cart, placed a clip board on top of the cart and poured medication that were in a bag on top of the

cart and some unto the clip board. After administering oral medication to patient #16, registered nurse (6F) then proceeded to administer intravenous medication of Protonix and Lasix to patient #16. Registered nurse (6F) removed an alcohol swab from the packet, placed the swab directly on the patient ' s bedside table which was not cleaned during medication administration procedure. Registered nurse (6F) used the same contaminated alcohol swab to clean the intravenous port of patient #16 prior to administering Lasix and Protonix to patient #16. After administering medication to patient #16, registered nurse 6F picked up the contaminated packet containing the patient ' s home medication and the clip board and left the room . Registered nurse (6F) placed the contaminated clip board unto the nurses ' station and returned the contaminated packet containing patient ' s home medication to the medication room. During an interview with registered nurse (6 F) on 01/11/2012 at 08:10 a.m. registered nurse said patient # 16 was receiving antibiotic therapy for a urinary tract infection. Subsequent interview on 01/11/2012 at 8:15 a.m. in the medication room, the surveyor informed her that she the surveyor observed her set up patient ' s medication on the dirty linen cart and that she had removed alcohol swab from the packet and placed it directly on the dirty bedside table of patient # 16. Registered nurse #6F stated " You are so right I will correct it " Review on 01/11/2012 of patient #16 ' s clinical record revealed a physician ' s order dated 01/07/2012 for antibiotic therapy of Intravenous Levaquin 750 mgs daily for urinary tract infection. Review of the patient ' s clinical record revealed a history and physical dated 01/07/2011 which indicated the following " Diagnosis , sepsis secondary to urinary tract infection, bilateral pneumonia. " 12000 Observation 1 /10/12 at 9:40 a.m. in the Cardiac Cath Lab revealed the patient table had red specs / splatter / hair and dirt on the base of the table. The red specs could be wiped clean using an alcohol swab. 23032 Patient #32 Observation on 01-11-12 at 9:10 a.m. revealed Registered Nurse (RN) (ID # 9-I) prepared to administer morning medication to Patient (ID #32). She went directly from the computer keyboard to the medication room and obtained the patient ' s (ID # 32) medication. The RN failed to wash or sanitize her hands before entering and prior to exiting the medication room. Further observation revealed RN (ID # 9-I) went directly from the medication room to the patient ' s (ID # 32) room. RN (ID # 9-I) entered the room and donned a pair of gloves without first washing or sanitizing her hands. RN (ID #9-I) administered several medications to Patient (ID # 32); removed her gloves, and washed her hands prior to exiting the room. During an interview on 01-12-12 at 9:45 a.m. with the Interim Chief Nursing Officer (CNO) (ID # 28 B), she stated the RN should have washed her hands prior to entering the medication room and also upon entering the patient ' s room and prior to donning gloves. 17028 Patient #1 Observation on 01/11/12 at 9: 30 a.m. revealed Patient # 1 had a pressure sore on the buttocks opened to air and wounds on both feet which were bandaged. Staff # 1 A, (Registered Nurse) started to clean the patients ' buttocks then decided to administer Intra venous (IV) Morphine to the patient. The Nurse administered the IV medication and did not remove the gloves and wash her contaminated hands. After administering the medication with the same contaminated gloves she was wearing , she completed cleaning the wound on the patient's buttocks, placed the Xenaderm ointment on her gloved hand and applied the ointment to the patient's buttocks. The nurse did not change the gloves and wash her hands prior to the application of the ointment. Staff # 29C (Licensed Vocational Nurse) who was assisting with the procedure removed a pair of scissors from her pocket and cut through the bandages covering wounds on both feet of the patient. Staff # 1 A removed the dressings from the patient ' s left foot, removed her gloves and left the room without washing her hands. Soon after, she returned to the room and donned a clean pair of gloves, assisted staff # 29C with changing the patient ' s disposable towel. She then proceeded to clean

	the wound on the patient ' s left foot with normal saline poured from a bottle onto gauze swabs. After cleaning the wounds without changing her gloves Staff # 1 A placed the Iodosorb gel on a gauze swab and applied the gel to the wounds moving from one wound to the next using the same swab. She then bandaged the patient's wounds. The Nurse never changed her gloves and wash her hands between tasks. The nurse then used the contaminated gloves to remove the soiled dressing from the patient ' s right foot, she changed one hand of her gloves and replaced it with a clean glove; she poured saline solution from the bottle onto a swab and cleaned the wound on the patient's heel. Without changing her gloves the staff applied Xenaderm ointment to one gloved hand and applied the ointment to the wound, she then applied a bandage, then remove one hand of glove and wrote on the bandages. After the wound care procedure staff #1 A and # 29 C repositioned the patient in bed. Staff # 29 C returned the soiled pair of scissors to her pocket without cleaning the scissors. After completing wound care staff # 1 A removed her gloves, picked up a clipboard she took to the room along with the saline bottle and tubes of medication started to leave the room, and then decided to wash her hands at the sink. She proceeded to the nurses ' station with the contaminated tubes of medication, clipboard and saline bottle without cleaning them. The medication was returned to the clean medication room. All these items were handled with soiled gloves. Patient # 29 Observation on 1/11/12 at 9:25 am revealed Patient # 29 had a surgical incision on her left hip. There was orders to clean with normal saline and apply dry dressing. Staff # 9 I (Registered Nurse) donned a pair of gloves, removed the soiled dressing, changed her gloves, put on clean gloves and used the saline soaked gauze to clean the wound. She then removed those gloves, put on clean gloves and applied the dry dressing. She did not wash her hands after each glove change. During an interview with Staff # 9I on 1/11/12 at 10:00 am she stated she realized she should have cleaned or washed her hands after the glove change. 30124 Surveyor observed at 09:30 a.m. of January 11, 2012 in the operating room # 4 a surgical procedure on patient #22. Surveyor observed the circulating nurse (ID # 11K) opening a sterile scrub pack for pre-operative cleaning of a surgical site. Circulating nurse (ID#11K) applied sterile gloves and preformed scrubbing/disinfection of the surgical area. Surveyor then observed staff (ID#11K) after completion of scrubbing /disinfection of surgical area collected the items used and discard the items into the trash. Surveyor then observed staff (ID#11K) removed her gloves and drop them into trash. Employee (ID#11K) them proceeded over to counter and began documenting on a piece of paper. Employee (ID#11K) failed to disinfect or wash her hands per hospital policy. Operating Room Director (ID# 8H) on January 11, 2012 stated the circulating nurse (ID#11K) should have left the operating room and washed her hands right outside the door or used a hand sanitizer. During initial tour surveyor observed at 1000 AM on January 10, 2012 along with Quality Assurance Director, (ID# 26Z) and OR Nurse (ID# 25Y) in the Operating Room Clean Supply room the following expired items readily available for use: Packing Strips 1 inch x 5 yards: 1 Bottle expired 10/09 1 Bottle expired 12/09 12 Bottles expired 01/10 2 Bottles expired 09/11 Packing Strips ? inch x 5 yards: 9 Bottles expired 9/11 8 Bottles expired 12/09 Packing Strips ? inch x 5 yards 3 Bottles expired 10/09 During initial tour surveyor observed at 1030a.m on January 10, 2012 along with Quality Assurance Director, (ID# 26Z) and OR Nurse, (ID# 25Y) in the Operating Room supply area the following expired items readily available for use: 4 Packages - Providen-Iodine Swabs Expired 07/2011 1 Box - Surgical Blade 6200 Expired 10/2010 6 Packages - Small Chisel Mini Blade S-6200 Expired 07/2011
K0000	

	This STANDARD is not met as evidenced by: A life safety code (LSC) resurvey was conducted on site on 01/12/2012. An entrance conference was held for the hospital ' s administrator and director, plant operations on the morning of 01/12/2012 to discuss the purpose of the LSC survey and the survey process were explained. Instructions were provided on writing plans of correction. An opportunity was provided for questions and discussion. The LSC survey was conducted under the authority of Chapter 2 of the State Operations Manual, Appendix A, Acute Care Hospitals, 42CFR482 to determine the Hospital ' s compliance. An LSC exit conference was conducted on 01/12/2012 in the hospital. In attendance were the hospital ' s administrator and director of plant operations. The preliminary findings of the survey and the next steps in the survey process were explained. An opportunity was provided for questions and discussion. Note: The CMS-2567 (Statement of Deficiencies) is an official, legal document. All information must remain unchanged except for entering the plan of correction, correction dates, and the signature space. Any discrepancy in the original deficiency citation(s) will be reported to the Dallas Regional Office (RO) for referral to the Office of the Inspector General (OIG) for possible fraud. If information is inadvertently changed by the provider/supplier, the State Survey Agency (SA) should be notified immediately.
K0027	LIFE SAFETY CODE STANDARD CFR(s): NFPA 101 Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Swinging doors are arranged so that each door swings in an opposite direction. Doors are self-closing and rabbets, bevels or astragals are required at the meeting edges. Positive latching is not required. 18.3.7.5, 18.3.7.6, 18.3.7.8 This STANDARD is not met as evidenced by: based on observation during the facility and discussions with the director of plant operations on 01/12/1012, it was noted that a set of cross-corridor smoke barrier doors did not shut completely during a testing of the facility fire alarm system. They failed to close together to form a smoke resistant barrier due to acombination of air flow differential for the HVAC system within the hallway on either side of the set of doors, and self closing devices not being adjusted properly to close against the air pressure differential.