Baptist Health System

CMS Statements of
Deficiencies
and
Plans of Correction
(CMS Form 2567)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	450058	A. BUILDING _____ B. WING _____	C 04/04/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAPTIST MEDICAL CENTER	111 DALLAS STREET SAN ANTONIO, TX 78205

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 000	INITIAL COMMENTS The 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 Dallas Regional Office (RO) for referral to the Office of Inspector General (OIG) for possible fraud if information is inadvertently changed by the provider/supplier, the State Survey Agency (SA) should be notified immediately. An unannounced visit was conducted on 04/04/14 to conduct a complaint investigation. An entrance conference was conducted in the conference room of the facility . In attendance was the facility Risk Manager. The purpose and process of the complaint survey were discussed and an opportunity for questions was provided. Complaint TX 00191512 was unsubstantiated with no deficiencies cited. An exit conference was conducted in the afternoon of 04/04/14 in the facility conference room. Several administrative staff were in attendance. Preliminary findings of the survey were discussed and an opportunity for questions was provided	A 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	PRESIDENT + COO	10/9/14

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	450058	A. BUILDING _____ B. WING _____	C 04/30/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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A 000	INITIAL COMMENTS An entrance conference was conducted at Mission Trails Baptist Hospital, 3333 Research Dr., San Antonio, Texas 78235, an accredited hospital. In attendance were the Hospitals ' Risk Manager, Hospitals ' Chief Nursing Officer, Director of Accreditation and the Hospitals Quality Manager. The purpose of the survey (complaint investigation) and the survey process were explained. An opportunity was provided for questions and discussion. A complaint investigation was conducted per Section 5100 (Investigation of Complaints for Deemed Providers/Suppliers) of the State Operations Manual (CMS Pub. 100-7), using the Medicare/Medicaid Hospital Surveyors Worksheet (Form CMS-1537), to determine validity of the allegations within the complaint and the hospital ' s compliance with the requirements at 42 CFR 482 (Conditions of Participation for Hospitals). Complaint Investigation TX00191920 was found UNSUBSTANTIATED. No deficiencies were cited. Complaint Investigation TX00193289 was found SUBSTANTIATED. No deficiencies cited. - Found Substantiated for Nursing Services. No deficiencies cited because before onsite Department of State Health Services investigation facility had taken immediate action. The facility had already, investigated, defined cause of deficiency, planned and implemented corrective actions to minimize chances of reoccurrence of deficiency before onsite investigation. These implementation which are still currently being monitored were reviewed by investigator and	A 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

LR — President + CEO — 10/9/14

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A 000	Continued From page 1 found acceptable. Recommend facility continue with Medicare participation as agreed. An exit conference was conducted at St. Luke ' s Baptist Hospital, 7700 Floyd Curl Dr., San Antonio, TX 78229 in the hospital ' s conference room. . In attendance were the Baptist Health Systems Regional Director of Risk Management, The hospitals ' Risk Manager, and the Hospitals ' Chief Nursing Officer. The preliminary findings of the survey and the next steps in the survey process were explained. An opportunity was provided for questions and discussion.	A 000		

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A 000	INITIAL COMMENTS An entrance conference was conducted at Mission Trails Baptist Hospital, 3333 Research Dr., San Antonio, Texas 78235, an accredited hospital. In attendance were the Hospitals ' Risk Manager, Hospitals ' Chief Nursing Officer, Director of Accreditation and the Hospitals Quality Manager. The purpose of the survey (complaint investigation) and the survey process were explained. An opportunity was provided for questions and discussion. A complaint investigation was conducted per Section 5100 (Investigation of Complaints for Deemed Providers/Suppliers) of the State Operations Manual (CMS Pub. 100-7), using the Medicare/Medicaid Hospital Surveyors Worksheet (Form CMS-1537), to determine validity of the allegations within the complaint and the hospital ' s compliance with the requirements at 42 CFR 482 (Conditions of Participation for Hospitals). Complaint Investigation TX00191920 was found UNSUBSTANTIATED. No deficiencies were cited. Complaint Investigation TX00193289 was found SUBSTANTIATED. No deficiencies cited. - Found Substantiated for Nursing Services. No deficiencies cited because before onsite Department of State Health Services investigation facility had taken immediate action. The facility had already, investigated, defined cause of deficiency, planned and implemented corrective actions to minimize chances of reoccurrence of deficiency before onsite investigation. These implementation which are still currently being monitored were reviewed by investigator and	A 000		

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PRESIDENT + CEO | 6/9/14

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A 000	Continued From page 1 found acceptable. Recommend facility continue with Medicare participation as agreed. An exit conference was conducted at St. Luke ' s Baptist Hospital, 7700 Floyd Curl Dr., San Antonio, TX 78229 in the hospital ' s conference room. . In attendance were the Baptist Health Systems Regional Director of Risk Management, The hospitals ' Risk Manager, and the Hospitals ' Chief Nursing Officer. The preliminary findings of the survey and the next steps in the survey process were explained. An opportunity was provided for questions and discussion.	A 000		

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A 000	INITIAL COMMENTS An entrance conference was conducted at North East Baptist Hospital, 8811 Village Dr., San Antonio, Texas, 78217 an accredited hospital. In attendance were the Hospitals ' Risk Manager, Hospitals ' Chief Nursing Officer, Director of Accreditation and Regional Risk Manager. The purpose of the survey (complaint investigation) and the survey process were explained. An opportunity was provided for questions and discussion. A complaint investigation was conducted per Section 5100 (Investigation of Complaints for Deemed Providers/Suppliers) of the State Operations Manual (CMS Pub. 100-7), using the Medicare/Medicaid Hospital Surveyors Worksheet (Form CMS-1537), to determine validity of the allegations within the complaint and the hospital ' s compliance with the requirements at 42 CFR 482 (Conditions of Participation for Hospitals). Complaint Investigation TX00194156 was found SUBSTANTIATED. No deficiencies were cited. No deficiencies cited because before onsite Department of State Health Services investigation facility had taken immediate action. The facility had already, investigated, defined cause of deficiency, planned and implemented corrective actions to minimize chances of reoccurrence of deficiency before onsite investigation. These implementation which are still currently being monitored were reviewed by investigator and found acceptable. Recommend facility continue with Medicare	A 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

AR | President + CEO | 10/9/14

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A 000	Continued From page 1 participation as agreed. An exit conference was conducted at this facility in the hospital ' s conference room. . In attendance were the Baptist Health Systems Regional Director of Risk Management, The hospitals ' Risk Manager, and the Hospitals ' Chief Nursing Officer. The preliminary findings of the survey and the next steps in the survey process were explained. An opportunity was provided for questions and discussion.	A 000		

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	450058	A. BUILDING _____ B. WING _____	C 07/31/2014

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A 000	INITIAL COMMENTS An entrance conference was conducted at Baptist Medical Center of San Antonio, an accredited hospital. In attendance was the hospital's Risk Manager and Director of Risk and Quality Management. The purpose of the survey (complaint investigation) and the survey process were explained. An opportunity was provided for questions and discussion. A complaint investigation was conducted per Section 5100 (Investigation of Complaints for Deemed Providers/Suppliers) of the State Operations Manual (CMS Pub. 100-7), using the Medicare/Medicaid Hospital Surveyors Worksheet (Form CMS-1537), to determine validity of the allegations within the complaint and the hospital's compliance with the requirements at 42 CFR 482 (Conditions of Participation for Hospitals). TX00196017 was found substantiated with no deficiencies. TX00196019 was found unsubstantiated. An exit conference was conducted. In attendance was the hospital's Chief Executive Officer, Chief Nursing Officer, and Director of Risk and Quality Management. The preliminary findings of the survey and the next steps in the survey process were explained. An opportunity was provided for questions and discussion.	A 000		

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PRESIDENT + CEO | 10/9/14

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Massachusetts Hospitals

CMS Statements of
Deficiencies
and
Plans of Correction
(CMS Form 2567)

The Commonwealth of Massachusetts
Executive Office of Health and Human Services
Department of Public Health
Division of Health Care Quality
99 Chauncy Street, 11th Floor, Boston, MA 02111
617-753-8000

DEVAL L. PATRICK
GOVERNOR

TIMOTHY P. MURRAY
LIEUTENANT GOVERNOR

JOHN W. POLANOWICZ
SECRETARY

CHERYL BARTLETT
INTERIM COMMISSIONER

June 12, 2013

Erik Wexler
President & CEO
ST VINCENT HOSPITAL
123 SUMMER STREET
WORCESTER, MA 01608

RE: Complaint #: 13-0084 - NOTIFICATION PLAN OF CORRECTION IS REQUIRED

Dear Mr. Wexler:

As a result of an on-site investigation conducted by the Department of Public Health, Division of Health Care Quality (the Department), at ST VINCENT HOSPITAL, the Department determined that deficiencies were found to exist. The deficiencies were sent to the Centers for Medicare and Medicaid Services (CMS) for their review and determination. CMS has sent you the deficiencies stating you are in compliance with the Medicare Conditions of Participation. Enclosed is a copy of the complaint investigation findings from the survey and for your information, a statement of deficiency is also enclosed.

Providers found in compliance with the Conditions of Participation will continue to be "deemed" to meet applicable Federal Requirements based upon your accreditation of Healthcare Organizations (Joint Commission) or other federally approved accreditation organizations.

Under Federal disclosure rules, a copy of the findings of this survey may be released to the public within sixty (60) days from the close of the survey.

State regulations require you to submit your Plan of Correction (POC) to the Department by e-mail, using this email address:
HCQComplaintPOC@MassMail.State.MA.US.

The following must be observed when submitting your POC by email:

- Submit your POC as a .pdf document
- Title the email "POC for [facility] - Survey Ending [date of survey]"

St V. Inst 2/20 - 2/28/13

INVESTIGATION REPORT

Facility: ST VINCENT HOSPITAL
123 SUMMER STREET
WORCESTER, MA, 01608

Reference # 13-0084
Page 1

Date Received: 01/24/2013

Date Investigated: 02/20/2013, 02/21/2013, 02/22/2013

A. INVESTIGATORY STEPS:

1. PERSONS INTERVIEWED

Arrhythmia Technician
Registered Nurse #1
Cardiologist #2
Director of Cardiovascular Services
Vice President of Quality & Safety
Quality Management Specialist
Risk Manager #1
Director of Medical Staff Services
Ultrasound Technician
Cardiology Fellow
Non-Invasive Cardiology Supervisor
Patient #1
Director of Quality
Director of Risk Management
Risk Manager #2
Complainant

2. RECORDS REVIEWED

Medical Records
Medical Records
Medical Records
Nursing Policy/Procedure
Echocardiology Protocol
Patient Listing
Patient Education Sheets/Pamphlets
Complaint
Hospital QA/PI Plan
Meeting Minutes
Meeting Minutes
Drug Update
Complaints
Medical Records
Medical Records
Administrative Policies/Procedures
Respiratory Policy/Procedure
Patient Schedules
Credential Files
Discharge Instructions
Complaint Investigation
Performance Improvement Projects
Meeting Minutes
Meeting Minutes
Incident/Variance Reports
Joint Commission Reports

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	220176	A. BUILDING _____ B. WING _____	C 02/22/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST VINCENT HOSPITAL	123 SUMMER STREET WORCESTER, MA 01608

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A 000	INITIAL COMMENTS A CMS authorized Substantial Allegation Survey (DPH Reference Number 13-0084) was conducted on 2/20/13, 2/21/13 and 2/22/13 at: Saint Vincent Hospital 123 Summer Street Worcester, MA 01608 The following Conditions of Participation were reviewed using a sample of 14 patients: Quality Assessment/Performance Improvement (482.21), Medical Staff (482.22) and Outpatient Services (482.54).	A 000		
A1077	482.54(a) INTEGRATION OF OUTPATIENT SERVICES Outpatient services must be appropriately organized and integrated with inpatient services. This Standard is not met as evidenced by: Based on medical record review, interviews and policy and procedure review, it was determined that Hospital Outpatient Service practices were not consistent with hospital-wide policies and procedures in relation to: 1.) 1 of 2 oxygen administrations. 2.) the documentation of 4 of 8 intravenous (IV) catheter insertions. 3.) the documentation of 5 of 8 IV catheter removals. 4.) the documentation of patient status at the conclusion of 3 of 8 outpatient visits. Findings include: 1.) Patient #1 presented to the Non-Invasive Cardiology Department for an outpatient dobutamine stress echocardiogram (a DSE; a stress test performed using ultrasound imaging	A1077		

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A1077	Continued From page 1 and the medication dobutamine to increase the heart rate instead of exercise) on 10/18/12. Patient #1's 10/18/12 Dobutamine Stress Worksheet indicated his/her medical history included chronic obstructive pulmonary disease, high blood pressure, heart attack and atrial fibrillation (an irregular heart rhythm). The Surveyor interviewed Patient #1's Cardiologist (Cardiologist #1) at 12:40 P.M. on 2/20/13. Cardiologist #1 said Patient #1's medical history also included cardiomyopathy (heart muscle disease due to deficient blood/oxygen supply) and congestive heart failure. The Surveyor interviewed the arrhythmia technician (tech) who escorted Patient #1 from the Non-Invasive Cardiology Waiting Area to a DSE room on 10/18/12 at 11:50 A.M. on 2/20/13. The Arrhythmia Tech said Patient #1 seemed a little winded walking to the DSE room. The Arrhythmia Tech said she asked Patient #1 if he/she was normally winded and Patient #1 replied yes and indicated that he/she used oxygen as needed. The Arrhythmia Tech said she checked Patient #1's oxygen saturation level (gives indication of the oxygen content of the blood) and when she found it to be 85 or 86% (normal is 98-100%, a level below 88% is critically low and requires immediate patient assessment and intervention), she applied nasal cannula oxygen at 2 liters/minute. The Arrhythmia Tech said she did not inform Patient #1's assigned nurse or the DSE physician of Patient #1's oxygen saturation level and her application of the oxygen because Patient #1 said he/she used oxygen at home. Patient #1's pre-oxygen administration oxygen	A1077		

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A1077	Continued From page 2 saturation level was not documented in his/her Outpatient Record, dated 10/18/12. The Hospital's Respiratory Care Services Policy/Procedure titled "Oxygen Therapy" indicated: 1.) oxygen is administered by physician order, 2.) the physician order must include the oxygen delivery device type and liter flow, 3.) registered nurses (RNs) may start oxygen ordered via nasal cannula or in emergency situations via a non-rebreather (face mask), 4.) the Respiratory Therapist or RN will review the medical record and assess the patient prior to administering the oxygen therapy and 5.) oxygen therapy is discontinued by physician order or protocol. The 10/18/12 Dobutamine Stress Worksheet indicated Patient #1 was on 2 liters of oxygen and used oxygen as needed at home. The 10/18/12 Dobutamine Stress Worksheet and DSE electrocardiogram (ECG; a record of the electrical activity of the heart) indicated Patient #1's oxygen saturation level was within normal limits throughout the DSE. The Arrhythmia Tech said that approximately 10 minutes after the completion of the DSE, RN #1 discontinued Patient #1's IV and said Patient #1 could go home. The 10/18/12 Dobutamine Stress Worksheet did not indicate when Patient #1's IV or oxygen therapy were discontinued or when Patient #1 left the Non-Invasive Cardiology Department. There was no evidence Patient #1's oxygen saturation level was evaluated following the discontinuation of the oxygen therapy. Cardiologist #1 said sometime between 6:00 and	A1077		

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A1077	Continued From page 3 7:00 P.M. on 10/18/12, Patient #1's Significant Other telephoned and said that Patient #1 had returned home from the DSE confused. 2.) The Hospital's Nursing Policy/Procedure titled "Intravenous Therapy" indicated documentation related to all intravenous catheter insertions is to include the date, time, catheter size and site. Four of 8 Outpatient Records of patients who had IVs inserted during the period of 10/18/12 to 2/21/13 (Patients #1, #4, #5 and #6) did not contain documentation regarding the IV insertion time, catheter size or site. 3.) The Hospital's Nursing Policy/Procedure titled "Intravenous Therapy" indicated documentation related to IV removals is to include date, time and an assessment of the (former) catheter site. Five of 8 Outpatient Records of patients who had IVs removed during the period of 10/18/12 to 2/21/13 (Patients #1, #4, #5, #9 and #10) did not contain documentation regarding the IV removal time or an assessment of the (former) catheter site. 4.) Three of 8 Outpatient Records of patients who had outpatient procedures during the period of 10/18/12 to 2/21/13 (Patients #1, #4 and #5) did not contain documentation regarding the patient's status at the conclusion of their visit.	A1077		

Response to
Department of Public Health
Formatted template to cut and paste

ID Prefix Tag	Summary Statement of Deficiencies	ID Prefix Tag	Providers Plan of Correction	Completion Date
A1077	482.54(a) INTEGRATION OF OUTPATIENT SERVICES Oxygen administration without a physician's order.		A. All technologists and nurses that care for patients in the Non-Invasive Cardiology Department were re-educated that: 1) Oxygen is a prescribed medication. 2) If a patient is on home Oxygen upon arrival, technologist may transfer to wall oxygen at the same dose so tank does not deplete while having test. 3) For inpatients, ticket to ride will document flow rate for O2- transfer to wall while the test is being performed. 4) If a patient arrives on room air and becomes short of breath and requires oxygen-a physician order must be obtained by an RN. 5) If the oxygen is subsequently discontinued during the same encounter, then this must be by physician order, and must be followed by an assessment of the patient's condition and a room air oxygen saturation measurement. (see Attachment 1) B. Compliance with the above requirements will be measured by audits. A total of 70 medical record audits will be completed each month with results brought back to staff and reported to Cardiology PI. This auditing	

			will continue monthly until 4 months of 90% compliance is achieved. It will be periodically monitored thereafter as a standing item on Cardiology PI. C. The Oxygen Therapy Policy will be revised to clearly specify the above provisions for outpatients who may require oxygen therapy. (see Attachment 2-presented to Medical Executive Committee on 7/11/13) D. Patient instruction letters will be updated to include instructions for patients on home O2 to bring their O2 tank in with them with sufficient oxygen for travel. (ordered)	
A1077	Appropriate assessment of patients undergoing stress testing with abnormal VS or other findings on arrival		A. All technologists and nurses that care for patients in the Non-Invasive Cardiology Department were re-educated that: 1) VS will be taken upon arrival, including oxygen saturation for any patient who is on oxygen therapy at home/sending facility. 2) If a technologist observes that a patient is in respiratory distress or having difficulty ambulating, their vital signs are abnormal or the patient has complaints of pain or discomfort this will be brought to the attention of the RN/MD/NP/PA for further clinical assessment. This assessment will be documented by the responding clinician. (see Attachment 1) B. Compliance with the above requirements will be measured by audits. Audits of the same 70 medical record audits will be completed each month with results brought back to staff and reported to Cardiology PI. This auditing will continue monthly until 4 months of 90% compliance is achieved. It will be periodically monitored thereafter as a standing item on Cardiology PI.	

A1077	Patient's oxygen saturation level was not evaluated following discontinuation		All technologists and nurses that care for patients in the Non-Invasive Cardiology Department were re-educated that: If the oxygen is subsequently discontinued during the same encounter, then this must be by physician order, and must be followed by an assessment of the patient's condition and a room air oxygen saturation measurement. (See 1) A. #5 above). Patient must be back to baseline and stable prior to leaving department. (see Attachment 1)	
A1077	Documentation of IV site insertion, discontinuation, and condition of site.		All technologists and nurses that care for patients in the Non-Invasive Cardiology Department were re-educated that the following must be documented on each patient receiving an IV for an exam/test: • IV insertion: to include date, time, size of catheter and site • IV removal: to include date, time and assessment of (former) catheter site Cardiology Patient Care Flow Sheet has been updated to prompt documentation of the elements above. (see Attachment 3) Compliance with the above requirements will be measured by audits. Audits of the same 70 medical record audits will be completed each month with results brought back to staff and reported to Cardiology PI. This auditing will continue monthly until 4 months of 90% compliance is achieved. It will be periodically monitored thereafter as a standing item on Cardiology PI.	

Attachment 1
SDN Nurses

Non-Invasive Cardiology Corrective Action Plan for DPH citation received on 6/12/13.

A complaint was filed after a patient had a Dobutamine Stress Echo on 10/18/13.

An allegation of poor quality of care was determined valid because:

1. **Patient was not provided with an appropriate clinical assessment:**
   Scheduled outpatient walked into department and appeared short of breath. Patient stated that he was on O2 at home but left his tank in the car. Tech checked his O2 Sat and put him on Oxygen.

   - Techs usually have the initial encounter with patients in our department. It is their role to prep the patient for testing . The baseline vital signs are measured and recorded, the patient is interviewed and the test is explained to the patients. If the tech observes that the patients is in respiratory distress or having difficulty ambulating ; the vital signs are abnormal or the patient has complaints of pain or discomfort this will be brought to the attention of the RN/MD/NP/PA for further clinical assessment. This assessment will be documented by the clinician.

2. **Oxygen was administered without a physician order:**

   - Oxygen is a prescribed medication- If a patient is on Home Oxygen upon arrival, tech may transfer to wall at the same dose so tank does not deplete while having test. For inpatients, ticket to ride will document flow rate for O2- transfer to wall while test being performed.
   - If a patient arrives on room air and becomes short of breath and requires oxygen-a physician order must be obtained by RN.
   - If oxygen is discontinued – must be a physician order and O2 sat documented on room air.

3. **Patient's oxygen saturation level was not evaluated following discontinuation of the oxygen therapy.**
   Patient was brought to his vehicle by tech while still on O2. He arrived to the department on room air so he needed to be evaluated at room air again before his oxygen could be stopped. He had oxygen in his car but chose not to use it.

   - Vital signs (O2 saturation, BP, HR) must be assessed pre/post procedure and documented.
   - Patient must be back to baseline and stable prior to leaving department

Policies to be revie wed:

- Respiratory Care Services: Oxygen Therapy: Section D7
- Nursing Procedure Manual: Section B-10 IV Therapy

Dobutamine nursing flow sheet being updated to document:

- IV insertion: to include date, time, size of catheter and site
- IV removal: to include date, time and assessment of (former) catheter site
- Timing of vitals
- Patient's status at conclusion of test

Re-education of techs in NIC by supervisor, Bridget Smith

Re-education of nursing in MSD by director, Erica Dodge

Re-education of mid-levels and Cardiology Fellows by Division Chief,

Joseph Kirkpatrick, MD

Monthly audits to be performed by Bridget Smith- 70 charts to be reviewed using audit tool that has been developed by Quality Mnt. These audits will be shared with staff on a weekly basis at huddle and posted on huddle board in dept. The audits will be reported to Cardiology PI Committee on-going on a monthly basis.

Patient instruction letters will be updated to include instructions for patients on home O2 to bring their O2 tank in with them with sufficient oxygen for travel.

Saint Vincent Hospital

Subject/Alert reviewed: Corrective Action Plan (DPH correction-6/12/13)
Date of Meeting: 7/9/13, 7/10/13

Printed Name	Printed Title	Signature	Date
Monica Gauthier	RN	Monica Gauthier	7-9-13
Maureen Baldwin	RN	Maureen Baldwin	7/10/13
Lisa Prytko	RN	Lisa Prytko	7-10-13
Susan Procida	RN	Susan Procida	7/10/13
Melissa Silva	RN	Melissa Silva	7/15/13

- ****Please retain a copy of the materials reviewed and all signatures collected in your unit/ department as well as send a completed copy to _____.**
- **Indicate the total # of staff on your unit/dept that NEED this review** 5
- **Indicate the total # of staff on your unit that have completed review** 5
- **Percent complete to date:** 100%
- **Date submitted:** 7/15/13
- **Manager/Director/Educator signature:** D Dodge

****Please make additional copies as needed**

Signature collection template
KC 3/2012

Saint Vincent Hospital

Subject/Alert reviewed: DPH citation 6/12/13
Date of Meeting: 6-27-13

Printed Name	Printed Title	Signature	Date
Eileen P. DeMartino	CCT	Eileen P DeMartino CCT	6/27/13
Mena S. Mohareb	Cardiac Tech	Mena Mohareb	6-27-13
Hema Dayeshwar	Cardiac Sonographer	H. Dayeshwar	6-27-13
Emelia George	EKG	Emelia George	6-27-13
LISA DOCIMO	Echo Tech	Lisa RDCS	6.27.13
Tammy Belliveau	Cardiac tech	Tammy Belliveau	6/27/13
Erica Bright	Cardiac Sonographer	Erica Bright	6-27-13
Donna Chase	cardiac tech	Donna Chase	6/27/13
Nancy Swett	Secretary	Nancy Swett	6-27-13
Mary Ellen Lambert	EKG tech	Mary Ellen Lambert	7/1/13
Melissa Golemo	EKG Tech	Melissa Golemo	7-1-13
Jessica Enes	Echo	Jessica Enes	7-2-13
~~Erica Bright~~ Patricia Cenedella	Physician Assistant	Patricia Cenedella PAC	7-2-13
Rebecca Rathbun	RCS	Rebecca Rathbun RCS	7.2.13
Ashley Schandelmeier	~~EKG~~	Ashley Schandelmeier	7-3-13
Russell Kuipers	EKG		7-3-13

- ****Please retain a copy of the materials reviewed and all signatures collected in your unit/ department as well as send a completed copy to _____.**
- **Indicate the total # of staff on your unit/dept that NEED this review** 23
- **Indicate the total # of staff on your unit that have completed review** 16
- **Percent complete to date:** 70%
- **Date submitted:** 7/8/13
- **Manager/Director/Educator signature:** Bridget M Smith RDCS
  Supervisor - Non Invasive Cardiology

****Please make additional copies as needed**

Non-Invasive Cardiology Corrective Action Plan for DPH citation received on 6/12/13.

A complaint was filed after a patient had a Dobutamine Stress Echo on 10/18/13.

An allegation of poor quality of care was determined valid because:

1. **Patient was not provided with an appropriate clinical assessment**:
   Scheduled outpatient walked into department and appeared short of breath. Patient stated that he was on O2 at home but left his tank in the car. Tech checked his O2 Sat and put him on Oxygen.

   - Techs usually have the initial encounter with patients in our department. It is their role to prep the patient for testing . The baseline vital signs are measured and recorded, the patient is interviewed and the test is explained to the patients. If the tech observes that the patients is in respiratory distress or having difficulty ambulating ; the vital signs are abnormal or the patient has complaints of pain or discomfort this will be brought to the attention of the RN/MD/NP/PA for further clinical assessment. This assessment will be documented by the clinician.

2. **Oxygen was administered without a physician order**:

   - Oxygen is a prescribed medication- If a patient is on Home Oxygen upon arrival, tech may transfer to wall at the same dose so tank does not deplete while having test. For inpatients, ticket to ride will document flow rate for O2- transfer to wall while test being performed.
   - If a patient arrives on room air and becomes short of breath and requires oxygen-a physician order must be obtained by RN.
   - If oxygen is discontinued – must be a physician order and O2 sat documented on room air.

3. **Patient's oxygen saturation level was not evaluated following discontinuation of the oxygen therapy.**
   Patient was brought to his vehicle by tech while still on O2. He arrived to the department on room air so he needed to be evaluated at room air again before his oxygen could be stopped. He had oxygen in his car but chose not to use it.

   - Vital signs (O2 saturation, BP, HR) must be assessed pre/post procedure and documented.
   - Patient must be back to baseline and stable prior to leaving department

Policies to be reviewed:

- Respiratory Care Services: Oxygen Therapy: Section D7
- Nursing Procedure Manual: Section B-10 IV Therapy

Dobutamine nursing flow sheet being updated to document:

- IV insertion: to include date, time, size of catheter and site
- IV removal: to include date, time and assessment of (former) catheter site
- Timing of vitals
- Patient's status at conclusion of test

Re-education of techs in NIC by supervisor, Bridget Smith

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Re-education of mid-levels and Cardiology Fellows by Division Chief,

Joseph Kirkpatrick, MD

Monthly audits to be performed by Bridget Smith- 70 charts to be reviewed using audit tool that has been developed by Quality Mnt. These audits will be shared with staff on a weekly basis at huddle and posted on huddle board in dept. The audits will be reported to Cardiology PI Committee on-going on a monthly basis.

Patient instruction letters will be updated to include instructions for patients on home O2 to bring their O2 tank in with them with sufficient oxygen for travel.

Attachment 2

SAINT VINCENT HOSPITAL, INC. WORCESTER, MASSACHUSETTS	ADMINISTRATIVE POLICY MANUAL Administration
SUBJECT: Oxygen Therapy	NO.

POLICY:

A. Special precautions to prevent fire hazards due to the presence of an oxygen-enriched atmosphere will be followed as directed in the Safety Manual, Policy # 1.5.10.

B. Oxygen is a prescribed medication and the Respiratory therapist/ RN is responsible to follow this guideline when administering oxygen.

PURPOSE:

To assure the safe and effective use of oxygen therapy in both and inpatient and outpatient setting.

DEFINITIONS:

IMPLEMENTATION SAFETY:

1. No Smoking signs will be posted in main oxygen storage areas. Smoking is prohibited in all areas of the hospital.
2. Oxygen will not be used when there is a potential for ignition present. Examples include faulty electric outlets or equipment, source of static electrical discharge, use of friction toys, smoking.
3. Oxygen will be stored separately from flammable gasses or liquids.
4. Portable oxygen cylinders shall be stored and handled as specified in the Safety Policy Manual #1.5.7 "Use and Storage of Compressed Gases."
5. Medical gas systems will be provided and maintained in compliance with applicable codes and standards as stated in the Engineering and Facilities Policy Manual, #4.3 WMC (E.1, E.2, E.3).

IMPLEMENTATION INPATIENT:

1. When administering oxygen the Respiratory Therapist or RN will verify the physician order, which must include device type and Liter Flow or FIO2.
2. Frequency of administration will be continuous unless otherwise directed by the physician's order.
3. PRN oxygen orders will not be accepted. MD will be contacted for clarification.
4. On the hospital units the RN may start oxygen ordered via nasal cannula or in emergency situations via a non-re-breather. The Respiratory Therapist must be called to assist with the set-up of all other oxygen administration devices, including the non-rebreather. In special care areas (e.g. PACU) the nursing staff may set-up and use all forms of oxygen administration devices for which they have been trained.
5. For inpatients, ticket to ride will document flow rate for O2- transfer to wall while the test is being performed.
6. The Respiratory Therapist or RN will review the medical record, identify and assess the patient and explain the procedure prior to administering the oxygen therapy.
7. The Respiratory Therapist or RN will complete and document all patient education associated with oxygen therapy using the standard format.
8. Documentation of oxygen use and relevant patient assessment will be completed on the Medical/Surgical Flow Sheet.
9. Oxygen Therapy may be discontinued by a written physician order or by protocol.
10. The Registered Nurse will monitor and document oxygen levels on a regular basis. They will inform the covering Respiratory Therapist of any equipment or clinical problems associated with the oxygen therapy.
11. The Respiratory Therapist will monitor and maintain large volume nebulizers on a per shift basis. The nursing team will also regularly monitor oxygen delivery by this device to assure that it is functioning properly.

IMPLEMENTATION OUTPATIENT:

1. If a patient is on home Oxygen upon arrival for any outpatient testing, technologist/nurse may transfer to wall oxygen at the same dose so tank does not deplete while having test.
2. If a patient arrives on room air and becomes short of breath and requires oxygen, a physicians order must be obtained by an RN. A Rapid Response may be activated if necessary.
3. If a technologist observes that a patient is in respiratory distress or their vital signs are abnormal or the patient has complaints of pain or discomfort this will be brought to the attention of the RN/MD/NP/PA for further clinical assessment. This assessment will be documented by the responding clinician.
4. If the oxygen is subsequently discontinued during the same encounter, then this must be by physician order, and must be followed by an assessment of the patient's condition and a room air oxygen saturation measurement.
5. Patient must be stable prior to leaving department if proceeding to home or returning to another facility.

Written by:_____ Date:

Issued by:_____ Date:

Approved by:_____ Date:

Approved by:_____ Date:

Approved by:_____ Date:

Approved by:_____ Date:

Original Policy with Signatures on File in Administration

Saint Vincent Hospital
Cardiology Patient Care Flow Sheet
Pre-Procedure

TIME (every 15 minutes)	BLOOD PRESSURE	HEART RATE	RHYTHM	RESPIRATORY RATE	PATTERN / QUALITY	O_2 SAT / O_2 MODE	ET CO_2 (mm Hg)	AIRWAY ✓	LOC	COLOR	PAIN (0-10)	MEDICATIONS / NURSING PROGRESS NOTES	INITIALS

Signature / Initials	Date / Time	Signature / Initials	Date / Time

MODIFIED ALDRETE SCORE – Time: _____

ACTIVITY
- Able to move 4 extremities voluntarily or on command — 2
- Able to move 2 extremities voluntarily or on command — 1
- Not able to move extremities voluntarily or on command — 0

RESPIRATION
- Able to breathe and cough freely — 2
- Dyspnea, shallow or limited breathing — 1
- Apneic — 0

CIRCULATION
- Blood Pressure plus or minus 20mm Hg of pre-sedation level — 2
- Blood Pressure plus or minus 21-50mm Hg of pre-sedation level — 1
- Blood Pressure plus or minus 51mm Hg of pre-sedation level — 0

CONSCIOUSNESS
- Fully Awake — 2
- Arousable on calling — 1
- Not responding — 0

O2 SATURATION
- Able to maintain SaO2 greater than 92% on room air — 2
- Needs O2 to maintain SaO2 greater than 90% — 1
- SaO2 less than 90% with O2 supplement — 0

Score of 8 or greater needed for discharge *exception for patient being transferred to the ICU or as indicated with an asterisk and explanation in the nursing progress notes* — **TOTAL**

TOTAL FLUIDS INTAKE:
IV Fluid / IV Med Total _____ mL
PO Fluid Total _____ mL
Blood / Blood Products Total _____ mL

TOTAL OUTPUT:
Void Total _____ mL
Other Total: _____ mL (specify): _____
Other Total _____ mL (specify)

DISPOSITION: ☐ Admit to inpatient unit
☐ Report given to _____
☐ Transferred to _____ via ☐ Stretcher ☐ W/C at (time): _____
accompanied by ☐ Transporter ☐ Other: _____
RN's Signature _____

OUTPATIENT DISPOSITION:
☐ Postprocedure teaching reviewed with patient / family; written instructions reviewed & provided
☐ Med. Reconciliation reviewed with patient
☐ Med. Reconciliation ☐ No Change ☐ See discharge instruction sheet for medication changes
☐ IV D/c'ed/Intact – Site: _____ WNL ☐ DSD Applied
☐ Oral intake tolerated
☐ Discharge criteria met
☐ Discharge at: (time): _____ accompanied by: _____
to ☐ Home ☐ Care Facility via ☐ Ambulatory ☐ Wheelchair ☐ Stretcher
RN Signature: _____ Time: _____ Date: _____

W.OR2647 (Rev. 6/13)

Saint Vincent Hospital
Cardiology Patient Care Flow Sheet
Pre-Procedure

Date: _____ ID Confirmed (name & DOB) ☐ Bracelet ☐ Verbal
Time: _____
Ride Home With: _____
Telephone: _____

Chief Complaint: _____
Procedure: _____
NPO Status: ☐ Yes ☐ No Height: _____ Weight: _____
Attending Physician: _____
Past Medical / Surgical History _____

IV Gauge and Site: _____
IV Fluid and Rate: _____
Unsuccessful Attempts: _____ Site: _____ Initials____

Fall Prevention Intervention(s): _____
Intervention(s) *(check all that apply)*
☐ Yellow wrist band ☐ Call light within reach ☐ Stretcher in low position
☐ Assistive devices and personal items ☐ Yellow slippers
☐ Remind patient to call for assistance within reach ☐ Educated patient and family regarding risk for falls

ACCUCHECK (Diabetics)
Time: _____ Result: ____
Normal fbs 65 - 99 NA_____

Allergies: _____ Reaction

Band ☐ NA ☐

Check List
- Verification ☐
- Consent Signed ☐
- LABS ☐
- CBC ☐
- Bmp ☐
- CDags ☐
- Ekg ☐
- Med List ☐
- PreProc Meds ☐

TIME	TEMP. / ROUTE	BLOOD PRESSURE	HEART RATE	RHYTHM	PULSES arm R/L leg R/L	RESPIRATORY RATE	PATTERN / QUALITY	O_2 SAT / O_2 MODE	AIRWAY ✓	LOC	COLOR	PAIN (0-10)

Time	Medication	INITIALS	ABSORBED

Nursing Progress Notes: _____

RN Signature: _____ Time: _____ Date: _____

8

Attachment 3

Saint Vincent Hospital
Cardiology Patient Care Flow Sheet
Pre-Procedure

Intra / Post Procedural Care Plan

Check all that apply	Focus / Problem	Patient Outcome (if outcome not met, see procedure note)
	Anxiety related to procedure and/or fear of outcome	Patient will demonstrate decreased verbal and non-verbal signs of anxiety
	Discomfort associated with procedure	Patient will experience minimal discomfort
	Potential alteration in respiratory status, level of consciousness, hemodynamics and body temperature	Patient will experience minimal deviation from baseline data
	Potential knowledge deficit	Understanding of postprocedure routines and discharge instructions
	Other:	Patient/Significant Other will verbalize

TIME every 5 minutes during procedure	BLOOD PRESSURE	HEART RATE	RHYTHM	RESPIRATORY RATE	PATTERN / QUALITY	O_2 SAT / O_2 MODE	Pulses / Site	AIRWAY /	LOC	COLOR	PAIN (0-10)	MEDICATIONS / NURSING PROGRESS NOTES	INITIALS

RESPIRATORY PATTERNS
6 = Normal
5 = Hyperventilation
4 = Tachypnea
3 = Hypoventilation
2 = Bradypnea
1 = Apnea

RESPIRATORY QUALITY
4 = Able to breathe and cough
3 = Able to breathe adequately
2 = Limited
1 = Apnea

OXYGEN MODE
4 = Room Air
3 = Nasal Cannula
2 = Mask
1 = Bag-Valve-Mask

LEVEL OF CONSCIOUSNESS (LOC)
4 = Lucid - Alert, Prompt, Appropriate
3 = Confused - Alert but unable to recognize and respond
2 = Drowsy - Sleep but arouses easily with verbal or tactile stimulus
1 = Stupor - Arousable by vigorous stimulus only

COLOR
4 = Normal
3 = Pale
2 = Dusky / Blotchy
1 = Cyanotic

Saint Vincent Hospital
Cardiology Patient Care Flow Sheet
Pre-Procedure

TIME every 5 minutes during procedure	BLOOD PRESSURE	HEART RATE	RHYTHM	RESPIRATORY RATE	PATTERN / QUALITY	O_2 SAT / O_2 MODE	Pulses / Site	AIRWAY /	LOC	COLOR	PAIN (0-10)	MEDICATIONS / NURSING PROGRESS NOTES	INITIALS

RN Signature: ______________________ Time: ____________ Date: ____________

Treatments, radiologic studies and medications recorded above are per my order.

Physician Signature ______________________ Time: ____________ Date: ____________

Print Physician name ______________________

W.OR26437 (Rev. 6/13)

Chandley, Kelly

From: Chandley, Kelly
Sent: Monday, July 15, 2013 5:18 PM
To: 'HCQComplaintPOC@massmail.state.ma.us'
Subject: POC for Saint Vincent Hospital Survey Ending 02.20.13-02.22.13
Attachments: POC for Saint Vincent Hospital Survey Ending 02.20.13-02.22.13.pdf

RE: Complaint # 13-0084- re: Survey 2/20 through 2/22/2013

To Whom It May Concern:

As requested, attached please find the Plan of Correction for the complaint named above. Auditing results will be submitted when completed under separate cover.

If I can be of further assistance, please contact me at 508-363-6086.

Kelly Chandley
Director of Risk Management
508-363-6086
pg: 2356
fax: 2/5186

Chandley, Kelly

From: POC, Complaint (DPH) [complaint.poc@state.ma.us]

Sent: Monday, July 15, 2013 5:18 PM

To: Chandley, Kelly

Subject: Out of Office: POC for Saint Vincent Hospital Survey Ending 02.20.13-02.22.13

PLEASE DO NOT REPLY TO THIS EMAIL. THIS ACCOUNT HAS BEEN ESTABLISHED ONLY TO RECEIVE PLANS OF CORRECTION.

Thank you for contacting the Department of Public Health, Division of Health Care Quality by email. If you have submitted a scanned .pdf copy of your plan of correction, this auto reply will serve as confirmation that the Department is in receipt of your plan.

If you have emailed a scanned plan of correction, please **do not mail or fax another copy of your plan** to the Department.

The Department will review your plan for acceptance.

If there are questions or concerns regarding your plan as written, or additional information is required, a surveyor will contact you directly.

If your plan is acceptable, surveyors will conduct a follow-up review either on-site or by means of record review to ensure compliance. You will be notified of the Department's findings at some point after the date you have alleged compliance, and once the Department has made a determination as to your compliance.

Please do not submit requests for Informal Dispute Resolution (IDR) to this email address. For information regarding the IDR process for federal deficiencies for nursing homes please see: http://www.mass.gov/eohhs/docs/dph/quality/hcq-circular-letters/dhcq-1112554.pdf

If you have any questions concerning your complaint survey results, please contact the Complaint Unit at 617-753-8150.

If you have any questions concerning the processing of your plan of correction please contact Lee Berryman at 617-753-8164 or Angela McCarthy at 617-753-8154.

For all other matters, please contact the appropriate staff person with the Department, or visit the Division's website at: http://www.mass.gov/dph/dhcq. To reach the main operator for the Division of Health Care Quality, please call 617-753-8000.

AGAIN, PLEASE DO NOT REPLY TO THIS EMAIL. THIS ACCOUNT HAS BEEN ESTABLISHED ONLY TO RECEIVE PLANS OF CORRECTION.

MA DPH/Divison of Health Care Facility Licensure and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	VLSSA	A. BUILDING: _____ B. WING	C 08/04/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
METROWEST MEDICAL CENTER	115 LINCOLN STREET FRAMINGHAM, MA 01701

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
p000	INITIAL COMMENTS A State Licensure Complaint Survey was conducted on 7/31/14 and 8/4/14, ACTS #MA00022269 at: Metrowest Medical Center 67 Union St Natick, MA 01760	P0G0		
P0241	130.200 INCORPORATION OF M'CARE CONDITIONS OF PARTIC Each hospital shall meet all of the requirements of the Medicare Conditions of Participation for Hospitals, 42 C.F.R. 482.11 through 482.62 (hereinafter Conditions of Participation), and as they may be amended from time to time, except the requirement for institutional plan and budget specified in 42 C.F.R. 482.12(d), for utilization review specified in 42 C.F.R. 482.30, the requirement for compliance with the Life Safety Code specified in 42 C.F.R. 482.41(b), and any requirement that conflicts with the supplementary standards in 105 CMR 130.000 Subparts C and D. This REQUIREMENT is not met as evidenced by: A) Standard A-449: The patient's medical record must contain information to justify admission and continued hospitalization, support the diagnosis, and describe the patient's progress and response to medications and services. Based on record review and interview, the Hospital failed to ensure that the services, including conversations with parents, provided by	p024	PLAN OF CORRECTION (POC) FOR P024 130.200 INCORPORATION OF MEDICARE CONDITIONS OF PARTICIPATION, STANDARD A-449: POC: IMMEDIATE ACTIONS: TO ENSURE THAT DOCUMENTATION IS COMPLETE IN THE PATIENT'S MEDICAL RECORD, INCLUDING BED SEARCH EFFORTS AND DISCUSSIONS WITH THE PATIENT AND FAMILY, AS APPROPRIATE, AN IMPROVED PROCESS HAS BEEN INSTITUTED. THE IMPROVED PRACTICE CAPTURES BED SEARCH INFORMATION FROM THE WORKSHEET, IN A NARRATIVE NOTE UNDER "BED SEARCH" ON PAGE TWO OF THE WRITTEN EVALUATION (PLEASE SEE ATTACHED). ERS STAFF WERE EDUCATED IN THIS REGARD VIA MEMO (ATTACHED) DATED AUGUST 8, 2014, AND IN A STAFF MEETING ON SEPTEMBER 8, 2014. NEW	8/8/14 AND 9/8/14

MA Division of Health Care Facility Licensure and Certification
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

MA DPH/Divison of Health Care Facilitv Licensure and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	VLBSA	A. BUILDING: _____ B. WING	C 08/04/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
METROWEST MEDICAL CENTER	115 LINCOLN STREET FRAMINGHAM, MA 01701

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
P 024	Continued From page 1 Evaluation and Referral Service Crisis Worker #1 and #2, for one patient (Patient #1), were documented in the medical record on 7/3/14 and 7/4/14. Findings include: ERS Crisis Worker #1 was interviewed by telephone at 2:45 P.M. on 7/31/14. ERS Crisis Worker #1 said she requested an admission to the CDU on 7/3/14 for the Patient. ERS Crisis Worker #1 said she was told by an unidentified CDU staff member that the Patient could not be admitted to the CDU. ERS Crisis Worker #1 said she reported that information to her Supervisor. Review of the Patient's medical record on 7/31/14 and 8/4/14, indicated that the Patient arrived to the Emergency Department at 4:30 P.M. on 7/3/14, was seen by ERS Crisis Worker #1 and a 10 page evaluation form was completed. However, the plan for the Patient was not documented and the discussion with the Patient's Parent was not documented. The medical record review indicated that, on 7/5/14, the Patient was transferred to Hospital #2 for a psychiatric hospitalization. During interview at 2:00 P.M. on 8/4/14, the Director of the ERS said she also participated in the search for finding the Patient an in-patient psychiatric bed. During interview with ERS Crisis Worker #1 at 2:45 P.M. on 7/31/14, ERS Crisis Worker #1 said if a patient was in the ED more than 24 hours, there should be a ERS re-evaluation of the Patient. During interview with ERS Crisis Worker #2, ERS !	p024	(POC FOR p024 CONTINUED:) HIRES WILL BE EDUCATED REGARDING THIS PRACTICE DURING THEIR ORIENTATION. IN ADDITION, ALL ERS STAFF HAVE BEEN RE-EDUCATED WITH REGARD TO THE RE-EVALUATION OF THE PATIENT, WHO HAS BEEN IN THE EMERGENCY DEPARTMENT FOR 24 HOURS, PER HOSPITAL POLICY. THIS RE-EDUCATION OCCURRED AT THE STAFF MEETING ON SEPTEMBER 8, 2014. LONG-TERM ACTIONS: A NEW PROCESS IS NOW BEING BUILT FOR ERS DOCUMENTATION IN ATHENA. THE MODULE IS BEING DESIGNED SO THAT ALL INFORMATION WITH REGARD TO A BED SEARCH WILL BE CAPTURED. NARRATIVE DOCUMENTATION REGARDING INFORMATION DISUSSED WITH PATIENTS AND FAMILIES, AS APPROPRIATE, WILL CONTINUE TO BE DONE AS DESCRIBED IN THE FIRST PART OF THE POC. ATHENA IS SCHEDULED TO GO LIVE IN OCTOBER 2014. STAFF TRAINING IS UNDERWAY. ALL ERS HAVE BEEN EDUCATED. DOCUMENTATION WILL BE MONITORED FOR COMPLIANCE	

MA DPH/Divison of Health Care Facilitv Licensure and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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METROWEST MEDICAL CENTER	115 LINCOLN STREET FRAMINGHAM, MA 01701

(X4) 1D PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(XS) COMPLETE DATE
P 024	Continued From page 2 Crisis Worker #2 said she met with the Patient and the Patient's Parent on 7/4/14 and discussed the psychiatric admission for the Patient. There was no documentation in the Patient's. medical record and there was no reevaluation of the Patient. ERS Crisis Worker #2 said on 7/5/14 she spoke with the Patient's Parent and arranged for the transferred to another hospital for a psychiatric admission. There was no documentation in the Patient's medical record to describe the services provided by the ERS. On page one, on the initial Behavioral Medicine Evaluation Form was written: Disposition at 3:00 P.M. on 7/5/14, hospital level of care, Hospital #2.	p024	(POC FOR p024 CONTINUED:) BY THE DIRECTOR OF THE EVALUATION AND REFERRAL SERVICES (ERS) THROUGH MONTHLY CHART REVIEWS OF 10 RANDOM CHARTS. IF THE DOCUMENTATION IS NOT 100% IN COMPLIANCE WITH THE IMPROVED PROCESS AT THE TIME OF THESE REVIEWS, DOCUMENTATION DETAILS WILL BE ADDED TO OUR LEAN DAILY MANAGEMENT PROBLEM-SOLVING BOARD FOR ACTION AND DISCUSSED DAILY AT OUR GEMBA WALK OCCURRING AT 8:35 a.m. ON WEEKDAYS.	ONGOING

Detroit Medical Center

CMS Statements of Deficiencies and Plans of Correction (CMS Form 2567)

DMC
DETROIT MEDICAL CENTER

Leon A. Coleman
Director
Corporate Regulatory & Governance
6071 West Outer Drive
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Detroit, MI 48235
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August 5, 2013

Kathy Cotter
Michigan Department of Licensing and Regulatory Affairs
BHCS/Health Facilities Division
611 W. Ottawa, 1st floor
Lansing, MI. 48909

Dear Ms. Cotter:

Attached please find the Children's Hospital of Michigan ESRD Plan of Correction in response to your letter dated July 25, 2013.

Should you have any questions regarding our responses, or require any changes in our submission, please contact either myself or Stanton M. Beatty at our office phone number listed above or via email.

Sincerely,

Leon A. Coleman

Leon A. Coleman

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CHILDREN'S HOSPITAL OF MICHIGAN	3950 BEAUBIEN BLVD DETROIT, MI 48201

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V 000	INITIAL COMMENTS Surveyor: 28273 State Facility ID: 835620 Hemodialysis Stations: 11 (9+2 isolation rooms), expansion from 7 to 11 stations. In-center Hemodialysis Patients: 15 Home Peritoneal Dialysis Training Stations:1 Home Peritoneal Dialysis Patients: 12 The purpose of this unannounced survey was for re-certification, relocation and expansion. The Department of Licensing & Regulatory Affairs has evaluated this facility and found the stated deficiencies to be those federal certification requirements not in compliance on the date(s) indicated.	V 000		
V 111	494.30 IC-SANITARY ENVIRONMENT The dialysis facility must provide and monitor a sanitary environment to minimize the transmission of infectious agents within and between the unit and any adjacent hospital or other public areas. This STANDARD is not met as evidenced by: Surveyor: 30988 Based on observation and interview, the facility failed to maintain a clean and sanitary environment, resulting in the potential to spread infectious agents to 15 patients served at the facility. Findings include: On 7/9/2013 at approximately 1100 during tour of the treatment area, thick dust and debris were found on all window sills (stations 1,2,3,4,5,6&7), dirt and dust was found in the storage cupboards between stations 3&4, 5&6, 7, 8&9 and 10&11.	V 111	**V111 Sanitary Environment** Unit cleaning commenced during survey. All patient areas, including support rooms and common areas received thorough cleaning of items, dusting of items, and removal of items; including thick dust and debris on window sills, dirt and dust in storage cupboards, discarding clean linen bags on sink and garbage can, pink substance on bottom of sink, discarding art supplies and gown, floors in treatment area ,discarding medication bottles, dirt on hard drive, dirt at nurses station, dirt on emergency cart, dirt on suction machine, dirt on supply cart, dirt on nurses station shelves, dirt on floor of nurses station, dirt on drip tray, removal of bicarbonate jugs from soiled utility rooms, dust and debris on equipment maintenance floor, removal of Kim Wipes on dialysis storage room floor, removal and changing of transport cart. Daily monitoring	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

CEO / President 8/5/13

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V 111	Continued From page 1 The foyer was found to have a sink that had two open bags of clean linen piled on the edge of the sink with the top of the garbage can laying on top of the clean linen pile. The sink at station 2 had a dried on pink substance covering the bottom of the sink. A desk chair full of art supplies with a ragged, worn cover gown over the back was found in the isolation room (station 2). The floors, throughout the treatment area were visibly dirty with accumulated dust and debris. A medication bottle containing pills was found under the treatment chair at station 6. These findings were all observed with staff F on 7/9/2013 at approximately 1100 during the tour who stated, "yes, I see the dirt and dust, the housekeepers are supposed to clean after treatments are completed." Surveyor: 27408 On 07/09/13 at approximately 0930 during the initial tour of the dialysis treatment area, observed that the following equipment had soiled surfaces: the top of the computer hard drive, behind the nurses' station, the top surface of the white emergency cart, the suction machine stored on top of the white emergency cart, the clean supply cart, shelves behind the nurses' station, the floor underneath the nurses' station, and the drip tray under the alcohol-based hand hygiene station, that was located across from the white emergency cart. On 07/09/13 at 0945 Staff D confirmed that the "surfaces should be dusted, cleaned, and monitored to ensure that facility policy and procedures are being followed." Surveyor: 26222 On 7/9/13 at approximately 1050 observed, that	V 111	log was developed, approved by the Medical Director and implemented. Unit environmental cleanliness rounds were initiated 7/24/2013 and are now completed daily by the Unit Manager and building Environmental Services Supervisor. Areas of deficiency will be immediately addressed by the EVS Supervisor. Deficiencies not immediately addressed will be escalated to the Unit Director for resolution. Results of unit rounding will be shared weekly with staff, unit and EVS leadership, Medical Director and the organization's Chief Operating Officer (COO) and President. Staff were re-educated at the 7/29/2013 staff meeting regarding the importance of unit cleanliness, including storing all supplies off the floor and reporting any unsanitary issues or non-functioning equipment. The Unit Manager is responsible for correction and ongoing monitoring.	

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V 111	Continued From page 2 bicarbonate jugs designated as "clean" are being stored in room 2137 which was labeled "soiled utility" with a biohazard symbol label on the door. This room contained shelving for "clean" jugs, directly adjacent to a bin labeled with a red biohazard sign, contained used dialyzers and blood lines. A trash can contained trash was also stored adjacent to the "clean" bicarbonate jug storage shelving. On 7/9/13 at approximately 1045 observed that the chlorine test was being performed in a room labeled "equipment maintenance". There was dust and debris accumulation observed on the floor of this room. On 7/9/13 at approximately 1055 boxes of dialysate concentrations and boxes labeled "Kim Wipes" (cleaning cloths impregnated with cleaning solution) were observed stored directly on the floor in the dialysis storage room. On 7/9/13 at approximately 1145 the cart that was used to transport bicarbonate jugs at the end of the treatment shift was observed to have pieces of plastic missing, and cardboard taped to the top of the cart covering where the plastic had broken off. Dried white precipitate was observed on the cardboard and plastic surfaces. An interview on 7/9/13 at approximately 1050 with staff #B, who was accompanying on the tour, confirmed that storage for "clean" bicarbonate jugs to be stored in room, 2137 labeled "soiled utility" was inappropriate. Staff B also confirmed that it was inappropriate to store soiled or contaminated patient care items adjacent to the"clean" bicarbonate jugs.	V 111		

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V 111	Continued From page 3 On 7/9/13 at approximately 1055 interview with staff #B, who was accompanying on the tour, confirmed that the chlorine test was being performed in a room where dust and debris have accumulated. On 7/9/13 at approximately 1145 interview with staff #B, who was accompanying on the tour, confirmed that "Kim Wipes" (cleaning cloths impregnated with cleaning solution) were observed stored directly on the floor in the dialysis storage room. On 7/8/13 at approximately 1145 interview with staff #B confirmed the cart that is used to transport bicarbonate jugs at the end of the treatment shift was observed to have pieces of plastic missing, and cardboard taped to top of the cart where the plastic had broken off and contained dried white precipitate on the cardboard and plastic surfaces.	V 111		
V 113	494.30(a)(1) IC-WEAR GLOVES/HAND HYGIENE Wear disposable gloves when caring for the patient or touching the patient's equipment at the dialysis station. Staff must remove gloves and wash hands between each patient or station. This STANDARD is not met as evidenced by: Surveyor: 30988 Based on observation, interview, and document review the facility failed to ensure proper use of gloves and performance of hand hygiene, resulting in the potential for the spread of	V 113	**V113 Wear Gloves/Hand Hygiene** All staff re-educated at the 7/29/13 staff meeting regarding hand hygiene and proper use of personal protective equipment by the organization's infection control practitioners. Compliance will be audited daily by the Unit Manager/Designee. Audit tool will be developed and implemented by 8/2/2013. Audit results will be shared weekly with staff, Medical Director and the organization's Chief Operating Officer and President. The Unit Manager is responsible for correction and ongoing monitoring.	

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V 113	Continued From page 4 infectious diseases to all 15 patients receiving in-center hemodialysis at the facility. Findings include: On 7/10/2013 at approximately 0730, during an observation of accessing of a perm cath at station 3, the RN (staff N) was observed wrapping a glove around the index finger of staff's N right hand to silence the alarm on the treatment machine instead of putting on the glove. Staff N did not perform hand hygiene after silencing the alarm and continued to finish setting up a treatment station. In an interview on 7/10/13 at 0900 with staff N, revealed "I know I am supposed to put the glove completely on." On 7/10/13 at approximately 1145, a review of the document titled "Hemodialysis: Infection Control" #CHM MOD IC 002 dated 2/20/09 states "4. a. Gloves are worn when caring for the patient or touching the patients equipment at the station and are removed and hands cleansed ..." Surveyor: 28273 On 07/10/2013 between 0730 and 0745, staff L (RN) was observed initiating treatment with a central venous catheter (CVC) for patient #2. Staff L was observed handling the lines of the CVC without gloves, then applied a pair of gloves without performing hand hygiene and cleaned the hubs of the CVC, removed the contaminated gloves, and then again, without performing hand hygiene applied a pair of sterile gloves and proceeded to complete the initiation of the treatment with the CVC. The observations were completed on 07/10/2013	V 113		

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V 113	Continued From page 5 between 0730 and 0745, with the Director of Quality and Corporate Compliance (staff F) who confirmed the findings. When queried about hand hygiene she stated, "staff are supposed to perform hand hygiene before putting on gloves and after removing gloves. When asked about handling the CVC lines without gloves staff F replied "she should have had gloves on when touching it."	V 113		
V 116	494.30(a)(1)(i) IC-IF TO STATION=DISP/DEDICATE OR DISINFECT Items taken into the dialysis station should either be disposed of, dedicated for use only on a single patient, or cleaned and disinfected before being taken to a common clean area or used on another patient. -- Nondisposable items that cannot be cleaned and disinfected (e.g., adhesive tape, cloth covered blood pressure cuffs) should be dedicated for use only on a single patient. -- Unused medications (including multiple dose vials containing diluents) or supplies (syringes, alcohol swabs, etc.) taken to the patient's station should be used only for that patient and should not be returned to a common clean area or used on other patients. This STANDARD is not met as evidenced by: Surveyor: 28273 Based on observation and interview, the facility failed to ensure that items placed/used at the treatment station are disinfected before being taken to a clean area resulting in the risk for spread of infectious organisms to all 15 patients receiving incenter hemodialysis treatments. Findings include:	V 116	**V116 Dispose/Dedicate/Disinfect** Unit Manager met with Infection control staff on 7/25/2013 and work flow process was revised to prevent patient clipboards from being moved between clean and dirty areas. All staff educated to the new process to prevent cross contamination on 7/29/2013 at the unit staff meeting. Education was provided by the organization's infection control practitioners. Compliance will be monitored by the Unit Manager/Designee daily utilizing a newly developed audit tool. Audit tool will be developed and implemented by 8/2/2013. Audit results will be shared weekly with staff, unit leadership, Medical Director the organization's Chief Operating Officer and President. The Unit Manager is responsible for correction and ongoing monitoring.	

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V 116	Continued From page 6 On 07/10/2013 between 0715 and 1000, staff L was observed on the treatment floor providing care for patients #8 and #10. All the treatment stations contained a black clipboard stored on the top of the treatment machine. Staff L was observed removing the clipboard from the top of the treatment machine at station #8 without gloves, took it over to the computer work station and placed it down on the shelf without disinfecting it. After staff L entered data into the computer, staff L then returned the clipboard to the top of the treatment machine at station #8. Staff L was then observed carrying out the same process for Station #10 taking the clipboard to the same computer work station that she had used for patient #8 and then returned it to station #10's machine without disinfecting it. After observing this practice from staff L, observations were made of staff M and O, who were all performing the task in the same manner described above at other treatment stations. On 07/10/2013 between 0715 and 1000, the Director of Quality and Corporate Compliance (staff F) was present during the observation of both staff L and staff F and the Clinic Manager, (staff A) was present during the observations of both staff M and O. Staff A stated "we have always done that, I don't think that anyone thinks about taking it from the machine to the computer and then back to the machine." When staff A was asked if the computer was considered clean or dirty she stated "clean." When asked about the treatment station, staff A stated that "the chair and the machine are considered dirty areas."	V 116		
V 196	494.40(a) CARBON ADSORP-MONITOR, TEST FREQUENCY	V 196	**V196 Carbon Absorption/Monitoring/Testing** Facilities Engineering staff educated by	

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V 196	Continued From page 7 6.2.5 Carbon adsorption: monitoring, testing freq Testing for free chlorine, chloramine, or total chlorine should be performed at the beginning of each treatment day prior to patients initiating treatment and again prior to the beginning of each patient shift. If there are no set patient shifts, testing should be performed approximately every 4 hours. Results of monitoring of free chlorine, chloramine, or total chlorine should be recorded in a log sheet. Testing for free chlorine, chloramine, or total chlorine can be accomplished using the N.N-diethyl-p-phenylene-diamine (DPD) based test kits or dip-and-read test strips. On-line monitors can be used to measure chloramine concentrations. Whichever test system is used, it must have sufficient sensitivity and specificity to resolve the maximum levels described in [AAMI] 4.1.1 (Table 1) [which is a maximum level of 0.1 mg/L]. Samples should be drawn when the system has been operating for at least 15 minutes. The analysis should be performed on-site, since chloramine levels will decrease if the sample is not assayed promptly. This STANDARD is not met as evidenced by: Surveyor: 26222 Based on observation and interview, the facility failed to have the RO (reverse osmosis) system running for at least fifteen minutes before properly testing for free chlorine, chloramine or total chlorine, and failed to ensure the person responsible for testing had sufficient visual color	V 196	Facilities Manager on 7/19/2013 regarding need to run RO water line for 15 minutes prior to sampling for free chlorine, chloramine and total chlorine. Current testing log amended to include start and stop times for 15 minute water run. Test strips were ordered and arrived on 08/05/13 for the samplings. All ESRD facilities engineering staff, and any other staff who test for free chlorine, chloramine or total chlorine will be color blindness tested. Staff C was tested for color blindness upon hire and test results are available as needed. Facilities Engineering is responsible for monitoring and maintenance of the log to ensure ongoing compliance.	

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V 196	Continued From page 8 acuity to discern a failed test result, resulting in the potential for patient harm for 15 incenter patients served. Findings include: On 7/9/13 at approximately 1045 while observing the chlorine test, staff C was asked how long the RO system is operating in the morning prior to testing. Staff C responded that the RO system runs for "a couple of minutes," and upon further clarification Staff C stated that "the system runs approximately 5-7 minutes in the morning prior to testing." On 7/9/13 at approximately 1045 during an interview, staff C stated that he "has never been tested for color blindness."	V 196		
V 226	494.40(a) MIX SYS-DFU/MONITOR/PM/LOG/SANITIZE 5.4.4.1 Mixing systems: follow DFU/monitor/PM/log/sanitization If a concentrate mixing system is used, the preparer should follow the manufacturer's instructions for mixing the powder with the correct amount of water. If a concentrate mixing system is used, the number of bags or the weight of powder added should be determined and recorded. Manufacturer's recommendations should be followed regarding any preventive maintenance and sanitization procedures. Records should be maintained indicating the date, time, person performing the procedure, and results (if applicable). 6.4.1 Mixing systems:	V 226	**V226 DFU/Monitor/Log/Sanitize** Staff re-educated 7/29/2013 by Unit Manager regarding manufacturer's instructions for preparing the bicarbonate solution. All staff were trained on 7/29/2013 by Unit Manager in the use of the monitor and a log was developed (on what date) to maintain records for mixing the solution. Testing strips were delivered on 08/05/13 for bicarbonate solution testing. pHoenix monitor from Mesa Labs has been ordered. This equipment monitors pH and conductivity of bicarbonate solution. This process will begin as soon as the equipment is delivered. Anticipated date of delivery 8/19/2013. Unit Manager will monitor completion of the logs.	

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V 226	Continued From page 9 Systems for preparing either bicarbonate or acid concentrate from powder should be monitored according to the manufacturer's instructions. This STANDARD is not met as evidenced by: Surveyor: 26222 Based on interview, the facility failed to follow manufacturer's instructions and maintain records for mixing bicarbonate solutions resulting in the potential for patient harm for 15 patients served by the facility. Findings include: On 7/9/13 at approximately 1145 during an interview with staff A, it was discovered that the facility does not have a log for mixing bicarbonate solutions. Staff A stated that "the Medical Assistant (MA) mixes the bicarbonate in individual jugs in the mornings, prior to the treatment shift." Staff A stated that "the MA brings the jugs from the storage shelf (located in soiled utility room 2137) and brings them over to the room used for bicarb mixing." Staff A stated "the powder from the individual packet is put into the jug, the jug is filled up with RO (reverse osmosis) water and then the jug is placed at the treatment station." When asked if there was a log used to record each jugs' concentration after this process, staff A confirmed that there are "no records kept for this process." When asked if the MA tests the solution after mixing to determine if it was mixed to the proper concentration, staff A responded that "the bicarbonate solution is not tested." Directions for use on the front of the bicarbonate powder bag state to "analyze the concentration prior to use."	V 226		
V 243	494.40(a) BICARB JUGS RINSED	V 243	**V243 Bicarb Jugs Rinsed Daily/Stored Dry**	

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V 243	Continued From page 10 DAILY/STORED DRY 6.5 Concentrate distribution: bicarb jugs rinsed daily/stored dry Bicarbonate concentrate jugs should be rinsed with treated water and stored inverted at the end of each treatment day. Pick-up tubes should also be rinsed with treated water and allowed to air dry at the end of each treatment day. This STANDARD is not met as evidenced by: Surveyor: 26222 Based on observation and interview the facility failed to properly rinse and store the bicarbonate jugs in a clean area resulting in the potential transmission of infectious agents among the 15 incenter patients served. Findings include: On 7/9/13 at approximately 1150, based on interview with Staff A, it was discovered that bicarbonate jugs are rinsed in the room marked "Soiled Utility" room 2137 and then stored on the designated shelving within that room. On 7/9/13 at approximately 1150, it was observed that Room 2137 does not contain RO water supply but only municipal water in the faucet of the two-compartment sink. Staff A confirmed that jugs are rinsed in the two-compartment stainless steel sink, located in this room.	V 243	Bicarbonate are no longer stored in the soiled utility room after being rinsed. A room has been converted and will be used as a clean utility room for rinsing and storing of the bicarbonate jugs with a RO line in the room. This will begin 8/2/2013. All staff involved in the new process were educated by the Unit Manager on 7/29/13. Compliance with storage of the bicarbonate jugs be audited daily by the Unit Manager/Designee and shared with staff, unit leadership, Medical Director, the organization's Chief Operating Officer and President. Director of Facilities will install an RO water line in a permanent room where the bicarbonate jugs will be cleaned. Installation will be completed by 8/19/2013. The Unit Manager is responsible for correction and ongoing monitoring.	
V 402	494.60(a) PE-BUILDING-CONSTRUCT/MAINTAIN FOR SAFETY The building in which dialysis services are furnished must be constructed and maintained to ensure the safety of the patients, the staff and the public.	V 402	**V402 Building Constructed for Safety** Drywall patched and painted. Completed 7/30/2013 Hand held sprayer with shut off valve removed and replaced with hand held shower type sprayer without shut off. Completed 7/29/2013. An indirect waste or air gap will be installed on the drain line for the ice machine prior to the sewer line at the hand sink	

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V 402	Continued From page 11 This STANDARD is not met as evidenced by: Surveyor: 26222 Based on observation and interview the facility failed to maintain a safe environment for all 15 incenter patients resulting in the risk for poor patient outcomes. Findings include: On 7/9/13 at approximately 1030 the drain line for the ice machine was observed directly connected to the sewer line at the adjacent hand sink drain. On 7/9/13 at approximately 1030, this was confirmed by staff B On 7/9/13 at approximately 1020, holes in the drywall were observed on the headwall of patient treatment stations where previous sharps containers had been removed. On 7/9/13 at approximately 1020, the holes were confirmed by staff B. On 7/9/13 at approximately 1050, the handheld sprayer at the soiled utility sink was observed to have a shut off valve. This shut off valve is located downstream from the atmospheric vacuum breaker. On 7/9/13 at approximately 1050, the location of the shut off valve was confirmed by staff B.	V 402	. This work will be completed by 8/15/2013. Responsible person is the Director of Facilities	
V 409	494.60(d)(1) PE-ER PREP STAFF-INITIAL/ANNUAL/INFORM PTS The dialysis facility must provide appropriate training and orientation in emergency preparedness to the staff. Staff training must be provided and evaluated at least annually and include the following: (i) Ensuring that staff can demonstrate a	V 409	**V409 Emergency Preparedness** All staff receive education regarding emergency codes upon hire. This training is provided by the organization's Safety Director. Additionally, all unit staff will be trained by 08/09/12 by Unit Manager and Safety Officer in emergency/disaster procedures specific to the dialysis unit and its patient population. A unit specific emergency	

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V 409	Continued From page 12 knowledge of emergency procedures, including informing patients of- (A) What to do; (B) Where to go, including instructions for occasions when the geographic area of the dialysis facility must be evacuated; (C) Whom to contact if an emergency occurs while the patient is not in the dialysis facility. This contact information must include an alternate emergency phone number for the facility for instances when the dialysis facility is unable to receive phone calls due to an emergency situation (unless the facility has the ability to forward calls to a working phone number under such emergency conditions); and (D) How to disconnect themselves from the dialysis machine if an emergency occurs. This STANDARD is not met as evidenced by: Surveyor: 30988 Based on interview the facility failed to provide appropriate training and orientation in emergency preparedness to all staff resulting in the potential for patient harm for all 15 incenter patients in an emergency situation. Findings include: On 7/10/2013 at approximately 0930 during interview of staff H, and at approximately 1015 during interview of staff I, when asked what they had been taught about their role in emergency preparedness, both staff H & I were unable to define their roles in the event of a disaster.	V 409	preparedness plan will be developed by 08/09/13. This plan will include a description of patient training on: what to do, where to go in the event of an evacuation, whom to contact if an emergency occurs when the patient is not in the facility, and how to disconnect themselves from the dialysis machine if an emergency occurs. Evacuation training with the use of the Stryker Evacuation Chair will be completed. Additionally, all staff will be trained regarding their individual role in the evacuation process. Current staff training will be completed by 08/09/13. This training will also take place for all new employees upon hire and for all staff annually thereafter. Training will be provided by the Safety Director and Unit Manager. Evacuation drills will be performed at least annually and will be documented. The education plan was reviewed with and approved by the unit Medical Director. The Medical Director, Unit Manager, and Chief Operating Officer are responsible for correction and ongoing monitoring.	
V 520	494.80(d)(2) PA-FREQUENCY REASSESSMENT-UNSTABLE Q MO In accordance with the standards specified in paragraphs (a)(1) through (a)(13) of this section, a comprehensive reassessment of each patient	V 520	**V520 Plan of Care for unstable patient** The Pediatric Dialysis Patient Plan of Care policy and the Unstable Dialysis Patient policy have been reviewed and revised to include verbiage specifically related to monthly revision of plan of care for unstable patients.	

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V 520	Continued From page 13 and a revision of the plan of care must be conducted- At least monthly for unstable patients including, but not limited to, patients with the following: (i) Extended or frequent hospitalizations; (ii) Marked deterioration in health status; (iii) Significant change in psychosocial needs; or (iv) Concurrent poor nutritional status, unmanaged anemia and inadequate dialysis. This STANDARD is not met as evidenced by: Surveyor: 27408 Based on document review and interview, it was determined that the facility failed to ensure the interdisciplinary team developed an individualized comprehensive reassessment of all unstable patient needs for 2 of 2 unstable records reviewed (patient #2 and #3). Findings include: On 07/09/13 at 1145 during the medical record review the following was confirmed: patient # 2 was hospitalized from May 3rd to May 22nd, 2013 (17 days), and again from May 29th to June 7th, 2013 (10 days). Upon discharge from the hospital, the patient resumed care at the ESRD facility on 06/10/13. According to the documents titled "Nephrology-Dialysis HD Clinic," the physician stated that the patient was "unstable " on 06/14/13. The physician also documented on the "Nephrology-Dialysis HD Clinic" visits for 03/11/13, 04/03/13, and 05/24/13, that the patient was also deemed as "unstable." The last "Comprehensive Multidisciplinary Patient Assessment/Care Plan" that was completed for patient #2 was on "11/16/12."	V 520	Policy Reviewed and revised on 7/19/2013 and will be approved by Medical Director. Unit Manager will obtain approval of Division Chief by 8/5/2013. All staff was educated regarding completion of a monthly revision of the plan of care for unstable patients; including but not limited to extended or frequent hospitalizations, marked deterioration in health status, significant change in psychosocial needs, poor nutritional status, unmanaged anemia and inadequate dialysis. Unit staff was educated by the Unit Manager and physician staff by the unit Medical Director. All education to be completed by 08/24/13. Staff nurses will audit medical records weekly for compliance beginning 8/5/2013. Audit results will be shared monthly with unit staff, leadership, Medical Director and Chief Operating Officer. The Medical Director, Unit Manager, and Chief Operating Officer are responsible for correction and ongoing monitoring.	

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V 520	Continued From page 14 On 07/10/13 at 1130, a review of the policy titled "Pediatric Dialysis Patient Plan of Care" number: CHM MOD PC 005, with an effective date of 02/20/09, revealed that under Provisions, #6, "A comprehensive reassessment of each patient with a revision of the plan of care will be conducted annually and prn (as needed) for stable patients and at least monthly for unstable (patients)." On 07/10/13 at 1000, these findings were confirmed with Staff A. Surveyor: 30988 On 7/10/13 at approximately 1100, document review for patient #3 revealed that patient #3 was identified as unstable on "2/13/2013" in the document titled "plan of care". There was no plan of care completed for patient # 3 in March 2013. The next plan of care found was dated "4/13/13" where the patient was made stable. On 07/10/13 at 1150, interview of staff A revealed "there are no additional plans of care (for patient #3)."	V 520		
V 542	494.90(a) POC-IDT DEVELOPS PLAN OF CARE The interdisciplinary team must develop a plan of care for each patient. This STANDARD is not met as evidenced by: Surveyor: 28273 Based on record review, interview and policy review, the facility failed to ensure that all members of the Interdisciplinary Team (IDT) were involved in the development of the Pediatric Plan of Care (PPOC) for 1 of 2 (patient #5) home patients reviewed, resulting in the potential for	V 542	**V542 Interdisciplinary POC** Dietician re-educated regarding presence at, participation in, and documentation after multidisciplinary care planning meetings on 7/11/2013 by the Unit Nurse Manager. Completion of the Nutrition section and the Pediatric Plan of Care by the Multidisciplinary Team will be audited monthly. Audit results will be shared monthly with staff, unit leadership, Medical Director, and the organization's Chief Operating Officer. The Medical Director, Unit Manager, and Chief Operating Officer are responsible for correction and ongoing monitoring.	

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V 542	Continued From page 15 poor patient outcomes and unmet patient needs for the twelve patients being served by the facility. Findings include: On 07/09/2013 at 1130, review of the medical record for patient #5 revealed a PPOC for the patient dated 09/26/2012. The PPOC lacked documentation by the dietician in the entire section titled "nutrition". On 07/09/2013 at 1500, the lack of findings in the PPOC was confirmed and discussed with staff A and staff G. When staff A was queried about the lack of documentation she stated "we have some issues in the area of nutrition." On 07/10/2013 at 1100, during an interview with staff I, discussion took place about the lack of documentation in the nutritional section of the PPOC. When queried, staff I did not give an explanation of why the documentation was not completed. A review on 07/10/2013 at 1145, of the "DMC Children's Hospital of Michigan" policy number CHM MOD PC 001, effective date 01/17/2009, revealed on page 5: "K. PPOC Completion (Pediatric Plan of Care) I. The PPOC will be completed by members of the IDT including the patient and/or patient family if desired by the patient or the patient's family member."	V 542		
V 556	494.90(b)(1) POC-COMPLETED/SIGNED BY IDT & PT The patient's plan of care must- (i) Be completed by the interdisciplinary team, including the patient if the patient desires; and	V 556	**V556 POC Signed by All Members of the Team** All staff were re-educated by the Unit Manager during the 7/29/2013 staff meeting regarding the importance of signing, dating and timing all medical record entries, including the plan of	

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V 556	Continued From page 16 (ii) Be signed by the team members, including the patient or the patient's designee; or, if the patient chooses not to sign the plan of care, this choice must be documented on the plan of care, along with the reason the signature was not provided. This STANDARD is not met as evidenced by: Surveyor: 27408 Based on record review and interview, the facility failed to document that all the members of the comprehensive interdisciplinary team (IDT) met together to discuss and review all aspects of the patient's care plan in 1 of 2 peritoneal patient charts reviewed, and 4 of 5 in-center hemodialysis patient charts reviewed, for a total of 5 of 7 patients charts (#2, #3, #5 #6, and #7). Findings include: On 07/10/13 at 1100 during document review of the plan of care and the comprehensive multidisciplinary patient assessment for patient #2, it was determined that the plan of care was not signed by all members of the Interdisciplinary treatment team, (only the physician and the social worker signatures were completed). On 07/10/13 at 1015 these findings were confirmed by Staff A. Surveyor: 30988 On 7/10/13 at approximately 1200 during document review, the plans of care and the comprehensive multidisciplinary patient assessment for patients #3, 6, and 7 were not signed by all members of the Interdisciplinary treatment team. Interview of staff A on 7/10/13 at approximately 1200 revealed "the staff get busy and forget to sign."	V 556	care and multidisciplinary patient assessment, including signatures of the patient care giver. A medical record audit specific to the dialysis unit was created 7/22/2013. Staff nurses will audit medical records weekly for compliance beginning 8/5/2013. Audit results will be shared monthly with unit staff and leadership, Medical Director and Chief Operating Officer. The Medical Director and Unit Manager are responsible for correction and ongoing monitoring.	

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V 556	Continued From page 17 Surveyor: 28273 On 07/09/2013 at 1400, review of the medical record for a pediatric home peritoneal dialysis patient (patient #5), revealed three pediatric plans of care (PPOC) for patient #5 all lacking complete signatures and dates of the IDT members and lacked a signature and date for the Care Giver on two of the three documents. The PPOC for August 9, 2011, lacked signatures and dates for the Dietician, Social Worker and Patient Care Giver. The PPOC for September 13, 2011 lacked signatures and dates for the Dietician, the Social Worker and the Patient Care Giver. The PPOC for September 26, 2012 lacked a signature and date for the Dietician. The above findings were all confirmed and discussed with staff A, (Clinic Manager) on 07/09/2013 at 1500, who stated "we have some issues in the area of nutrition."	V 556		
V 625	494.110 CFC-QAPI This CONDITION is not met as evidenced by: Surveyor: 28273 Based on document review and interview the facility failed to comply with the Condition of Quality Assessment Performance Improvement in the areas of aggregated data, developed plans for improvement of care, monitored outcomes of improvement plans and prioritized plans for performance improvement resulting in the potential for poor patient outcomes and ongoing unmet patient care goals for all 27 patients receiving services from the facility. Findings include: (See individual tag citations)	V 625	**V625 QAPI Program** The unit Medical Director & Unit Manager will develop a QAPI plan specific to the dialysis department by 08/24/13. The plan will identify program goals, metrics, auditing and trending methods, reporting structure. Medical Director and Chief Operating Officer will implement a quality assurance and performance improvement program by 08/24/13 that encompasses, at a minimum: aggregated data related to quality indicators, plans for improvement of care and monitoring outcomes of such plans, and prioritizing plans for improvement based on potential severity, including monitoring indicators to ensure improved health outcomes, quality indicators that reflect performance components, monitoring of medical injuries and errors, monitoring and tracking of grievances and	

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V 625	Continued From page 18 (V-627) Failure to have ongoing program monitoring indicators to ensure improved health outcomes. (V-628) Failure to monitor quality indicators that reflect performance components. (V-634) Failure to monitor medical injuries and errors. (V-636) Failure to monitor and track grievances and use patient satisfaction surveys. (V-638) Failure to monitor performance improvement. (V-639) Failure to prioritize performance improvement activities.	V 625	patient satisfaction, monitoring and prioritizing of performance improvement. The unit Medical Director will lead the monthly unit multidisciplinary Quality Council. The newly created Dialysis QAPI Dashboard will be reviewed at each Quality Council meeting and performance improvement plans will be developed by the team as needs are identified.	
V 627	494.110(a)(1) QAPI-ONGOING;USES INDICATORS=IMPROVEMENT The program must include, but not be limited to, an ongoing program that achieves measurable improvement in health outcomes and reduction of medical errors by using indicators or performance measures associated with improved health outcomes and with the identification and reduction of medical errors. This STANDARD is not met as evidenced by: Surveyor: 28273 Based on quality meeting review and interview, the facility failed to show evidence of an ongoing program that continuously monitors indicators, trends outcomes and develops an improvement plan when needed, resulting in the lack of identification of quality improvement opportunities. Findings include: On 07/09/2013 at 1130 during review of the quality documents labeled "quality meeting minutes" no evidence of performance measures	V 627	**V627 QAPI Ongoing QAPI Program** The Hospital will ensure that the QAPI program includes, but is not limited to, an ongoing program that achieves measurable improvement in health outcomes and reduction of medical errors by using indicators or performance measures associated with improved health outcomes and with the identification and reduction of medical errors. Minutes of the monthly multidisciplinary Quality Council will reflect review of performance measures, aggregate and trended data, development of action plans to address areas not meeting goals, and monitoring of any action plans currently in place, and development of improvement plans when the data indicates that they are needed for improvement of patient care. This review will be made standing agenda item beginning at the August, 2013 Quality Council meeting. The Medical Director and Chief Operating Officer is responsible for correction and ongoing monitoring.	

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V 627	Continued From page 19 (health outcomes - physical and mental functioning, and patient survival) were documented or monitored and when indicated developed an improvement plan to improve health outcomes and reduce medical errors. A review of the two quality documents labeled "quality meeting minutes," provided by staff A (one each dated January 24, 2013 and June 11, 2013), revealed that the Quality Committee did review some quality indicators but failed to aggregate and trend data outcomes and develop action plans to improve those outcomes. On 07/10/2013 at 1315 during interview with staff A, when queried about quality indicators, trending outcomes and action plans she stated: "When we have a quality meeting we discuss things that need to be looked at." When asked to see the data in regards to trending and action plans taken to improve outcomes, staff A was unable to produce the data.	V 627		
V 628	494.110(a)(2) QAPI-MEASURE/ANALYZE/TRACK QUAL INDICATORS The dialysis facility must measure, analyze, and track quality indicators or other aspects of performance that the facility adopts or develops that reflect processes of care and facility operations. These performance components must influence or relate to the desired outcomes or be the outcomes themselves. This STANDARD is not met as evidenced by: Surveyor: 28273 Based on document review and interview, the facility failed to monitor all aspects of the End Stage Renal Disease (ESRD) program by	V 628	**V628 QAPI Quality Indicator Tracking** The Hospital will ensure the dialysis facility measures, analyzes, and tracks quality indicators or other aspects of performance that the facility adopts or develops that reflect processes of care and facility operations. Specifically, a Dialysis QAPI Dashboard was developed which includes all required quality indicators, and monitoring of, assessment and improvement of care, medical injuries/errors, patient satisfaction and grievance intervention, infection control compliance, prioritize improvement activities, organizational goals, monthly tracking of aggregate data with progress toward goals of influencing desired patient outcomes. This "snapshot" of 12 months of data	

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V 628	Continued From page 20 tracking and keeping current, their monitoring logs of the assessment and improvement of care in the facility, resulting in the potential for missed/un-identified opportunities for improvement related to medical injuries/errors, patient satisfaction & grievance intervention and infection control compliance. Findings include: On 07/10/2013 at 1130 a review of the documentation titled "quality meeting minutes" and tracking documentation revealed that the facility did not keep complete and up- to- date logs for analyzing and tracking quality indicators to influence desired patient outcomes. Review of the logs for tracking quality indicators, provided by the Clinic Manager (staff A) revealed that the documentation did not address medical injuries/errors or patient satisfaction/grievances, and did not prioritize improvement activities. The document titled "quality meeting minutes" for 01/24/2013 lacked data regarding infection rates and dialysis adequacy. The quality meeting minutes dated 05/30/2013 contained only documentation regarding "Reviewing water quality and dialysate quality ESRD conditions for coverage." On 07/10/2013 at 1315, the content of meeting minutes and tracking logs were discussed and confirmed with the Clinic Manager (staff A). During the interview on 07/10/2013 at 1315, a review of the tracking log titled "Hemodialysis Infection Rates-2013" revealed a lack of documentation (data) for May and June. The log for "Home PD Infection Rates-2013" also lacked data for May 2013 and June 2013. The Clinic Manager (staff A) stated "I just have not plugged	V 628	allows easy review of progress or lack thereof and facilitates the creation of timely action plans. The dashboard was created 7/29/2013, and was implemented 8/1/2013. Responsible persons are the Medical Director and the Chief Operating Officer.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	232328	A. BUILDING _____ B. WING _____	07/10/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHILDREN'S HOSPITAL OF MICHIGAN	3950 BEAUBIEN BLVD DETROIT, MI 48201

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
V 628	Continued From page 21 in the numbers yet."	V 628		
V 634	494.110(a)(2)(vi) QAPI-INDICATOR-MEDICAL INJURIES/ERRORS The program must include, but not be limited to, the following: (vi) Medical injuries and medical errors identification. This STANDARD is not met as evidenced by: Surveyor: 28273 Based on document review and interview, the facility failed to include variance data for medical injuries and medical error reporting in the Quality Assessment Performance Improvement (QAPI) Program minutes discussion resulting in the potential for missed opportunities for improvement of patient care for all 27 patients served by the facility. Findings include: On 07/10/2013 at 1315, interview and review of the tracking logs and quality meeting minutes with the Clinic Manager (staff A), revealed that there was no tracking completed in 2013 for either medical errors or machine errors. When queried, the Clinic Manager stated "we have not had any reported, so we don't put anything in the minutes about it."	V 634	**V634 QAPI** Tracking for Medical injuries/errors and machine errors is accomplished in the organization's electronic reporting program. Beginning 8/1/2013, monthly reports will be run and the resulting data will be included on the Dialysis QAPI dashboard and reported at the Dialysis Quality Council. The Medical Director, Unit Manager and Chief Operating Officer are responsible for correction and ongoing monitoring.	
V 636	494.110(a)(2)(viii) QAPI-INDICATOR-PT SATIS & GRIEVANCES The program must include, but not be limited to, the following: (viii) Patient satisfaction and grievances. This STANDARD is not met as evidenced by:	V 636	**V636 QAPI** Beginning 8/1/2013, a monthly report of patient grievances will be provided and reported on the Dialysis QAPI Dashboard at the Dialysis Quality Council. The Medical Director, Unit Manager and Chief Operating Officer are responsible for correction and ongoing monitoring.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	232328	A. BUILDING _____ B. WING _____	07/10/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHILDREN'S HOSPITAL OF MICHIGAN	3950 BEAUBIEN BLVD DETROIT, MI 48201

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V 636	Continued From page 22 Surveyor: 28273 Based on document review and interview, the facility failed to include variance data for patient satisfaction and patient grievance reports in the Quality Assessment Performance Improvement (QAPI) Program resulting in the potential for missed opportunities for improvement of patient care for all 27 patients served by the facility. Findings include: On 07/10/2013 at 1315, interview and review of the tracking logs and quality meeting minutes with the Clinic Manager (staff A), revealed no tracking of patient satisfaction or grievances for 2013 . When queried, the Clinic Manager stated "we have not done any satisfaction surveys and we have not had any grievances, so there is not anything in the meeting minutes about it."	V 636	The Unit Manager and Manager of the organization's Patient & Family Relations department are currently creating a satisfaction survey for Dialysis patients and families. The survey will be completed and implemented by 08/24/13. Survey results will be reported on the Dialysis QAPI Dashboard and reported at the Dialysis Quality Council monthly. The Medical Director and Unit Manager are responsible for correction and ongoing monitoring.	
V 638	494.110(b) QAPI-MONITOR/ACT/TRACK/SUSTAIN IMPROVE The dialysis facility must continuously monitor its performance, take actions that result in performance improvements, and track performance to ensure that improvements are sustained over time. This STANDARD is not met as evidenced by: Surveyor: 28273 Based on review of the Quality Assessment Performance Improvement (QAPI) documentation and interview, the facility failed to ensure that it continuously monitors, takes action and tracks performance improvement outcomes, resulting in unidentified opportunities for improved patient outcomes for all 27 patients receiving services from the facility. Findings include:	V 638	**V638 QAPI Monitoring/Tracking/Sustaining** Unit goals have been identified for all indicators, including continuous monitoring of performance, actions taken from monitoring of performance for performance improvement, tracking performances for continuous improvement over time, and are clearly noted on the Dialysis QAPI Dashboard. The dashboard will become effective 8/1/2013. Data for the previous 6 months has been loaded into the dashboard. The Medical Director, Unit Manager and Chief Operating Officer are responsible for correction and ongoing monitoring.	

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	232328	A. BUILDING _____ B. WING _____	07/10/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHILDREN'S HOSPITAL OF MICHIGAN	3950 BEAUBIEN BLVD DETROIT, MI 48201

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V 638	Continued From page 23 On 07/10/2013 at 1315, review of the QAPI documentation with the Clinic Manager (Staff A), revealed a lack of data documentation for the months of May and June 2013. A further review of the documented data for April 2013, revealed unmet goals for the 14 in-center hemodialysis (ICHD) patients in the areas of Albumin Management and Bone and Mineral Metabolism. Review of data for Home Peritoneal Dialysis (HPD) patients receiving services for the months of May and June 2013 revealed no data documented. QAPI data for April 2013 revealed 9 patients receiving HPD services from the facility. The tracking document for Anemia Management did not identify a facility goal. It read that "6/9= 67% of patient are between Hemoglobin range of 9-11." The document did not identify a facility goal as to what percentage of the patients they want in this range. The QAPI HPD document identified a "goal for Nutritional Status as >80% of dialysis patients will have Serum Albumin >3.5." The documented "Albumin for April 2013 was 1/9=11%." During the QAPI documentation review and interview with the Clinic Manager (staff A) on 07/10/2013 at 1315, when queried about where the specific goals/targets and plans are identified/documented for Anemia Management, Bone and Mineral Management and Serum Phosphorus, she stated "I gave you all the quality documentation that I have."	V 638		
V 639	494.110(c) QAPI-PRIORITIZING IMPROVEMENT ACTIVITIES The dialysis facility must set priorities for	V 639	**V639 QAPI Prioritizing Improvement Activities** Action plans will be prioritized by the Medical Director based on prevalence and severity of the problem identified. The QAPI plan will identify	

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	232328	A. BUILDING _____ B. WING _____	07/10/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHILDREN'S HOSPITAL OF MICHIGAN	3950 BEAUBIEN BLVD DETROIT, MI 48201

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V 639	Continued From page 24 performance improvement, considering prevalence and severity of identified problems and giving priority to improvement activities that affect clinical outcomes or patient safety. This STANDARD is not met as evidenced by: Surveyor: 28273 Based on document review and interview the facility failed to incorporate data reports results and prioritize performance improvement actions resulting in the potential for poor patient outcomes for all 27 patients receiving services from the facility. Findings include: On 07/10/2013 at 1315, during review of documents titled "quality," it was determined that the quality documentation lacked data for the months of May 2013 and June 2013. The quality documents also lacked designation as to what improvement projects the facility considered a high priority, moderate priority or low priority for meeting targeted outcome goals. When the Clinic Manger (staff A) was queried about the prioritization she stated "No, that has not been done." When asked about the lack of data for the months of May and June staff A stated "I just have not plugged in the numbers yet."	V 639	improvement projects with severity levels of high priority, moderate priority, or low priority for each indicator in meeting targeted outcome goals. The QAPI plan will be completed by 08/24/13. The Medical Director and Unit Manager are responsible for correction and ongoing monitoring.	
V 712	494.150(a) MD RESP-QAPI PROGRAM Medical director responsibilities include, but are not limited to, the following: (a) Quality assessment and performance improvement program. This STANDARD is not met as evidenced by: Surveyor: 28273 Based on document review and interview, it was determined that the Medical Director failed to	V 712	**V712 Medical Director Responsibility** Unit Medical Director and COO is responsible for all aspects the dialysis QAPI program. Unit Medical Director (with input from the Unit Manager) will develop a QAPI plan specific to the dialysis department by 08/24/13. The plan will identify program goals, metrics, auditing and trending methods, and reporting structure. As of August, 2013, the unit Medical Director will lead the monthly unit multidisciplinary Quality Council and will ensure the presence of a quality assurance and performance improvement	

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	232328	A. BUILDING _____ B. WING _____	07/10/2013

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V 712	Continued From page 25 ensure that the facility had an operational quality assurance and performance improvement program that reviewed all aspects of the dialysis program including established quality indicators and prioritized performance improvement projects. Findings include: (see citations listed below and previously cited) V-625, V-628, V-634, V-638, V-639	V 712	program that encompasses, at a minimum, the established quality indicators and includes prioritized performance improvement projects based on deficiencies identified during data collection and analysis. The newly created Dialysis QAPI Dashboard will be reviewed at each Unit Quality Council meeting monthly and performance improvement plans will be developed and implemented. The minutes of the Council will reflect all QAPI activities. Dialysis QAPI data and activities will be reported to the organization's Leadership Performance Improvement Committee at least bi-annually.	
V 713	494.150(b) MD RESP-STAFF ED, TRAINING & PERFORM Medical director responsibilities include, but are not limited to, the following: (b) Staff education, training, and performance. This STANDARD is not met as evidenced by: Surveyor: 30988 Based on interview, the medical director failed to ensure that the facility staff members received appropriate education and training in emergency preparedness job responsibilities resulting in the potential for poor patient outcomes in the event of a disaster/emergency. Findings include: On 7/10/2013 during an interview with staff H at approximately 0930, and with staff I at approximately 1015, when asked what they were taught about emergency preparedness both staff H & I were unable to define their roles in the event of a disaster.	V 713	**V713 Medical Director Responsibility** The Unit Medical Director and COO are ultimately responsible for staff education, training and performance. The Medical Director and Unit Manager will collaborate to determine education and training needs, disaster/emergency training needs, facilitate the provision of training and monitor staff performance to ensure the safe provision of patient care, which will be a standing item at the Quality Council. The Medical Director will be included in all decision making regarding educational needs, manner of training, and monitoring techniques. The Medical Director and Unit Manager will create an Education Plan, including emergency preparedness job responsibilities for all unit staff by 08/09/13. The plan will include education required, how it will be provided and by whom, timelines for education and re-education, and monitoring for effectiveness.	

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	232328	A. BUILDING **02 - CHILDRENS HOSPITAL OF MICHIGAN ESRD** B. WING _____	**07/09/2013**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHILDREN'S HOSPITAL OF MICHIGAN	**3950 BEAUBIEN BLVD DETROIT, MI 48201**

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K 000	INITIAL COMMENTS This Life Safety Code (LSC) survey was conducted on 07/15/2013. The facility was found to be in compliance with the 2000 edition of the National Fire Protection Association (NFPA) LSC chapter 21.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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

DMC
Detroit Receiving Hospital

always there.

Iris A. Taylor, Ph.D., R.N.
EVP & President
Detroit Receiving Hospital &
University Health Center
4201 St. Antoine
Detroit, MI 48201
Phone: 313-745-3104
Fax: 313-966-7206

July 17, 2013

Rick Brummette
Department of Licensing and Regulatory Affairs
Health Facilities Division
Specialized Health Services Section
611 W. Ottawa
P.O. Box 30664
Lansing, MI 48909

Re: Psychiatric Program Survey Report

Dear Mr. Brummette:

Attached please find the Plan of Correction for Detroit Receiving Hospital's Psychiatric Program Survey of June 27, 2013.

Included in the Plan of Correction are the corrections/actions for each deficiency as well as our Implementation Plan and Audit Plan which are highlighted in yellow and green respectively.

Should you have any questions regarding our responses, or require any changes in our submission, please either contact Leon A. Coleman at 313-993-0317 or myself at 313-745-3104.

Sincerely,

Iris A. Taylor PhD.

Iris Taylor, PhD, RN
Executive Vice President & President
Detroit Receiving Hospital

July 15, 2013

Rick Brummette, Section Manager
Health Facilities Division
Specialized Health Services Section

Re: Detroit Receiving Hospital Psychiatric Program Survey Report

Dear Mr. Brummette:
Attached please find the corrective plan of action to address deficiencies identified in survey findings.

SURVEY FINDINGS	PLAN OF ACTION (POA)
1 Patient did not receive a psychosocial assessment to determine if he had knowledge, resources and/or barriers to fill a prescription.	1 Knowledge/Resources/Barriers to Filling Prescription A Developed/Implemented a *Post-Discharge Continuation of Care Needs Assessment* form (Attachment 1). The form documents the collaborative efforts between the assigned Social Worker and Registered Nurse and patient to identify discharge needs and provide community resources/referrals. Areas included in this needs assessment are: ability to obtain appropriate nutrition, safe living arrangements, discharge medication assistance, discharge transportation assistance, and chronic disease management. B Updated Community Resources Guides: Shelter, Food Bank, Prescription Assistance, Community Mental Health Clinic (Attachment 2) Responsibility for Plan of Action: Patient Care Services, Director of Psychiatry
2 Patient did not receive discharge instructions for the address for follow-up outpatient psychiatric treatment.	2 Discharge Instructions for Follow-Up Outpatient Psychiatric Treatment A. Revised *Emergency Psychiatry Discharge Instructions* (Attachment 3) to include community resources/referrals for identified discharge needs (see 1A) including post-discharge appointment location address and telephone number B. Updated general community resources on *Emergency Psychiatry Discharge Instructions* C Community Resource Guides (see 1B above) to be provided as appropriate to address identified needs. Xerox copies of all community resources/referral documents given to the patient will be included in the patient's medical record. Responsible for Plan of Action: Patient Care Services, Director of Psychiatry
3 Patient did not receive a follow-up dietary assessment, including psychosocial assessment to determine if he had funds to eat.	3 Dietary assessment / ability to secure nutrition A *MHT Intake Screen* form (Attachment 4) revised to include more specific information on current nutritional status and actions taken (i.e. providing fluids/nourishment at time of arrival in Crisis Center). Unless contraindicated, all patients receive box meal and beverage on arrival in Crisis Center. Patients provided with three meals and snacks each day of stay.

	B *Post-Discharge Continuation of Care Needs Assessment* form (See 1A above) documents collaborative efforts between the assigned Social Worker and Registered Nurse to identify nutritional needs and ability to obtain adequate nutrition. Referrals given at time of discharge. Responsible for Plan of Action: Patient Care Services, Director of Psychiatry
4 Implementation Plan	4 Implementation Plan A Staff education provided by Unit Manager on process and documentation changes to begin 07/15/13 with completion by 08/15/13. B Full implementation of process and documentation changes by 08/15/13. Responsible for Plan of Action: Patient Care Services, Director of Psychiatry

5 Audit Plan		
	Population	All Crisis Center patients discharged home or to other independent living arrangements (e.g. shelter)
	Sample	50% of the population (approximately 15 discharges/day)
	Methodology	Retrospective review of medical record to validate that all patients with identified needs for any of the following receive the information on discharge: Discharge prescription assistance, Community Mental Health (CMH) follow up appointment address/phone number Nutritional referrals
	Frequency	Daily review Reported monthly to Leadership Performance Improvement Committee and Psychiatric Practice Group
	Duration	Ongoing

ATTACHMENT 1

DMC
Detroit Receiving Hospital

Emergency Psychiatry (Adult) Post-Discharge Continuation of Care Needs Assessment

Next Level of Care Recommendation

☐ Discharge to Shelter ☐ Home ☐ Adult Foster Care (AFC) ☐ Transitional Housing
☐ Inpatient Psychiatric Facility ☐ Nursing Home ☐ Residential Substance Abuse
☐ Medical Facility Other: _____

Registered Nurse and Social Worker collaborate with the patient to identify discharge needs and resources for patients whose Next Level of Care Recommendation is: Discharge to Shelter, Home, AFC or Transitional Housing

Social Work Assessment

Nutrition
☐ Resource provided

Does the patient have resources to obtain food on a daily basis? ☐ Yes ☐ No

Describe: ☐ Personal income ☐ Bridge card ☐ Family/Friends ☐ Community Organizations
☐ Other _____

Living Arrangements
☐ Resource provided

Are the patient's current living arrangements safe? ☐ Yes ☐ No
Can the patient return to current living arrangements? ☐ Yes ☐ No
Is the patient willing to return to current living arrangements? ☐ Yes ☐ No

Community Mental Health Follow-Up Care Appointment
☐ Resource provided

Does patient have outpatient mental health provider? ☐ Yes ☐ No
☐ Patient refuses follow-up treatment ☐ Patient has previously scheduled appointment

Discharge Medication Assistance
☐ Resource provided

Does the patient have financial resources to obtain discharge medications? ☐ Yes ☐ No ☐ NA
Does the patient know where to fill discharge prescriptions? ☐ Yes ☐ No ☐ NA

Guardian Notification
☐ Resource provided

Has guardian been notified of admission to Emergency Psychiatry-Crisis Center? ☐ Yes ☐ No ☐ NA
Is guardian in agreement with Next Level of Care Recommendation? ☐ Yes ☐ No ☐ NA

Registered Nurse Assessment

Discharge Transportation Assistance
☐ Resource provided

Does the patient have safe transportation to their discharge destination? ☐ Yes ☐ No

Chronic Disease Management
☐ Resource provided

Does the patient have a plan for continued care for chronic disease/condition? ☐ Yes ☐ No ☐ NA

Clothing
☐ Resource provided

Is patient's clothing adequate/appropriate for season (e.g. coat in winter, footwear)? ☐ Yes ☐ No

RN Signature _____ Date _____ Time _____ MSW Signature _____ Date _____ Time _____

ATTACHMENT 2

Shelters

Warming Center-Winter Only (313) 963-7829

Shelter Hot Line:
Salvation Army (800) 274-3583
Chatman House (313) 963-7829

Coalition on Temporary Housing (COTS)
26 Peterboro

(313) 831-3777

Men / Women / Families

T.C. Simmons
10501 Orangelawn

(313) 934-3331

Men / Women / Children

Detroit Rescue Mission
3535 Third Street

(313) 993-6703

Men Only / Walk-In / Opens at 5PM

NSO Walk-In Shelter
3430 third Street

(313) 832-3100

Men / Women / No beds / Opens at 5PM

New Life Rescue Mission
2600 18th Street

(313) 237-0390

Men / No Beds / Opens at 5PM

Domestic Violence Shelters

Interim House
Call (313) 861 5300

First Step
Call (734) 722-6800 or (888) 453-5900

Youth / Adolescent Shelters

Covenant House
2659 Martin Luther King

(313) 463-2500
Youth / Adolescents

Counter Points
715 Inkster

(313) 563 5005 or (866) 672-4357
Boys / Girls ages 10-20

Alternatives for Girls
903 W Grand Blvd

(313) 361-4000 or (888) 234-3919

Off the Streets
680 Virginia Park

(313) 873-0678

Ruth Ellis Second Story
(313) 867-6936

Gay / Lesbian Youth ages 12-24

Places to Find a Meal Near Detroit Receiving Hospital

BREAKFAST / LUNCH

Capuchin Community Center	8:30 AM to 9:00 PM	Everyday but Sunday	1760 Mt Elliott
Cass Community United Methodist	12 Noon	Saturday	3901 Cass
Cass Park Baptist Center	9:00 AM to 9:30 AM Breakfast 11:15 AM Lunch	Monday & Wednesday	2700 Second Street
Central United Methodist	10:30 AM to 12:00 PM	Monday & Thursday	23 E Adams
Crossroads	12:00 PM to 3:00 PM	Sunday	92 E Forest
First Presbyterian Church	11:00 AM to 12:30 PM	Wednesday	2930 Woodward
Fort Street Open Door	9:00 AM to 11:00 AM	Thursday	631 W. Fort Street
Just Love Ministries	10:00 AM to 12:00 PM	Monday, Thursday & Friday	481 W. Colombia
Manna Meals	9:00 AM to 11:00 AM	Monday, Tuesday, Wednesday, Friday, Saturday	1950 Trumbull
St Dominic's Church	10:00 AM to 11:00 AM	Everyday, but Thursday	1421 W. Warren
St Leo's Church	11:30 AM - 1:30 PM	Everyday, but Sunday	4860 15th Street
Trinity Episcopal Church	12:00 PM to 2:00 PM	Saturday	1519 Martin Luther King Blvd

DINNER

Detroit Rescue Mission	5:30 PM to 6:00 PM	Everyday	3535 Third Street
Salvation Army-Bagley	12:00 PM to 3:00 PM	Everyday	601 Bagley
Salvation Army-Harbor Inn	6:00 PM to 8:00 PM	Everyday	2642 Park

CDM 07/07/2013

Low Cost Prescription Assistance

PharmModD Pharmacy / Doctors Pharmacy
3423 Woodward Ave
Detroit, 48201

Phone (313) 832-4819
Fax (313) 832 4812

Hours
Monday-Friday 9:00 AM to 5:30 PM
Saturday 9:00 AM to 2:00 PM

$4.00 Prescriptions

CrossRoads Pharmacy

East Side
14641 East Jefferson
(313) 822-5200

West Side
2424 West Grand Blvd,
Corner of 15th Street-near Henry Ford Hospital
(313) 831-2000

Hours
Monday-Friday 9:00 AM to 4:00 PM
Saturday 9:00 AM to 12:00 PM

Provides a one-time 15-day supply of medications
You must call for an appointment

Herman Kiefer
1151 Taylor
Detroit 48202

(313) 876-4846

Hours
Monday-Friday 9:00 AM to 5:00 PM

You must call for an appointment

World Medical Relief
11745 Rose Park Blvd
Detroit 48026

(313) 866-5333

Call for an appointment if you are 62 years or older to see if you quality for Senior Prescription Program

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Additional Pharmacies

Call for hours and eligibility for free/low cost medications

Advanced Care Pharmacy- Metro
2051 W Grand Blvd
Detroit, 48208
(313) 309-1084

Advance Care Pharmacy-NEGC
12800 E Warren
Detroit, 48215
(313) 347-2025

Advanced Care Pharmacy-NC
24788 Forterra Drive
Warren 48089
(586) 758-7000

Advanced Care Pharmacy
22170 W Nine Mile Road
Southfield 48034
(248) 799-8125

Davis Cut Rate Drugs
14039 W. McNichols Rd
Detroit 48235
(313) 861-9300

Jana Drugs
1684 Fort Street
Lincoln Park 48146
(313) 383-5700

Specialty Prescription Assistance Programs

Michigan Lupus Foundation
26507 Harper Avenue
St Clair Shores 48081

(586) 775-8310

Hours
Monday-Friday 9:00 AM to 5:00 PM

Provides one-time emergency prescription assistance for patients with Lupus

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Michigan Parkinson Foundation
30161 Southfield Rd
Southfield 48075

(248) 433-1011 or (800) 852-9781

Hours
Monday-Friday 8:30 AM to 8:00 PM

Medication assistance for patients with Parkinson's disease.

Myasthenia Gravis Association
17117 W Nine Mile Road Suite # 1745
Southfield 48085

(248) 423-9700 or (800) 227-1763

Hours
Monday-Friday 8:30 AM to 4:00 PM

Provides help in obtaining mail-order supplies needy patients diagnosed with Myasthenia Gravis

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Hemophilia Foundation of Michigan
117 N First Street, Suite 40
Ann Arbor, 48104

(734) 761-2535 or (800) 482-3041

Hours
Monday-Friday 9:00 AM to 5:00 PM

Helps cover medications for needy adults and children with hemophilia

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DMC
Detroit Receiving Hospital

Detroit Receiving Hospital and University Health Center
Emergency Psychiatric Crisis Center
4201 St Antoine, Detroit, Michigan 48201

(313) 745-3546 or (313) 966-8747

Community Mental Health Clinics

Adult Well-Being Services
1423 Field Avenue
Detroit, MI 48214
313-924-7860

Adult Well-Being Services
5555 Conner, Suite 1000
Detroit, 48213
313-347-2070

Adult Well-Being Services
6700 Middlebelt Road
Romulus, 48174
734-629-5000

Arab-American and Chaldean Council (ACC)
62 W. 7 Mile Road
Detroit, 48203
313-893-6172

Arab-American and Chaldean Council
16921 W. Warren Road
Detroit, 48228
313-581-7287

Community Care Services
26184 W Outer Drive
Lincoln Park, 48146
313-389-7500

Community Care Services
25 Owen Street
Belleville, 48111
734-697-7880

Community Care Services
26650 Eureka, Suite A
Taylor, 48186
734-955-3550

Detroit Central City Community Mental Health, Inc.
10 Peterboro
Detroit, 48201
313-831-3160

Detroit East Community Mental Health Center
11457 Shoemaker
Detroit, 48213
313-331-3435

Detroit East Community Mental Health Center
3646 Mt. Elliott
Detroit, 48207
313-921-4700

Detroit East Community Mental Health Center
6309 Mack
Detroit, 48207
313-921-4700

Development Centers, Inc
24424 W McNichols
Detroit 48219
(313) 531-2500

Guidance Center
13101 Allen Road #500
Southgate 48195
(734) 785 7700

Hegira Programs, Inc
8623 N Wane Road, #200
Westland 48185
(734) 458-4601

Lincoln Behavioral Services
9315 Telegraph Road
Redford, 48239
313-450-4500

Lincoln Behavioral Services
24425 Plymouth Road
Redford, 48239
313-450-0411

Lincoln Behavioral Services
14500 Sheldon Road, Suite 160
Plymouth, 48170
734-459-5590

Neighborhood Services Organization (NSO)
220 Bagley, #1200
Detroit, 48226
(313) 961-7990

New Center Community Mental Health, Inc
2051 W Grand Blvd
Detroit 48215
(313_ 961-3200

DMC
Detroit Receiving Hospital

Detroit Receiving Hospital and University Health Center
Emergency Psychiatric Crisis Center
4201 St Antoine, Detroit, Michigan 48201

(313) 745-3546 or (313) 966-8747

Community Mental Health Clinics

New Center North Park
10001 Puritan
Detroit, 48235
(313) 494-4000

North Central Community Mental Health Center
17141 Ryan Road
Detroit, MI 48212
313-369-1717

North Central Community Mental Health Center
4321 E. McNichols
Detroit, MI 48212
313-369-1717

Northeast Guidance Center
12800 E Warren
Detroit, 48215
(313) 824-8000

Sinai Grace Outpatient Services
14230 W. McNichols
Detroit, MI 48234
313-966-3100

Southwest Solutions
1700 Waterman
Detroit, 48209
(313) 841 7474

Team Mental Health Services
2939 Russell Street
Detroit, MI 48207
313-396-5300

Team Mental Health Services
19170 Eureka Road
Southgate, MI 48195
734-324-8326

University Psychiatric Services
3901 Chrysler Service Drive
Detroit, MI 48207
(313) 577-1396

Gateway Community Health has a 24 hour a day 7 days a week phone number for you to call if you have ANY questions about your placement, medication(s) or any thing concerning your care.

1-800-973-4283

Gateway Community Health Outpatient Clinics

Adult Well Being Services
1143 Field Street
Detroit, 48213

(313) 347-2070 *Prescription Assistance Available*

Arab-American & Chaldean Council (ACC)
62 W 7 Mile
Detroit 48203

(313) 893-6172 *Prescription Assistance Available*

Community Care Services-Taylor
26650 Eureka
Taylor 48180

(734) 955-3550 *Prescription Assistance Available*

Community Care Services-Belleville
416 Sumpter Rd, Building B
Belleville 48111

(734) 389-7546 *Prescription Assistance Available*

Community Care Services-Lincoln Park
26184 W Outer Drive
Lincoln Park 48186

(313) 389-7525 *Prescription Assistance Available*

Detroit Central City CMH, Inc
10 Peterboro
Detroit 48201

(313) 831-3160 *Prescription Assistance Available*

Gateway Detroit East, Inc
11457 Shoemaker
Detroit 48213

(313) 331-3435 *Prescription Assistance Available*

Lincoln Behavioral Services
9315 Telegraph
Redford 48239

(313) 450-4500 *Prescription Assistance Available*

A.C.C.E.S.S.
6451 Schaefer Road
Dearborn 48126

(313) 945-8128 *Prescription Assistance Available*

University Physician Group-Livonia
16836 Newburgh Road
Livonia 48154

(313) 577-7607

Sinai Grace Hospital
14230 W McNichols
Detroit 48235

(313) 966-4880

Team Mental Health Services
14799 Dix-Toledo Road
Southgate 48195

(734) 274-3700 *Prescription Assistance Available*

Team Mental Health Services
2939 Russell Street
Detroit 48207

(313) 396-5300 *Prescription Assistance Available*

University Physicians Group-University Psychiatry
3901 Chrysler Service Drive
Detroit 48207

(313) 577-1396

FOR MEDICATIONS IF YOU HAVE NO INSURANCE

Davis Drugs (across from Sinai-Grace Outpatient Clinic)
14039 W. McNichols, Detroit 48235
(313) 861 - 9300

Cobb Pharmacy
4603 S. Wayne Rd, Wayne 48185
(734) 728 - 6000

Or Any Out Patient Clinic listed above with
Prescription Assistance Available

Tell them you are a Gateway Community Health member.

Your Gateway Community Health Number is

revised 6/27/13 CDM

ATTACHMENT 3

DMC
Detroit Receiving Hospital

1010

Patient label

Emergency Psychiatry Discharge Instructions

☐ A follow-up care appointment has been made for you at

Location _____

Address _____

Date / Time _____ Phone Number _____

☐ Please call _____ to schedule your follow up appointment

To assist you in planning for your continuing care needs we are offering you the following community resources and referrals

☐ Food Banks / Meal Centers
☐ Low Cost Prescription Assistance
☐ Shelters / Alternative Housing
☐ Community Mental Health Clinics
☐ Veterans Assistance
☐ Health Care Clinics
☐ Domestic Violence Assistance
☐ Substance Abuse Treatment

Discharge Transportation Assistance ☐ Bus Ticket issued ☐ Cab Voucher issued

Patient Signature _____ Social Worker Signature _____

Discharge Medications

The following medications have been prescribed for you

Name	Dose	Route	Frequency	# Given	Source
					☐ Prescription
					☐ Prescription
					☐ Prescription

The patient has been instructed on the following:

1 Goals, benefits, and risks of medication(s) including taking medication(s) as directed, not operating heavy machinery or driving until adapted to the effects of any medication(s)
2 Importance of cooperating with the treatment plan and refraining from substance abuse
3 The need to follow-up with the outpatient referrals and that failure to completely and accurately follow the provided instructions may result in failure of the treatment process and worsening of symptoms
4 There can be no guarantee of cure for any medical or psychiatric condition
5 The option of returning to the Detroit Receiving Hospital Emergency Department, Crisis Center or the nearest Emergency Department for any type of urgent or emergent health related situations (example: unpleasant medication side effects or worsening of symptoms)

The above discharge instructions were explained and/or reviewed with me and my questions answered. I understand and agree with the content.

Patient's Signature _____

RN Signature _____ Discharge Date/Time _____

Distribution: Original-Medical Record, Yellow Copy-Patient
CDM 07/11/13 49291169 (09/08, 1/11/12)

Additional Community Resources

Detroit Receiving Hospital
Emergency Psychiatric Department
4201 St. Antoine, Detroit, Mi 48201
(313) 745-3540 or
(313) 966-8747

24 Hour Crisis Line-Suicide Hotline (313) 224-7000
Alcoholics Anonymous Hotline (313) 831-5550
Narcotics Anonymous Hotline (248) 543-7200
Gamblers Anonymous (888) 844-2891

Substance Abuse Services

Access Center at Herman Kiefer Complex
1151 Taylor, Building #1, Detroit MI,
1st Floor Room 110 (enter on John C Lodge entrance of main building)

Hours of Operation
07:00 AM to 5:00 PM Monday through Friday

For questions and treatments services call: 1 (800) 467 2452
24 hours / 7 days a week

Harbor Light Treatment Center-Detox
3737 Lawton, Detroit, MI
1 (313) 361-6136.

Drug Program Information for Detroit Residents Only
Call 1 (800) 467 2452 (24 hours / 7 days a week).

If you have a Private Health Insurance or HMO / Clinic Plan Medicaid
Contact your insurance provider for a substance abuse referral.

Thank you for choosing Detroit Receiving Hospital

ATTACHMENT 4

DMC
Detroit Receiving Hospital

Emergency Psychiatry (Adult)
MHT Intake Screen

Admitted from ☐ Home ☐ Homeless / Shelter ☐ Transitional Housing ☐ Emergency Department ☐ AFC ☐ Transfer from:

Accompanied by ☐ Family ☐ Police ☐ Transitional / AFC Staff ☐ ED Staff: ☐ Unaccompanied ☐ Other:

Petition Completed by _____ ☐ None ☐ NA

Temperature	
Pulse	
Respirations	
Blood Pressure	
Pain ☐ Yes ☐ No *If yes, notify RN*	

Diabetic? ☐ No ☐ Yes *If Yes, notify RN and obtain CBG* Results _____ Time completed _____

Heart Condition or Blood Pressure Problems? ☐ No ☐ Yes
If yes, is the patient taking medication for this condition? ☐ No ☐ Yes

Asthmatic? Difficulty Breathing? ☐ No ☐ Yes *If yes, notify RN and obtain pulse oximetry* Results _____%

Seizure history ☐ No ☐ Yes, *last seizure* _____
If yes, is the patient taking medication for this condition? ☐ No ☐ Yes, last taken _____

Suspect intoxication? ☐ No ☐ Yes
If yes, notify RN, perform screening test if requested *Results* _____

List any tubes/drains/lines, prosthesis, appliances or ambulatory aides ☐ None

When was your last Meal?

What did you last eat?

Notify RN if intake appears insufficient.
Unless contraindicated, offer fluids / nourishment

Offered ☐ Yes ☐ No ☐ Contraindicated

Patient Response ☐ Accepted ☐ Refused

Visual Body Scan/Search conducted by Signature/title

Clothing/Property searched / secured by Signature/title

Valuables secured by Signature/title ☐ No valuables

Medication(s) secured by Signature/title ☐ No medications

Completed by

MHT Signature _____ Date _____ Time _____

Reviewed by

RN Signature _____ Date _____ Time _____

DMC
DETROIT MEDICAL CENTER

Leon A. Coleman
Director, Accreditation and Compliance

Corporate Audit & Compliance
6071 West Outer Drive
Lourdes Bldg., 7th Floor
Detroit, MI 48235
Phone: (313) 993-0317
Fax: (313) 745-7929

August 25, 2010

Department of Community Health
Bureau of Health Services
611 West Ottawa
1st floor, Ottawa Building
P.O. Box 30664
Lansing, MI 48909
Attn: Richard Benson

Regarding: Harper University Hospital, CMS Provider # 230104

Dear Sirs/Madam:

Attached for filing with your office is the Plan of Correction "PoC" for the deficiency sited by CMS at our April 6, 2010 and June 24, 2010 surveys.

Should you have any questions or concerns regarding the plan of correction, or need any additional information please do not hesitate to contact me.

Sincerely,

Leon A. Coleman

LAC/ams

Attachment(s)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1)PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	230104	A. BUILDING _____ B. WING _____	06/24/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARPER UNIVERSITY HOSPITAL	3990 JOHN R STREET DETROIT, MI. 48201

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	INITIAL COMMENTS Surveyor: 15195 This survey was conducted for the purpose of state monitoring. The department has evaluated and found the facility non-compliant with state licensure and/or federal certification requirements on the dates(s) specified. Harper University Hospital and Hutzel Women's Hospital = Campus A DMC Surgical Hospital = Campus B	A 000		
A 057	482.12(b) CHIEF EXECUTIVE OFFICER The governing must appoint a chief executive officer who is responsible for managing the hospital. This STANDARD is not met as evidenced by: Surveyor: 28267 Based on interview and record review the governing body failed to appoint a single chief executive officer who is responsible for managing the facilities that are under a single CMS Certification Number (CNN). Findings include: On 6/22/10 at approximately 0830 during a visit to Campus B it was stated by staff # M that Campus B has their own President and that they are a separate facility from Campus A. On 6/23/10 at approximately 0900 during the governing body interview when queried about the CEO that was appointed by the governing body to head up both Campus A and Campus B, staff #EE stated "We are not set up that way." On 6/23/10 at approximately 0915 during the governing body interview staff # FF presented a System Executive Organizational Chart that indicated that four (4) different facilities with three (3) different CMS Certification Numbers all had a Senior Vice President over each	A 057	The organization has been restructured effective September 1 2010, such that the President of Campus A is responsible for the management of both Campus A and Campus B. The hospital has appointed a RN to serve as Vice President for Campus B's Administration & Patient Care. The new position will be onsite at Campus B and report to the hospital President in regards to administration issues and to the hospital's VP Patient Care Services in regards to nursing services.	9/1/10

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIERS REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	President	8-25-10

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1)PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	230104	A. BUILDING _____ B. WING _____	06/24/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 057	Continued From page 1 facility and all four (4) then respectively report to a Corporate (System) President/Chief Executive Officer.	A 057		
A 117	482.13(a)(1) PATIENT RIGHTS: NOTICE OF RIGHTS A hospital must inform each patient, or when appropriate, the patient's representative (as allowed under State law), of the patient's rights, in advance of furnishing or discontinuing patient care whenever possible. This STANDARD is not met as evidenced by: Surveyor: 28273 Based on record review and interview, the facility failed to provide all Medicare patients with the "Important Message from Medicare" document. Findings include: Review of records on the Psychiatric Unit at Campus B on 06/23/2010, 3 of 3 Medicare patient's (#29, #77 & #78) records did not contain the "Important Message from Medicare." During interview on 06/23/2010 @ 1300, Employee O confirmed at this time that patient's # 29, #77 and # 78 were all medicare recipients, had been admitted for more than 2 days and that the records did not contain the required document "Important Message from Medicare." She went on to say that she was unfamiliar with the document and had not seen it prior to obtaining one today from patient registration.	A 117	**"Important Message from Medicare" Missing** 1. Implemented process to provide Important Message from Medicare forms to Psychiatric patients. 2. Educated Staff on process. 3. Weekly monitoring done by admitting department manager until compliance is achieved for 6 months. 4. Vice President of Operations/Patient Care Services to ensure findings and action plans presented monthly to Leadership Performance Improvement and Medical Safety Coordinating Committee.	8/9/10 8/6/10 8/20/10
A 123	482.13(a)(2)(iii) PATIENT RIGHTS: NOTICE OF GRIEVANCE DECISION At a minimum: In its resolution of the grievance, the hospital must provide the patient with written notice of its decision that contains the name of the hospital contact person, the steps taken on behalf of the patient to investigate the grievance, the results of the grievance process, and the date of completion. This STANDARD is not met as evidenced by: Surveyor: 28273	A 123		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 123	Continued From page 2 Based on interview, record review and policy review, the facility failed to provide 4 of 11 patients' (#84, #85, #86 & #87) with a written response regarding the resolution of a grievance. Findings include: Meeting with Employee M at Campus B on 06/23/2010 at 1300, she began the interview by stating "I'll just tell you I'm not following the policy." When queried about what she meant by the statement she went on to say that patients had not been sent a letter regarding resolution of their grievance. Review of the files for patients # 84, #86 & #87 confirmed that there were no written responses sent to patients in regards to a resolution of the grievance they filed. Employee M was unable to provide any documentation/file regarding the grievance for patient #85. Review of Detroit Medical Center (DMC) policy on 06/22/2010, Title: Patient & Family Grievance and Complaints Policy No: 1 CLN 033 Effective Date: 07/01/08 reads under Provisions 7. "In matters determined by Patient/Guest Relations (or other appropriate site staff) to be Medical Grievances, including those involving care rendered by a physician, the involved physician management, or facility assigned designee, must send a written response, reviewed by Risk management, to the complainant(s), within 30 days, notifying them of the disposition of their complaint, the name and address of the hospital contact person, the steps taken to review and resolve the complaint and the date of completion."	A 123	**Written Grievance Resolution Response** 1. New Patient Relations Representative hired. 2. Process per Tier 1 policy to be implemented to ensure that medical grievances have a written resolution response. 3. Monthly monitoring by Quality Department until 100% compliance rate is achieved for 6 months. 4. Vice President of Operations/Patient Care Services to ensure findings and action plans presented monthly to Leadership Performance Improvement and Medical Safety Coordinating Committee.	8/16/10 8/25/10 8/25/10
A 143	482.13(c)(1) PATIENT RIGHTS: PERSONAL PRIVACY The patient has the right to personal privacy. This STANDARD is not met as evidenced by: Surveyor: 27408 Based on observation, it was determined that the facility failed to properly protect the privacy of patients who were registered for out patient surgical services in the pre op area on Campus B. Findings include:	A 143		

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	230104	A. BUILDING _____ B. WING _____	06/24/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARPER UNIVERSITY HOSPITAL	3990 JOHN R STREET DETROIT, MI. 48201

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 143	Continued From page 3 During observation on 06/22/10 at 1000 of the pre-op area on Campus B it was determined that the facility posted the patients last name, first initial, age, surgeon's name, and the status of the surgical procedure. Patient names were being utilized and were accessible for public viewing. When the Operating Room Nurse Manager # AA was queried about patient privacy, she indicated that the facility had been posting this identifying information since she had been employed for the facility. The Operating Room Nurse #AA was unable to explain why the monitor was still being used by staff.	A 143	**Patient Privacy in the Pre-Op Area** 1. The surgical Electronic Tracking Board will not display the age of the patient, date of birth or the surgical procedure on the tracking board in the pre-op area.	9/7/10
A 144	482.13(c)(2) PATIENT RIGHTS: CARE IN SAFE SETTING The patient has the right to receive care in a safe setting. This STANDARD is not met as evidenced by: Surveyor: 26222 Based upon observation, interview, and record review, the facility failed to provide a safe environment for patients in the Hemodialysis Unit of Campus A and the Psychiatric Unit of Campus B. Findings include: On 6/22/10 at 10:45 AM during the tour of the Hemodialysis unit at Campus A, it was discovered that batches of bicarbonate to be used in the dialysis solution are not being recorded when mixed. Standard of Practice ANSI/AAMI RD52:2004 states that bicarbonate solutions shall be used within 24 hours of when mixed. Interview with Clinical Manager III confirmed that there is no mixing log for bicarbonate solutions. Daily log sheets available in the unit did not include bicarbonate mixing records. On 6/22/10 at 10:45 AM during the tour of the Hemodialysis unit at Campus A, during an interview with the Clinical Manager III, it was discovered that water hardness is checked monthly and documented on the monthly log sheet. Daily log sheets available in the	A 144	**Hemodialysis Safety: Bicarbonate** 1. Clinical Manager implemented recording of mixing for bicarbonate solutions on daily log. 2. Staff educated by Clinical Manager. 3. Conduct weekly audits by unit management to ensure compliance. 4. Findings and action plans presented to Leadership Performance Improvement and Medical Safety Coordinating Committee monthly and unit PI committee by Clinical Manager. **Hemodialysis Safety:Water Hardness** 1. Clinical Manager implemented water hardening testing daily.	8/19/10 8/27/10 8/30/10 6/23/10

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIERS REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	230104	A. BUILDING _____ B. WING _____	06/24/2010

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A 144	Continued From page 4 unit did not include hardness checks. Standard of Practice ANSI/AAMI RD52:2004 specifies that hardness shall be tested at the end of each treatment day, and that timers shall be checked at the beginning of each day and interlocked with the RO system. On 6/24/10 between 11:30 AM and 2:30 PM based upon observation, it was discovered that the cabinet underneath the hand sink in the Psych Unit of Campus B was unlocked. Chemical cleaners were found to be stored in this cabinet unsecured. Additionally, staff food items were found stored in this cabinet. All other cabinets in the room containing activities supplies were observed locked. Surveyor: 27065 Based on observation, interview and policy review, the facility failed to ensure patient safety by properly securing items in two patient care areas and following policies to reduce the risk of infection in three patient areas. Findings include: On 6/21/10 at 1120 one crumpled-up mask was observed stored with clean patient protective equipment outside patient #3's room on Campus A. Patient #3's door indicated that contact precautions were in effect. These findings were confirmed by staff member WW. On 6/21/10 at approximately 1400 one pair of scissors was observed in the medication cart drawer, on the psychiatric unit at Campus B, with whitish substance on the blades. At the same time, one opened suture removal kit package, containing a scissors and tweezers, was observed.	A 144	2. Selected staff educated by Clinical Manager. 3. Documentation on log sheets is maintained by department. 4. Conduct weekly audits by unit management to ensure compliance 5. Results are reported quarterly to Environment of Care Committee. 6. Findings and action plans presented to Leadership Performance Improvement and Medical Safety Coordinating Committee monthly by Safety Officer and unit PI committee by Clinical Manager. **Unlocked Cabinet Under Sink** 1. Items found in unlocked cabinet were discarded. 2. Had lock installed - WO 15398 **Crumpled Mask** 1. Removed mask from area. 2. Detroit Medical Center Infection Control annual NetLearning competencies completed by all staff. **Disposable supplies** 1. Scissors and tweezers discarded. 2. Daily shift change checklist for Medication Room amended to include checking for any improper items in medication cart.	6/23/10 6/23/10 7/19/10 3rd Quarter 2010 6/29/10 8/6/10 6/21/10 7/1/10 6/21/10 8/19/10

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIERS REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1)PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	230104	A. BUILDING _____ B. WING _____	06/24/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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A 144	Continued From page 5 At 1440 an unsecured metal grate was observed in the patient court yard on the psychiatric unit Campus B. These findings were confirmed by the Vice President of Operations/Patient Care Services for Campus B. Policy 2 IC 033, dated 1/31/07 states: "Disposable supplies are used according to the manufacturer guidelines and not reused." Surveyor: 28267 On 6/21/10 at approximately 1045 during the observational tour an IV cart containing intravenous catheter needles and supplies was found and unattended in patient room 17. In patient rooms (a four bed ward) contained an IV cart that was found unlocked and unattended. Both the IV carts were accessible by patients and/or visitors. These findings were confirmed by staff # F at the time of the findings. Staff # F when queried about the carts being secured stated "the IV carts should be locked at all times unless they are attended by a staff member". Surveyor: 15195 During the observational tour of the 3rd floor postpartum and neonate areas, on 6/21/10 at approximately 1215, an infant old medication cart with neonate intravenous supplies in the utility room was noted to be dirty with brown/orange material. This observation was verified with the Manager Postpartum # J at the time.	A 144	**Unsecured Metal Grate** 1. Secured grate to ground on day of survey. **Unsecured IV cart** 1. Cart locked immediately. 2. Additional IV cart keys ordered and distributed to ED staff. 3. ED Management monitoring cart daily to ensure lock is engaged when not attended. **Old Medication** 1. Old cart removed and discarded.	6/21/10 6/21/10 6/22/10 6/22/10 8/19/10
A 168	482.13(e)(5) PATIENT RIGHTS: RESTRAINT OR SECLUSION The use of restraint or seclusion must be in accordance with the order of a physician or other licensed independent practitioner who is responsible for the care of the patient as specified under §482.12(c) and authorized to order restraint or seclusion by hospital policy in accordance with State law. This STANDARD is not met as evidenced by: Surveyor: 27408	A 168		

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A 168	Continued From page 6 Based on interview and record review, the facility failed to obtain an order for restraints from the attending physician for 1 of 3 (#15) patients restrained. Findings include: Record review of patient #15's open chart revealed that there was an order from the physician's assistant for restraints dated 06/20/10 at 0611 for "soft limb x 2" (restraints). The attending physician failed to complete the restraint order. Interview with the Vice President of Outpatient Services on 6/24/10 on at 1130, confirmed that the order needed to be co signed by the attending physician and was incomplete for patient #15.	A 168	**Physician Restraint Orders:** 1. Rotating ICU Physicians educated monthly on restraint order requirements. 2. Policy 1CLN 008 Restraint Use Adult (Non-Psychiatric Setting) changed to "only physicians can order restraints". 3. Electronic Medical Record (EMR) updated to restrict restraint ordering to physicians only. RN/NP/PA may obtain a verbal or phone order for initial restraint application from the attending physician. 4. Subsequent EMR restraint renewal orders are the responsibility of the attending physician 5. Audit compliance with restraint orders monthly. 6. Vice President Medical Affairs (VPMA) to present findings and action plans to Leadership Performance Improvement and Medical Safety Coordinating Committee and Medical Staff Operating Committee monthly.	5/2010 9/1/10 9/14/10 9/14/10
A 386	482.23(a) ORGANIZATION OF NURSING SERVICES The hospital must have a well-organized service with a plan of administrative authority and delineation of responsibilities for patient care. The director of the nursing service must be a licensed registered nurse. He or she is responsible for the operation of the service, including determining the types and numbers of nursing personnel and staff necessary to provide nursing care for all areas of the hospital. This STANDARD is not met as evidenced by: Surveyor: 28267 Based on interview and record review the facility failed to ensure the organization of a single hospital-wide nursing service under the direction of one Registered Nurse (RN). Findings include: On 6/22/10 at approximately 0830 during a visit to Campus B it was stated by staff # M that Campus B has is a separate facility from Campus A. In addition staff #	A 386	**One Director of Nursing Services** The organization has been restructured effective September 1 2010, such that the President of Campus A is responsible for the management of both Campus A and Campus B. The hospital has appointed a RN to serve as Vice President for Campus B's Administration & Patient Care. The new position will be onsite at Campus B and report to the hospital President in regards to administration issues and to the hospital's VP Patient Care Services in regards to nursing services.	9/1/10

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A 386	Continued From page 7 M stated "I am the CNO for this facility and I report to the President." On 6/23/10 at approximately 1200 upon review of the document titled "Corporate Nursing Organization Chart" with staff # UU. When staff # UU was queried regarding the set up and reporting structure, she indicated that the corresponding Chief Nursing Office at Campus A and Campus B report to their President at the respective campus. In addition, the Chief Nursing Officer at Campus A and the one at Campus B report to a corporate Chief Nursing Officer.	A 386		
A 450	482.24(c)(1) MEDICAL RECORDS SERVICES All patient medical record entries must be legible, complete, dated, timed, and authenticated in written or electronic form by the person responsible for providing or evaluating the service provided, consistent with hospital polices and procedures. This STANDARD is not met as evidenced by: Surveyor: 28267 Based on record review and interview the facility failed to ensure that 4 of 4 (#31, #39, #45, #83) hard copy medical records were complete, accurate, and legible. Findings include: On 6/21/10 at approximately 1500 during an observational tour and medical record review of open charts on unit 4-WS (neuroscience) the medical record of patient # 39 consisted of the following incomplete and inaccurate medical records: The form titled "Resuscitation Designation Order Form" was placed in the patients chart and was not filled out. Staff # Y stated that if this form is not filled out sometimes a note will be in the physician's progress note. After reviewing the physician's progress notes Staff # Y stated that no discussion was noted in the progress notes either.	A 450	**Blank Resuscitation Designation Order Form** 1. VPMA to educate physicians and LIPs to complete resuscitation form on inpatients through physician newsletter, posters in Doctors' Lounge, elevator tip sheets, Doctors' Dining Room table cards, and Medical Staff Operations Committee. 2. Quality & Compliance to audit resuscitation designation forms completion compliance monthly. 3. VPMA to present findings and action plans to Leadership Performance Improvement and Medical Safety Coordinating Committee and Medical Staff Operating Committee monthly.	9/15/10

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A 450	Continued From page 8 A form titled "Acknowledgement of Advance Directive for Health Care" was found in patient #39's medical record and was absent of documentation and belonged to patient #45's medical record. This finding was confirmed by staff # Y at the time of the finding. The medical staff by laws rules and regulations document indicates under section Q titled "Code Status and Advance Directives", "Code status and advance directive, if known, must be designated on all patients when admitted, in accord with DMC policy. In the event of a code change, documentation must be present to indicate the reason for change." Surveyor: 28273 Based on record review and interview the facility failed to ensure that 1 of 4 (#31) hard copy medical record was complete, accurate, and legible. Findings include: During record review (of expired patient # 31) at Campus A on 06/21/2010 at 1400, a document dated 02/14/2010 titled "Patient Expiration Form" was incomplete. The area for documentation of "Authorization to Release Body and Body Released by" were left blank. Interview with Employee P at the time of record review, she stated that the document should have been completed by staff when the body was released.	A 450	**Blank & Misfiled Acknowledgement of Advance Directive for Health Care Form** 1. Registration Director to educate staff on form completion requirements. 8/23/10 2. Monthly audit conducted by department management. 9/1/10 3. Findings and action plans presented to Leadership Performance Improvement and Medical Safety Coordinating Committee monthly and department staff. **Patient Expiration Form section: Authorization to Release Body and Body Released By** 1. Process revised: HIM to notify Security when Funeral Home arrives to pick up patient. Security will pick up Patient Expiration Form from HIM and escort Funeral Home staff sign form after body released. Security will return form to HIM. 9/30/10 2. Revise 3 HUHHWH CLN 8410 Post Mortem policy. 9/7/10 3. Security and HIM Directors to educate staff 8/30/10 4. Audit conducted by HIM management monthly. 5. Findings and action plans presented to Leadership Performance Improvement and Medical Safety Coordinating Committee monthly and department staff.	
A 466	482.24(c)(2)(v) CONTENT OF RECORD-INFORMED CONSENT [All records must document the following, as appropriate:] Properly executed informed consent forms for procedures and treatments specified by the medical staff, or by Federal or State law if applicable, to require	A 466		

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A 466	Continued From page 9 written patient consent. This STANDARD is not met as evidenced by: Surveyor: 28267 Based on record review and interview the facility failed to ensure that a properly executed informed consent procedure was followed in 3 of 14 (#38, #57, #59) patient's medial records. Findings include: On 6/21/10 at approximately 1500 during an observational tour and medical record review of open charts on unit 4-WS (neuroscience) the medical record of patient # 38 consisted of a form titled "Consent for Surgery, Invasive and/or Diagnostic Procedures, Anesthesia, and/or Blood Transfusion" which is the form the facility utilized for evidence of the informed consent process contained under the section titled "The procedure(s) is (are): B Sphenoidal. Staff # DD stated that the procedure was the "placement of bilateral sphenoidal electrodes" and that the procedure wasn't written out like it was suppose to be, this finding was also confirmed by Staff # F. The policy # 1 CLN 006 titled "Informed Consent for Medical/Surgical Treatment, and Diagnostic Procedure does not contain specific instructions to indicate writing out the specific procedure to be performed and consent to be given.	A 466	**Informed Consent** 1. Revised policy 1 CLN 006 Informed Consent for Medical/ Surgical Treatment, and Diagnostic Procedure to include writing out the specific procedure to be performed. 2. VPMA to educate physicians and LIPs to complete consent correctly through physician newsletter, posters in Doctors' Lounge, elevator tip sheets, Doctors' Dining Room table cards, and Medical Staff Operations Committee. 3. Department of Anesthesia to audit consents monthly. 4. Findings and action plans presented to Leadership Performance Improvement, Surgical Committee, and Medical Safety Coordinating Committee and Medical Staff Operating Committee monthly by VPMA.	9/1/10 9/15/10
A 491	482.25(a) PHARMACY ADMINISTRATION The pharmacy or drug storage area must be administered in accordance with accepted professional principles. This STANDARD is not met as evidenced by: Surveyor: 27065 Based on observation, interview and policy review, the facility failed to ensure that medications dispensed to discharged patients were not stored on the medication cart on one unit. Findings include:	A 491		

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A 491	Continued From page 10 Policy 2 MED 300 states: "There must be regular inspection of mediations stored in patient care areas of the hospitals and clinics with the purpose of determining proper labeling, product stability, product safety, and proper storage condition." The policy states that a pharmacist or designee is responsible for inspections in all areas were medications are stored. On 6/21/10 at approximately 1400, inspection of the medication cart on the psychiatric unit on Campus B, revealed medications dispensed to five discharged patients (#66, #67, #68, #69 and #70). The Coordinator of Pharmacy Services at Campus B confirmed these findings and stated that she did not know who was responsible for removing these items from the medication cart. In addition, one Advair Diskus 100/50 with no patient name was noted. These findings were confirmed by the Vice President of Operations/Patient Care Services for Campus B.	A 491	**Patient Medications** 1. Revised Discharge Form to add Medication cart checked for home medication. 2. Educated staff by department management. 3. Revised process for returning patient home medications on discharge. 4. Process implemented by pharmacy to label Advair Diskus 100/50 with patient name. 5. Weekly auditing by Quality Department for 6 months. 6. Vice President Operations/Patient Care Services to ensure findings and action plans presented monthly to Leadership Performance Improvement and Medical Safety Coordinating Committee.	8/5/10 8/11/10 8/11/10 6/25/10 8/13/10
A 700	482.41 PHYSICAL ENVIRONMENT 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: Surveyor: 15195 The facility failed to provide and maintain a safe environment for patients and staff. This is evidenced by the Life Safety Code deficiencies identified. See A-710.	A 700	See A-710	
A 701	482.41(a) MAINTENANCE OF PHYSICAL PLANT The condition of the physical plant and the overall	A 701		

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A 701	Continued From page 11 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 evidence by: Surveyor: 26222 Based upon observation and record review, the facility failed to maintain the hospital environment to assure the safety of patients. Findings include: On 6/22/10, 6/23/10, and 6/24/10 between the hours of 8:00 AM and 3:00 PM, based upon observation, it was discovered that coffee dispensing machines in patient pantries throughout Campus A are not equipped with proper backflow prevention devices on water inlet lines. On 6/22/10 between the hours of 9:00 AM and 3:00 PM, it was discovered through observation that weekly testing logs for eyewash stations located in 8 Webber South (8WS) soiled utility room and 6 Webber South Mechanical Room of Campus A are not being completed on a regular basis. Facilities Manager # FFF confirmed that the eyewash station in 8WS is not needed in that location. On 6/22/10 at 1:50 PM, based upon observation, it was discovered that plastic laminate is damaged at charting stations on 4 Webber South, and at the 4ICU Nurse Station in Campus A. On 6/22/10 at 2:00 PM, based upon observation, it was discovered that the exhaust in the toilet room in Exam Room 7 and the toilet room adjacent to Exam Room 6 in 3-Labor Reception Center (LRC) at Campus A is not functioning. On 6/22/10 at 2:30PM, based upon observation, it was discovered that the Respite Nurseries are being used for storage on 2 Webber North of Campus A (Rooms 2235 and 2227). Clinical Manager JJJ stated during interview 6/22/10 at 2:40 PM that nurseries are rarely used because most babies room-in with the mothers, and that Room 2227 is never used for babies, and sometimes room 2235 is used for babies if needed.	A 701	**Coffee Dispensing Machines** 1. Equipped coffee dispensing machines in patient pantries with proper backflow prevention devices on water inlet lines. **Eyewash Stations** 1. Removed 8WS eyewash station. 2. Weekly eyewash station testing procedure for 6WS Mechanical Room reviewed & station added to Inventory List. 3. Facilities management educated staff and is monitoring completion of log monthly. **Plastic Laminate** 1. Repaired plastic laminate at charting stations on 4 Webber South. 2. Repair plastic laminate at the 4ICU Nurse Station. **Exhaust in Toilet Room** 1. Repaired exhaust in toilet room of exam room #7 and toilet room adjacent to exam room #6 in 3-LRC. **Respite Nurseries** 1. Removed file cabinets/chair in Respite Nurseries on 2WN. Areas to remain as Respite Nurseries.	7/15/10 7/15/10 8/19/10 8/19/10 8/25/10 8/27/10 7/15/10 7/14/10

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A 701	Continued From page 12 On 6/22/10 at 2:15 PM, based upon observation, it was discovered that the ice machine located in the Pantry of Labor and Delivery/LDRP (Campus A) has a drain line for the ice bin that is directly connected to the waste drain. On 6/23/10 between 8:30 AM and 9:30 AM, based upon observation, it was discovered that the kitchen of Campus A has damage in the following areas, walls at cart washing, walls outside of pot/pan washing, coving tiles at cart storage, coving and floor tiles in walk-in-cooler corridor. On 6/23/10 at 10:45 AM, based upon observation, it was discovered that the walls are damaged in the transportation storage and Environmental Services Equipment Room (Campus A). On 6/23/10 at 11:00 AM, based upon observation, it was discovered that there is debris accumulation on the floor of the walk in cooler in the central pharmacy of Campus A. On 6/23/10 at 12:45 PM, based upon observation, the following areas were observed damaged in the Laboratory Department of Campus A: Plastic laminate countertops of HLA, Biochemical genetics, blood bank, specimen processing, stat lab, and flow cytometry. Drywall damage was observed in blood bank (adjacent to tube station) and specimen processing (behind hand sink). On 6/24/10 between 8:00 and 9:00 AM, based upon observation it was discovered that the following areas of the Surgery Department of Campus A are damaged: cabinet and door frame damage throughout cores 1,2, and 3. On 6/24/10 between 11:30 AM and 2:30 PM, based upon observation and record review it was discovered that eyewash stations are not being tested on a weekly basis in the following locations of Campus B: Exam room 1 of the emergency department and housekeeping room 1043. On 6/24/10 between 11:30 AM and 2:30 PM, based upon observation it was discovered that there is the	A 701	**Ice Machine** 1. Repaired ice machine drain line for ice bin located in the pantry of Labor and Delivery/LDRP. **Main Kitchen** 1. Repair Kitchen (Main) walls at cart wash and walls outside of pot/pan wash area. 2. Repair cove tiles at cart storage, cove and floor tiles in walk-in-cooler corridor. **Repaired Walls** 1. In the transportation storage room 2. In EVS equipment room **Cleaned Debris** 1. On the floor of the walk-in cooler in central pharmacy. **Plastic Laminate** Repair plastic laminate countertops are damaged in the following areas: HLA Lab, Biochemical genetics, Blood Bank, Specimen Processing, Stat Lab, and Flow Cytometry. **Repair Drywall** 1. Repair drywall in blood bank 2. Repair drywall Specimen processing. **Surgery Department Repairs** 1. Repair damaged cabinets, door frames, throughout Cores 1, 2 and 3 in Surgery Department (OR Suite). **Eyewash Station Testing** 1. Emergency department and	7/15/10 8/27/10 9/15/10 7/15/10 8/23/10 6/24/10 9/15/10 8/27/10 8/27/10 9/6/10

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A 701	Continued From page 13 following physical facilities damage in Campus B: holes underneath hand sinks in ED exam rooms and ortho Clean Utility room; countertop damage in Radiology X-Ray 1 held together with tape; damaged flooring in Pantry of Psych Unit; coffee cart damaged in Pantry of Psych Unit; plastic laminate damage at hand sink in lab; countertop backsplash damage at dirty sink in lab; wall damage in main kitchen where papers have been taped to the wall; plastic laminate damage at beverage station in main kitchen. On 6/24/10 between 11:30 AM and 2:30 PM, based upon observation, debris accumulation was discovered in the following areas of Campus B: behind ice machine of pantry in Psych Unit; in kitchen: underneath crates used for shelving, underneath cookline prep sink on the PVC drain line and flooring; in walk-in-freezer; and in the floor drain at the 3 compartment sink. On 6/24/10 between 11:30 AM and 2:30 PM, based upon observation it was determined that chemical dispensing units are attached to mop sink faucets in housekeeping rooms (Rooms 1012, 1043 and 1061) throughout Campus B. This set-up results in shut off valves being located downstream of the built in atmospheric vacuum breaker (AVB) subjecting AVB to constant pressure.	A 701	housekeeping management educated staff and monitoring completion of log. 2. Department management monitoring log for weekly documentation. **Repairs** 1. Repaired holes underneath hand sinks in ED exam rooms - WO 15435 2. Repaired Ortho Clean Utility room - WO 15434 3. Repaired Countertop damage in Radiology X-Ray 1 - WO 15399 4. Repaired Damaged flooring in Pantry of Psych Unit – WO 15402 5. Repaired Plastic laminate at hand sink in lab and countertop backsplash damage at dirty sink in lab – WO 14810 6. Repaired Wall damage in main kitchen – WO 15404 7. Repaired Plastic laminate at beverage station in main kitchen – WO 15403 8. Cleaned behind ice machine of pantry in Psych Unit, underneath cook line prep sink on PVC drain line and floor, walk-in-freezer, and floor drain at the 3 compartment sink. 9. Installed shelving in kitchen. 10. Installed water wasting tee's in Rooms 1012, 1043 and 1061 housekeeping closets. WO 15422	6/25/10 6/25/10 7/28/10 7/29/10 7/30/10 8/18/10 7/28/10 7/27/10 7/28/10 7/28/10 8/2/10 7/20/10
A 710	482.41(b)(1)(2)(3) LIFE SAFETY FROM FIRE (1) Except as otherwise provided in the section – (i) The hospital must meet the applicable provisions of the Life Safety Code of the National Fire Protection Association. The Director of the Office of the Federal Register has approved the NFPA 101 2000 edition of the Life Safety Code, issued January 14, 2000, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR Part 51. A copy of the Code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to:	A 710		

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A 710	Continued From page 14 http://ww.archives.gov/federal_register/code_of_federal_regulations/ibr_lovations.html Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Qunicy, MA 02269. if any changes in the edition of the Code are incorporated by reference, CMS will publish notice in the Federal Register to announce the changes. (ii) Chapter 19.3.6.3.2, exception number 2 of the adopted edition of the LSC does not apply to hospitals. (2) After consideration of State Survey agency findings, CMS may waive specific provisions of the Life Safety Code which, if rigidly applied, would result in unreasonable hardship upon the facility, but only if the waiver does not adversely affect the health and safety of the patients. (3) The provisions of the Life Safety Code do not apply in a State where CMS finds that a fire and safety code imposed by State law adequately protects patients in hospitals. This STANDARD is not met as evidenced by: Surveyor: 15191 Based upon on-site observation and document review by Life Safety Code (LSC) surveyors on June 21-24, 2010, the facility does not comply with the applicable provisions of the 2000 Edition of the Life Safety Code. See the K-tags on the CMS-2567 dated June 24, 2010, for Life Safety Code.	A 710		
A 724	482.41(c)(2) FACILITIES, SUPPLIES EQUIPMENT MAINTENANCE Facilities, supplies, and equipment must be maintained to ensure an acceptable level of safety and quality. This STANDARD is not met as evidenced by: Surveyor: 27408 Based on observation and interview the facility failed to ensure that Glucometer test strips and control solutions	A 724		

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A 724	Continued From page 15 bottles (supplies) were kept current and not outdated. Findings include: On tour of the Pre-operative holding area on 6/22/10 at 1000 on Campus B, it was observed that the glucometer test strips were not dated when they were opened, and the control solutions bottles were outdated on 6/11/10. Nurse Manager #AA confirmed these findings.	A 724	**Glucometer Test Strips and control solutions** 1. Quality Department developed a checklist for Point of Care supply dating, including glucometer test strips and control solutions bottles. 2. Department management educated staff. 3. Point of Care Coordinator to audit monthly. 4. Vice President Operations/Patient Care Services to ensure findings and action plans presented monthly to Leadership Performance Improvement and Medical Safety Coordinating Committee.	7/23/10 7/27/10 8/4/10
A 726	482.41(c)(4) VENTILATION, LIGHT, TEMPERATURE CONTROLS There must be proper ventilation, light, and temperature controls in pharmaceutical, food preparation, and other appropriate areas. This STANDARD is not met as evidenced by: Surveyor: 26222 Based upon observation, the facility failed to provide proper lighting in patient care and food preparation areas. Findings include: On 6/23/10 between 8:30 AM and 9:30 AM based upon observation it was discovered that the kitchen of Campus A has lighting levels in all walk-in-coolers below the minimum 20 foot-candles of illumination (Illuminating Engineering Society of North America, IESNA Publication CP29, Lighting for Heath Facilities). On 6/22/10 at 2:15 PM based upon observation lighting at hand sinks in Rooms 3412 and 3212 of Campus A were recorded at 14 and 20 foot-candles, respectively. This is below the minimum 30 foot-candles of illumination required (Illuminating Engineering Society of North America, IESNA Publication CP29, Lighting for Heath Facilities). On 6/23/10 at 11:30 AM based upon observation,	A 726	**Lighting** 1. Restored lighting in Kitchen walk-in coolers to minimum 20 foot-candles of illumination. WO #327997 2. Restored lighting at hand sink in room 3212 to minimum 30 foot-candles of illumination WO #327996. 3. Restored lighting at hand sink in room 3412 to minimum 30 foot-candles of illumination WO #327995	8/25/10 7/20/10 7/19/10

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A 726	Continued From page 16 lighting levels at hand sinks in Diagnostic and Evaluation and Emergency Department South of Campus A are below the 30 foot-candles of illumination required. Lighting levels recorded at 14 foot-candles. On 6/23/10 at 1:30 PM, based upon observation, the cardiac cath lab 3 scrub sink lighting level was recorded at 35 foot-candles; minimum required level is 75 foot-candles (IESNA Publication CP29). On 6/24/10 at 9:00 AM, based upon observation it was discovered that the hand sink in the Central Sterile Processing (located in the basement level of Detroit Receiving Hospital) had lighting levels less than the 30 foot-candles minimum required (IESNA Publication CP29). On 6/24/10 between 11:30 AM and 2:30 PM based upon observation it was discovered that the hand sinks in the cardiac room of the Emergency Department of Campus B were recorded at 14 and 18 foot-candles; lighting levels at the hand sink in the Psych unit Activities room were recorded at 7 foot-candles. (30 foot-candles required, IESNA Publication CP29).	A 726	4. Restored lighting at hand sinks in D/E and Emergency Department South to minimum 30 foot-candles of illumination WO #327998 5. Restored lighting at scrub sinks in Cardiac Cath Lab #3 to minimum 75 foot-candles of illumination WO # 327999 6. Restored lighting at hand sinks in the Central Sterile Processing to minimum 30 foot-candles of illumination. 7. Restored lighting at hand sinks in the cardiac room of the Emergency Department of Campus B to minimum 30 foot-candles of illumination WO #15391	7/19/10 8/27/10 7/12/10 7/28/10
A 747	482.42 INFECTION CONTROL The hospital must provide a sanitary environment to avoid sources and transmissions of infections and communicable diseases. There must be an active program for prevention, control and investigation of infections and communicable diseases. This CONDITION is not met as evidenced by: Surveyor: 26222 Based upon observation and interview, the facility failed to provide a sanitary environment and avoid sources of transmission in 6 of 6 Endoscopy Procedure Rooms at Campus A, and the kitchen of Campus A and Campus B. This practice could affect all patients of the Endoscopy suite in Campus A, as well as all patients served food from the kitchens of Campus A and Campus B. Findings include:	A 747	8. Restored lighting at hand sinks in Psych Unit Activities Room to minimum 30 foot-candles of illumination WO #15392	7/30/10

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A 747	Continued From page 17 On 6/23/10 at 11:30 AM during the tour of the Endoscopy Decontamination Room, it was discovered that scopes used in procedures are gross cleaned in the procedure room prior to be being brought into the decontamination room. Sinks in the Procedure Rooms were observed to have the soap and paper towel dispensers removed. Interview with Staff # LLL on 6/23/10 at 11:30 AM confirmed that sinks in the Procedure Rooms are no longer used for handwashing, and are dedicated to cleaning of scopes. Staff # LLL stated that staff used a handwashing sink located in an alcove in the corridor for handwashing purposes. Facilities Manager # FFF confirmed that soap and paper towel dispensers were removed to dedicate sinks within the rooms for scope cleaning, and handwashing sink in the corridor was installed for staff in this area. On 6/23/10 between 8:30 AM and 9:30 AM, based upon observation, it was determined that a drain fly infestation is present in the dish machine area and cart washing area of the kitchen of Campus A. Drain flies were observed flying around in these areas. Bio-film accumulation was observed in floor drains in these areas, which are breeding grounds for these files. On 6/23/10 between 8:30 AM and 9:30 AM, based upon observation, a food preparation employee in the kitchen of Campus A was observed adjusting their hair net and continuing food preparation activities without performing hand hygiene. General Manager KKK addressed the employee, and the employee washed hands immediately. On 6/24/10 between 1:50 PM and 2:30 PM, based upon observation a dishwashing employee at Campus B was observed handling dirty dishes and clean dishes without handwashing in between tasks.	A 747	**Hand Washing Sinks** 1. Installed hand sinks with soap and paper towel dispensers in each room. **Cleaning Needed** 1. Treat dish machine and all kitchen floor drains monthly to remove fly infestation and biofilm accumulation. WO#328003. 2. Food Service Management to monitor daily and report to facilities if any additional treatment necessary. 3. Facilities to monitor drains monthly. **Hand Hygiene Campus A** 1. Department Management educated all employees on hand hygiene. 2. Audit conducted by department management monthly . 3. Findings and action plans presented to Leadership Performance Improvement and Medical Safety Coordinating Committee monthly and department staff. **Hand Hygiene Campus B** 1. Department management educated staff on separating clean and dirty	8/25/10 8/25/10 8/25/10 6/28/10 6/24/10

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A1002	Continued From page 18 482.52(b)(1) PRE-ANESTHESIA EVALUATION Anesthesia services must be consistent with needs and resources. Policies on anesthesia procedure must include the delineation of pre-anesthesia and post-anesthesia responsibilities. The policies must ensure that the following are provided for each patient: Anesthesia services must be consistent with the needs and resources. Polices on anesthesia procedures must include the delineation of pre-anesthesia and post-anesthesia responsibilities. The policies must ensure that the following are provided for each patient: This STANDARD is not met as evidenced by: Surveyor: 27408 Based on records reviewed and interview the agency failed to follow their pre-anesthesia policy for 1 of 2 (patient # 50) records reviewed. Findings include: During record review on 6/22/10 at Campus B, it was revealed that in the pre-op holding area patient # 50's chart was reviewed. The anesthesiologist had pre-signed the "I was present for induction" area on the form titled "Anesthesia Record" when the patient hadn't even been back to surgery. The "Anesthesia Record" form did not contain a patient name, date, or any other identifiers. This was confirmed by the nurse administrator of Campus B on 6/22/10 at 1100.	A1002	processes. 2. Audit conducted by department management monthly. 3. Findings and action plans presented to Leadership Performance Improvement and Medical Safety Coordinating Committee monthly and department staff. **Anesthesia Record Pre-signed** 1. Anesthesiology staff re-educated about "Present on Induction" documentation, even for local cases, and labeling of form. 2. Audit conducted by department management monthly. 3. Vice President Operations/Patient Care Services to ensure findings and action plans presented monthly to Leadership Performance Improvement and Medical Safety Coordinating Committee monthly.	6/29/10 7/2/10
A1005	482.52(b)(3) OUTPATIENT POST-ANESTHESIA EVALUATION [The policies must ensure that the following are provided for each patient:] A post-anesthesia evaluation completed and documented by an individual qualified to administer anesthesia, as specified in paragraph (a) of this section, no later than 48 hours after surgery or a procedure requiring anesthesia services. The post-anesthesia evaluation for anesthesia recovery must be completed in accordance with State law and with hospital policies	A1005		

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A1005	Continued From page 19 and procedures, which have been approved by the medical staff and which reflect current standards of anesthesia care. This STANDARD is not met as evidenced by: Surveyor: 27408 Based on records reviewed and interview the facility failed to ensure a post anesthesia evaluation had been documented within 48 hours after surgery for 1 of 13 (patient # 55) records reviewed. Findings include: MR #55: The patient had surgery on 06/02/10. During the review of the clinical record on 6/22/10, it was noted a 48 hour post anesthesia evaluation had not been completed. Request for the nursing unit's clinical supervisor to look for the presence of the post anesthesia evaluation on the clinical record produced no document confirming such. These findings were discussed with the hospitals leadership team during the exit conference on 6/22/10 at Campus B.	A1005	**Post Anesthesia Documentation** 1. Anesthesia staff educated by Specialist in Chief on documentation requirements. 2. Audit conducted by department management monthly. 3. Findings and action plans presented monthly to Leadership Performance Improvement and Medical Safety Coordinating Committee.	6/29/10
A1100	482.55 EMERGENCY SERVICES The hospital must meet the emergency needs of patients in accordance with acceptable standards of practice. This CONDITION is not met as evidenced by: Surveyor: 28267 Based on record review and interview the facility failed to meet the patient's pain and vital sign needs in the Emergency Department at Campus B. Findings include: On 6/22/10 at approximately 0930 during an observational tour and open medical record review at Campus B emergency department the following 3 out of 4 patients (#41, #42, #43) pain needs were not met: Patient #41 came into the ED with a left little finger injury. A thorough pain assessment was not completed	A1100	**Emergency Department Pain Assessment & Management** 1. Department Manager re-educated ED staff to Policy 2 ED 047 Patient Assessment Documentation. 2. Manager monitoring compliance	6/23/10 6/28/10

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A1100	Continued From page 20 but there was documentation that her finger was "aching". No pain medication was administered in the emergency department or no reassessment of pain prior to discharge. Patient #42 came into the ED with a complaint of chest pain and left arm pain. The patient was admitted into the ED at 1357 and his pain was assessed, the patient rated his pain a 5 out of 10. The patient was then discharged at 1543 with no reassessment of pain and no medication was administered to the patient for pain during his admission. Patient #43 came into the ED with a complaint of acute back pain. The patient's pain was assessed upon admission into the ED 2257 and had rated her pain as a 7 out of 10 then her pain was reassessed again at 2312 and the patient rated her pain as a 5 out of 10. The patient was discharged from the emergency department within 22 minutes and no documentation that the patient's complaint of pain was addressed. On 6/23/10 at approximately 1015 upon review of the facility policy and procedure titled "Pain Management" Policy No. 1 CLN 043 under the section titled Policy has documented "All patients will have their pain assessed and managed." On 6/22/10 at approximately 0930 during an observational tour and open medical record review at Campus B emergency department the following 2 of 2 (#42, #44) out of a total sample of 4 emergency department patients vital signs were not taken within one hour of their discharge as follows: Patient #42 was admitted into the Emergency Department at 1357 and discharged at 1543. The only set of vital signs documented was at 1357. Patient #44 was admitted into the Emergency Department at 2037 and discharged at 2245. The only	A1100	weekly until 100% compliant for 6 months. 3. Vice President Operations/Patient Care Services to ensure findings and action plans presented monthly to Leadership Performance Improvement and Medical Safety Coordinating Committee and ED staff. **Emergency Department Vital Signs** 1. Department Manager re-educated ED staff to Policy 2 ED 047 Patient Assessment Documentation. 2. Manager monitoring compliance weekly until 100% compliant for 6 months. 3. Vice President Operations/Patient Care Services to ensure findings and action plans presented monthly to Leadership Performance Improvement and Medical Safety Coordinating	6/23/10 6/28/10

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A1100	Continued From page 21 set of vital signs documented was at 2041. On 6/23/10 at approximately 1015 upon review of a facility policy and procedure titled "Patient Assessment, Documentation/Data Collecting" has documented under the section Provision the following: number 4 – "Vital Signs may include temperature, respiratory rate, pulse, blood pressure, pain, Glasgow Coma Score (GSC) and Capillary Blood Glucose." and number 5. stated "All patients discharged from the emergency department must have vital signs taken within one hour prior to discharge, transfer, or admission. The above findings were witnessed and confirmed at the times posted above by staff # M.	A1100	Committee and ED staff.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
K 000	INITIAL COMMENTS Surveyour:13546 This Federal Monitoring Life Safety Code (LSC) survey was conducted on 06/21, 23, 24/2010 between the times of 9:00 AM and 5:00 PM. The 2000 edition of the LSC (NFPA 101), existing section, was used in conjunction with the requirements of 42 CFR 483.70 (a). The facility does not meet the standard. The survey consisted of the main building Harper University Hospital located in Detroit, This will be known as building 1. Also surveyed was DMC Surgery Center located in Madison Heights. This will be known as building 2. The building details are as follows. Building 1 Harper-construction type: 10-stories Type II (222). The building is partially sprinkler protected. The facility has a total capacity of 506 beds at the time of the survey and was at full capacity during the survey. Building 2 DMC Surgery-construction type: Type I (332). Building is fully sprinkled and has a total capacity of 36 beds at the time of the survey.	K 000		
K 017	NFPA 101 LIFE SAFETY CODE STANDARD Corridors are separated from use areas by walls constructed with at least ½ hour fire resistance rating. In sprinklered buildings, partitions are only required to resist the passage of smoke. In non-sprinklered buildings, walls properly extend above the ceiling. (Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Charting And clerical stations, waiting areas, dining rooms, and activity spaces may be open to the corridor under certain conditions specified in the Code. Gift shops may be separated from corridors by non-fire rated walls if the	K017		

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Name	President	8·25·10

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	230104	A. BUILDING 01 – Harper University Hospital B. WING _____	06/24/2010

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K 017	Continued From page 1 gift shop is fully sprinklered.) 19.3.6.1, 19.3.6.2.1, 19.3.6.5 This STANDARD is not met as evidenced by : Surveyor: 18760 Based on observation it was determined that the facility failed to provide corridor walls that could provide at least 30 minute fire-resistance rating in accordance with the LSC section 19.3.6.1, 19.3.6.2.1. This deficient practice could potentially affect all occupants of the facility. Findings include: On 06/23/10 the following observations were made: At approximately 10:40 AM, Observed an unsealed penetration (approximately 1/8" wide) in the Brush Building basement corridor, above the ceiling tile, above the door marked 6870A. This penetration would not prevent the spread of smoke and heat into the corridor wall. These findings were observed and confirmed by the Facility Maintenance Director during the inspection.	K 017	Sealed penetration above the ceiling, above door marked 6870A to prevent the spread of smoke and heat into the corridor (K-017.1)	8/25/10
K 018	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 13/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities.	K 018		

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K 018	Continued From page 2 This STANDARD is not met as evidenced by: Surveyor: 18760 Based on observation the facility failed to provide corridor doors that would close and resist the passage of smoke and/or able to provide a positive latch in accordance with the LSC section 19.3.6.3. This deficient practice could potentially affect all occupants of the facility. Findings include: On 06/24/2010, the following observations were made: At approximately 11:35 AM, Observed an unsealed penetration (approximately ¼" wide) in the corridor door leading to the Radiology Reception, across from room G252. This penetration would not prevent the spread of smoke and heat into the corridor. These findings were observed and confirmed by the Corporate Fire Safety Inspector. Surveyor: 27171 Based on observation the facility failed to provide corridor doors that would close and resist the passage of smoke and/or able to provide a positive latch in accordance with the LSC section 19.3.6.3. This deficient practice could potentially affect all occupants of the facility. Findings include: On 06/24/2010, the following observations were made: At approximately 11:14 AM, Observed that the West door to the 10th floor Pantry (Webber South Bldg.) did not fully close to a positive latch. These findings were observed and confirmed by the Corporate Plant Operations Manager.	K 018	Sealed penetration in corridor door leading to Radiology Reception, across from room G252 to prevent the spread of smoke and heat into the corridor (K-018.1) Adjusted closer on 10th floor Pantry to fully close to a positive latch (K-018.2)	8/25/10 8/25/10
K 020	NFPA 101 LIFE SAFETY CODE STANDARD	K 020		

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K 020	Continued From page 3 Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least one hour. An atrium may be used in accordance with 8.2.5.6. 19.3.1.1. This STANDARD is not met as evidenced by: Surveyor: 13546 Based on observation the facility failed to provide 1-hour fire resistive separation for the vertical openings in accordance with the LSC section 19.3.1.1. This deficient practice could potentially affect ALL occupants of the facility. On 06/21/2010, the following observations were made: At approximately 11:14 AM, Observed that the stairwell door HAR-42 is sticking and does not fully close to a positive latch. This penetration would allow smoke and heat to enter the stairwell. These findings were observed and confirmed by the Corporate Facility Director. Surveyor: 18760 Based on observation the facility failed to provide 1-hour fire resistive separation fro the vertical openings in accordance with the LSC section 19.31.1. This deficient practice could potentially affect All occupants of the facility. Findings include: On 06/23/2010, the following observations were made: At approximately 9:45 AM, Observed an unsealed conduit penetration (approximately ½" wide) protruding through the 2-hr fire, wall above the door to exit access stairwell HUH-47 (2nd floor Brush Bldg. This penetration would allow smoke and heat to enter the stairwell. These findings were observed and confirmed by the Corporate Plant Operations Manager.	K 020	Adjusted all doors along stairwell HAR-42 to fully close to a positive latch (K-020.1) Sealed penetration protruding through 2-hr fire wall above door to stairwell HUH-47 to prevent the spread of smoke and heat into the stairwell (K-020.2)	8/23/10 8/25/10

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K 020	Continued From page 4 Stairwell door HUH-32 (Webber North Bldg.) at room 3502 did not fully close to a positive latch. This deficiency would allow smoke and heat to enter the stairwell. These findings were observed and confirmed by the Facility Maintenance Director Surveyor: 27171 Based on observation the facility failed to provide 1-hour fire resistive separation for the vertical openings in accordance with the LSC section 19.3.1.1. This deficient practice could potentially affect all occupants of the facility. Findings include: On 06/21/2010, the following observations were made: At approximately 11:32 AM, Observed that stairwell door HUH-32 (10th floor, Webber South Bldg.) did not fully close to a positive latch. This deficiency would allow smoke and heat to enter the stairwell. These findings were observed and confirmed by the Plant Operations Manager. At approximately 11:36 AM, Observed that stairwell door HUH-36 (10th floor Webber South Bldg.) does not fully close to a positive latch. This deficiency would allow smoke and heat to enter the stairwell. These findings were observed and confirmed by the Plant Operations Manager.	K 020	Repaired door to stairwell HUH-32 on 3 Webber North at room 3502 to fully close to a positive latch(K-020.3) Repaired door to stairwell HUH-32 on 10WS to fully close to a positive latch (K-020.4) WO #: 328058 Repaired door to stairwell HUH-36 on 10WS to fully close to a positive latch (K-020.5)	8/23/10 8/23/10 8/25/10
K 025	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two	K 025		

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K 025	Continued From page 5 separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. Continued from page 6 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 This STANDARD is not met as evidenced by: Surveyor: 13546 Based on observation the facility failed to provide smoke barriers that would provide at least a one half hour fire resistance rating in accordance with the LSC sections 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4. This deficient practice could potentially affect All occupants of the facility. Findings include: On 06/23/10, the following observations were made: At approximately 10:00 AM, Observed an unsealed penetration (Approximately 2" wide) through the cross-corridor smoke barrier wall at room 8601. This deficiency would allow smoke and heat to travel between smoke compartments. These findings were observed and confirmed by the Facility Maintenance Director. At approximately 10:37 AM, Observed a 3" x 5" section of missing drywall (above ceiling tile) in the corridor, across from room 8702. These finding were observed and confirmed by the Facility Maintenance Director. On 6/21/10, the following observations were made: At approximately 1:00 PM, Observed three sealed floor	K 025	Sealed penetration through cross-corridor smoke barrier at room 8601 to prevent the smoke and heat to travel between smoke compartment (K-025.1) Repaired drywall in corridor across from room 8702 (K-025.2) Sealed three floor penetration in Brush	8/25/10 8/25/10 8/25/10

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K 025	Continued From page 6 conduits (approximately 2" wide) in the Brush Building Telephone Closet, at the elevator foyer. This deficiency would allow smoke and heat to travel between floors. These findings were observed and confirmed by the Facility Maintenance Director. On 06/23/10, the following observations were made: At approximately 2:02 PM, Observed multiple unsealed wall penetrations (approximately 2" wide) above the cross-corridor smoke barrier doors at room 3712. This deficiency would allow smoke and heat to travel between smoke compartments. These findings were observed and confirmed by the facility Maintenance Director. Surveyor: 18760 Based on observation the facility failed to provide smoke barriers that would provide at least a one half hour fire resistance rating in accordance with the LSC sections 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4. This deficient practice could potentially affect All occupants of the facility. Findings include: On 06/23/10, the following observations were made: At approximately 10:00 AM, Observed an unsealed open penetration (approximately 3" x 3") in the 2-hr fire wall, above the ceiling tile, (approximately 3' from the entrance to the Surgical Lounge, on the 2nd floor of the Brush Building). This deficiency would allow smoke and heat to travel between smoke compartments. These findings were observed and confirmed by the Corporate Operations Director. Surveyor: 27171 Based on observation the facility failed to provide smoke barriers that would provide at least a one half	K025	Building Telephone Closet at elevator foyer to prevent smoke and heat to travel between floors (K-025.3) Sealed multiple wall penetrations above cross-corridor smoke barrier doors at room 3712 to prevent the spread of smoke and heat between smoke compartments (K-025.4) Sealed open penetration in 2-hr fire wall above ceiling from entrance to Surgical Lounge – actually on 1st floor Brush Building - to prevent smoke and heat to travel between smoke compartments (K-025.5)	8/25/10 8/25/10

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K 025	Continued From page 7 hour fire resistance rating in accordance with the LSC sections 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4. This deficient practice could potentially affect all occupants of the facility. Findings include: On 06/21/10, the following observations were made: At approximately 11:38 AM, Observed an unsealed section of the cable tray, located at the cross-corridor smoke barrier (near the I.C.U. Elevators, on the 10th Floor, Webber South Building) wall. These findings were observed and confirmed by the Plant Operations Manager. At approximately 11:42 AM, Observed an unsealed pipe penetration (Approximately 2" wide) through the cross-corridor smoke barrier, (located near 10-I.C.U. Electrical Closet, Webber South Building). This deficiency would allow smoke and heat to travel between smoke compartments. These findings were observed and confirmed by the Plant Operations Manager. At approximately 1:13 PM, Observed an unsealed conduit penetration in the cross-corridor smoke barrier wall. (located on the east side of the 9th floor nurses station, in the Webber South Building). This deficiency would allow smoke and heat to travel between smoke compartments. These findings were observed and confirmed by the Plant Operations Manager. At approximately 1:33 PM, Observed an unsealed section of the cable tray located at he 9th floor Webber Building cross-corridor smoke barrier, at South entrance to I.C.U).	K 025	Sealed section of cable tray at cross-corridor smoke barrier (near ICU elevators on 10th floor) (K-025.6) Sealed pipe penetration through cross-corridor smoke barrier (near electrical closet in Hemodialysis, on 10th floor) to prevent smoke and heat to travel between smoke compartments (K-025.7) Sealed conduit penetration (9WS Nurses Station) to prevent smoke and heat to travel between smoke compartments (K-025.8) Sealed section of cable tray (9WS cross-corridor smoke barrier at south entrance into 9ICU) (K-025.9)	8/25/10 8/25/10 8/25/10 8/25/10

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K 025	Continued From page 8 These findings were observed and confirmed by the Plant Operations Manager. At approximately 1:40 PM, Observed an unsealed section of cable tray. Located at the cross-corridor smoke barrier wall, near I.C.U. Room 8522. These findings were observed and confirmed by the Plant Operations Manager.	K 025	Sealed cable tray at cross-corridor smoke barrier wall near room 8522 (8ICU) (K-025.10)	8/25/10
K 027	NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 13/4-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. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7 This STANDARD is not met as evidenced by: Surveyor: 13546 Based on observation the facility failed to provide for the smoke barrier doors to be self-closing or automatic closing in accordance with the LSC section 19.2.2.2.6. This deficient practice could potentially affect All occupants of the facility. Findings include: On 06/23/10, the following observations were made: At approximately 2:02 pm. Observed that the coordinator on the cross-corridor smoke barrier doors, located at room 5719, did not function when tested. This deficiency would allow smoke and heat to travel between smoke compartments.	K 027	Repaired coordinator on cross-corridor smoke barrier doors located at room 5719 to prevent smoke and heat to travel between smoke compartments (K-027.1)	8/23/10

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K 027	Continued From page 9 These findings were observed and confirmed by the Facility Maintenance Director. At approximately 12:22 PM, Observed an approximately 1/8" gap between the edges of the cross-corridor smoke barrier doors, adjacent to room 3820. This deficiency would allow smoke and heat to travel between smoke compartments. These findings were observed and confirmed by the Facility Maintenance Director. On 06/21/10, the following observations were made: At approximately 11:27 AM, Observed that the cross-corridor smoke barrier doors (Located adjacent to the 10th floor Webber-South I.C.U. Entrance) did not fully close. This deficiency would allow smoke and heat to travel between smoke compartments. These findings were observed and confirmed by the Facility Maintenance Director. At approximately 1:20 PM, Observed that the cross-corridor smoke barrier wall (Located at the 9th floor, Webber South nurse's station) did not extend to the ceiling. This deficiency would allow smoke and heat to travel between smoke compartments. These finding were observed and confirmed by the Facility Maintenance Director.	K 027	Sealed 1/8" gap between edges of cross-corridor smoke barrier doors, adjacent to room 3820 to prevent smoke and heat to travel between smoke compartments (K-027.2) Repaired smoke barrier doors adjacent to 10th floor, south entrance to Hemodialysis to fully close to prevent smoke and heat to travel between smoke compartments (K-027.3) WO #: 328060 Extended smoke barrier wall to ceiling to prevent smoke and heat to travel between smoke compartments (9WS Nurses Station) (K-027.4)	8/23/10 8/23/10 8/25/10
K 029	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do	K 029		

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K 029	Continued From page 10 not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Surveyor: 13546 Based on observation the facility failed to provide for the protection of hazardous areas in accordance with the LSC section 19.3.2.1. This deficient practice could potentially affect all occupants of the facility. Findings include: On 6/21/10, the following observations were made: At approximately 12:46 PM, Observed that the door to clean utility room/storage room 3627 requires a self-closer. This deficiency would allow smoke and heat to enter the exit corridor. These findings were observed and confirmed by the Corporate Fire Safety Inspector. At approximately 10:01 AM, Observed an unapproved trash receptacle in the Brush Center corridor at room 3820. These findings were observed and confirmed by the Corporate Fire Safety Inspector. At approximately 2:46 PM, Observed that the door to supply room 8701 does not meet the 45-minute rating requirement. These findings were observed and confirmed by the Corporate Fire Safety Inspector. At approximately 2:46 PM, Observed an unsealed wall penetration between the corridor and the room 8701. This deficiency would allow smoke and heat to enter the exit corridor. These findings were observed and confirmed by the	K 029	Room 3627 does not exist, the only clean utility room/storage room on the unit is 3617 and the door has a self-closer, preventing smoke and heat to travel between smoke compartments (K-029.1) Removed unapproved trash receptacle (K-029.2) Install replacement door for supply room 8701 that meets the 45-minute rating requirement (K029.3) To be installed by 9/19/10 Responsible: Director of Facility Engineering and Construction Sealed wall penetration between corridor and room 8701 to prevent smoke and heat to enter the exit corridor (K-029.4)	8/23/10 8/23/10 8/25/10

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K 029	Continued From page 11 Corporate Fire Safety Inspector. At approximately 2:49 PM, Observed that the door to supply room 8712 does not meet the minimum 45-minute rating requirement. These findings were observed and confirmed by the Corporate Fire Safety Inspector. At approximately 12:46 PM, Observed that the door to Janitor's Closet 7702 does not self-close and latch. This deficiency would allow smoke and heat to enter the exit corridor. These findings were observed and confirmed by the Corporate Fire Safety Inspector. At approximately 12:46 PM, Observed an unsealed wall penetration (Approximately 1" x 2" wide) above the door to Janitor's closet 7702. This deficiency would allow smoke and heat to enter the exit corridor. These findings were observed and confirmed by the Corporate Fire Safety Inspector. At approximately 2:49 PM, Observed that the storage room door, at entrance to 6-Brush center, is not rated. These findings were observed and confirmed by the Corporate Fire Safety Inspector. At approximately 2:55 PM, Observed that the door to the storage closet at room 6812 is not rated. These findings were observed and confirmed by the Corporate Fire Safety Inspector. At approximately 2:49 PM, Observed that the door to storage room 6605A does not have a self-closer.	K 029	Install replacement door for supply room 8712 that meets the 45-minute rating requirement (K-029.5) To be installed by 9/19/10 Responsible: Director of Facility Engineering and Construction Room 7702 is an office that is occupied by one person, closer not required. The janitors closet door across from room 7702 adjusted to self close and latch to prevent smoke and heat to enter the exit corridor (K029.6) Sealed penetration above janitors closet across from room 7702; the wall above room 7702 was also checked to verify no penetrations. (K-029.7) Install a rated door for storage room at 6B Center (K-029.8) To be installed by 9/19/10 Responsible: Director of Facility Engineering and Construction Install a rated door for storage closet 6812 (K-029.9) To be installed by 9/19/10 Responsible: Director of Facility Engineering and Construction Installed self-closer on door to storage room 6605A (K-029.10)	8/23/10 8/25/10 8/23/10

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K 029	Continued From page 12 These findings were observed and confirmed by the Corporate Fire Safety Inspector. At approximately 2:19 PM, Observed that the dimensions of the clean linen/storage room 5718 exceed 100 square feet and is not sprinkler protected. These findings were observed and confirmed by the Corporate Fire Safety Inspector. At approximately 2:57 PM, Observed heat producing appliances were observed in staff lounge 5708. This room is not sprinkled or have a rated door with closer. This deficiency would allow smoke and heat to enter the exit corridor. These findings were observed and confirmed by the Corporate Fire Safety Inspector. At approximately 2:58 PM, Observed wiring and combustibles not properly secured inside of Mechanical closet 2627. These findings were observed and confirmed by the Facility Maintenance Director. Surveyor: 18760 Based on observation the facility failed to provide for the protection of hazardous areas in accordance with the LSC section 19.3.2.1. This deficient practice could potentially affect All occupants of the facility. Findings include: On 6/21/10, the following observations were made: At approximately 11:32 AM, Observed that the door to the Soiled Linen Room marked G114/1114a did not close to a positive latch. This deficiency would allow smoke and heat to enter the exit corridor. These findings were observed and confirmed by the Corporate Fire Safety Inspector.	K 029	Install sprinkler to room 5718 (K-029.11) To be installed by 8/31/10 Responsible: Director of Facility Engineering and Construction Install sprinkler (K-029.12) To be installed by 8/31/10 Responsible: Director of Facility Engineering and Construction Removed wiring and combustibles that were not properly secured inside of mechanical closet 2627 (K-029.13) Repaired door to soiled utility room G114/114a to close to a positive latch (K-029.14)	8/25/10 8/25/10

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K 029	Continued From page 13 At approximately 11:50 AM, Observed that the door to the Weber Building O.R. janitor's closet did not close to a positive latch. This deficiency would allow smoke and heat to enter the exit corridor. These findings were observed and confirmed by the Corporate Fire Safety Inspector.	K 029	Repaired door to janitors closet in OR to close to a positive latch (K-029.15)	8/25/10
	At approximately 1:25 PM, Observed that the door to the Wendy's kitchen janitor's closet did not close to a positive latch. This deficiency would allow smoke and heat to enter the exit corridor. These findings were observed and confirmed by the Corporate Fire Safety Inspector.		Repaired door to janitors closet in Wendy's kitchen to close to a positive latch (K-029.16)	8/19/10
	At approximately 1:35 PM, Observed ceiling tiles missing in the Webber Building ground floor service elevator area. These findings were observed and confirmed by the Corporate Fire Safety Inspector.		Replaced ceiling tile in Webber 1st floor service elevator (K-029.17) WO #: 328067	8/23/10
	At approximately 10:20 AM, Observed an unsealed wall penetration (Approximately 3" x 3" in diameter) in the Brush Building Upper Café janitor's closet. This deficiency would allow smoke and heat to enter the exit corridor. These findings were observed and confirmed by the Corporate Fire Safety Inspector.		Sealed wall penetration in janitors closet in cafeteria to prevent smoke and heat to enter the exit corridor(K-029.18)	8/25/10
	At approximately 10:25 AM, observed that the door to the Upper Café Storage Room in the Brush Building did not close to a positive latch. These findings were observed and confirmed by the Corporate Fire Safety Inspector.		Repaired door to storage room in cafeteria to close to a positive latch (K-029.19)	8/25/10
	At approximately 10:40 AM, Observed that the ceiling tile in the 1st floor Brush Building Hospitality Storage		Replaced ceiling tile in Hospitality Storage Room (catering) (K-029.20)	8/23/10

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K 029	Continued From page 14 room is missing. These findings were observed and confirmed by the Corporate Fire Safety Inspector. At approximately 10:55 AM, Observed an unsealed penetration (Approximately 1" x 6" in diameter) in the Brush Basement EVA Storage Room. This deficiency would allow smoke and heat to enter the exit corridor. These findings were observed and confirmed by the Corporate Fire Safety Inspector. At approximately 11:00 AM, Observed an unsealed conduit (Approximately 1" in diameter) protruding through the corridor wall, in the Brush Building basement kitchen. This deficiency would allow smoke and heat to enter the exit corridor. These findings were observed and confirmed by the Corporate Fire Safety Inspector. At approximately 11:00 AM, Observed a concrete block missing (Approximately 6" x 12") missing from the corridor wall in the Brush Building basement kitchen storage room. This deficiency would allow smoke and heat to enter the exit corridor. These findings were observed and confirmed by the Corporate Fire Safety Inspector. At approximately 1:05 PM, Observed that the 4th floor Weber North clean linen room door did not close to a positive latch. These findings were observed and confirmed by the Corporate Fire Safety Inspector. At approximately 11:00 AM, Observed an unsealed penetration around a pipe (Approximately 1" in diameter) protruding through the rear wall of the 4th floor Weber South janitor's closet, adjacent to room 4445. This deficiency would allow smoke and heat to enter the	K 029	WO #330528 Sealed penetration in EVS storage room to prevent smoke and heat to enter the exit corridor(K-029.21) Sealed conduit penetration protruding through wall in basement kitchen to prevent smoke and heat to enter the exit corridor (K-029.22) Repaired concrete wall in basement kitchen storage room to prevent smoke and heat to enter the exit corridor (K-029.23) Adjusted door to clean linen room on 4WN to close to a positive latch (K-029.24) Sealed penetration around pipe in janitors closet across from room 4445 on 4WS to prevent smoke and heat to enter the exit corridor (K-029.25)	8/25/10 8/25/10 8/25/10 8/19/10 8/25/10

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K 029	Continued From page 15 exit corridor. These findings were observed and confirmed by the Corporate Fire Safety Inspector. Surveyor: 27171 Based on observation the facility failed to provide for the protection of hazardous areas in accordance with the LSC section 19.3.2.1. This deficient practice could potentially affect all occupants of the facility. Findings include: On 6/21/10, the following observations were made: At approximately 10:57 AM, Observed an unsealed conduit penetration (Approximately 1" in diameter) next to the HVAC duct in the 11th floor North Penthouse Plumbers Shop. This deficiency would allow smoke and heat to enter the exit corridor. These findings were observed and confirmed by the Facility Maintenance Director At approximately 1:50 PM, Observed missing ceiling tiles at the HVAC unit in room 8450 in the Webber South Building. These findings were observed and confirmed by the Facility Maintenance Director At approximately 2:26 PM, Observed two unsealed large diameter conduit penetrations (Approximately 4" in diameter) in Room 5444, Webber South Building. This deficiency would allow smoke and heat to enter the exit corridor. These findings were observed and confirmed by the Facility Maintenance Director	K 029	Sealed penetration next to HVAC duct on 11th floor in Plumbers Shop to prevent smoke and heat to enter the exit corridor (K-029.26) Replaced ceiling tiles in room 8450 on 8WS (K-029.27) WO # 330530 Sealed two penetrations in room 5444 on 5WS to prevent smoke and heat to enter the exit corridor (K-029.28)	8/25/10 8/25/10 8/25/10
K 038	NFPA 101 LIFE SAFETY CODE STANDARD	K 038		

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K 038	Continued From page 16 Exit access is arranged so that exits are ready accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Surveyor: 18760 Based on observation the facility failed to provide approved exit access in accordance with the LSC section 19.2.1. This deficient practice could potentially affect All occupants of the facility. Findings include: On 6/23/10, the following observations were made: At approximately 11:00 AM, Observed that the door to the "Old Sump Room" was secured with a clasp and pad lock, that prevents the door from being opened from the egress side. These findings were observed and confirmed by the Facility Maintenance Director At approximately 10:05 AM, Observed exit access at the 2nd floor Brush Surgical Suite was obstructed by a 6-ft slab of ¾ inch plywood laid across the stairway. These findings were observed and confirmed by the Facility Maintenance Director. At approximately 10:25 AM, Observed that the exit door at the 1st floor Doctors Dining Room in the Brush Building was obstructed by chairs. These findings were observed and confirmed by the Facility Maintenance Director. At approximately 10:35 AM, Observed that the rear door to the exit access corridor, in the Brush Building Upper Café, has a dead bolt lock.	K 038	Removed clasp and pad lock and installed hardware to allow the door to be opened from the egress side (K-038.1) Removed wood plank to allow unobstructed exit access (K-038.2) Removed chairs from exit to allow unobstructed exit access. Signage was be placed to instruct occupants not to block the exit doors. (K-038-3) Removed deadbolt from rear door to the in the cafeteria and replaced with hardware to allow for egress (K-038.4)	8/25/10 8/23/10 8/25/10 8/25/10

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K 038	Continued From page 17 These findings were observed and confirmed by the Facility Maintenance Director. At approximately 10:40 AM, Observed that the door to the exit access corridor in the Brush Building basement EVA Equipment Storage Room has a dead bolt lock. These findings were observed and confirmed by the Facility Maintenance Director. At approximately 11:20 AM, Observed that the door to the exit access corridor in the Brush Building Basement Stretcher Equipment Storage Room has a dead bolt lock. These findings were observed and confirmed by the Facility Maintenance Director.	K 038	Removed deadbolt from door in EVS storage room and replaced with hardware to allow for egress (K-038.5) Removed deadbolt from door in transportation storage room (Brush Basement) and replaced with hardware to allow for egress (K-038.6)	8/25/10 8/25/10
K 039	NFPA 101 LIFE SAFETY CODE STANDARD Width of aisles or corridors (clear and unobstructed) serving as exit access is at least 4 feet. 19.2.3.3 This STANDARD is not met as evidenced by: Surveyor: 27171 Based on observation the facility failed to provide exit access in accordance with the LSC section 19.2.3.3. This deficient practice could potentially affect all occupants of the facility. Findings include: On 06/23/10, the following observations were made: At approximately 1:15 PM, Observed a patient bed being stored in the corridor, by Room 9411, in the Webber South Building. These findings were observed and confirmed by the Facility Maintenance Director.	K 039	Bed was removed from 9WS corridor during the visit. Staff educated on maintaining corridor clearance. Unit leaders monitor their areas daily and periodic rounds are conducted. (K-039.1)	6/23/10

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K 046	Continued From page 18 NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1 ½ hour duration is provided in accordance with 7.9. 19.2.9.1. This STANDARD is not met as evidenced by: Surveyor: 18760 Based on observation the facility failed to provide emergency lighting in accordance with the LSC section 19.2.9.1. This deficient practice could potentially affect All occupants of the facility. On 6/23/10, the following observations were made: At approximately 11:10 AM, Observed that the emergency lighting in the brush Building Basement Sub-Station # 1 exit access stairway did not operate when tested. These findings were observed and confirmed by the Facility Maintenance Director.	K 046	Repaired emergency lighting in Brush Basement Substation #1 (K-046.1)	7/15/10
K 047	NFPA 101 LIFE SAFETY CODE STANDARD Exit and directional signs are displayed in accordance with section 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 This STANDARD is not met as evidenced by: Surveyor: 18760 Based on observation the facility failed to provide exit and directional signs in accordance with the LSC section 19.2.10.1. This deficient practice could potentially affect All occupants of the facility. Findings include: On 06/23/10, the following observations were made:	K 047		

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K 047	Continued From page 19 At approximately 10:55 AM, Observed that there is no exit directional signs located in the Weber Building Sub-Basement to identify the direction of travel. These findings were observed and confirmed by the Corporate Fire Safety Inspector. At approximately 11:00 AM, Observed that the exit door from the Weber Building "Old Sump Room" is not identified with an exit sign. These findings were observed and confirmed by the Corporate Fire Safety Inspector. On 6/23/10, the following observations were made: At approximately 11:20 AM, Observed that there are no directional signs in the Weber Sub-Basement Tunnel and the exit door by the "Old Am-Cart elevator is not identified with an exit sign. These findings were observed and confirmed by the Corporate Fire and Safety Inspector On 06/23/10, the following observations were made: At approximately 10:10AM, Observed that the exit door to the Administration Suite, located in the 2nd Floor stairway marked HUH-4C, does not have an exit sign. These findings were observed and confirmed by the Corporate Fire Safety Inspector. On 06/23/10, the following observations were made: At approximately 11:10 AM, observed there are no exit directional signs from the Brush Building Basement Sub-Station #1 to the exit access stairway. These findings were observed and confirmed by the Corporate Fire Safety Inspector.	K 047	Install exit directional signs in Webber South sub-basement (K-047.1) To be installed by 8/31/10 Responsible: Director of Facility Engineering and Construction Install exit signage to exit door from "Old Sump Room" (K-047.2) To be installed by 8/31/10 Responsible: Director of Facility Engineering and Construction Installed directional signage in Webber Sub-basement tunnel (K-047.3) Installed exit sign at exit door by the "Old Amscar" elevator Installed exit signage at exit door to Administration Suite at stairwell HUH-4C (K-047.4) Installed directional signage from Brush Building basement Substation #1 to exit access stairway(K-047.5)	8/25/10 8/25/10 8/25/10 7/15/10

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K 062	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not med as evidenced by: Surveyor: 13546 Based on observation and/or review of records the facility failed to provide documentation that the automatic sprinkler system is maintained and/or tested in accordance with the LSC sections 19.7.6, 4.6.12, 9.7.5. This deficient practice could potentially affect all occupants of the facility. Findings include: On 06/21/10, the following observations were made: At approximately 10:46 AM, Observed a Central Brand recalled sprinkler head in the corridor at room 8622. These findings were observed and confirmed by the Corporate Fire Safety Inspector. At approximately 10:00 AM, Observed a large gap (Approximately 1") around the sprinkler head in room 7481. These findings were observed and confirmed by the Corporate Fire Safety Inspector. At approximately 2:34PM, Observed that the data room sprinkler head is not within 12" of ceiling. These findings were observed and confirmed by the Corporate Fire Safety Inspector.	K 062	Replace sprinkler head in corridor at room 8622 with compliant sprinkler head (K-062.1) To be installed by 8/31/10 Responsible: Director of Facility Engineering and Construction Repair gap around sprinkler head in room 7481 (K-062.2) To be installed by 8/31/10 Responsible: Director of Facility Engineering and Construction Readjust sprinkler head in data room (K-062.3) To be installed by 8/31/10 Responsible: Director of Facility Engineering and Construction	

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K 062	Continued From page 21 Surveyor 18760 Based on observation and/or review of records the facility failed to provide documentation that the automatic sprinkler system is maintained and/or tested in accordance with the LSC sections 19.7.6, 4.6.12, 9.7.5. This deficient practice could potentially affect All occupants of the facility. Findings include: On 06/21/10, the following observations were made: At approximately 10:45 AM, Observed that the automatic sprinkler valve drain located in the Webber Building Sub-Basement did not have a sign to identify its purpose. These findings were observed and confirmed by the Corporate Fire Safety Inspector. At approximately 1:30 PM, Observed that combustible storage was within 18" of the automatic sprinkler heads in the Weber Building Pharmacy Storage Room. These findings were observed and confirmed by the Corporate Fire Safety Inspector. At approximately 1:25PM, Observed that the automatic sprinkler head located in the Webber North Building room 3435 is missing an escutcheon plate. These findings were observed and confirmed by the Corporate Fire Safety Inspector.	K062	Place appropriate signage on sprinkler valve drain (K-062.5) To be installed by 8/31/10 Responsible: Director of Facility Engineering and Construction Storage removed at time of visit and is monitored during rounds (K-062.6) Replaced escutcheon plate on automatic sprinkler head located in room 3435 (3WN) (K-062.7) WO #: 330531	6/21/10 8/23/10
K 064	NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10	K064		

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K 064	Continued From page 22 This STANDARD is not met as evidenced by: Surveyor: 18760 Based on observation and/or review of records the facility failed to provide fire extinguishers in accordance with the LSC section 19.3.5.6. This deficient practice could potentially affect All occupants of the facility. Findings include: On 06/23/10, the following observations were made: At approximately 1:10PM, Observations that the portable fire extinguishers located in the Wendy's restaurant kitchen was not mounted to the wall. These findings were observed and confirmed by the Facility Maintenance Director. At approximately 10:05 AM, Observed the portable fire extinguisher located in the 1st floor Brush Center Doctors Dining Room was not mounted to the wall. These findings were observed and confirmed by the Facility Maintenance Director. At approximately 11:10AM, Observed the portable fire extinguisher located in the Brush Building Basement De-Con Mechanical/Electrical Room is not mounted to the wall. These findings were observed and confirmed by the Facility Maintenance Director.	K 064	Mounted fire extinguisher in Wendy's kitchen (K-064.1) WO #: 330532 Mounted fire extinguisher outside of Doctors Dining Room (K-064.2) WO #: 330533 Mounted fire extinguisher in Decon Mechanical/Electrical Room (K-064.3) WO #: 330535	8/19/10 8/19/10 8/19/10
K 069	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3 19.3.2.6, NFPA 96 This standard is not met as evidenced by:	K 069		

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K 069	Continued From page 23 Surveyor 18760. Based on observation and/or review of records the facility failed to provide cooking facilities in accordance with the LSC section 19.3.2.6. This deficient practice could potentially affect All occupants of the facility. Findings include: On 06/21/10, the following observations were made: At approximately 1:20PM, Observed the manual station for the Wendy's hood suppression system was damaged and the seal was broken. These findings were observed and confirmed by the Corporate Fire Safety Inspector. At approximately 1:25PM, Observed that the kitchen hood grease filters in the Wendy's restaurant were not installed properly and had an approximate two ¼" gaps between the filters. These findings were observed and confirmed by the Corporate Fire Safety Inspector.	K 069	Repaired manual station for Wendy's hood suppression system (K-069.1) WO #: 328102 Properly installed kitchen hood grease filters in Wendy's to eliminate gaps between filters (K-069.2) WO #: 330537	8/23/10 8/19/10
K 076	NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu. ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4. This STANDARD is not met as evidenced by: Surveyor: 13546	K076		

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K 076	Continued From page 24 Based on observation the facility failed to provide protection of medical gases in accordance with NFPA 99. This deficient practice could potentially affect all occupants of the facility. Findings include: On 06/21/10, the following observations were made: At approximately 1:46PM, Observed an unsecured oxygen cylinder in room 3809. These findings were observed and confirmed by the Facility Maintenance Director. At approximately 2:34PM, Observed an unsecured oxygen cylinder in soiled utility room 3616. These findings were observed and confirmed by the Facility Maintenance Director. Surveyor 18760 Based on observation the facility failed to provide protection of medical gases in accordance with NFPA 99. This deficient practice could potentially affect All occupants of the facility. Findings include: On 06/21/10, the following observations were made: At approximately 1:10PM, Observed two unsecured oxygen cylinders in the 4th floor Webber North Clean Linen Room. These findings were observed and confirmed by the Corporate Fire Safety Inspector.	K 076	Secured tank, unit leaders conduct daily monitoring. (K-076.1) Secured tank, unit leaders conduct daily monitoring. (K-076.2) Secured tank, unit leaders conduct daily monitoring. (K-076.3)	8/23/10 8/23/10 8/23/10
K 147	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with	K 147		

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K 147	Continued From page 25 NFPA 70, National Electrical Code 9.1.2. This STANDARD is not met as evidenced by: Surveyor: 13546 Based on observation the facility failed to provide the electrical system in accordance with the LSC section 9.1.2. This deficient practice could potentially affect All occupants of the facility. Findings include: On 06/21/10, the following observations were made: At approximately 2:46PM, Observed an electrical junction box missing a cover plate at room 8702. These findings were observed and confirmed by the Facility Maintenance Director. Surveyor 18760. Based on observation the facility failed to provide the electrical system in accordance with the LSC section 9.1.2. This deficient practice could potentially affect All occupants of the facility. Findings include: On 06/21/10, the following observations were made: At approximately 10:45AM, Observed an electrical junction box, located in the Weber South basement, missing a cover plate. These findings were observed and confirmed by the Corporate Fire Safety Inspector. At approximately 11:20 AM, Observed that there is an electrical junction box located above the ceiling tile, above the smoke barrier doors by room G207 in Webber Building Radiology that is missing a cover	K 147	Replace junction box cover plate at room 8702 (K-147.1) WO #: 330538 To be installed by 8/31/10 Responsible: Director of Facility Engineering and Construction Replaced junction box cover plate in Webber South basement (K-147.2) WO #: 330538 Replaced junction box cover plate above ceiling tile by room G207 (K-147.3) WO #: 328101	8/19/10 7/19/10

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K 147	Continued From page 26 plate. These findings were observed and confirmed by the Corporate Fire Safety Inspector. At approximately 11:25AM, observed by the Corporate Fire Safety Inspector that there is an electrical junction box located above the ceiling tile, above the smoke barrier doors by room G234 in Webber Radiology that is missing a cover plate. These findings were observed and confirmed by the Corporate Fire Safety Inspector. At approximately 9:45AM, Observed that there is an electrical junction box above the ceiling tile, above the door to the stairway marked HUH-47 on the 2nd Floor of the Brush Building that is missing a cover plate. These findings were observed and confirmed by the Corporate Fire Safety Inspector. At approximately 10:03AM, observed that there is exposed wiring to a construction light located above the ceiling tile, above the entrance to the Surgical Lounge, on the 2nd Floor of the Brush Building. These findings were observed and confirmed by the Corporate Fire Safety Inspector. At approximately 10:50AM, observed an electrical junction box in the Brush Building Basement storage room next to stairway marked HUH-40 that is missing a cover plate. These findings were observed and confirmed by the Corporate Fire Safety Inspector. At approximately 10:50AM, Observed an electrical junction box in the Brush Building Basement above the ceiling tile above the smoke barrier doors by the	K 147	Replace junction box cover plate above ceiling tile near room G234 (K-147.4) WO #: 330540 To be installed by 8/31/10 Responsible: Director of Facility Engineering and Construction Replace junction box cover plate above door to stairwell HUH-47 on 2 Brush (K-147.5) WO #: 330541 To be installed by 8/31/10 Responsible: Director of Facility Engineering and Construction Adjust exposed wire above entrance to Surgical Lounge on 1 Brush (K-147.6) WO #: 330543 To be installed by 8/31/10 Responsible: Director of Facility Engineering and Construction Replace junction box cover plate in Brush Basement storage room next to stairwell HUH-40 (K-147.7) WO #: 330544 To be installed by 8/31/10 Responsible: Director of Facility Engineering and Construction Replace junction box cover plate above smoke barrier doors at Pharmacy entrance in Brush Basement (K-147.8) WO #: 330545	

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K 147	Continued From page 27 Pharmacy Entrance that is missing a cover plate. These findings were observed and confirmed by the Corporate Fire Safety Inspector. At approximately 10:55AM, Observed that there is a damaged 220 volt electrical outlet located in the Brush Building Basement Kitchen Storage Room. These findings were observed and confirmed by the Corporate Fire Safety Inspector. At approximately 11:00AM, observed an electrical junction box located in the Brush Building Basement Kitchen Storage room that is missing a cover plate. These findings were observed and confirmed by the Corporate Fire Safety Inspector. At approximately 11:00AM, Observed an electrical junction box located in the Fire Sprinkler Cabinet in the Brush Building Basement Grey Tunnel that is missing a cover plate. These findings were observed and confirmed by the Corporate Fire Safety Inspector. At approximately 1:30PM, Observed an electrical junction box located in the 3rd floor Webber North Building Electrical Room #3236 that is missing a cover plate. These findings were observed and confirmed by the Corporate Fire Safety Inspector. Surveyor: 27171 Based on observation the facility failed to provide the electrical system in accordance with the LSC section 9.1.2. This deficient practice could potentially affect all occupants of the facility. Findings include:	K 147	To be installed by 8/31/10 Responsible: Director of Facility Engineering and Construction Repaired damaged 220 volt outlet in kitchen storage area (Brush Basement) (K-147.9) WO #: 330546 Replaced junction box cover plate in kitchen storage room (Brush Basement) (K-147.10) WO #: 330547 Replace junction box cover plate in fire sprinkler cabinet in Brush Basement grey tunnel (K-147.11) WO #: 330548 To be installed by 8/31/10 Responsible: Director of Facility Engineering and Construction Replace junction box cover plate 3WN electrical room #3236 (K-147.12) WO #: 330549 To be installed by 8/31/10 Responsible: Director of Facility Engineering and Construction	8/19/10 8/18/10

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K 147	Continued From page 28 On 06/21/10, the following observations were made: At approximately 10:41AM, Observed an electrical junction box missing a cover plate, located in Substation 6 on the 11th Floor Penthouse North. These findings were observed and confirmed by the Plant Operations Manager. At approximately 10:43AM, Observed that there were two electrical panels missing filler blanks (Panels RP-112 and RP-113) located in the 11th Floor Penthouse North. These findings were observed and confirmed by the Plant Operations Manager. At approximately 11:01AM, Observed that there was an electrical junction box missing a cover plate, located in the Mechanical/Control Room, located on the 11th Floor Penthouse North. These findings were observed and confirmed by the Plant Operations Manager. At approximately 11:20AM, Observed that there was an electrical panel missing filler blanks, located in Room 10443, on the 10th Floor of Webber South Building. These findings were observed and confirmed by the Plant Operations Manager. At approximately, 2:26PM, Observed that there were two electrical junction boxes missing cover plates, located in the Mechanical Room near air conditioning units 9 and 10, on the 6th floor – Webber North Building. These findings were observed and confirmed by the Plant Operations Manager.	K 147	Replace junction box cover plate in substation 6 on 11th floor Penthouse (K-147.13) WO #: 330550 To be installed by 8/31/10 Responsible: Director of Facility Engineering and Construction Replaced filler blanks in two electrical panels in 11th floor penthouse (K-147.14) WO #: 330552 Replace junction box cover plate in mechanical/control room on 11th floor penthouse (K-147.15) WO #: 330555 To be installed by 8/31/10 Responsible: Director of Facility Engineering and Construction Replace filler blanks in two electrical panels in room 10443 10WS (K-147.16) WO #: 330556 To be installed by 8/31/10 Responsible: Director of Facility Engineering and Construction Replace two junction box cover plates in mechanical room on 6th floor of Webber Building (K-147.17) WO #: 330558 To be installed by 8/31/10 Responsible: Director of Facility Engineering and Construction	8/20/10

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIERS REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1)PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	230024	A. BUILDING _____ B. WING _____	11/21/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SINAI-GRACE HOSPITAL	6071 W OUTER DRIVE DETROIT, MI 48235

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PROCEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	INITIAL COMMENTS Surveyor: 29955 The purpose of this survey was for State Monitoring. The Department has evaluated this facility and determined that it is not in compliance with federal certification requirements. See the following citation(s) for details.	A 000	By submitting this plan of correction Sinai-Grace Hospital ("SGH" or the "Hospital") is not waiving its right to amend the Plan of Correction as necessary and/or to contest the deficiencies, findings, conclusions, and actions of CMS and/or the State Survey Agency. SGH has taken immediate actions to ensure it is in compliance with federal certification requirements. Such actions are more fully described hereafter and is committed to ongoing compliance.	
A 115	482.13 PATIENT RIGHTS A hospital must protect and promote each patient's rights. This CONDITION is not met as evidenced by: Surveyor: 29313 Based on record review, policy review and interview, it was determined the facility failed to protect and promote the rights of patients as evidenced by: (A 117) failure to inform each patient, or when appropriate, the patient's representative (as allowed under State law), of the patient's rights; (A 144) failure to provide patient care in a safe setting; (A 168) failure to ensure that restraint orders were completed and authenticated by a physician; (A 170) failure to notify the patients attending physician as soon as possible after being placed in restraints when the attending did not originally give the order; (A 171) failure to provide complete restraint orders and (A 175) failure to monitor patients in restraints as ordered.	A 115	The Hospital has taken effective measures to protect and promote each patient's rights. Specifically, the Hospital has: • Revised its processes to ensure that each patient is provided notice of his/her rights through provision of the initial and follow-up IMM (A117) and provided education to staff regarding the provision of the IMM, as more fully described herein; • provided education to its staff to ensure that patient care is rendered in a safe setting, identifying the importance of maintaining open access to the lines (A144), as more fully described herein; • revised its processes for initiating and continuing restraints and/or seclusion (A170) and provided education to relevant staff regarding the initiation and continuation of restraints and/or seclusion, as more fully described below;	Completed 11/06/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIERS REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	President	2/14/13

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1)PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	230024	A. BUILDING _____ B. WING _____	11/21/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SINAI-GRACE HOSPITAL	6071 W OUTER DRIVE DETROIT, MI 48235

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A 115	Continued from page 1	A 115	• drafted and implemented guidelines and protocols for use of medical restraints at SGH to provide more definition on the notification of attending physicians of restraint orders entered by a medical resident, other LIP, or MLP and to clarify the authentication / countersignature procedures (A171); • implemented the measures more fully described herein to ensure that patients in restraint or seclusion are appropriately monitored by a physician, other LIP, and/or appropriately trained MLP's, the Hospital (A175). **Monitoring** The Hospital has implemented monitoring of the actions taken for Tags A117, A144, A169, A170, A171, and A175, as described below in the Plan of Correction for each referenced Tag. **Responsible Person(s)** President	
A 117	482.13(a)(1)PATIENT RIGHTS: NOTICE OF RIGHTS A hospital must inform each patient, or when appropriate, the patient's representative (as allowed under State law), of the patient's rights, in advance of furnishing or discontinuing patient care whenever possible.	A 117	The Hospital has taken effective measures to inform the patient, or patient's representative, of the patient's rights in advance of furnishing or discontinuing patient care whenever possible. Specifically, as of 11/06/12, the Hospital provides the patient and family and caregivers with a comprehensive care plan that encourages the patient, family and caretaker's/representative's input. The patient/family/caretaker/representative is provided education regarding the care plan that is clear and understandable. The patient/family/caretaker/representative is provided information and instructions for discharge planning post-hospital care placement; patient/family/caretaker/representative will be involved in the discharge planning process 100% of the time (when applicable). Unit Social Workers and/or Unit Case Mangers will document evidence of the plan in the patient's medical record.	12/20/12

A 117	Continued From page 2 This STANDARD is not met as evidenced by: Surveyor: 36164 Based on medical record review, interview, and policy review the facility failed to ensure 7 or 9 patients (#18, #27, #28, #34, #35, #38, and #39) received the Important Message from Medicare (IMM) Findings include: During medical record review on 11/19/12 at approximately 1400 it was revealed that patient #18's medical record failed to have the required IMM. During an interview with staff EE on 11/19/12 at approximately 1415 it was confirmed that the IMM was not in the medical record. Staff EE stated "I looked and it's not in there." During medical record review on 11/21/12 between the hours of 1000 – 1115 it was revealed that the medical record for patients #34, #35, #38, and #39 failed to have the required IMM. During an interview with staff FF on 11/21/12 at approximately 1100 it was confirmed that the IMM was not available for these patients. Staff FF stated "I can't find it." Surveyor: 30988 During medical record review of patient #27 and #28 on 11/19/2012 at approximately 1330 (1:30 PM) , it was revealed that the IMM had not been given to, or signed by the patient or his/her representative. Patient #27 had been admitted on 11/17/2012 and had signed consent for treatment, however, did not have signed IMM. Patient #28 was admitted on 11/05/12 and had signed consent for treatment, however, did not have signed IMM. Review of the "Management Operating Directive-4 SGH MOD 001 001" revealed #3. If the patient or his/her representative refuses to sign the first IMM, the admitting staff member will notate "refused to sign" and add their name and date to the bottom of the form....#4. Patients who are unable to sign due to sedation, pain, mental status, or acuity, the admitting staff should contact the patient rep and the IMM should be read to the representative. The admitting staff should document who they spoke with including name and phone number even if the pt rep refused to listen to the IMM. Documentation that the attempt was made is important. These findings were confirmed during interviews with staff FF at approximately 1330 (1:30 PM) on 11/19/12 and with staff S on 11/20/12 at approximately 0830 (8:30 AM).	A 117	To comply with Medicare regulations effective July 2, 2007, which require that the Important Message from Medicare (IMM) is provided to Medicare patients within the first 2 days of their admission and a follow-up copy of the IMM is provided within 2 days of the patient's discharge; to ensure that each Medicare patient is informed of the right to appeal his/her discharge; and to allow ample time for the patient's discharge appeal to be processed, the Hospital has implemented the following measures: 1. Unit Clinical Social Workers and Case Managers review patient charts to verify if an initial IMM is present within 2 days after admission; if not, the Admitting Department is alerted and patient/family/representative is notified of their rights at that time. 2. Unit Clinical Social Workers and Case Managers discuss possible/confirmed discharges in the daily multidisciplinary rounds. Within 2 days prior to discharge Unit Clinical Social Workers or Case Managers present the IMM to Medicare patients (or family/representative, as appropriate) scheduled for discharge the second IMM. 3. Unit Clinical Social Workers and Case Managers will be alerted via pager from the Teletracking system that a discharge order has been entered and the patient is to be discharged; at which time the second ("follow-up") IMM will be provided to the patient/family /representative prior to actual discharge by the Unit Clinical Social Worker or Case Manager. 4. On Fridays, for Medicare patients identified for weekend discharge, the Unit Clinical Social Workers or Case Managers reminds the patient of their Medicare rights by providing the follow-up IMM and having them re-sign the IMM. 5. Competencies regarding the IMM and the patients' rights have been reviewed with all Unit Clinical Social Workers and Case Managers and will be reviewed annually hereafter. Intensive education provided to the Clinical Resource Management department employees on 12/19/2012 regarding the new process and the implementation of daily chart reviews, which were initiated 12/20/2012. **Monitoring** The Hospital continues to track the compliance by completing a monthly audit of 20 cases to ensure patients/family/caregivers are informed of the care plan and post discharge placement.	12/20/12 12/20/12 12/20/12 12/20/12 12/20/12 12/20/12 12/20/12

A 117	Continued from page 3	A 117	Lead Clinical Social Worker or Lead Case Manager audits patient charts daily to determine if a signed copy of the IMM is located in the patients chart and shares department compliance with staff. The Lead Clinical Social Worker or Lead Case Manager is to be notified by unit Clinical Social Workers and Case Manager of all daily Medicare patients that have signed IMM and have been notified of their discharge rights; this is to be compared to the daily Medicare discharge list to ensure 100% compliance. The number of audits is based on the number of Medicare patients discharged daily. **Responsible Person(s)** Vice President, Medical Affairs ("VPMA")	12/20/12
A 144	482.13(c)(2) PATIENT RIGHTS: CARE IN SAFE SETTING The patient has the right to receive care in a safe setting. This STANDARD is not met as evidenced by: Surveyor: 29774 Based on observation, interview and document review, it was revealed that the facility failed to take steps to ensure patient safety in 1 out of 10 patient's hemodialysis stations observed. Findings include: On 11/19/12 at approximately 1100 during facility tour on 4-East, revealed in the in-patient hemodialysis unit, the patient at station #10 was dialyzing; lying in bed, covered from head to toe with a blanket, including the access site. Interview with Staff O, the unit's nursing manager on 11/19/12 at 1100 confirmed that the patient was covered from head to toe and said "he shouldn't be covered like that". On 11/19/12 at approximately 1530, during review of facility policy title "Hemodialysis – Initiation" dated 4/1/12 revealed "...15. Keep lines and access visible to nursing staff..".	A 144	To ensure the patient is receiving care in a safe setting, the Hospital has taken the following actions: 1. The issue was immediately corrected on 11/19/2012 by uncovering the access site of patient at Station #10. 2. Re-education of 4E staff on policy 2 PC 5105 Hemodialysis initiation, with emphasis on keeping lines and access site visible. Re-education conducted by nurse educators, nurse specialists, and unit managers on 12-20-12. 3. Established a new process for the use of a Drape sheet around the dialysis access site in a manner that ensures lines are accessible and visible. Instituted 12/20/12. **Monitoring** Audits began on 12/20/12 and are conducted on a weekly basis with a goal of 100% compliance **Responsible Person(s)** Vice President, Patient Care	11/19/12 12/20/12 12/20/12
A 168	482.13(e)(5) PATIENT RIGHTS: RESTRAINT OR SECLUSION The use of restraint or seclusion must be in accordance with the order of a physician or other licensed independent practitioner who is responsible for the care of the patient as specified under §482.12(c) and authorized to order restraint or seclusion by hospital policy in accordance with State law.	A 168	To ensure the use of restraint and/or seclusion are in accordance with the order of a physician or other LIP on behalf of the physician, provided such is within the scope of the LIP's practice, who is responsible for the care of the patient and authorized to order restraint and/or seclusion by hospital policy in accordance with State law, the Hospital has taken the following actions:	Completed 12/19/12

A 168	Continued from page 4 This STANDARD is not met as evidenced by: Surveyor: 30988 On 11/19/12 at approximately 1330 (1:30 PM) during medical record review of patient #27 it was discovered that restraint orders were written on 11/16/12 at 18:17 (6:17 PM) by a medical resident and discontinued on 11/16/12 at 07:39 (7:39 AM) by a different medical resident. The orders have not been counter signed by the attending physician. On 11/19/12 at approximately 1345 (1:45 PM) during medical record review of patient #28 it was discovered that restraint orders were written on 11/09/12 at 21:48 (9:48 PM) by a medical resident and discontinued on 11/12/12 at 21:41 (9:41 PM) by a PA-C , restraints were ordered again on 11/19/12 at 17:15 (5:15 PM) by the PA-C and then discontinued. The orders have not been counter signed by the attending physician. Surveyor: 29955 Based on medical record review, interview, and policy review the facility failed to ensure restraint orders were ordered or authenticated by the attending physician for six out of eight patients (#2,#3,#4,#27,and #28) resulting in the restraint of a patient without an order. On 11/19/2012 at approximately 11:00 am during the medical record review of patient #2 it was revealed the patient #2 was in bilateral soft restraints for medical necessity were ordered by the medical resident on 11/10/2012 at 10:06 am and the order was rejected by the attending physician on 11/17/2012 at 06:26 am. The rejected order stated "wrong clinician". Staff #G was asked why the physician did not authenticate the orders and he stated "it was a misunderstanding between the intensivist and attending physician who would authenticate the order". On 11/19/2012 at approximately 11:20 am during the medical record review of patient #3 it was revealed the patient #3 was in bilateral soft restraints for medical necessity were ordered by the medical resident on 11/5/2012 at 10:08 am and the order was rejected by the attending physician on 11/16/2012 at 04:42 am. The rejected order stated "wrong clinician". Staff #G was asked why the physician did not authenticate the orders and he stated "it was a misunderstanding between the intensivist and attending physician who would authenticate the order". On 11/19/12 at approximately 11:35 am during the medical record review of patient #4 it was revealed the patient #2 was in bilateral soft restraints for medical necessity were ordered by the medical resident on 11/15/2012 at 12:33 pm and the order was rejected by the attending physician on 11/17/2012 at 14:21pm. The rejected ordered stated "wrong clinician". Staff	A 168	On 12/21/2012, SGH drafted and implemented guidelines and protocols for use of medical restraints and/or seclusion across all inpatient units at the Hospital, including ICU and specialty care units, to provide more definition on the notification of attending physicians of restraint and/or seclusion orders entered by a medical resident or other licensed independent practitioner and to clarify the authentication/countersignature procedures. These changes included: 1. The Initiate Restraint Protocol Order has been discontinued in the EMR as of 12/21/2012, and this electronic order has been de-activated in the EMR, which eliminates the order going to the inbox of a physician that did not order the restraints thereby eliminating the possibility of a "refusal to sign" the restraint order. 2. An EMR enhancement was also developed and is in the testing phase to capture the notification of the attending physician that the patient is in restraints for immediate physical safety. 3. An EMR report draft has been developed to alert the VPMA/VP of Quality & Safety on a daily basis (i) of all orders entered by an RN or licensed independent practitioner (LIP), (ii) that an order was sent to Message Center /Inbox of the attending physician, and (iii) the order was signed by the attending physician. VPMA/VP Quality & Safety will follow up with all physicians with unsigned orders to ensure orders are signed on time. 4. All orders are entered as initiate restraint orders by a physician or on behalf of a physician. When orders are entered by a medical resident or by a licensed independent practitioner (LIP) on behalf of a physician, the orders are now directed to the primary treating physician, who is defined as the "Attending Physician" for purposes of the protocol, for authentication/countersignature as appropriate. The medical resident or LIP ordering the restraints must notify the attending physician as soon as possible (and in every case within 1 hour) of the initial or renewal order for a patient requiring medical restraints for immediate physical safety. This notification shall be documented in the patient's medical record. These revised procedures were implemented as of 12/21/2012. 5. During each shift or more often as appropriate, the nursing teams review a list of patients in restraints, and their current orders. The Nursing team communicates with the Floor Assigned	

A 168	Continued from page 5 #G was asked why the physician did not authenticate the orders and he stated it was a misunderstanding between the intensivist and attending physician who would authenticate the order". On 11/19/12 at approximately 11:35 am during the medical record review of patient #4 it was revealed the patient #2 was in bilateral soft restraints for medical necessity were ordered by the medical resident on 11/15/2012 at 12:33 pm and the order was rejected by the attending physician on 11/17/2012 at 14:21pm. The rejected ordered stated "wrong clinician". Staff #G was asked why the physician did not authenticate the orders and he stated it was a misunderstanding between the intensivist and attending physician who would authenticate the order". According to Policy No. 1 CLN 008 "restraint us in the non-psychiatric, medical/surgical healthcare setting" (p. 12) "the physician must be contacted prior to the application of restraints, face to face assessment by physician required, order good for a maximum of one calendar day". The attending physician refused to sign the restraint order and did not evaluate the order per the facility's policy and rejected the order subsequently days later.	A 168	LIP a list of patients in restraints for review and assessments as to whether restraints should be continued. 6. The LIP team ensures that the Primary Treating Physician is aware of the present assessment of patient condition and discusses the need for a "continue" or "discontinue" restraint order and obtains order to continue or discontinue. 7. Orders entered by a LIP on behalf of the Primary Physician are countersigned by Primary Physician according to organizational policy on verbal/ telephone orders. VPMA or VP, Quality & Safety ensures that orders are placed in EMR and all countersignatures are completed on time. Education: VPMA and/or VP, Quality & Safety shall provide education to all LIPs, RNs, and medical residents regarding the revised restraint protocols (i) initially, no later than January 31, 2013, (ii) prior to employ's first day of employment with Hospital, and (iii) on an annual basis thereafter. **Monitoring** Senior administration and informational technology staff developed a restraint audit tool for daily monitoring of restraint compliance to be conducted by VP Quality & Safety. Daily restraint monitoring was implemented on 12/19/12. **Responsible Person(s)** Vice President, Medical Affairs	
A 170	482.13(e)(7) PATIENT RIGHTS: RESTRAINT OR SECLUSION The attending physician must be consulted as soon as possible if the attending physician did not order the restraint or seclusion. This STANDARD is not met as evidenced by: Surveyor: 30988 Based on record review, interview, and policy review the facility failed to ensure that the attending physician who is responsible for the management and care of the patient was notified as soon as possible when the attending physician did not write the restraint order in 6 of 8 medical records of patients in restraints reviewed (#2, #3, #4, #27, &#28) . This has the potential to impact the care and safety of all patients in restraints. Findings include:	A 170	To ensure the attending physician is consulted as soon as possible if he/she did not order the restraint or seclusion, the Hospital revised its process to require RN, LIP, or other ordering physician to notify attending physician as soon as possible, and in all cases, within 1 hour, of initial or renewal order for patient requiring medical restraints (non-violent; non-self destructive) for immediate physical safety. This notification and consultation is documented in the medical record. Implemented 12/21/12. 1. The nurse reassesses the patient according to policy and confers with the LIP team regarding the need for an order continuing or discontinuing the restraints. The LIP team ensures that the Attending Physician is aware of the present assessment of patient condition, the initiation of restraints and/or seclusion, and discusses the need for a "continued" or "discontinue" restraint order and obtains order	12/21/12

A 170	Continued from page 6 On 11/19/12 at approximately 1330 (1:30 PM) during medical record review of patient #27 it was discovered that restraint orders were written on 11/16/12 at 18:17 (6:17 PM) by a medical resident and discontinued on 11/18/12 at 07:38 (7:39 AM) by a different medical resident. The orders have not been counter signed by the attending physician and there is no documentation of the attending physician being notified. On 11/19/12 at approximately 1345 (1:45 PM) during medical record review of patient #28 it was discovered that restraint orders were written on 11/09/12 at 21:48 (9:48 PM) by a medical resident and discontinued on 11/12/12 at 21:41 (09:41 PM) by a PA-C , restraints were ordered again on 11/19/12 at 17:15 (5:15 PM) by the PA-C and then discontinued. The orders have not been counter signed by the attending physician and there is no documentation of the attending physician being notified. Review of policy# 1 CLN 008 titled "Restraint Use in the Non-Psychiatric, Medical/Surgical Healthcare Setting" states under Orders...#2 The ordering physician must consult the attending physician as son as possible (within 1 hour) of application if the attending physician did not order the restraint. Interview of staff FF on 11/21/12 at approximately Surveyor: 29955 On 11/19/2012 at approximately 11:00 am during the medical record review of patient #2 it was revealed the patient #2 was in bilateral soft restraints for medical necessity were ordered on 11/10/2012 at 10:06 am and the order was rejected by the attending physician on 11/17/2012 at 06:26 am. The rejected ordered stated "wrong clinician". Staff #G was asked why the physician did not authenticate the orders and he stated "it was a misunderstanding between the intensivist and attending physician who would authenticate the order". The attending physician was not notified within one hour according to the facility's policy. On 11/19/2012 at approximately 11:20 am during the medical record review of patient #3 it was revealed that the patient #3 was in bilateral soft restraints for medical necessity were ordered by the medical resident on 11/5/2012 at 10:08 am and the order was rejected by the attending physician on 11/16/2012 at 04:42 am. The rejected ordered stated "wrong clinician". Staff #G was asked why the physician did not authenticate the orders and he stated "it was a misunderstanding between the intensivist and attending physician who would authenticate the order". The attending physician was not notified within one hour according to the facility's policy	A 170	to continue or discontinue. 2. The LP team ensures that orders continuing or discontinuing restraints and/or seclusion are entered in EMR on behalf of the Attending Physician for his authentication/countersignature. 3. Education has been provided to nursing unit staff and LIPs. Education of the Medical Staff and Medical Residents is ongoing. **Monitoring** VP, Quality & Safety will conduct 100% concurrent review of daily report against the medical record to ensure compliance. **Responsible Person(s)** Vice President, Patient Care Vice President, Medical Affairs	

A 170	Continued from page 7 On 11/19/2012 at approximately 11:35 am during the medical record review of patient #4 it was revealed the patient #2 was in bilateral soft restraints for medical necessity were ordered by the medical resident on 11/15/2012 at 12:33 pm and the order was rejected by the attending physician on 11/17/2012 at 14:21pm. The rejected ordered stated "wrong clinician". Staff #G was asked why the physician did not authenticate the orders and he stated it was a misunderstanding between the intensivist and attending physician who would authenticate the order". The attending physician was not notified within one hour according to the facility's policy.	A 170		
A 171	482.13(e)(8) PATIENT RIGHTS: RESTRAINT OR SECLUSION Unless superseded by State law that is more restrictive-- (i) Each order for restraint or seclusion used for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, a staff member, or others may only be renewed in accordance with the following limits for up to a total of 24 hours: (A) 4 hours for adults 18 years of age or older; (B) 2 hours for children and adolescents 9 to 17 years of age; or (C) 1-hour for children under 9 years of age; This STANDARD is not met as evidenced by: Surveyor: 29955 On 11/19/2012 at approximately 11:00 am during the medical record review of patient #2 it was revealed the patient #2 was in bilateral soft restraints for medical necessity were ordered by the medical resident on 11/10/2012 at 10:06 am	A 171	To the best of Hospital's knowledge, none of the patient records reviewed involved the use of restraints in the management of violent or self-destructive behavior. To the extent the survey is addressing the use of restraint or seclusion for the management of such patients, the Hospital requires that each order for restraint or seclusion used for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, a staff member, or others may only be renewed in accordance with the following limits for up to a total of 24 hours: A) 4 hours for adults 18 years of age or older; (b) 2 hours for children and adolescents 9 t0 17 years of age; or (C) 1 hour for children under 9 years of age. For purpose of medical restraints (for non-violent, non-self-destructive patients), the Hospital has implemented the following measures: 1. The RN, LIP, or other ordering physician notifies attending physician as soon as possible, and in every case within 1 hour, of initial or renewal order for patient requiring medical restraints (non-violent; non-self-destructive) for immediate physical safety. This notification is documented in the medical record. 2. The Initiate Restraint Protocol Order has been discontinued in the EMR as of 12/21/2012, and this electronic order has been de-activated in the EMR, which eliminates the order going to the inbox of a physician that did not order the restraints thereby eliminating the possibility of a "refusal to sign" the restraint order. 3. An EMR enhancement was also developed and is in the testing phase to capture the notification of the attending physician that the patient is in restraints for immediate physical safety.	Completed 12/21/12

A 171	Continued from page 8	A 171	4. An EMR report draft has been developed to alert the VPMA/VP of Quality & Safety on a daily basis (i) of all orders entered by an RN or licensed independent practitioner (LIP), (ii) that an order was sent to Message Center /Inbox of the attending physician, and (iii) the order was signed by the attending physician. VPMA/VP Quality & Safety will follow up with all physicians with unsigned orders to ensure orders are signed on time. 5. All orders are entered as initiate restraint orders by a physician or on behalf of a physician. When orders are entered by a medical resident or by a licensed independent practitioner (LIP) on behalf of a physician, the orders are now directed to the primary treating physician, who is defined as the "Attending Physician" for purposes of the protocol, for authentication/countersignature as appropriate. The medical resident or LIP ordering the restraints must notify the attending physician as soon as possible (and in every case within 1 hour) of the initial or renewal order for a patient requiring medical restraints for immediate physical safety. This notification shall be documented in the patient's medical record. These revised procedures were implemented as of 12/21/2012. 6. During each shift or more often as appropriate, the nursing teams review a list of patients in restraints, and their current orders. The Nursing team communicates with the Floor Assigned LIP a list of patients in restraints for review and assessments as to whether restraints should be continued. 7. The LIP team ensures that the Primary Treating Physician is aware of the present assessment of patient condition and discusses the need for a "continue" or "discontinue" restraint order and obtains order to continue or discontinue. 8. Orders entered by a LIP on behalf of the Primary Physician are countersigned by Primary Physician according to organizational policy on verbal/ telephone orders. 9. VPMA or VP, Quality & Safety ensures that orders are placed in EMR and all countersignatures are completed on time.	

A 171	Continued From page 9 And the order was rejected by the attending physician on 11/17/2012 at 06:26 am. The rejected ordered stated "wrong clinician". Staff #G was asked why the physician did not authenticate the orders and he stated it was a misunderstanding between the intensivist and attending physician who would authenticate the order". No renewal of orders occurred for the use of restraints from 11/10/2012 to 11/20/2012. On 11/19/2012 at approximately 11:20 am during the medical record review of patient #3 it was revealed that the patient #3 was in bilateral soft restraints for medical necessity were ordered by the medical resident on 11/5/2012 at 10:08 am and the order was rejected by the attending physician on 11/16/2012 at 04:42 am. The rejected ordered stated "wrong clinician". Staff #G was asked why the physician did not authenticate the orders and he stated "it was a misunderstanding between the intensivist and attending physician who would authenticate the order". No renewal of orders occurred for the use of restraints from 11/15/2012 to 11/20/2012. On 11/19/2012 at approximately 11:35 am during the medical record review of patient #4 it was revealed the patient #2 was in bilateral soft restraints for medical necessity were ordered by the medical resident on 11/15/2012 at 12:33 pm and the order was rejected by the attending physician on 11/17/2012 at 14:21pm. The rejected ordered stated "wrong clinician". Staff #G was asked why the physician did not authenticate the orders and he stated it was a misunderstanding between the intensivist and attending physician who would authenticate the order". No renewal of orders occurred for the use of restraints from 11/15/2012 to 11/20/2012. Surveyor: 30988 Based on medical record review , interview, and policy review the facility failed to renew restraint orders no less than once every calendar day based on face to face assessment of the patient in 6 of 8 restrained patients records reviewed (#2, #3, #4, #27, and #28). Resulting in the potential for patients to be restrained longer than necessary and without a physician order. Findings include: On 11/19/12 at approximately 1330 (1:30 PM) during medical record review of patient #27 it was discovered that restraint orders were written on 11/16/12 at 18:17 (6:17 PM) by a medical resident and discontinued on 11/18/12 at 07:38 (7:39 AM) by a different medical resident.	A 171	**Monitoring** Vice President, Quality & Safety is conducting 100% concurrent review of all patients in medical restraints. **Responsible Person(s)** Vice President, Patient Care Vice President, Medical Affairs	

A 171	Continued from page 10 The orders have not been counter signed by the attending physician and there is no documentation of the attending physician being notified. There are no orders to renew the restraints for 11/17/12, 11/18/12 and 11/19/12. On 11/19/12 at approximately 1345 (1:45 PM) during medical record review of patient #28 it was discovered that restraint orders were written on 11/09/12 at 21:48 (9:48 PM) by a medical resident and discontinued on 11/12/12 at 21:41 (9:41 PM) by a PA-C , restraints were ordered again on 11/19/12 at 17:15 (5:15 PM) by the PA-C and then discontinued. The orders have not been counter signed by the attending physician and there is no documentation of the attending physician being notified. There are no orders to renew the restraints for 11/10/12, 11/11/12, and 11/12/12. Review of policy# 1 CLN 008 titled "Restraints Use in the Non-Psychiatric, Medical/Surgical Healthcare Setting" states under Orders...#5 A restraint order is good for a maximum of one calendar day....B Continued use of restraint beyond the first day requires an order by the physician no less than nonce every calendar day based on face to face assessment of the patient. Interview of staff FF on 11/21/12 at approximately 1000 (10:00 AM) confirmed there are no further restraint orders.	A 171		
A 175	482.13(e)(10) PATIENT RIGHTS: RESTRAINT OR SECLUSION The condition of the patient who is restrained or secluded must be monitored by a physician, other licensed independent practitioner or trained staff that have completed the training criteria specified in paragraph (f) of this section at an interval determined by hospital policy. This STANDARD is not met as evidenced by: Surveyor 30988 Based on medical record review , interview, and policy review the facility failed to monitor restrained patients in 7 of 8 restrained patients records reviewed (#2, #3, #4, #5, #27, and #28). Resulting in the potential for physical harm to the patients. Findings include: During medical record review on 11/19/12 at approximately 1330, it was revealed on the Electronic medical record (EMR) a shift	A175	To ensure that the condition of the patient who is restrained or secluded is monitored by a physician, other LIP, or trained staff the Hospital, SGH has taken the following measures: 1. Educators and Unit Managers of the Non-Psychiatric, Medical/Surgical Units, including the ICUs, provided re-education to the RN staff on the requirement to complete the "Restraint Q2hr (every 2 hours) Check task" in the EMR, on every patient with an active Restraint order. Completed 12-21-12 2. On a daily basis, Unit Managers or designee of the Non Psychiatric, Medical/Surgical Units, including the ICUs, monitor the "Restraint Q2hr (every 2 hours) Check task" in the EMR on every restraint patient. Implemented 12/21/12	Completed 12/21/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1)PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	230024	A. BUILDING _____ B. WING _____	11/21/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SINAI-GRACE HOSPITAL	6071 W OUTER DRIVE DETROIT, MI 48235

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PROCEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 175	Continued From page 11 Assessment is completed and restraint is a yes or no question there is no documentation of patient care during restraint. Review of policy# 1 CLN 008 titled "Restraint Use in the Non-Psychiatric, Medical/Surgical Healthcare Setting" states under "Patient care during restraint...#2 when restraint is in place, the patient is assessed, monitored and re-evaluated based on the patients care needs, at a minimum of every two (2) hours. #3 monitoring includes and determines: A the proper application of the restraint B. Skin integrity and circulation to affected areas C Need to provide active/passive range of motion D Protection of the patients rights, dignity, and safety E Patients behavior/activity F Physical comfort/safety G Whether less restrictive alternatives are possible #4. Nutrition/Hydration, Toileting , and Hygiene . During an interview with staff S on 11/20/12 at approximately 0900 (9:00 AM) "the staff do hourly checks and write on the white boards but they do not have an every 2 hour documentation record". An interview with FF on 11/20/12 at approximately 1330 (1:00 PM) it was confirmed there is no documentation of reassessment every two (2) hours while is restraint.	A 175	**Monitoring** Implemented 'Oversight' audit (12/19/12) by nursing quality staff on Non Psychiatric, Medical/Surgical Units, including the ICUs - to monitor the "Restraint Q2hr (every 2 hours) Check task" in the EMR , on all patients with an active Restraint order. Schedule of the oversight audit: daily x (1) month; weekly x (1) month; 2 times/month; monthly ongoing. Target = 100% compliance. The result of the 'Oversight audit' to be reported to the VP of Patient Care Services, Unit Managers, and Unit Staff (daily) and subsequently to Professional Nurse Council and site's High Reliability Organization Committee(monthly). Implemented 12/19/12 Non-compliance by staff is addressed by Unit Managers in accordance the HR Policy on Progressive disciplinary actions. Reference: 1 HR 506 -- progressive discipline. Implemented 12/21/12. **Responsible Person(s)** Vice President, Patient Care Vice President, Medical Affairs	
A 396	482.23(b)(4) NURSING CARE PLAN The hospital must ensure that the nursing staff develops, and keeps current, a nursing care plan for each patient. This STANDARD is no met as evidenced by:	A 396	To ensure that nursing staff develops and keeps current a nursing care plan for each patient, the Hospital has taken the following actions: 1. Educators and Unit Managers of all patient care Units re-educated nursing staff regarding initiation, review and updating the patient's Plan of Care. Completed 12-21-12. 2. A Tier 3 SGH policy on Plan of Care developed and implemented to guide the updating of the patient's Plan of Care – to include 'admitting' nurse and 'subsequent' nurses' responsibilities. Completed 12-20-12.	Completed 12/21/12

A 396	Continued from page 12 Surveyor: 29313 Based on medical record review and interview the facility failed to ensure that nursing staff keeps a current care plan for each patient in 1 out of 2 (#40) medical records reviewed. Findings include: During medical record review on 11/19/12 at approximately 1430 I was found that patient #40 had not had an updated plan of care since 11/12/12. During this time frame the patient had a change in his mental health status and no update to the plan of care was completed. During the medical record review on 11/19/12 at approximately 1430 staff EE was the person explaining the chart content to this surveyor and confirmed the lack of an updated plan of care for this patient.	A 396	3. Initiated development of an EMR enhancement for the addition of two fields – "Last reviewed" and "Last updated" that includes date and time (12/21/12). **Monitoring** Unit Managers monitor staff's compliance with updating plan of care. Target = 100% compliance. Non-compliance by staff is addressed by Unit Managers in accordance with the HR Policy on Progressive disciplinary actions. Reference: **1 HR 506 -- progressive discipline**. Implemented 'Oversight' audit (12/20/12) by nursing quality Schedule of the oversight audit: daily x (1) month; weekly x (1) month; 2 times/month; monthly ongoing. Target = 100% compliance. **Responsible Person(s)** Vice President, Patient Care Vice President, Medical Affairs	
A 469	482.24(c)(2)(viii) CONTENT OF RECORD – DISCHARGE DIAGNOSIS [All records must document the following, as appropriate:] Final diagnosis with completion of medical records within 30 das following discharge This STANDARD is not met as evidenced by: Surveyor: 29955 Based on document review and interview the facility failed to ensure 100 medical records were completed within 30 days. On 11/19/2012 at approximately 3:00 pm during a meeting with medical records administration it was revealed 100 records were not completed within 30 days. Seventy four records were within the 30 to 59 day range, 15 records within 60 to 89 days, 4 records within 90 to 119 days, 3 records within 120 to 149 days, 1 record within 150 to 179 days, 3 records within 200 plus days. When asked if the physicians had been made aware of the records were not completed it was stated "yes. Physicians are notified in writing and by fax that they have delinquent records. Their offices are also notified. The department heads are notified. We have done everything to try to get physicians to complete records, yet some still do not fall in compliance".	A 469	To ensure that medical record documents within 30 days following discharge the Hospital has implemented the following measures: 1. Reminder to the Medical Staff regarding the Medical Staff By-laws' guidelines for addressing Delinquent Medical Records are clearly communicated, and consistently and strictly enforced on a daily basis, such that any physician with delinquent charts greater than 25 days begins the suspension process. After the CMS-allowed 30 days, the physician is suspended: this includes no boarding of surgical cases, no admissions, and no other clinical activities until such time that the medical records are in full compliance. 2. Creation of a SGH/Tier 3 Policy: Notification Process for Medical Record Completion to support daily enforcement of delinquent medical records, effective 12/21/2012. 3. In cases where delays longer than 45 days occur, despite suspension, the Specialist in Chief, Department Chief, or the VPMA work together to complete the records as "Administrative Physicians" and the case is to be closed according to new SGH/Tier 3 Policy: Notification Process for Medical Record Completion. Such will result in additional medical staff action	12/21/12

A 469	Continued from page 13	A 469	pursuant to the Medical Staff Bylaws. **Monitoring** Monthly audits of 100 % of medical records by practitioner . **Responsible Person(s)** Vice President, Medical Affairs	12/21/12
A 700	482.41 PHYSICAL ENVIRONMENT 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: Surveyor: 22182 The facility failed to provide and maintain a safe environment for patients and staff. This is evidenced by the Life Safety Code deficiencies identified. See A-709	A 700	To ensure that the Hospital provides and maintains a safe environment for patients and staff, the Hospital has taken a number of immediate actions, as well as, other permanent actions, as more fully described in the Plan of Correction for the K Tags cited in CMS form 2567, dated November 20, 2012. The Plan of Correction for same is included herewith.	
A 701	482.14(a) MAINTENANCE OF PHYSICAL PLANT 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: Surveyor: 22182 Based on interview and observation, the facility failed to provide an environment that ensures the safety and well being of patients. Findings include: During the facility tour on the morning of November 19, 2012, three patients on stretchers were observed unattended in the corridor of the Nuclear Med Suite. Interview with the Nuclear Med Manager during the facility tour revealed that the patients either were waiting transport or waiting to enter a Nuclear Med Room. It was also stated during the interview that on average a patient is waiting unattended in the corridor for about 20 or 30 minutes. During this time, the patient has no device to call for staff during an emergency unless they are physically able to yell loud enough that staff can hear the staff which is usually in a room off of the corridor. During the facility tour on the morning of November 19, 2012, dead flies/insects were observed in the light fixtures throughout the radiology department located on the 6th floor of the facility. During the facility tour on the morning of November 20, 2012, the floor in the Decon room in Central Sterile looked stained/soiled. Interview	A 701	Effective 12/17, 2012, the Hospital has prohibited patients waiting unattended on stretchers in the corridor near the Nuclear Medicine Suite. All patients awaiting Nuclear Medicine studies will be held in the patient holding room in Nuclear Medicine and monitored as appropriate. This policy change has been communicated to appropriate staff members. **Monitoring** Quality & Safety staff will conduct visual spot-checks of the patient holding area and the referenced corridor and report to the VP, Quality & Safety. **Responsible Person(s)** Vice President, Quality & Safety WO# 212277 Removed flies from light fixture and cleaned. Light fixture cleaning has been added to the routine cleaning checklist. WO# 213286 To be painted by Accurate Painting. Quote accepted. PO#2012 0201 620 579 SGS	12/17/12 11/21/12 Completed 12/23/12

A 701	Continued from page 14 with the Central Sterile Manager revealed that the floor is cleaned each night but some stains cannot be removed which makes the floor look dirty even after cleaning.	A 701		
A 709	482.41(b) LIFE SAFETY FROM FIRE Life Safety from Fire This STANDARD is not met as evidenced by: Surveyor: 22182 Based upon on-site observation and document review by Life Safety Code (LSC) surveyors, the facility does not comply with the applicable provisions of the 2000 Edition of the Life Safety Code. See the K-tags on the CMS-2567 dated November 20, 2012 for Life Safety Code.	A 709	To ensure that the Hospital complies with the applicable provisions of the 2000 Edition of the Life Safety Code, the Hospital has taken a number of immediate actions, as well as, other permanent actions, as more fully described in the Plan of Correction for the K Tags cited in CMS form 2567, dated November 20, 2012. The Plan of Correction for same is included herewith.	
A 726	482.41 (c)(4) VENTILATION, LIGHT, TEMPERATURE CONTROLS There must be proper ventilation, light, and temperature controls in pharmaceutical, food preparation, and other appropriate areas. This STANDARD is not met as evidenced by: Surveyor: 22182 Based on observation and interview, the facility failed to provide proper ventilation to the inpatient dialysis unit. Findings include: During the facility tour on November 20, 2012 it was observed that two portable air conditioning units were within the inpatient dialysis unit. Interview with the Dialysis Manager revealed that these units had been installed a while back and are utilized year round. It was also stated that the unit was originally designed as an infusion unit and converted to dialysis. The existing ventilation was not designed to account for the dialysis machine heat load. The portable air conditioning units were connected to the plumbing under the hand wash sinks and one of the two air conditioning units was blocking access to the hand wash sink.	A 726	To provide proper ventilation to the inpatient dialysis unit, the Hospital has taken the following action WO# 213287 Two portable AC units were removed from the Dialysis unit. They are being replaced with a recessed ceiling mounted DX AC system. To be completed by 02-08-13. Current units have been repositioned to not block sink access. PO#2012 0201 621 600 SGS	Estimated Completion 2/08/13
A 749	482.42(a)(1) INFECTION CONTROL OFFICER RESPONSIBILITIES 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: Surveyor: 29313	A 749	To ensure that the Hospital maintains a sanitary environment and ensures that staff are using personal protective equipment according to policy to protect again the potential for spread of infectious agents to patients, the Hospital has taken the following immediate actions:	

A 749	Continued from page 15 Based on observation, policy and procedure review and interview the facility failed to, maintain a sanitary environment and ensure staff are using personal protective equipment according to policy, resulting in the potential for the spread of infectious agents to patients. Findings include: During the tour of the facility on 11/19/12 between the hours of 1130-1500 the following was observed: 1-West: 1. In room 114-west the sink was dirty with debris 2. The freezer in the nourishment room on 1-west was dirty with debris and had a large amount of ice build up. 3. In room 106-west there was a lack of high dusting throughout the room, including the cabinets and closets. The front of the cabinets were soiled and dirty from not being cleaned appropriately. This was all confirmed by staff CC at the time of the tour observations. 2-East 1. In room 107-E the inside the closets were dusty and high surfaces had dust build up. 2. In room 110-E the bath tub and sink were dirty and high surfaces through out the room had dust build up. This was all confirmed by staff DD at the time of the tour observations. 5-South 1. The dietary room was unsanitary, it had debris on the counters, cabinets had dried material on it, Fingerprints could be seen. 2. The seclusion rooms bathroom was unsanitary, it's toilet, shower and sink appeared to not have been cleaned after the last patient that occupied the room. 3. The medication room had patient equipment and care items on the counter next to the sink with the risk of contamination by the splashing/dripping of water. The pill crusher had left over residue from the previous medication that was crushed on it. This was all confirmed by staff EE at the time of the tour observations. During the tour of the facility on 11/20/12 between the hours of 1000-1200 the following was observed:	A 749	• The Hospital has reviewed and updated its housekeeping schedule for the entire facility, including, without limitation, all patient care areas, and those areas of the Hospital directly impacting patients and patient care. • The Hospital has revised its housekeeping checklists for each area of the Hospital to ensure thorough cleaning and, as appropriate, disinfecting. • The Hospital is in the process of providing additional staff education regarding infection control procedures, including, without limitation, the use of gowns, gloves, and/or masks, as appropriate. 1-West 1. Patient room (114W) sink is cleaned twice daily. The manager of environmental services is in charge of this process. Implemented 12/19/12. 2. Dietary staff defrosted and cleaned the freezer on 1 West. Freezer placed on weekly cleaning schedule effective 12/20/12. 3. Regular dusting and cleaning cabinet fronts (106W) are done once daily and high dusting is done weekly. The manager of environmental services is in charge of this process. Implemented 12/19/12. 2-East 1. Regular dusting and cleaning cabinet fronts (107E) are done once daily and high dusting is done weekly. The manager of environmental services is in charge of this process. Implemented 12/19/12. 2. Patient room (110E) sink and tub are cleaned twice daily. The manager of environmental services is in charge of this process. Implemented 12/19/12. 5-South 1. Dietary room cleaned, counters, cabinets and finger prints. Placed on daily cleaning schedule. Effective 12/20/12. 2. As of 12/19/12, Seclusion rooms including toilet, shower, and sink are cleaned daily and upon discharge of patient. The director of Psychiatric Services is in charge of ensuring that this process occurs. Effective 12/19/12. 3. (a) All patient equipment and care items on the counter next to the sink were removed. Unit Manager is monitoring staff compliance. Effective 12/19/12. (b) Pill crusher was cleaned 11/21/12.	12/12/12 01/01/13 01/04/13 12/19/12 12/20/12 12/19/12 12/19/12 12/19/12 12/20/12 12/19/12 12/19/12 11/21/12

A 749	Continued from page 16 Rehabilitation Unit 1. The shower and tub on the rehabilitation unit was unsanitary, they had debris and dirt inside of them 2. The rehabilitation gym had dirty parallel bars and floor runner dirty with debris 3. The rehabilitation refrigerator was dirt with debris and dried on liquid. 4. The rehabilitation kitchen was unsanitary, the cabinets and drawers had a lot of debris and dried on liquid that had not been cleaned. Finger prints were visible on the outside of the cabinets. This was all confirmed by staff CC at the time of the tour observations. When staff CC was asked how the unit ensured the equipment was disinfected between patient usage, he replied that the staff cleaned them between patients, but there was no type of check list or terminal cleaning list to ensure that it was being completed, housekeeping wiped down the equipment periodically. Surveyor: 29774 On 11/19/12 at approximately 1130 during observational tour of 4-East in-patient hemodialysis unit, observed Staff R, a hemodialysis nurse, in a private room, labeled Station #1, without gown or gloves. The private room was labeled with a sing "Contact Precautions...Gown and gloves required upon room entry". Staff R was asked why she didn't have the required gown and gloves on to which she replied, "I was just taking his vital signs". Staff O confirmed on 11/19/12 at 1130, that Staff R "should have worn the personal protective equipment listed on the sign".	A 749	1) Educators and Unit Managers of all patient care Units re-educated nursing staff regarding the cleaning of 'Pill Crusher' – upon every use – to ensure of no residue. Completed 12-21-12. 2) Unit Managers monitoring staff's compliance regarding the cleaning of 'Pill Crusher' – upon every use – to ensure of no residue. Target = 100% compliance. 3) Non-compliance by staff shall be addressed by Unit Managers with the HR Policy on Progressive disciplinary actions. Reference: 1 HR 506 -- progressive discipline. Rehabilitation Unit 1. As of 12/19/12, Rehab unit is cleaned on a daily basis, including the shower, tubs, and floor runner. The director of environmental services is in charge of in- patient and the director of Rehab services is in charge of the out- patient areas. 2. Parallel bars are cleaned in between patient therapy daily by rehab staff. Parallel bars are cleaned weekly by EVS and included in their log. Effective 12/21/12. 3. Refrigerator in the Rehab practice kitchen cleaned and maintained by therapy personnel. Cleaning is included on equipment weekly cleaning log. Implemented 12/21/12. 4. Kitchen is utilized as a training tool and cleaned by rehab staff, special cleaning is also done upon request. Cabinets in the rehab practice kitchen are part of a weekly deep clean by EVS and documented in the EVS log . Effective 12/19/12, Equipment in Rehab gym is cleaned between patients and patient hand hygiene is observed per policy 2 IC 046 – Rehabilitation Services Guidelines for Infection Control and Equipment Cleaning Log was implemented to further document weekly cleaning. Effective 12/21/12. <u>4-East</u> Contact Precautions 1. Educators and Unit Managers of all patient care Units re-educated nursing staff regarding the Contact Precaution – Gown and gloves required upon room entry. Completed 12-21-12. 2. Unit Managers ongoing monitoring staff's compliance regarding the Contact Precaution – Gown and gloves required upon room entry. 3. Unit Managers to perform observational monitoring of all staff, as well as patient's family/visitors' compliance to the	12/21/12 12/21/12 12/21/12 12/19/12/ 12/21/12 12/21/12 12/21/12 12/21/12

A 749	Continued from page 17 On 11/19/12 at approximately 1540 a review of facility policy titled "DMC Isolation Policy" dated May 29, 2012 revealed "Contact Precautions...Used to prevent transmission of infectious agents which are spread by direct or indirect contact with the patient or the patient's environment...Gown and gloves required upon room entry. Discard PPE (personal protective equipment) before exiting room...". On 11/19/12 at approximately 1150 during observational tour of 4-East in-patient hemodialysis unit revealed one of two blood glucose testing machines with white paper-tape around the base of one of the two machines. Staff Q, the certified nurse educator was asked how the machine is cleaned with residual tape remaining on the unit to which she replied, "they really can't clean it. We are going to be replacing these (blood glucose testing) machines this month." On 11/19/12 at approximately 11:45, during the observational tour of 5-East revealed in the medication area a pill crusher soiled with residual white powder. Staff P, the charge nurse mentioned, "wow, look at that". Staff P was asked on 11/19/12 at 1145 what the cleaning policy was for using these pill crushers to which she replied, they should be cleaned between uses for each patient".	A 749	'Isolation Precaution' requirements. Schedule of the audit: Daily x 1 week, Weekly x (1) month; biweekly X (2) months; then monthly ongoing. Target = 100% compliance. 4. Non-compliance by staff shall be addressed by Unit Managers with the HR Policy on Progressive disciplinary actions. Reference: **1 HR 506 -- progressive discipline**. Glucose testing machine was removed from service and replaced with 2 new machines. Staff were re-educated regarding proper maintenance of glucose testing machine. If machine requires the use of tape, it will not be used and will be returned to the laboratory for repair or replacement. Machines replaced 12/21/12. Pill crusher was cleaned 11/21/12. 1. Educators and Unit Managers of all patient care Units re-educated nursing staff regarding the cleaning of 'Pill Crusher' – upon every use – to ensure of no residue. Completed 12-21-12. 2. Unit Managers monitoring staff's compliance regarding the cleaning of 'Pill Crusher' – upon every use – to ensure of no residue. Target = 100% compliance. 3. Non-compliance by staff shall be addressed by Unit Managers with the HR Policy on Progressive disciplinary actions. Reference: 1 HR 506 -- progressive discipline. **Responsible Person(s)** Vice President, Patient Care Unit Managers	12/21/12 11/21/12 12/21/12 12/21/12 12/21/12
A 800	482.43(a) CRITERIA FOR DISCHARGE EVALUATIONS The hospital must identify at an early stage of hospitalization all patients who are likely to suffer adverse health consequences upon discharge if there is no adequate discharge planning. This STANDARD is not met as evidenced by: Surveyor: 32164 Based on medical record review, interview, and policy review the facility failed to identify patients at an early stage of hospitalization in need of discharge planning according to their policy in four of six patients (#35, #36, #37, and #38,). Findings include: During medical record review on 11/21/12	A 800	1. Emergency Room Clinical Social Worker (when applicable – upon consultation or if patient has a health condition that requires a discharge plan assessment to be completed within 48 hours of admission per policy) completes an initial assessment for a patient with a full admit order and communicates daily with in-house Social Worker that assessment has been completed 2. The Hospital has revised its SGH MOD CRM 20, 22 and 24 policy to require that Unit Clinical Social Workers and Case Managers check daily for new patients to their unit, for new consultations or health conditions that would require a discharge plan	12/20/12 12/20/12

A 800	Continued from page 18 between the hours of 1000-1115 it was revealed that patient #35 was admitted on 8/14/12 and had a health condition that would require a discharge plan assessment to be completed within 48 hours of admission per hospital policy. The discharge plan was completed on 8/18/12, the day of discharge. During medical record review on 11/21/12 between the hours of 1000-1115 it was revealed that patient #36 was admitted on 6/15/12 and had a health condition that would require a discharge plan assessment to be completed within 48 hoursof admission per hospital policy. The discharge plan was completed on 6/19/12, the day of discharge. During medical record review on 11/21/12 between the hours of 1000-1115 it was revealed that patient #37 was admitted on 8/17/12 and had a health condition that would require a discharge plan assessment to be completed within 48 hours of admission per hospital policy. The discharge plan was completed on 8/20/12 with a discharge date of 8/21/12. During medical record review on 11/21/12 between the hours of 1000-1115 it was revealed that patient #38 was admitted on 8/16/12 and had a health condition that would require a discharge plan assessment to be completed within 48 hours of admission per hospital policy. The medical record did not contain a social work assessment or discharge plan. During the interview with Staff FF on 11/21/12 at approximately 1110 when asked if he could produce any further social work documentation he stated " No. " On 11/21/12 at approximately 1130 a review of the facility's policy title " Initial Social Work Assessment " dated 01/01/10 revealed " It is the policy of the Clinical Resource Management Department of Social Work staff to assess patient' s needs for services, plans of discharge, and post acute setting health management services. Patients will be assessed based on the following trigger criteria for their need for services. The Social Work assessment form should be completed either after consultation or within 48 hours of admission. " Triggers include but are not limited to: Chronic disease/Complex needs with risk for readmission and history of falls, abnormal gait or unsteady gait. Each of the above listed patients had one or more triggers documented in their medical records.	A 800	assessment within 48 hours of consultation or identification of a health condition that would require a discharge plan. 3. Unit Clinical Social Workers and Case Managers along with the bedside nurse review the patient needs daily in multidisciplinary rounds to discuss identified discharge needs or barriers, document these findings, and update the discharge plan as warranted. 4. Lead Unit Clinical Social Worker or Lead Case Manager audits patient charts daily to determine documentation compliance and shares with staff daily Intensive education provided to the Clinical Resource Management department employees on 12/19/2012 and the new process including daily chart review which was initiated 12/20/2012. **Monitoring** Lead Unit Clinical Social Worker or Lead Case Manager completes a total of 45 daily chart reviews to ensure assessment/d/c planning documentation with 48 hours of an admission to ensure compliance with new process and department policy. **Responsible Person(s)** Vice President, Patient Care Vice President, Medical Affairs	12/20/12 12/20/12 12/20/12
A 821	482.43(c)(4) REASSESSMENT OF A DISCHARGE PLAN The hospital must reassess the patient's discharge plan if there are factors that may affect continuing care needs or the appropriateness of the discharge plan. This STANDARD is not met as evidenced by: Surveyor: 29313	A821	The Hospital has initiated the following actions to ensure that the discharge planning process commences with the patient's admission and continues throughout the patient's hospital stay: 1. Instituted a revised process whereby	12/20/12

A 821	Continued from page 19 Based on medical record review, policy and procedure review and interview the facility failed to ensure that the discharge plan was being reassessed for the appropriateness of the discharge plan in 1 out of 2 (#40) medical records reviewed. Findings include: During medical record review on 11/19/12 at approximately 1430 it was found that patient #40 had not had an updated discharge plan completed since 11/14/12. During this time frame the patient had a change in his mental health status and no update to the discharge plan of care was completed. During the medical record review on 11/19/12 at approximately 1430 staff EE was the person explaining the chart content to this surveyor and confirmed the lack of an updated discharge plan for this patient. During policy and procedure review of 11/20/12 at approximately 1000 it was found in the policy titled, "Discharge Planning" states, "Discharge planning is initiated on patient presentation to the health care setting and is continuously assessed and updated throughout the hospital stay".	A 821	the Unit Clinical Social Workers and Case Managers along with the bedside nurse review the patient needs daily in multidisciplinary rounds to discuss identified discharge needs or barriers, and revise/update discharge plans and documents the updates. 2. Re-educated the Unit Clinical Social Workers and Case Managers regarding the required communication with the family/patient/representative regarding the updated plan or needs. 3. Intensive education provided to the Clinical Resource Management department employees on 12/19/2012 and the new process including daily chart review which was initiated 12/20/2012. **Monitoring** Lead Unit Clinical Social Worker or Lead Case Manager completes a total of 45 daily chart reviews to ensure assessment/d/c planning documentation with 48 hours of an admission to ensure we are complaint with our new process and department policy. **Responsible Person(s)** Vice President, Patient Care Vice President, Quality & Safety	12/20/12 12/20/12 12/20/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	230024	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	11/20/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SINAI-GRACE HOSPITAL	6071 W OUTER DRIVE DETROIT, MI 48235

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS Surveyor: 13546 A Life Safety Code Validation Survey was conducted by the State of Michigan Bureau of Fire Services on November 19, 2012 and November 20, 2012 between the times of 9:00 AM and 5:00 PM. At this survey, Sinai Grace Hospital was found to be not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR Subpart 482.41(b), Life Safety from Fire, and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. This 7 story facility with a basement was determined to be of Construction Type II (222) and partially sprinkled. The facility has a total capacity of 383 beds at the time of the survey. The requirement at 42 CFR Subpart 482.41(b) is NOT MET as evitence by:	K 000		
K 017	NFPA 101 LIFE SAFETY CODE STANDARD Corridors are separated from use areas by walls constructed with at least ½ hour fire resistance rating. In sprinklered buildings, partitions are only required to resist the passage of smoke. In non-sprinklered buildings, walls properly extend above the ceiling. (Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Charting and clerical stations, waiting areas, dining rooms, and activity spaces may be open to the corridor under certain conditions specified in the Code. Gift shops may be separated from corridors by non-fire rated walls if the gift shop is fully sprinklered.) 19.3.6.1, 19.3.6.2.1, 19.3.6.5	K 017		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: President | (X6) DATE: 2/14/13

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

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K 017	NFPA 101 LIFE SAFETY CODE STANDARD Corridors are separated from use areas by walls constructed with at least ½ hour fire resistance rating. In sprinklered buildings, partitions are only required to resist the passage of smoke. In non-sprinklered buildings, walls properly extend above the ceiling. (Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Charting and clerical stations, waiting areas, dining rooms, and activity spaces may be open to the corridor under certain conditions specified in the Code. Gift shops may be separated from corridors by non-fire rated walls if the gift shop is fully sprinklered.) 19.3.6.1, 19.3.6.2.1, 19.3.6.5	K 017		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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K 017	Continued From page 1 This STANDARD is not met as evidenced by: Surveyor: 13546 Based on observation it was determined that the facility failed to provide corridor walls that could provide at least 30 minute fire-resistance rating in accordance with the LSC section 19.3.6.1, 19.3.6.2.1. This deficient practice could potentially affect all occupants of the facility. Findings include: The following violations were noted during a validation inspection conduct on November 19, 2012 and November 20, 2012 between the hours of 9:00 AM and 5:00 PM. These findings were observed and confirmed by the facility maintenance director during the inspection. * Observed an unsealed wall penetration in the door frame to room S683B. * Observed multiple unsealed wall and ceiling penetrations in communication closet M615C. * Observed an unsealed ceiling penetration in room M615. * Observed that the drywall patch needed to be repaired to meet the rating in the ceiling in closet W30E.	K 017	WO# 213245 Sealed holes in the door frame of room S683B Penetration prevention to be enforced through above the ceiling work permit program. Correction through monthly Life Safety Assessment for penetrations completed by Brooks Fire Stopping. In addition, Environmental Rounds will monitor monthly. Hospital representative responsible: Director Plant Operations WO# 211592 Sealed multiple penetrations on the walls and ceiling of M615C with HiltiSF1 Penetration prevention to be enforced through above the ceiling work permit program. Correction through monthly Life Safety Assessment for penetrations completed by Brooks Fire Stopping. In addition, Environmental Rounds will monitor monthly. Hospital representative responsible: Director Plant Operations WO# 212369 Seal penetration around junction box in ceiling and conduit coming out of ceiling down wall and 2 small holes above door. with HiltiSF1 Penetration prevention to be enforced through above the ceiling work permit program. Correction through monthly Life Safety Assessment for penetrations completed by Brooks Fire Stopping. In addition, Environmental Rounds will monitor monthly. Hospital representative responsible: Director Plant Operations WO# 213196 Patched hole with the appropriate rated drywall sealed and fire stopped as needed. Penetration prevention to be enforced through above the ceiling work permit program. Correction through monthly Life Safety Assessment for penetrations completed by Brooks Fire Stopping. In addition, Environmental Rounds will monitor monthly. Hospital representative responsible: Director Plant Operations	Completed 12/19/2012 Completed 12/19/2012 Completed 12/12/2012 Completed 12/19/2012
K 018	NFPA 101 LIFE SAFETY CODE STANDARD	K 018		

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K 018	Continued From page 2 Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. This STANDARD is not met as evidenced by: Surveyor: 13546 Based on observation the facility failed to provide corridor doors that would close and resist the passage of smoke and/or able to provide a positive latch in accordance with the LSC section 19.3.6.3. This deficient practice could potentially affect all occupants of the facility. Findings include: The following violations were noted during a validation inspection conduct on November 19, 2012 and November 20, 2012 between the hours of 9:00 AM and 5:00 PM. These findings were observed and confirmed by the facility	K 018		

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K 018	Continued From page 3 maintenance director during the inspection. · Observed the doors to room E185 were not smoke tight when closed. · Observed the doors to the Rehab area did not close to a smoke tight seal. The doors need a coordinator to allow the doors to close properly.	K 018	WO# 213170 Installed 83 1/4" aluminum astragal cut out notch to accommodate the strike plate repaired push/pull drilled & re-tapped bottom hinge. Door Deficiency prevention and correction to be accomplished through Life Safety Assessments completed monthly by Jarvis Lock and Door. Environmental Rounds will monitor monthly. Hospital representative responsible: Director Plant Operations WO# 213176 Installed 1 set of 831/8" brushes. Door Deficiency prevention and correction to be accomplished through Life Safety Assessments completed monthly by Jarvis Lock and Door. Environmental Rounds will monitor monthly. Hospital representative responsible: Director Plant Operations	Completed 12/19/2012 Completed 12/19/2012
K 027	NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-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. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7 This STANDARD is not met as evidenced by: Surveyor: 13546 Based on observation the facility failed to provide for the smoke barrier doors to be self-closing or automatic closing in accordance with the LSC section 19.2.2.2.6. This deficient practice could potentially affect all occupants of the facility. Findings include: The following violations were noted during a validation inspection conduct on November 19, 2012 and November 20, 2012 between the hours of 9:00 AM and 5:00 PM. These findings were observed and confirmed by the facility	K 027		

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K 027	Continued From page 4 maintenance director during the inspection. · Observed the cross corridor doors, WG36, do not close to a smoke tight seal due to the air pressure within the unit. · Observed that the required smoke barrier door 2G21F has been removed. · Observed an unapproved hold-open device on the smoke barrier door SG02-2 to Express Care.	K 027	WO# 213216 Installed only 1 4041 LCN closer remount coordinating catch on door / supplied & installed 1 LCN 4041 closer. Door Deficiency prevention and correction to be accomplished through Life Safety Assessments completed monthly by Jarvis Lock and Door. Environmental Rounds will monitor monthly. Hospital representative responsible: Director Plant Operations	Completed 12/19/2012
			WO# 213207 Jarvis is measuring door for replacement. Quote being processed. PO#2012 0201 632 314 SGS. Door Deficiency prevention and correction to be accomplished through Life Safety Assessments completed monthly by Jarvis Lock and Door. Environmental Rounds will monitor monthly. Hospital representative responsible: Director Plant Operations	Door installed on 01/15/13
			WO# Shaw Fire received quote and PO and removed unapproved hold open device. Door Deficiency prevention and correction to be accomplished through Life Safety Assessments completed monthly by Jarvis Lock and Door. Environmental Rounds will monitor monthly. Hospital representative responsible: Director Plant Operations	Completed 01/07/13
K 029	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Surveyor: 13546 Based on observation the facility failed to provide for the protection of hazardous areas in accordance with the LSC section 19.3.2.1. This deficient practice could potentially affect all occupants of the facility. Findings include: The following violations were noted during a	K 029		

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K 029	Continued From page 5 validation inspection conduct on November 19, 2012 and November 20, 2012 between the hours of 9:00 AM and 5:00 PM. These findings were observed and confirmed by the facility maintenance director during the inspection. · Observed the door to the storage area in the NICU needs a closer. This area is being used for storage which requires a closer on the door. · Observed that the 2nd floor clean utility storage room is not sprinkled or properly rated. · Observed that the door to the storage room at elevator 11 does not self-close and latch. · Observed a large ceiling and wall penetrations in janitor's closet located inside room M205. · Observed a large unsealed wall penetration in mechanical room M245. · Observed wood pallets being stored in soiled utility room M249. · Observed unsealed wall penetrations in electrical closet M243. · Observed an unsealed ceiling penetration around pipes in janitor's closet JC W204. · Observed an unsealed penetration above the door to the Joint Plus center. · Observed unsealed penetrations and missing pieces of block, 2nd floor, in the 2- hour wall adjacent the elevator in the small closet.	K 029	WO# 203362 Jarvis installed closer for storage room door. Door Deficiency prevention and correction to be accomplished through Life Safety Assessments completed monthly by Jarvis Lock and Door. Environmental Rounds will monitor monthly. Hospital representative responsible: Director Plant Operations	Door installed on 12/24/12
			Sprinkler head to be installed. letter of intent to repair has been received. Fire Sprinkler deficiency prevention and correction to be accomplished through adherence to building codes and AHJ inspections. Life Safety Assessments through Environmental rounds will monitor monthly. Hospital representative responsible: Director Plant Operations	Completed 1/13/2013
			WO# 213172 Door lock was repaired and closer was installed. Door Deficiency prevention and correction to be accomplished through Life Safety Assessments completed monthly by Jarvis Lock and Door. Environmental Rounds will monitor monthly. Hospital representative responsible: Director Plant Operations	Completed 12/18/2012
			WO# 213180 Ceiling & Wall penetration sealed. Penetration prevention to be enforced through above the ceiling work permit program. Correction through monthly Life Safety Assessment for penetrations completed by Brooks Fire Stopping. In addition, Environmental Rounds will monitor monthly. Hospital representative responsible: Director Plant Operations	Completed 12/18/2012
			WO# 213188 Repaired wall. Penetration prevention to be enforced through above the ceiling work permit program. Correction through monthly Life Safety Assessment for penetrations completed by Brooks Fire Stopping. In addition, Environmental Rounds will monitor monthly. Hospital representative responsible: Director Plant Operations	Completed 12/18/2012
			WO# 213242 removed pallet from room M249. Storage deficiency prevention and correction to be enforced by Life Safety Assessments accomplished through monthly Environmental rounds. Hospital representative responsible: Director Materials Mgmt.	Completed 12/19/2012
			WO# 213186 Wall penetration in electrical closet was sealed with HiltiSF1. Penetration prevention to be enforced through above the ceiling work permit program. Correction through monthly Life Safety Assessment for penetrations completed by Brooks Fire Stopping. In addition, Environmental Rounds will monitor monthly. Hospital representative responsible: Director Plant Operations	Completed 12/18/2012
			WO# 213190 Penetrations around pipes were sealed with HiltiSF1. Penetration prevention to be enforced through above the ceiling work permit program. Correction through monthly Life Safety Assessment for penetrations completed by Brooks Fire Stopping. In addition, Environmental Rounds will monitor monthly. Hospital representative responsible: Director Plant Operations	Completed 12/19/2012
			WO# 213218 Wall penetrations were sealed with HiltiSF1. Monitoring/Compliance: See WO# 213190 above.	Completed 12/19/2012
			WO# 213190 Penetrations around pipes conduit and wiring were sealed with HiltiSF1. Broken block was removed. Monitoring/Compliance: See WO# 213190 above.	Completed 12/19/2012

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K 029	Continued From page 6 · Observed the door to the utility closet W10F did not latch when closed. · Observed the leaf door to the OR equipment storage room does not latch to the floor or the upper jam. · Observed wood and other combustibles being stored in the electrical room inside the janitor's closet across from elevator 11. · Observed that the door to the janitor's closet at elevator 11 does not self-close and latch. · Observed an unsealed wall penetration above door 2G21F. · Observed unsealed wall penetrations in electrical closet MG25D. · Observed that the door to mechanical room MG23 does not self-close and latch. · Observed paints, solvents and combustibles being stored in the 6-west mechanical room. · Observed missing ceiling tiles in the soiled utility room communication closet M615C. · Observed ceiling tile missing in room M625. · Observed the door to the storage area in the NICU needs a closer. This area is being used for storage which requires a closer on the door.	K 029	WO# 213174 Repair latch on closet door. Door Deficiency prevention and correction to be accomplished through Life Safety Assessments completed monthly by Jarvis Lock and Door. Environmental Rounds will monitor monthly. Hospital representative responsible: Director Plant Operations	Completed 12/19/2012
			WO# 213707 Installed manual flush bolts and adjusted closer to ensure positive latch of OR equipment storage room door. Door Deficiency prevention and correction to be accomplished through Life Safety Assessments completed monthly by Jarvis Lock and Door. Environmental Rounds will monitor monthly. Hospital representative responsible: Director Plant Operations	Completed 12/28/2012
			WO# 213205 Removed wood pallets and other items stored in room. Storage deficiency prevention and correction to be enforced by Life Safety Assessments accomplished through monthly Environmental rounds. Hospital representative responsible: Director, Materials Management	Completed 12/18/2012
			WO# 213172 Door lock was repaired and closer was installed. Duplicate. Door Deficiency prevention and correction to be accomplished through Life Safety Assessments completed monthly by Jarvis Lock and Door. Environmental Rounds will monitor monthly.Hospital representative responsible: Director Plant Operations	Completed 12/18/2012
			WO# 213288 Patched and sealed penetrations above ceiling with HiltiSF1. Penetration prevention to be enforced through above the ceiling work permit program. Correction through monthly Life Safety Assessment for penetrations completed by Brooks Fire Stopping. In addition, Environmental Rounds will monitor monthly. Hospital representative responsible: Director Plant Operations	Completed 12/19/2012
			WO# 213213 Patched and sealed penetrations in the walls and ceiling with HiltiSF1. Penetration prevention to be enforced through above the ceiling work permit program. Correction through monthly Life Safety Assessment for penetrations completed by Brooks Fire Stopping. In addition, Environmental Rounds will monitor monthly. Hospital representative responsible: Director Plant Operations	Completed 12/19/2012
			WO# 213273 Installed door closer. Door Deficiency prevention and correction to be accomplished through Life Safety Assessments completed monthly by Jarvis Lock and Door. Environmental Rounds will monitor monthly. Hospital representative responsible: Director Plant Operations	Completed 12/19/2012
			WO# 213265 Removed paint and solvents from mechanical room. Storage deficiency prevention and correction to be enforced by Life Safety Assessments accomplished through monthly Environmental rounds. Hospital representative responsible: Director, Materials Management	Completed 12/19/2012
			WO# 213241 replaced missing ceiling tile in M615C Penetration prevention to be enforced through above the ceiling work permit program. Correction through monthly Life Safety Assessment for penetrations completed by Brooks Fire Stopping. In addition, Environmental Rounds will monitor monthly. Hospital representative responsible: Director Plant Operations	Completed 12/19/2012
			WO# 212353 replaced missing ceiling tile in M625. Management/Compliance: See WO# 213241 above.	Completed 12/19/2012
K 034	NFPA 101 LIFE SAFETY CODE STANDARD Stairways and smokeproof towers used as exits	K 034	WO# 203362 Jarvis installed closer for storage room door. Management/Compliance: See WO# 213273 above.	Door installed on 12/24/12

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K 034	Continued From page 7 are in accordance with 7.2. 19.2.2.3, 19.2.2.4 This STANDARD is not met as evidenced by: Surveyor: 13546 Based on observation the facility failed to provide approved means of egress in accordance with the LSC section 19.2.2.3, 19.2.2.4. This deficient practice could potentially affect all occupants of the facility. Findings include: The following violations were noted during a validation inspection conduct on November 19, 2012 and November 20, 2012 between the hours of 9:00 AM and 5:00 PM. These findings were observed and confirmed by the facility maintenance director during the inspection. · Observed cleaning supplies being stored in stairwell SGH-07. · Observed the light in the stairwell, SCH07 5th floor, was not illuminated. · Observed that stairwell door SGH-16 did not self-latch when tested. · Observed the light in stairwell SGH03 was not illuminated when inspected. CORRECTED · Observed the door handle on the secondary exit door was loose on the interior side of the door.	K 034	WO# 213266 Removed cleaning supplies Storage deficiency prevention and correction to be enforced by Life Safety Assessments accomplished through monthly Environmental rounds. Hospital representative responsible: Director Environmental Services WO# 213247 Light replaced and is in working order. Lighting deficiency prevention and correction to be enforced by Life Safety Assessments accomplished through monthly Environmental rounds. In addition, daily work order correction is accomplished through Plant Operation assignment. Hospital representative responsible: Director Plant Operations. WO# 213271 4th floor stairwell panic bar was dogged down; loosened screw to activate latching mechanism tightened screw on strike plate. Door Deficiency prevention and correction to be accomplished through Life Safety Assessments completed monthly by Jarvis Lock and Door. Environmental Rounds will monitor monthly. Hospital representative responsible: Director Plant Operations. WO# Corrected during Inspection. Lighting deficiency prevention and correction to be enforced by Life Safety Assessments accomplished through monthly Environmental rounds. In addition, daily work order correction is accomplished through Plant Operation assignment. Hospital representative responsible: Director Plant Operations WO# 213222 repaired door handle rubbing on door. Door Deficiency prevention and correction to be accomplished through Life Safety Assessments completed monthly by Jarvis Lock and Door. Environmental Rounds will monitor monthly. Hospital representative responsible: Director Plant Operations	Completed 12/21/2012 Completed 11/20/2012 Completed 12/19/2012 Completed 11/20/2012 Completed 12/19/2012
K 038	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily	K 038		

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K 038	Continued From page 8 accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Surveyor: 13546 Based on observation the facility failed to provide approved exit access in accordance with the LSC section 19.2.1. This deficient practice could potentially affect all occupants of the facility. Findings include: The following violations were noted during a validation inspection conduct on November 19, 2012 and November 20, 2012 between the hours of 9:00 AM and 5:00 PM. These findings were observed and confirmed by the facility maintenance director during the inspection. · Observed patient beds obstructing the door to stairwell SGH-10. · Observed the corridor at rehab stairs W20A was obstructed by equipment.	K 038	WO# 213267 Patient beds removed. Discussed with management and staff to reinforce staff awareness of egress requirements. Storage deficiency prevention and correction to be enforced by Life Safety Assessments accomplished through monthly Environmental rounds. Hospital representative responsible: Director, Environmental Services. WO# 213268 Equipment removed. Notified department to reinforce awareness of ingress and egress requirements. Storage deficiency prevention and correction to be enforced by Life Safety Assessments accomplished through monthly Environmental rounds. Hospital representative responsible: Director, Environmental Services.	Completed 11/20/2012 Completed 12/19/2012
K 045	NFPA 101 LIFE SAFETY CODE STANDARD Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in darkness. (This does not refer to emergency lighting in accordance with section 7.8.) 19.2.8	K 045		

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K 045	Continued From page 9 This STANDARD is not met as evidenced by: Surveyor: 13546 Based on observation the facility failed to provide lighting in accordance with the LSC section 19.2.8. This deficient practice could potentially affect all occupants of the facility. Findings include: The following violations were noted during a validation inspection conduct on November 19, 2012 and November 20, 2012 between the hours of 9:00 AM and 5:00 PM. These findings were observed and confirmed by the facility maintenance director during the inspection. · Observed the light in the electrical room was not working at time of inspection.	K 045	WO# 213169 Light bulb in E10F was replaced. Lighting deficiency prevention and correction to be enforced by Life Safety Assessments accomplished through monthly Environmental rounds. In addition, daily work order correction is accomplished through Plant Operation assignment. Hospital representative responsible: Director Plant Operations	Completed 12/18/2012
K 046	NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1. This STANDARD is not met as evidenced by: Surveyor: 13546 Based on observation the facility failed to provide emergency lighting in accordance with the LSC section 19.2.9.1. This deficient practice could potentially affect all occupants of the facility. Findings include: The following violations were noted during a validation inspection conduct on November 19, 2012 and November 20, 2012 between the hours of 9:00 AM and 5:00 PM. These findings were observed and confirmed by the facility maintenance director during the inspection.	K 046		

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K 046	Continued From page 10 · Observed that the catherization OR's don't have battery operated emergency lights as required where the patient is under anesthesia and incapable of self-preservation.	K 046	WO# 213270 Lights in stock have been installed. Lighting deficiency prevention and correction to be enforced by Life Safety Assessments accomplished through monthly Environmental rounds. In addition, daily work order correction is accomplished through Plant Operation assignment. Hospital representative responsible: Director Plant Operations	Completed 12/19/2012
K 047	NFPA 101 LIFE SAFETY CODE STANDARD Exit and directional signs are displayed in accordance with section 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 This STANDARD is not met as evidenced by: Surveyor: 13546 Based on observation the facility failed to provide exit and directional signs in accordance with the LSC section 19.2.10.1. This deficient practice could potentially affect all occupants of the facility. Findings include: The following violations were noted during a validation inspection conduct on November 19, 2012 and November 20, 2012 between the hours of 9:00 AM and 5:00 PM. These findings were observed and confirmed by the facility maintenance director during the inspection.	K 047		
	· Observed an exit sign in the 6-west mechanical room not illuminated.		WO# 213274 Light replaced in exit sign and is in working order. Lighting deficiency prevention and correction to be enforced by Life Safety Assessments accomplished through monthly Environmental rounds. In addition, daily work order correction is accomplished through Plant Operation assignment. Hospital representative responsible: Director Plant Operations.	Completed 12/19/2012
	· Observed that an additional exit sign is needed above cross-corridor smoke barrier door 2GC33.		WO# 213275 Installed additional exit sign in area. Lighting deficiency prevention and correction to be enforced by Life Safety Assessments accomplished through monthly Environmental rounds. In addition, daily work order correction is accomplished through Plant Operation assignment. Hospital representative responsible: Director Plant Operations.	Completed 12/19/2012
K 052	NFPA 101 LIFE SAFETY CODE STANDARD	K 052		

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K 052	Continued From page 11 A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 This STANDARD is not met as evidenced by: Surveyor: 13546 Based on observation the facility failed to provide a fire alarm system in accordance with the LSC section 9.6.1.4. This deficient practice could potentially affect all occupants of the facility. Findings include: The following violations were noted during a validation inspection conduct on November 19, 2012 and November 20, 2012 between the hours of 9:00 AM and 5:00 PM. These findings were observed and confirmed by the facility maintenance director during the inspection. · Observed that former patient room E670 has been converted into a 6-person office space and does not have a fire alarm audio/visual device. · Observed that the smoke detector in room E40B was in alarm but was not showing on panel.	K 052	WO# 213283 Fire strobe device installed; tested and is functioning according to design. Fire Alarm deficiency prevention and correction to be enforced by daily response to monitor and trouble alarms at the panel and quarterly fire alarm equipment inspections. Hospital representative responsible: Director Plant Operations WO# 213284 Panel repaired and functioning properly. Fire Alarm deficiency prevention and correction to be enforced by daily response to monitor and trouble alarms at the panel and quarterly fire alarm equipment inspections. Hospital representative responsible: Director Plant Operations	Completed 12/19/2012 Completed 12/19/2012
K 062	NFPA 101 LIFE SAFETY CODE STANDARD	K 062		

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K 062	Continued From page 12 Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Surveyor: 13546 Based on observation and/or review of records the facility failed to provide documentation that the automatic sprinkler system is maintained and/or tested in accordance with the LSC sections 19.7.6, 4.6.12, 9.7.5. This deficient practice could potentially affect all occupants of the facility. Findings include: The following violations were noted during a validation inspection conduct on November 19, 2012 and November 20, 2012 between the hours of 9:00 AM and 5:00 PM. These findings were observed and confirmed by the facility maintenance director during the inspection. · Observed that the sprinkler head was taped in electrical closet M243. · Observed that the sprinkler head at the cross-corridor smoke barrier doors SGC26 is obstructed by the lay-in ceiling and doesn't provide complete coverage. · Observed that mechanical room MG23 is not sprinkler protected. · Observed unsealed wall penetrations in electrical closet MG25D.	K 062	WO# 213187 Removed tape from sprinkler head. Fire Sprinkler deficiency prevention and correction to be accomplished through adherence to building codes and AHJ inspections. Life Safety Assessments through Environmental rounds will monitor monthly. Hospital representative responsible: Director Plant Operations WO# 213276 One sprinkler head to be installed to cover the lower ceiling area. Letter of intent to repair has been received. PO#2013 0301 666 430 SGS. Fire Sprinkler deficiency prevention and correction to be accomplished through adherence to building codes and AHJ inspections. Life Safety Assessments through Environmental rounds will monitor monthly. Hospital representative responsible: Director Plant Operations WO# 213289 One sprinkler head to be installed to cover the room. Letter of intent to repair has been received. PO#2013 0301 666 430 SGS. Fire Sprinkler deficiency prevention and correction to be accomplished through adherence to building codes and AHJ inspections. Life Safety Assessments through Environmental rounds will monitor monthly. Hospital representative responsible: Director Plant Operations WO# 213213 Penetrations patched and sealed with HiltiSF1. Penetration prevention to be enforced through above the ceiling work permit program. Correction through monthly Life Safety Assessment for penetrations completed by Brooks Fire Stopping In addition, Environmental Rounds will monitor monthly. Hospital representative responsible: Director Plant Operations.	Completed 12/19/2012 Completed 1/13/13 Completed 1/13/13 Completed 12/19/2012

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K 062	Continued From page 13 · Observed room MG25G is not sprinkler protected.	K 062	WO# 213290 Sprinkler heads to be installed to cover the room. Letter of intent to repair has been received. PO#2013 0301 666 430 SGS. Fire Sprinkler deficiency prevention and correction to be accomplished through adherence to building codes and AHJ inspections. Life Safety Assessments through Environmental rounds will monitor monthly. Hospital representative responsible: Director Plant Operations	Completion 1/13/13
K 069	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 This STANDARD is not met as evidenced by: Surveyor: 13546 Based on observation and/or review of records the facility failed to provide cooking facilities in accordance with the LSC section 19.3.2.6. This deficient practice could potentially affect all occupants of the facility. Findings include: The following violations were noted during a validation inspection conduct on November 19, 2012 and November 20, 2012 between the hours of 9:00 AM and 5:00 PM. These findings were observed and confirmed by the facility maintenance director during the inspection. Upon review of records the following deficiencies were noted on the Fire Defense kitchen hood inspection report: · Ducts not welded · Hood missing filter · Nozzles out of adjustment · Tanks rusted · Incorrectly sized pipe · Not all systems are UL 300 compliant	K 069	WO# 213291 Elite Fire Safety conducted inspection on 12/20/12. Documented report of dusts, hood filter, adjustment of nozzles, pipe inspection and UL compliance were reviewed and corrections completed where necessary. Fire Defense replaced rusted tanks. Special Hazard Fire Suppression deficiency prevention and correction to be accomplished through adherence to building codes and AHJ inspections. Life Safety Assessments through Environmental rounds will monitor monthly. Hospital representative responsible: Director Plant Operations	Completed 12/20/12
K 135	NFPA 101 LIFE SAFETY CODE STANDARD Flammable and combustible liquids are used from and stored in approved containers in	K 135		

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K 135	Continued From page 14 accordance with NFPA 30, Flammable and Combustible Liquids Code, and NFPA 45, Standard on Fire Protection for Laboratories Using Chemicals. Storage cabinets for flammable and combustible liquids are constructed in accordance with NFPA 30, Flammable and Combustible Liquids Code, NFPA 99. 4.3, 10.7.2.1. This STANDARD is not met as evidenced by: Surveyor: 13546 Based on observation the facility failed to provide protection of flammable and combustible liquids in accordance with NFPA 30/99. This deficient practice could potentially affect all occupants of the facility. Findings include: The following violations were noted during a validation inspection conduct on November 19, 2012 and November 20, 2012 between the hours of 9:00 AM and 5:00 PM. These findings were observed and confirmed by the facility maintenance director during the inspection. · Observed flammable liquids in the dialysis work room not properly stored. · Observed an unsecured tank in the storage area of Great Lakes Coffee.	K 135	WO# 213277 All flammables have been stored in a flammable cabinet. Department was informed of flammable liquid storage requirements. Storage deficiency prevention and correction to be enforced by Life Safety Assessments accomplished through monthly Environmental rounds. Hospital representative responsible: Safety Officer WO# 213278 tanks have been secured and staff have been in serviced on compressed gas safety. Storage deficiency prevention and correction to be enforced by Life Safety Assessments accomplished through monthly Environmental rounds. Hospital representative responsible: Safety Officer and Director Respiratory Therapy.	Completed 12/21/2012 Completed 11/20/2012
K 147	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2	K 147		

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K 147	Continued From page 15 This STANDARD is not met as evidenced by: Surveyor: 13546 Based on observation the facility failed to provide the electrical system in accordance with the LSC section 9.1.2. This deficient practice could potentially affect all occupants of the facility. Findings include: The following violations were noted during a validation inspection conduct on November 19, 2012 and November 20, 2012 between the hours of 9:00 AM and 5:00 PM. These findings were observed and confirmed by the facility maintenance director during the inspection. · Observed a junction box missing its protective cover plate in data closet 6ME1. · Observed a non-code compliant extension cord in use on a fan in the kitchenette area of the Psych ward. · Observed an open junction box above 5 West doors, entry doors to unit. · Observed an open junction box on the East wall by the West passenger elevators. · Observed an open junction box in room E30D. · Observed an open junction box next to the cable box in room E10E. · Observed the light in the electrical room was not working at time of inspection.	K 147	WO# 213279 Junction cover plate replaced. Junction cover plates deficiency prevention and correction to be enforced by Life Safety Assessments accomplished through monthly Environmental rounds. In addition, daily work order correction is accomplished through Plant Operation assignment. Hospital representative responsible: Director Plant Operations. WO# 213217 Removed extension cord and made outlet accessible. Rounding to remove non-code compliant extension cords has been completed. In addition, Environmental rounds will monitor on a monthly basis. Hospital representative responsible: Manager, Psychiatric Unit. WO# 213198 Junction box cover plate replaced. Junction cover plates deficiency prevention and correction to be enforced by Life Safety Assessments accomplished through monthly Environmental rounds. In addition, daily work order correction is accomplished through Plant Operation assignment. Hospital representative responsible: Director Plant Operations. WO# 213199 Junction box cover plate replaced. Junction cover plates deficiency prevention and correction to be enforced by Life Safety Assessments accomplished through monthly Environmental rounds. In addition, daily work order correction is accomplished through Plant Operation assignment. Hospital representative responsible: Director Plant Operations. WO# 213194 put covers on e electrical junction boxes and made 12" x 8" cover for box over door. Junction cover plates deficiency prevention and correction to be enforced by Life Safety Assessments accomplished through monthly Environmental rounds. In addition, daily work order correction is accomplished through Plant Operation assignment. Hospital representative responsible: Director Plant Operations. WO# 213280 Installed cover on open electric junction box. Junction cover plates deficiency prevention and correction to be enforced by Life Safety Assessments accomplished through monthly Environmental rounds. In addition, daily work order correction is accomplished through Plant Operation assignment. Hospital representative responsible: Director Plant Operations. WO# 213169 Light bulb was replaced. Lighting deficiency prevention and correction to be enforced by Life Safety Assessments accomplished through monthly Environmental rounds. In addition, daily work order correction is accomplished through Plant Operation assignment. Hospital representative responsible: Director Plant Operations	Completed 12/18/2012 Completed 12/18/2012 Completed 12/18/2012 Completed 12/18/2012 Completed 12/18/2012 Completed 12/19/2012 Completed 12/18/2012

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K 147	Continued From page 16 · Observed the magnetic hold open device on the doors within the ICU unit was not secured to the wall. · Observed an open junction box above the cross corridor doors by office WG36.	K 147	WO# 213282 Magnetic hold secured to wall and in working order. Door Deficiency prevention and correction to be accomplished through Life Safety Assessments completed monthly by Jarvis Lock and Door. Environmental Rounds will monitor monthly. Hospital representative responsible: Director Plant Operations WO# 213214 Put cover on open junction box. Junction cover plates deficiency prevention and correction to be enforced by Life Safety Assessments accomplished through monthly Environmental rounds. In addition, daily work order correction is accomplished through Plant Operation assignment. Hospital representative responsible: Director Plant Operations.	Completed 12/19/2012 Completed 12/18/2012