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A 000	INITIAL COMMENTS	A 000		

MEDICARE RECERTIFICATION SURVEY

The Washington State Department of Health (DOH) in accordance with the Medicare Conditions of Participation set forth in 42 CFR 482, conducted this health and safety survey.

Onsite dates: 05/14/18 to 5/18/18, 5/22/18 to 05/23/18 and 05/25/18.

The survey was conducted by:
Surveyor #1
Surveyor #2
Surveyor #3
Surveyor #4
Surveyor #5
Surveyor #6
Surveyor #7
Surveyor #8
Surveyor #9
Surveyor #11

Surveyors investigated complaint #81321 during the survey.

The Washington Fire Protection Bureau conducted the fire life safety (F/LS) inspection.

During the course of this survey, the DOH surveyors determined that there was high risk of serious harm, injury, and death due to the scope and severity of patient safety deficiencies. IMMEDIATE JEOPARDY (IJ) was declared on 05/22/18 at 6:45 PM as follows:

The hospital did not perform a ligature risk assessment related to the fire suppression

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

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A 000	Continued From page 1 system in all patient care areas within the hospital. The hospital also did not take action to mitigate known ligature risks. The presence of ligature attachment points in a psychiatric hospital risks patient harm and death related to suicide by hanging or strangulation. The state of IJ was removed on 05/25/18 at 1:35 PM. (Cross reference: A0700, A701) Condition-level deficiencies remained uncorrected at the time of survey exit. DOH staff found the facility NOT IN COMPLIANCE with the following Conditions of Participation: 42 CFR 482.12 Governing Body 42 CFR 482.21 Quality Assessment and Performance Improvement 42 CFR 482.23 Nursing Services 42 CFR 482.41 Physical Environment .	A 000		
A 023	LICENSURE OF PERSONNEL CFR(s): 482.11(c) The hospital must assure that personnel are licensed or meet other applicable standards that are required by State or local laws. This STANDARD is not met as evidenced by: . Based on observation and interview, the hospital failed to provide staff with education relating to safe handling and control of department-specific hazardous material. Failure to provide education for the use and control of hazardous materials puts patients and staff at risk of exposure to harmful materials.	A 023		

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A 023	Continued From page 2	A 023		

Reference: WAC 296-856-20020 Department of Labor and Industries "Provide training and information to employees exposed to formaldehyde at all of the following times: At the time of initial assignment to a work area where there is formaldehyde exposure; Whenever there is a new exposure to formaldehyde in their work area; At least every twelve months after initial training."

Findings included:

1. On 05/16/18 from 1:30 PM to 3:00 PM, Surveyor #5 and Staff #502 inspected the podiatry, gynecological, orthopedic and electrocardiogram procedure rooms. The observation showed multiple 30 mL containers of 10% buffered formalin (4% formaldehyde solution used as a preservative for biological specimens) stored in each room.

At the time of the observation, Surveyor #5 asked Staff #502 about safe handling education for staff who utilize formalin in their work areas. Staff #502 stated that the hospital did not provide new hire or annual education on the safe handling and control of formalin.

2. On 05/16/18 at 4:30 PM, Surveyor #5 requested the hospital's policy for hazardous materials/formalin safe handling, storage and education. Staff Member #501 stated that there were no hospital policies that contained information related to the management of formalin, and that the staff had not received new hire or annual education on safe handling and control of formalin.
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A 043	GOVERNING BODY CFR(s): 482.12 There must be an effective governing body that is legally responsible for the conduct of the hospital. If a hospital does not have an organized governing body, the persons legally responsible for the conduct of the hospital must carry out the functions specified in this part that pertain to the governing body ... This CONDITION is not met as evidenced by: . Based on observation, interview, record review, and review of hospital policies and procedures and Governing Body bylaws, the Governing Body failed to develop and maintain effective systems that ensured that patients received high quality health care in a safe environment. Failure to ensure patients are provided with care that meets acceptable standard of practice and meets the patient's healthcare needs in a safe environment risks poor health care outcomes, injury, and death. Findings included: 1. Document review of the hospital's Governing Body bylaws, adopted 01/26/17, showed that the Governing Body's purpose was "to assure that the hospital is capable of effectively providing medical and mental health care" and to "Provide effective mechanisms for hospital planning, management, and operational activities." The bylaws stated the Governing Body would: a. Establish and implement an effective program for improvement of performance throughout the hospital; and	A 043		

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A 043	Continued From page 4 b. Ensure that the hospital followed all local, state, and federal laws and met all regulatory requirements. 2. Observation, interviews, record review, review of hospital policies and procedures, and review of the hospital's quality program showed the following: a. The hospital failed to develop and implement an effective process for assessing the hospital environment for ligature risks and for mitigation of those risks. Cross Reference: A0700 b. The hospital failed to ensure that nursing staff members provided nursing care in accordance with the patient's health care needs. Cross Reference: A0385 c. The hospital failed to correct and sustain correction of deficiencies cited during previous hospital surveys and complaint investigations. Cross Reference: A0263 Due to these findings and the scope and severity of deficiencies detailed under 42 CFR 482.21 Condition of Participation for Quality Assessment and Performance Improvement; 42 CFR 482.23 Nursing Services; and 42 CFR 482.41 Condition of Participation for Physical Environment, the Condition of Participation for Governing Body was NOT MET. .	A 043		
A 117	PATIENT RIGHTS: NOTICE OF RIGHTS	A 117		

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A 117	Continued From page 5 CFR(s): 482.13(a)(1) 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: . Based on record review and interview, the hospital failed to ensure that the medicare notice of patient rights included accurate information for the Quality Improvement Organization (QIO). Failure to inform patients of the correct QIO risks the inability of patients to report concerns that could lead to poor quality of care. Findings included: 1. On 05/25/18 at 1:47 PM, Surveyors #2 and #5 interviewed Patient #201 regarding patient rights at the hospital. The patient stated that the medicare patient rights notification provided to patients upon admission included the incorrect name and phone number for the QIO. The documents provided by the patient showed that the QIO was Qualis Health. 2. Record Review of the document titled, "An Important Message from Medicare about Your Rights," no revision date, stated that Qualis Health was the QIO. 3. Record review of the document titled, "Memorandum of Agreement (MOA) between Livanta LLC and Western State Hospital," signed 02/07/18, showed that Livanta LLC was the	A 117		

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A 117	Continued From page 6 current QIO for Western State Hospital. 3. On 05/25/18 at 5:38 PM, the Quality Director (Staff #206) provided Surveyor #2 with a copy of the medicare notice of patient rights that the hospital gives to patients. Document review of the patient rights notification confirmed that the notice showed Qualis Health as the QIO not Livanta. .	A 117		
A 119	PATIENT RIGHTS: REVIEW OF GRIEVANCES CFR(s): 482.13(a)(2) [The hospital must establish a process for prompt resolution of patient grievances and must inform each patient whom to contact to file a grievance.] The hospital's governing body must approve and be responsible for the effective operation of the grievance process, and must review and resolve grievances, unless it delegates the responsibility in writing to a grievance committee. This STANDARD is not met as evidenced by: . Based on document review and interview, the hospital's Governing Body failed to delegate responsibility for review and resolution of patient grievances to a grievance committee. Failure to delegate review and resolution of grievances to a committee instead of an individual risks incomplete or inadequate evaluation of all aspects of the grievance issue. Findings included: 1. Document review of the hospital's Governing Body Bylaws, adopted 01/26/17, showed that the governing body delegates to the Chief Executive	A 119		

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A 119	Continued From page 7 Officer or his designee responsibility for investigating and resolving grievances. The bylaws also state the "Governing Body may delegate responsibility for review and resolution of these grievances to a hospital grievance committee." 2. On 05/22/18 at 1:15 PM, Surveyor #3 interviewed the Deputy Chief Executive Officer (Staff #302) and the Director of Patient Right Grievance coordinator (Staff #301) about the grievance investigation and resolution process. Staff #301 stated that currently there is no hospital grievance committee. The Deputy Chief Executive Officer (Staff #302) stated that Staff #301 has full authority to close and resolve patient grievances. .	A 119		
A 123	PATIENT RIGHTS: NOTICE OF GRIEVANCE DECISION CFR(s): 482.13(a)(2)(iii) 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: . Based on interview and document review, the hospital failed to ensure the results of grievance investigations were shared with the patient for 2 of 5 patient grievances reviewed (Patients #301, #302).	A 123		

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Failure to inform the patient of the results of the grievance investigation violates their right to be informed and risks patient safety due to unmet care needs.

Findings included:

1. Document review of the hospital's policy and procedure titled, "Patient Comments, Grievances and Resolution," Policy # 10.07, effective May 1, 2017, showed that the Director of Patient Right Grievances will provide the investigation results in a closure letter to the patient. The closure letter will include the hospital's decision, steps taken on behalf of the patient to investigate the grievance, and results of the grievance process.

2. On 05/09/18 at 9:00 AM, Surveyor #3 selected five patient grievances for review of process and resolution. Sources included the patient grievance log. The surveyor reviewed each complaint for evidence of receipt, hospital review, investigation, findings, and resolution of the grievance issue with the findings sent in a closure letter to the patient who filed the grievance. The surveyor noted the following:

a. Patient #301 called the hospital's abuse/neglect call line on 05/03/18 with concerns about physician care. The abuse/neglect line coordinator forwarded the grievance to Clinical Risk Management (CRM) for investigation. Patient #301 received a closure letter on 05/07/18 stating her concerns had been referred to the Treatment Team for review. The surveyor found no documentation in the grievance file to indicate the treatment team had discussed the issue and addressed it with the patient.

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A 123	Continued From page 9 b. Patient #302 called the hospital's abuse/neglect call line on 05/08/18 with concerns for receipt of funds resulting from the reported death of parents. The abuse/neglect line coordinator forwarded the grievance to CRM for investigation. Patient #301 received a closure letter on 05/09/18 stating her concerns had been referred to the Treatment Team for review. The surveyor found no documentation in the grievance file to indicate the treatment team had discussed the issue and addressed it with the patient. 3. On 05/22/18 at 1:15 PM, Surveyor #3 interviewed the Director of Patient Right Grievances (Staff #301) and the Deputy Chief Executive Officer (Staff #302) about the grievance process and resolution. Surveyor #3 asked the staff members how patients' grievances are reviewed and incorporated into the treatment plan. Staff #302 stated that they do not currently have a process in place for this issue. Staff #302 confirmed the process should be "tightened up". .	A 123		
A 174	PATIENT RIGHTS: RESTRAINT OR SECLUSION CFR(s): 482.13(e)(9) Restraint or seclusion must be discontinued at the earliest possible time, regardless of the length of time identified in the order. This STANDARD is not met as evidenced by: . Based on interview and document review, the hospital failed to implement its policies and	A 174		

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procedures for releasing patients from restraints at the earliest possible time for 2 of 6 patients reviewed (Patient #303, #901).

Failure to remove patients from restraints at the earliest possible time puts patients at risk for psychological harm, loss of dignity, and loss of personal freedom.

Findings included:

1. Document review of the hospital's policy and procedure titled, "Seclusion or Restraint," Policy #8.442, effective 04/16/18, showed that the restraint is to be discontinued at the earliest possible time.

Document review of the hospital's nursing services standards manual titled, "Management of the Patient in Seclusion and Restraint," Protocol 302, revised 05/18, showed that the patient should be released as soon as the patient is no longer an imminent danger to self or others.

2. On 5/14/18 at 10:30 AM, Surveyor #3 reviewed ten restraint episodes for Patient #303 and noted the following:

a. On 04/19/18, Patient #303 was restrained from 5:30 PM until 9:00 PM. Between 7:45 PM and 9:00 PM (1 hour and 15 minutes), Staff documented the patient's observed behavior as "not agitated".

b. On 05/10/18, Patient #303 was restrained from 4:00 PM until 7:50 PM. The patient's observed behavior from 6:00 PM until 7:50 PM (1 hour and 50 minutes) was documented as not agitated.

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A 174	Continued From page 11 3. On 05/22/18 at 1:50 PM, Surveyor #3 interviewed the RN3 shift leader (Staff #303) about the process and procedure for removing patients from restraints. She stated that the registered nurse conducts an hourly assessment or whenever notified by the patient monitor for an evaluation. Staff #303 reviewed Patient #303's restraint episode on 05/10/18 and confirmed that, based on the restraint documentation, staff should have released the patient earlier. 4. On 05/15/18 at 3:30 PM, during open record review, Surveyor #9 reviewed the record of Patient #901 who was placed in 5-point restraints on 04/30/18 at 3:29 PM. Review of the restraint record showed that beginning at 4:29 PM, staff documented the patient's behavior as "not agitated". Staff repeated this description through 15-minute checks that occurred at 4:44 PM, 4:59 PM and 5:14 PM before his release from the 5-point restraints. 5. At the time of the review, Surveyor #9 discussed the patient's time in restraints with the clinical unit RN3 (registered nurse) (Staff # 901). Staff #901 stated that the staff monitoring the patient would be expected to notify the RN 2 when the patient was not agitated and expedite release from restraints as soon as patient was no longer agitated. .	A 174		
A 216	PATIENT VISITATION RIGHTS CFR(s): 482.13(h)(1), (h)(2) [A hospital must have written policies and procedures regarding the visitation rights of patients, including those setting forth any clinically necessary or reasonable restriction or limitation	A 216		

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that the hospital may need to place on such rights and the reasons for the clinical restriction or limitation.] A hospital must meet the following requirements:

(1) Inform each patient (or support person, where appropriate) of his or her visitation rights, including any clinical restriction or limitation on such rights, when he or she is informed of his or her other rights under this section.

(2) Inform each patient (or support person, where appropriate) of the right, subject to his or her consent, to receive the visitors whom he or she designates, including, but not limited to, a spouse, a domestic partner (including a same-sex domestic partner), another family member, or a friend, and his or her right to withdraw or deny such consent at any time.

This STANDARD is not met as evidenced by:
.
Based on interview and review of the hospital's patient rights information, the hospital failed to develop and implement a process for informing patients of all of their visitation rights when admitted to the hospital.

Failure to inform patients of their rights and to incorporate those rights into visitation policies and procedures, limits the patient's ability to exercise those rights.

Findings included:

1. Document review of the hospital's policy and procedure titled, "Patient Rights," Policy 10.01 dated 10/09/17, showed that patients would be

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A 216	Continued From page 13 informed of their rights on admission to the hospital. The list of rights included the right for patients to have "visitors at reasonable times". The rights did not inform the patient that they had the right to receive the visitors whom he or she designated, including, but not limited to, a spouse, a domestic partner (including a same-sex domestic partner), another family member, or a friend, and his or her right to withdraw or deny such consent at any time. 2. On 05/25/18 at 1:45 PM, during an interview with Surveyor #6, the Chief Clinical Officer (Staff #614) confirmed that the list of patient rights did not include the information above. .	A 216		
A 217	PATIENT VISITATION RIGHTS CFR(s): 482.13(h)(3), (h)(4) [A hospital must have written policies and procedures regarding the visitation rights of patients, including those setting forth any clinically necessary or reasonable restriction or limitation that the hospital may need to place on such rights and the reasons for the clinical restriction or limitation. A hospital must meet the following requirements]: (3) Not restrict, limit, or otherwise deny visitation privileges on the basis of race, color, national origin, religion, sex, gender identity, sexual orientation, or disability. (4) Ensure that all visitors enjoy full and equal visitation privileges consistent with patient preferences.	A 217		

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A 217	Continued From page 14 This STANDARD is not met as evidenced by: . Based on interview and review of the hospital's visitation policy, the hospital failed to incorporate all patient visitation rights into its visitation policy and procedure. Failure to inform patients of their rights and to incorporate those rights into visitation policies and procedures limits the patient's ability to exercise those rights. Findings included: 1. Document review of the hospital's policy and procedure titled "Patient Visitation," Policy 12.05 dated 01/08/18, showed that hospital staff members could restrict patient visitation if the visit compromised patient safety, security, or other individual treatment needs. The policy did not state that this restriction would not be based on the visitor's race, color, national origin, religion, sex, gender identity, sexual orientation, or disability. 2. On 05/25/18 at 1:45 PM, during an interview with Surveyor #6, the Chief Clinical Officer (Staff #614) confirmed that visitation policy did not include the statement above.	A 217		
A 263	QAPI CFR(s): 482.21 The hospital must develop, implement and maintain an effective, ongoing, hospital-wide, data-driven quality assessment and performance improvement program.	A 263		

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A 263	Continued From page 15 The hospital's governing body must ensure that the program reflects the complexity of the hospital's organization and services; involves all hospital departments and services (including those services furnished under contract or arrangement); and focuses on indicators related to improved health outcomes and the prevention and reduction of medical errors. The hospital must maintain and demonstrate evidence of its QAPI program for review by CMS. This CONDITION is not met as evidenced by: . Based on observation, interview, record review, and review of the hospital's quality program and performance data, the hospital failed to correct and sustain correction of deficiencies cited during previous hospital surveys and complaint investigations. Failure to correct and sustain correction of deficient practice risks patient harm and poor healthcare outcomes. Reference: 482.21 (b) Program Data (2) [The hospital must use the data collected to ... (ii) Identify opportunities for improvement and changes that will lead to improvement ... 482.21 (c) (3) The hospital must take actions aimed at performance improvement and, after implementing those actions, the hospital must measure its success, and track performance to ensure that improvements are sustained. Findings included:	A 263		

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A 263	Continued From page 16 1. On 05/21/18 at 9:45 AM, Surveyor #7 interviewed the Deputy of Hospital Operations (Staff #701) and the acting Chief Quality Officer (Staff #702). The interview showed that the hospital was not tracking completion of ligature risk assessments, analyzing the results of these assessments, and developing action plans to mitigate ligature risks through the hospital's quality assessment and performance improvement (QAPI) program. (Previously cited in April 2016) Cross Reference: A0700 2. On 05/22/18 at 3:10 PM, Surveyor #7 interviewed the Deputy of Hospital Operations (Staff #701) and the Chief Nursing Officer (Staff #703). The interview and review of hospital performance data showed that the quality indicator for nursing care plans monitored only fall risk and the patient's nutritional needs. The hospital had not developed a quality indicator to ensure care plans addressed the patient's entire medical and nursing care needs. (Previously cited in November 2015, March 2016, July 2016, March 2017, May 2017, and August 2017) Cross Reference: A0396 3. On 05/22/18 at 3:10 PM, Surveyor #7 interviewed the Deputy of Hospital Operations (Staff #701) and the Chief Nursing Officer (Staff #703). During the interview, review of hospital performance data showed that the quality indicator for cancellation of appointments related to the availability of medical escorts indicated that the hospital met its goal for first four months of 2018. The interview revealed that the hospital	A 263		

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failed to include canceled appointments for physical therapy and dental care in the performance data. The hospital failed to develop and implement an effective process for ensuring that the patients were transported to appointments with health care consultants and specialists as scheduled. (previously cited in May 2017)

Cross Reference: A0392

4. On 05/22/18 at 3:10 PM, Surveyor #7 interviewed the Deputy of Hospital Operations (Staff #701) and the Chief Nursing Officer (Staff #703). The interview and review of hospital performance data showed that the hospital had met its quality goal for removal of restraints at the earliest possible time. However, Survey findings showed the hospital had not met this goal. (Previously cited in November 2015, March 2016, and May 2017).

Cross Reference A0174

5. On 05/23/18 at 7:30 AM, Surveyor #7 interviewed the acting Chief Quality Officer (Staff #702), the acting Director of Quality Assurance (Staff #704), the Chief Medical Officer (Staff #705), and the Deputy Chief Medical Officer (#706). The interview and review of hospital performance data showed the hospital was not meeting performance goals for medical record documentation (dating, timing, and authentication). The hospital had not developed a systematic action plan for improvement. (Previously cited in May 2017)

Cross Reference A0450

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A 263	Continued From page 18 6. The fire life safety survey showed the hospital failed to correct deficiencies related to the hospital's sprinkler system, fire alarm system, and fire drills (previously cited in June 2017 and May 2015) Cross Reference: A0710 (K0345, K0353, K0712) Due to the scope and severity of these deficiencies, the Condition of Participation at 42 CFR 482.21, Quality Assurance and Performance Improvement was NOT MET. .	A 263		
A 357	MEDICAL STAFF QUALIFICATIONS CFR(s): 482.22(c)(4) [The bylaws must:] (4) Describe the qualifications to be met by a candidate in order for the medical staff to recommend that the candidate be appointed by the governing body. This STANDARD is not met as evidenced by: . Based on observation, interview, and document review, the hospital failed to ensure that medical staff completed and maintained cardiopulmonary resuscitation (CPR) certification as required by the Medical Staff Bylaws for 2 of 11 medical staff reviewed (Staff #612, #613). Failure to ensure Medical Staff maintains CPR certification places patients at risk for inadequate care. Findings included:	A 357		

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A 357	Continued From page 19 1. Document review of the 2017 [sic] Medical Staff Bylaws, section 2.3 B. 2. c. (approved 02/17/18) showed that medical staff are to complete and maintain CPR certification. 2. On 05/16/18 between 1:20 PM and 3:05 PM, Surveyor #6 met with the Credentials Manager (Staff #608), the Medical Staff Coordinator (Staff #609), the acting Chief Medical Officer (Staff #610), and a consultant (Staff #611) to review selected Medical Staff credential files. Two of the Medical Staff files reviewed showed that a podiatrist (Staff #612), and an ophthalmologist (Staff #613) did not have evidence of current CPR certification. 3. At the time of the observation, Surveyor #6 interviewed Staff #608, #609, and #610 about the CPR certification status. Staff #608 confirmed that the requirement is included in the Medical Staff Bylaws. .	A 357		
A 385	NURSING SERVICES CFR(s): 482.23 The hospital must have an organized nursing service that provides 24-hour nursing services. The nursing services must be furnished or supervised by a registered nurse. This CONDITION is not met as evidenced by: . Based on interview, record review and review of hospital policies and procedures, the hospital failed to ensure that nursing staff members provided nursing care in accordance with physician's orders and the patient's health care needs.	A 385		

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Failure to provide nursing care based on patient assessments, physician's orders, and recommendation of health care consultants places patients at risk for deterioration of the health status and poor health outcomes.

Findings included:

1. The hospital failed to monitor patients as ordered by a provider for completion of blood work, neurological assessments, patient weights, oxygen saturation, blood glucose levels and intake and output.

Cross Reference: A0392, Items #2 through #7

2. The hospital failed to ensure nursing staff assessed patients who returned from offsite procedures.

Cross Reference: A0395

3. The hospital failed to ensure that treatment care plans for patients were developed, initiated and continuously updated to meet patient care needs.

Cross Reference: A0396, Item #2

4. The hospital failed to ensure that staff referred patients for nutritional consults with a dietician.

Cross Reference: A0396, Item #3

5. The hospital failed to ensure patients are returned to physical therapy for treatment as ordered.

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A 385	Continued From page 21 Cross Reference: A0396, Item #1 6. The hospital failed to have adequate patient escorts available to accompany patients to medical appointments. Cross Reference: A0392, Item #1 Due to the scope and severity of these deficiencies, the Condition of Participation at 42 CFR 482.23, Nursing Services was NOT MET. .	A 385		
A 392	STAFFING AND DELIVERY OF CARE CFR(s): 482.23(b) The nursing service must have adequate numbers of licensed registered nurses, licensed practical (vocational) nurses, and other personnel to provide nursing care to all patients as needed. There must be supervisory and staff personnel for each department or nursing unit to ensure, when needed, the immediate availability of a registered nurse for bedside care of any patient. This STANDARD is not met as evidenced by: . ITEM #1- PATIENT ESCORTS Based on interview, medical record review, and document review, the hospital failed to provide sufficient personnel to escort patients to medical and dental appointments. Failure to provide an adequate number of trained escorts risks patient safety and delays in care and treatment. Findings included:	A 392		

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1. Document review of the hospital's policy and procedure titled, "Escorting and transportation of patients on and off hospital campus (routine and emergent)," Procedure Number 211, revised 04/18, showed that medical escorts are designated nursing personnel responsible for timely, and safe therapeutic transportation of patients to and from appointments on and off the hospital's campus. On-campus destinations include appointments to east campus medical clinic, dental clinic, physical therapy and podiatry.

2. On 05/14/18 at 2:25 PM, Surveyor #5 and a registered nurse (Staff #503) reviewed the medical record of Patient #501. The record review showed an Optometry appointment scheduled for 04/03/18 was canceled because the escort, "lost his keys." At the time of the record review, the appointment had not been rescheduled.

3. At the time of the record review, the registered nurse (Staff #503) and the ward administrator (Staff #504) confirmed the finding and stated that the process has improved but there continues to be gaps.

4. On 05/16/18 from 1:30 PM until 2:30 PM, Surveyor #5, a dental hygienist (Staff #505), and a quality coordinator (Staff #506) inspected the hospital's dental clinic. During the inspection, Surveyor #5 reviewed an appointment tracking sheet. The observation showed that in April 2018, there were 31 canceled patient appointments due to a lack of escorts.

5. At the time of the document review, Staff #505 confirmed the finding and stated that the dental

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A 392	Continued From page 23 clinic had begun tracking canceled appointments because the volume of canceled appointments had significantly impacted the clinic. . ITEM #2 - COMPLETION OF HEMOGLOBIN A1C BLOOD TESTING Based on record review, interview and review of policy and procedure, the hospital failed to ensure that a Hemoglobin A1c (a blood test to measure for blood glucose levels over time) ordered for Patient #902 was either completed or that the patient refused the blood draw. Failure to ensure that a Hemoglobin A1c is performed could lead to patient harm due to potential organ damage. Findings included: 1. Document review of the hospital's policy and procedure titled, "Diabetic Care Team and Blood Glucose monitoring," Policy 6.12 Effective 04/16/18, showed that staff are to monitor and document laboratory results. 2. On 05/15/18 at 2:30 PM, Surveyor #9 reviewed the medical record of Patient #902. A provider (Staff #902) wrote an order on 05/04/18 for a Hemoglobin A1c test. A registered nurse (RN) (Staff #903) noted the order on 05/04/18. During record review, Surveyor #9 was unable to find a result for the test and asked the RN 2 (Staff #904) to locate the result in the patient's medical record. Staff #904 was unable to locate the test result or verify that blood had been drawn to perform the test.	A 392		

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At the time of the review, Staff #904 stated that the patient might have refused to have his blood drawn, but was unable to locate any information in the patient record. Staff #904 also stated that the test result should have been in the record by now, 11 days later.

When the surveyor asked about a tracking system for completion of blood tests, the staff member was unable to identify a tracking system.

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ITEM #3 - NEUROLOGICAL ASSESSMENTS

Based on record review, interview and review of hospital policy and procedure, the hospital failed to ensure that Patient #903 was appropriately evaluated after a fall that involved a head injury.

Failure to appropriately evaluate a patient after a fall that included a head injury could lead to serious harm due to neurological trauma.

Findings included:

1. Document review of the hospital's protocol, titled, "Management of the Patient Who Has Fallen," Protocol #340 revised 05/17, showed that a neurological flowsheet is to be utilized if a patient falls and strikes their head.

2. On 05/16/18 at 1:30 PM, Surveyor #9 reviewed the medical record of Patient #903. The record showed that the patient had fallen on 02/12/18 and was found by staff in a prone position in the bathroom with a hematoma on the left side of her forehead. At 8:15 AM the patient's vital signs, including a neurological check was charted by a

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staff member. Staff documented a record of pulse and blood pressure at 8:30 AM, 8:45 AM and 9:00 AM. There was no evidence that staff performed neurological checks during those times. At 10:00 AM, the hospital transported the patient to an acute care hospital for observation.

3. At the time of the record review, Surveyor #9 discussed the lack of continuing neurological evaluation with the RN 2 (Staff # 905) and RN 3 (Staff #906). They stated that because of the patient's apparent head injury, staff should have performed neurological checks every 15 minutes until the patient was transported to an acute care hospital.

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ITEM #4 - MONITORING PATIENT WEIGHTS

Based on record review, interview and review of hospital policy and procedure, the hospital staff failed to assess Patient #902's weight in a timely manner.

Failure to assess a patient's weight could lead to poor nutritional status and poor health outcomes.

Findings included:

1. Document review of the hospital's policy titled, "Height, Weight and Routine Vital Signs," Procedure #232 Revised 04/18, showed that weight and vital signs are taken routinely on every patient during the first week of the month.

2. On 05/15/18 at 1:00 PM, Surveyor #9 reviewed the medical record of Patient #902. The record showed that on 04/16/18 the dietician (Staff #907) performed a nutritional assessment for this

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patient. She stated that a weight had not been taken on the patient since 03/05/18 and asked that a weight be obtained. On 04/20/18 a second dietician (Staff #908) stated that she had attempted to assess the patient's weight, but staff had still not obtained the patient's weight.

3. At the time of the record review, Surveyor #9 discussed the missing weight assessment with the RN 2 (Staff #902) who stated that the patient may have refused to have his weight checked. In reviewing the vital sign flow sheet for Patient #902, there was no documentation on 04/16/18 or 04/20/18 to indicate that the patient refused to have his weight checked.

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ITEM #5 - MONITORING OXYGEN SATURATION

Based on record review, interview and review of hospital policy and procedure, the hospital staff failed to perform and document 30-minute oxygen saturation checks for Patient #904 as ordered by the patient's provider.

Failure to assess a patient's oxygen saturation could lead to anoxic brain injuries and serious harm to a patient's health.

Findings included:

1. Document review of the hospital's policy titled, "Height, Weight and Routine Vital Signs," Procedure #232 revised 04/18, showed that abnormal vital signs should be recorded as ordered and reported to the provider.

2. On 05/15/18 at 2:00 PM, Surveyor #9 reviewed

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the medical record of Patient #904. The record showed that the patient had an asthma exacerbation and was short of breath on 04/26/18 at 1:30 PM with an oxygen saturation measured at 88% on room air. At 1:30 PM, the provider (Staff #902) ordered oxygen saturation (amount of oxygen in the blood) to be checked every 30 minutes for 24 hours.

Surveyor #9 reviewed the vital sign flow sheet for this time period. From 1:30 PM until 2:30 PM the oxygen saturations were recorded every 30 minutes as ordered. No further oxygen saturations were recorded until 8:00 PM. The patient's oxygen saturation was not recorded again until 12:05 AM where every 30 minute oxygen saturations were resumed.

3. At the time of the record review, Surveyor #9 discussed the finding with the RN 3 (Staff #906) who agreed that documentation of the oxygen saturation was missing.

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ITEM #6 - MONITORING BLOOD GLUCOSE LEVELS AND TREATMENT

Based on interview, record review, review of policy and procedure, the hospital failed to ensure that staff measured blood glucose levels and documented actions taken to address hyper or hypoglycemia.

Failure to ensure that staff measured blood glucose levels and documented actions taken to address hyper or hypoglycemia places patients at risk for harm and possibly death.

Findings included:

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1. Document review of the hospital policy and procedure titled, "Diabetic Care Team and Blood Glucose Monitoring," Policy 6.12, issued 04/18, showed that team members should monitor laboratory, diet and medication therapies.

2. On 05/22/18 at 9:45 AM, Surveyor #9 reviewed the medical record of patient #905. The patient had orders that showed instructions to administer correction doses of insulin if the patient's glucose was high and actions to take if levels were low. There was a flow sheet to document blood glucose levels and actions taken if glucose was abnormal or to note if no action was required. Surveyor #9 reviewed the diabetic flow sheet from 05/07/18 to 05/22/18. During that time, in 38 separate incidents, staff documented the patient's blood glucose results, but there was no other documentation addressing if the patient was given correction insulin doses, hypoglycemia was treated or that no action was required.

3. At the time of the record review, Surveyor #9 interviewed the RN 3 (Staff #909) and she agreed with the finding that the documentation on the diabetic flow sheet for Patient #905 was incomplete and did not follow policy.

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ITEM #7 - MONITORING INTAKE AND OUTPUT

Based on interview, record review, and review of hospital policies and procedures, the hospital failed to ensure that nursing staff members implemented fluid restriction orders, and documented intravenous fluid administration for 1 of 1 patients reviewed (Patient #502).

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Failure to provide nursing care based on patient assessments and physician orders places patients at risk for deterioration of health status and poor health care outcomes.

Findings included:

1. Document review of the hospital's policy titled, "Completed Medical Record," policy #9.10, effective 11/27/17, showed that the medical record must contain information sufficient to promote continuity of care and document the course of care, treatment and service.

2. On 05/22/18 at 9:30 AM, Surveyor #5 reviewed the medical record of Patient #502 who was receiving treatment for hyponatremia (low sodium in the blood) secondary to polydipsia (extreme thirstiness) secondary to psychogenic polydipsia (desired to drink excessive water related to a mental disorder). The record review showed:

a. On 05/21/18 (no time documented), a physician order to administer 2 liters of Normal Saline at 125 cc/hr and give Lasix (a diuretic medication) 20 mg now by mouth.

b. On 05/21/18 (no time documented) a physician order for fluid restriction 800 cc AM/PM shift and 400 cc on night shift.

c. The Intake/Output Summary form showed one documentation entry on 05/21/18 for 720 cc oral fluid and 325 cc of IV fluid on one entry of zero fluid intake on night shift. The Input for the 24 hour period was documented "375."

d. The Intravenous Access and Fluid Record on 05/21/18 showed that 0.9% NS (Normal Saline)

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A 392	Continued From page 30 was started on 05/21/18 at 12:00 PM. No infused volume was documented. e. On 5/22/18 at 6:45 PM a nursing note stated that the patient removed the IV catheter and there was 158 mL "LTC" (left to count) in the bag of normal saline. 3. At the time of the record review, the registered nurse (Staff #507) confirmed the findings and stated that he did not know why the input wasn't being documented and did not know if the fluid restriction included the intravenous fluid. 4. On 05/22/18 at 10:20 AM, the psychiatric security nurse (Staff #508) assigned to monitor the patient 1:1 told Surveyor #5 that she believed that the patient did not get free water, only fluid with meals.	A 392		
A 395	. RN SUPERVISION OF NURSING CARE CFR(s): 482.23(b)(3) A registered nurse must supervise and evaluate the nursing care for each patient. This STANDARD is not met as evidenced by: . Based on interview, record review, and review of policy and procedures, the hospital failed to ensure nursing staff members assessed patients on return to the hospital from off-site medical procedures, as demonstrated by 1 of 1 patients reviewed (Patient #809). Failure to assess patients for changes in healthcare needs places patients at risk for	A 395		

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delays in care and treatment.

Findings included:

1. Document review of the hospital policies and procedures showed the following:

a. The policy titled "Acceptance of Medical Authority," Policy #1.04 dated 04/17, showed that nurses were to perform a nursing assessment within four hours of the patient's return from an off-site appointment, regardless of the duration of the absence. The policy directed nurses to document the assessment findings in a progress note in the patient's medical record.

b. The policy titled "Assessment and Treatment of Wounds," Policy #6.11 Rev 4/16/18, showed that all patients are examined for wounds upon return from outside treatments.

2. On 05/16/18 at 9:30 AM, Surveyor #8 reviewed the current medical record for Patient #809 and interviewed a registered nurse (RN) (Staff #807) and a psychologist (Staff #805). The record showed that the patient had a history of Rhombencephalosynapsis (RS) (a congenital abnormality of the cerebellum with neurologic impairment). The patient had impaired swallowing and required feedings through a gastrostomy tube.

At the time of the record review, the nurse (Staff #807) stated that the patient's gastroenterologist placed a new feeding tube in the patient's abdomen during an off-site procedure on 04/10/18.

3. Review of the record revealed the following:

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A 395	Continued From page 32 a. There were no entries indicating the time of the patient's return to the hospital on 04/10/18. b. There was no report of the pharmaceuticals the patient may have received during the procedure, any estimated blood loss, or the length of the procedure. c. There was no documentation of any communication between the consultant and the hospital staff members regarding the procedure, following the patient's return to the hospital. d. Once the patient returned to the hospital, there was no nursing assessment to indicate the status of the abdominal wound. Also, there was no documented pain assessment or current vital signs. 4. During the interview, the RN (Staff #807) stated that off-site consultants often do not send written information with the patient. The nurse stated that consultants might not send their reports for several weeks. The nurse stated nursing staff members do not follow any specific procedure for assessing patients on return from off-site appointments. .	A 395		
A 396	NURSING CARE PLAN CFR(s): 482.23(b)(4) The hospital must ensure that the nursing staff develops, and keeps current, a nursing care plan for each patient. The nursing care plan may be part of an interdisciplinary care plan This STANDARD is not met as evidenced by:	A 396		

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ITEM #1 - TREATMENT PLAN

Based on review of hospital policies and procedures and review of medical records, the hospital failed to ensure that staff developed, initiated, and updated patient care plans for 10 of 22 patients reviewed (Patient #502, #503, #504, #505, #506, #507, #508, #509, #510, and #511).

Failure to develop care plans to address patient care may lead to patient harm and failure to appropriately treat a medical condition.

Findings included:

1. Document review of the hospital's policy titled, "Treatment Planning," Policy #8.01, effective date 05/03/18, showed that treatment plans must be continuously evaluated and treatment addendums are used for changes that do not merit a full revision of the treatment plan including medical treatment.

2. On 05/14/18 from 10:05 AM until 12:15 PM, Surveyor #5 and a registered nurse (Staff #503) reviewed the medical record of Patient #503 who was transferred from another ward on 02/16/18 for safety and sexually acting out behavior. The medical record review showed:

a. On 03/02/18, the Treatment and Recovery Plan Review and Update stated, "She does struggle a little more with appropriate boundaries with others and does need reminders."

1) On 03/29/18 at 7:30 PM, the patient entered the room of two male peers and demanded to perform oral sex.

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A 396	Continued From page 34 2) On 04/11/18 at 8:01 PM, the patient engaged in sexual intercourse. 3) On 04/21/18 at 9:30 PM, the patient removed her clothing on the patio in front of a male peer. The nursing notes showed that that the patient "has been warned numerous times to abstain from such behavior and continues to express it anyway." 4) On 05/06/18 at 6:35 PM, the patient pulled down her pants and exposed her breasts to a staff member. 5) On 05/13/18 at 9:15 PM, the patient attempted to perform felatio (an oral sex act) on a male peer out on the patio. b. Surveyor #5 found no evidence the treatment plan had been updated to reflect increasing sexually acting out behaviors or interventions developed or implemented to ensure patient, peer, and staff safety. c. On 03/02/18, the Treatment and Recovery Plan Review and Update stated that the patient was medication compliant. 1) On 04/04/18 at 8:00 PM the patient was observed spitting her medications into the toilet and flushing them. 2) On 04/06/18 the patient was observed "cheeking" medication and placed on medication watch. d. Surveyor #5 found no evidence a treatment plan addendum had been developed to reflect	A 396		

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changes in the patient's behavior and treatment interventions.

e. At the time of the review, the registered nurse (Staff #503) confirmed the findings and stated that she worried the patient would get pregnant.

3. On 05/15/18 at 11:30 AM, Surveyor #5 and a registered nurse (Staff #509) reviewed the medical record for Patient #511 who was admitted on 08/09/90 for treatment of paranoid schizophrenia and intermittent explosive disorder. The medical record showed:

a. The patient was incontinent of urine, used an adult incontinence garment (adult diapers) and had physician orders to treat a severe groin and buttock rash. Review of physician treatment orders showed:

1) On 01/18/18 at 5:45 PM, a physician order for wound care to the buttocks and scrotum and an order for the patient to wear brief type underwear.

2) On 01/22/18 at 12:15 PM, a physician order for rash care for perianal rash and an order that patient is not allowed to wear adult diapers.

3) On 02/26/18 at 10:00 AM, a physician order for wound care to a severe buttocks rash and an order to "never wear diapers."

b. The patient recently sustained several wounds including an eyebrow laceration, a head wound from banging head, and a left great toe wound. Review of physician orders showed:

1) On 02/26/18 at 10:00 AM, a physician order for wound care to the left great toe.

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2) On 03/01/18 at 12:45 PM, a physician order for daily wound care for forehead laceration.

3) On 03/14/18 at 7:30 PM, a physician order to begin neurological checks for head injury.

4) On 03/29/18 at 2:20 PM, a physician progress note accepting unit transfer stated that the patient had a history
of head-banging.

5) On 05/13/18 at 9:35 PM, a physician order to apply derma-bond to eyebrow laceration above right eye.

c. Surveyor #5 found no evidence that treatment plan addendums had been developed to reflect changes in the patient's medical condition or treatment interventions ordered by the physician. Surveyor #5 found no evidence wound care had been added to or documented in the treatment flow record.

d. At the time of the record review, Staff #509 confirmed the findings. She stated she was unaware of the orders not to put adult diapers on the patient.

e. On 05/15/18 at 1:50 PM, during interview with Surveyor #5, a registered nurse (Staff #510) verified the findings and stated that there wasn't a good process for tracking wound care or stages of wound healing unless the wound is significant.

4. On 05/22/18 at 9:30 AM, Surveyor #5 reviewed the medical record of Patient #502 who was receiving treatment for hyponatremia (low sodium in the blood) secondary to polydipsia (extreme

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thirstiness) secondary to psychogenic polydipsia (desire to drink excessive water related to a mental disorder). The record review showed:

a. On 05/21/18, physician orders to place the patient on fluid restriction and to infuse 2 liters of intravenous normal saline.

b. Surveyor #5 found no evidence a treatment plan addendum had been completed to reflect changes in the patient's medical condition or treatment ordered by the physician.

c.. At the time of the record review, the registered nurse (Staff #507) confirmed the findings.

5. On 05/22/18 at 11:59 AM, Surveyor #5 and a registered nurse (Staff #507) reviewed the medical record of Patient #510 who was admitted on 11/27/17 schizoaffective disorder, polysubstance abuse, HIV and active Hepatitis C. The record review showed:

a. On 05/18/18 at 10:00 AM, physician orders for culture of a right axilla (underarm) wound, wound care orders with dressing change every day for seven days, and oral antibiotics.

b. on 05/18/18 at 10:37 PM, a nursing note that stated when the patient moved his arm across the wound it began bleeding and the wound was covered with a 2 X 2 gauze.

c. On 05/21/18 at 9:30 AM, physician orders to change the antibiotics based on the culture and sensitivity report.

d. Surveyor #5 found no evidence that staff had developed a treatment plan addendum to reflect

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the changes in the patient's medical condition and treatment interventions; and no evidence that staff had added or documented wound care in the patient's treatment flow record.

e. At the time of the record review, the registered nurse (Staff #507) confirmed the findings and stated he did not know why it was not added to the treatment plan or treatment flow record.

6. Review of the medical records for patients #504, #505, #506, #507, #508, and #509 showed similar findings that the treatment plans were not updated to reflect changes in patient condition and treatment.

ITEM #2 - TREATMENT RECORD FLOWSHEET

Based on document review and interview, the hospital failed to follow its policy and procedure for documenting care or treatment ordered by the physician.

Failure to document care given or not given in the medical record places patients at risk for receiving delayed or inadequate treatment.

Findings included:

1. Document review of the hospital's policy and procedure titled, "Treatment Record Flowsheet (WSH 23-78)," last reviewed 08/15, showed that the treatment record is used to document any treatment given to a patient which uses non-pharmacy issued items. The flowsheet was not to be used as "FYI" for your information or "Information Only" on patients. The procedure directed the treatment nurse to record his/her

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initials in the appropriate time block according to the date and time the treatment is completed. The treatment nurse was to enter a code in the appropriate block if they did not give the treatment.

2. On 05/17/18 at 1:30 PM, Surveyor #3 reviewed the May 2018 treatment record of Patient #304. Patient #304 had an order for a blood glucose test once weekly on Monday before breakfast. The surveyor observed the treatment record flowsheet was blank and not filled out for the first two Mondays of May.

3. On 05/17/18 at 1:45 PM, Surveyor #3 reviewed the May 2018 treatment record of Patient #305, who had an order for daily thumb dressing changes. The surveyor observed that the treatment record flowsheet was blank and not filled out for May 6th, 11th, 12th, and 15th.

4. On 05/17/18 at 2:30 PM, Surveyor #3 interviewed the charge nurse (Staff # 304) about the treatment record observations for Patient's #304 and #305. Staff #304 stated the blank boxes were probably due to the patient refusing care. The nurse stated if a patient refuses care, an "R" should be written in on the flowsheet in the indicated box.

5. On 05/18/18 at 12:00 PM, Surveyor #3 reviewed the treatment record of Patient #306 for the month of April 2018. The patient had orders on the treatment record flowsheet for protein powder, 2 scoops, 3 times a day with meals; one can of Glucerna (meal replacement shake) three times a day; and to add Juven (therapeutic nutritional drink for wound healing) to meals three times a day. The surveyor observed the treatment

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record flowsheet was blank and not completed for the day and evening shifts for April 8th, 9th, and 10th.

ITEM #3 - PHYSICAL THERAPY CONSULT

Based on record review and interview, the hospital failed to establish a process to refer patients for physical therapy, as demonstrated by 1 of 1 patient reviewed (Patient #902).

Failure to refer patients for physical therapy could lead to increased falls and resulting harm.

Findings included:

1. On 05/15/18 at 11:30 PM, Surveyor #9 reviewed the medical record of Patient #902. On 01/19/18 the patient saw a physical therapist (PT) (Staff #910) who performed an evaluation of the patient who had undergone a right great toe amputation on 10/25/17. His wound was slow healing and the patient was not able to bear weight on the right lower extremity at that time. The patient was discharged from PT after this visit. The physical therapist (Staff #910) wrote in his consult that the patient should return to PT when he was able bear weight on his right lower extremity. The Registered Nurse (RN) 2 (Staff #911) and the provider (Staff #912) noted the consult.

On 04/10/18, a nursing progress note stated that the patient's right toe wound had healed and the patient is wearing a "boot", but also noted that the patient was using his wheel chair for mobility. On 04/14/18, a nursing progress note stated that the patient was partially able to bear weight on his

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right foot. On 04/24/18 the nursing progress note stated that patient was walking short distances.

2. On 05/15/18, Surveyor #9 asked the RN 2 (Staff #904) if the patient had returned to physical therapy as he was able to bear weight on his right foot. He stated an orthotic shoe was on "back order" from the distributor and when it was received the patient would be referred back to PT. Surveyor #9 asked how staff would be alerted to send the patient back to PT and if there was a tracking system with this information. Staff #904 stated he knew that the patient was to return to PT but there was no specific tracking system.

ITEM #4 - NUTRITIONAL CONSULT
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Based on interview, medical record review and document review, the hospital failed to ensure that staff referred patients for a nutritional consult with a dietician as directed by hospital policy and procedure for 2 of 2 patients (Patient #509 and #512).

Failure to refer a patient for a nutritional consult may lead to poor nutrition and poor health outcomes.

Findings included:

1. Document review of the hospital's policy and procedure titled, "Nutrition Assessment and Risk Evaluation," Policy #11.11, effective date 05/01/17, showed that patients are screened for nutrition risk on the admission nursing assessment and if the body mass index (BMI) is less than 18.5 or greater than 35, a referral to the

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registered dietician is required.

2. On 05/15/18 at 10:40 AM, Surveyor #5 and a registered nurse (Staff# 509) reviewed the medical record for Patient #512 who was admitted for treatment of schizoaffective disorder, medication non-compliance and a history of traumatic brain injury, hypokalemia, Hepatitis C, and hypertension. The medical record showed:

a. On admission, the patient had a weight of 227 pounds and a height of five feet six inches.

1) The nursing assessment nutritional screening was not completed on admission. A note written on the nursing assessment stated, "Pt (Patient) put on a lot weight." Based on the patient's documented weight and height, Surveyor #5 calculated the patient's BMI as greater than 35.

2) A physician note stated the patient was overweight, however, the physician failed to order a nutritional assessment upon admission.

3) Surveyor #5 found no evidence a nutritional consult had been ordered as directed by hospital policy.

b. At the time of the record review, Staff #509 confirmed the finding and stated that the nursing dietary screening should have been completed on admission.

3. On 05/17/18 at 4:15 PM, Surveyor #5 and a registered nurse (Staff #511) reviewed the medical record of Patient #509, who was admitted on 04/19/18 for the treatment of schizoaffective disorder bipolar type. The record reviewed showed:

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A 396	Continued From page 43 a. On admission, the patient's weight was 332 pounds and height was five feet three inches. The patient's BMI was 57. 1) The nursing assessment nutritional screening was not completed on admission. 2) No Dietary consult was ordered in the computerized order system. 3) No nutritional assessment was ordered on the physician admission orders. 4) A nutritional assessment was completed by the dietician on 04/20/18. b. At the time of the finding, the registered nurse (Staff #511) and the ward administrator (Staff #512) verified the lack of screening by both the admission nurse and the physician and stated that they were uncertain how the dietician was notified of the patient but thought it might have been through lab results as the patient is diabetic. .	A 396		
A 450	MEDICAL RECORD SERVICES CFR(s): 482.24(c)(1) 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 policies and procedures. This STANDARD is not met as evidenced by: . Based on observation, interview, and review of	A 450		

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A 450	Continued From page 44	A 450		

hospital's policies and procedures, the hospital failed to ensure health care staff documented in medical records according to hospital charting requirements for five of five records reviewed (Patients #804, #805, #806, #807, #808.)

Failure to ensure medical records are accurate, legible, and complete risks ineffective and inappropriate clinical care, which can result in poor patient outcomes.

Findings included:

1. Document review of the hospital policy and procedure titled "Charting Requirements," Policy # 1.4, revised 06/17, showed all patient record entries must be accurate, legible, and complete. Entries must be dated, timed and authenticated.

2. Review of the medical records of five patients currently receiving treatment in the hospital showed the following:

a. Patient # 804's record included a Medical Nurse Consultant progress record note without a date, time or authentication of the author.

b. Patient #805's record included two suicide risk assessments with narrative entries that were not dated, timed, or authenticated, and three sets of multi-page Physician Notes by the psychiatrist (Staff #808) that were not dated, timed, or authenticated.

c. Patient #806's record included a 10-page document titled "Treatment and Recovery Plan Review" without an identifying name or author(s) initials, dates or times of the multiple page document.

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A 450	Continued From page 45 d. Patient #807's record showed the "Treatment and Recovery Plan Review" which was dated with the incorrect date of signature (June 2018). e. Patient #808's record included a two page History and Physical document without the time, date or signature of the author. 3. On 05/22/18, at 11:30 AM, Surveyor #8 interviewed a ward clerk (Staff #804), who stated that they were unaware of the standards of charting in the medical record. .	A 450		
A 467	CONTENT OF RECORD: ORDERS,NOTES,REPORTS CFR(s): 482.24(c)(4)(vi) [All records must document the following, as appropriate:] All practitioner's orders, nursing notes, reports of treatment, medication records, radiology and laboratory reports, and vital signs and other information necessary to monitor the patient's condition. This STANDARD is not met as evidenced by: . Based on interview, record review and review of policies and procedures, hospital staff failed to document pertinent patient information in the medical record to ensure continuity of care when patients transferred from one ward to another for 5 of 5 patient records reviewed (Patients #1101, #1102, #1103, #1104 #1105). Failure to provide patient information upon	A 467		

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transfer places patients at risk for harm to self or others, and unsuccessful integration into the ward milieu.

Findings included:

1. Document review of hospital policies and procedures showed the following:

a. The hospital policy and procedure titled, "Internal Civil Patient Transfers," Policy #8.30 issued 10/17, showed that at a minimum, physician-to-physician and nurse-to-nurse reports, both verbal and written in the patient record, will occur before staff transfer a patient to another ward.

In addition, the policy stated that the transferring and receiving physicians, nurse, social worker, and psychologist must each write a note with a brief summary of the patient's status and assessment by the discipline, any factors that may affect the patient's level of dangerousness, as well as any other information the receiving ward needs to know.

b. The hospital nursing services policy and procedure titled, "Transfer of Patient between Wards," Procedure #209 revised 02/18, showed that the transferring registered nurse (RN) documented destination, date and time of transfer, reason for transfer, patient's psychological and physiological condition, response to treatment plan and current treatments. The receiving RN documented the time, date, transferring ward, accounting of personal items, orientation to milieu, and assessment of psychological and physiological condition following transfer.

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2. Review of the records of five patients transferred from one ward to another during their hospitalization showed the following:

a. Patient #1101 transferred from ward F2 to C6 on 02/16/18. There was no receiving psychiatrist progress note, no medical provider progress note from the transferring ward or receiving ward, no transferring RN progress note, and no transferring social worker progress note.

b. Patient #1102 transferred from ward S10 to C3 on 02/26/18. There was no transferring medical provider progress note.

c. Patient #1103 transferred from ward F8 to E1 on 03/07/18. There was no transferring or receiving medical provider progress note, no transferring or receiving social worker progress note, and no transferring RN progress note.

d. Patient #1104 transferred from ward E5 to E8 on 03/14/18. There was no transfer note from the medical provider and no RN progress note from the transferring ward or the receiving ward.

e. Patient #1105 transferred from ward C2 to E7 on 03/16/18. There was no RN progress note from the transferring or receiving ward, and no social worker progress note from the transferring ward.

3. On 05/18/18 at 11:40 AM, Surveyor #11 interviewed the Deputy Chief Nursing Officer (Staff #1101) about the results of the record review. Staff #1101 reviewed the medical records looking for the missing documentation and then confirmed that the documentation was not there.

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A 467	Continued From page 48	A 467		
A 700	PHYSICAL ENVIRONMENT CFR(s): 482.41 The hospital must be constructed, arranged, and maintained to ensure the safety of the patient, and to provide facilities for diagnosis and treatment and for special hospital services appropriate to the needs of the community. This CONDITION is not met as evidenced by: . Based on observation, interview, record review, and review of hospital policies and procedures, the hospital failed to provide a safe and secure environment for patients. Failure to maintain a safe and secure environment risked serious injury or death for patients, staff, and visitors in the hospital. Findings included: The hospital failed to maintain a safe and secure patient care environment that included the following: 1. Systems to detect and mitigate ligature risks in the patient care environment. Cross Reference: A0701, Item #1 2. Systems to ensure that the physical environment and items used in the patient environment are maintained in good repair. Cross Reference: A0701, Item #2	A 700		

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A 700	Continued From page 49 3. Systems for ensuring supplies were available, ready to use, and not expired. Cross Reference: A0724 4. Systems to ensure refrigeration for food products and laboratory specimens were properly monitored and maintained within acceptable ranges. Cross Reference: A0726 5. Systems for fire prevention, detection, and suppression that meet the 2012 Fire Life Safety Code. Cross Reference: A0710 Due to the scope and severity of deficiencies identified during the survey, the Condition of Participation for Physical Plant and Environment was NOT MET .	A 700		
A 701	MAINTENANCE OF PHYSICAL PLANT CFR(s): 482.41(a) The condition of the physical plant and the overall hospital environment must be developed and maintained in such a manner that the safety and well-being of patients are assured. This STANDARD is not met as evidenced by: . ITEM #1 - ASSESSMENT AND MITIGATION OF LIGATURE RISKS Based on observation, interview, and document review, the hospital failed to ensure that it	A 701		

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identified and mitigated all ligature risks in the patient care environment.

Failure to identify and mitigate ligature risks can result in patient harm and death related to suicide by hanging.

Findings included:

1. Record review of the document titled, "Environment of Care - Physical Risk Assessment Report 2017," dated 01/13/17, showed that ward S9 was vacant at the time of assessment and that staff failed to identify potential ligature risks for that unit. Review also showed that the seclusion and restraint rooms in ward S8 were not included on the risk assessment and the fire suppression system was only included for one patient bathroom, room #342. The identified risks on ward C7 were included on the master spreadsheet for the hospital, but the detailed ward assessment was not provided in the risk assessment notebook.

Record Review of the document titled, "Clinical and Physical Environment Suicide Risk Assessment," dated 03/17, showed that Building 21, which houses wards S8 and S9, was not included on the ligature abatement plan. An addendum dated 04/30/18 mentioned that a shower room risk assessment for wards S6-S10 was on file in the Facilities Office but made no other mention of ligature risks in building 21.

2. On 05/22/18 at 4:10 PM, Surveyor #5, a registered nurse (Staff #512) and the ward administrator (Staff #513) inspected a restraint and seclusion room on ward S8. The observation showed:

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a. In the main room, a wall-mounted smoke detector near the ceiling was not flush with the wall, leaving a 1 1/2 to 2 inch gap.

b. Below the smoke detector a chair had been secured to the floor.

c. In the bathroom, a fire strobe light was attached to the wall about five feet from the floor. The box was square and extended into the room approximately three to four inches with a face plate on the front that created a lip.

3. At the time of the finding, Staff #512 and Staff #513 acknowledged that the findings were a ligature risk. Staff #512 stated that the bathroom is always locked for safety. Upon inspection by the surveyor, the door was unlocked.

4. On 05/22/18 at 6:00 PM, in an interview with with Surveyor #5 and Surveyor #2, the Deputy Facilities Manager (Staff #514) stated that the hospital was aware of the ligature risk due to the strobe light and they were unable to find a cover that would be acceptable. She stated that the smoke detectors had been retrofitted with a ligature mitigating cover. Surveyor #5 and Staff #514 inspected the smoke detector and Staff #514 acknowledged the gap and the ligature risk. Staff #514 stated that because floors S9 and S10 were the same floor plans, the same ligature issues existed.

5. On 05/23/18 at 8:45 AM, the Deputy of Hospital Operations (Staff #205) stated in a morning briefing with the survey team that the fire suppression system "slipped through the cracks" during the environmental risk assessment.

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6. On 05/23/18 at 9:51 AM Surveyor #2 interviewed the Deputy of Hospital Operations (Staff #205) regarding environmental risk assessments at the hospital. The deputy stated that in 2018 the hospital staff postponed the environmental risk assessment from January until June due to the routine rounding performed by ward administrators. The deputy also stated that when the hospital brought wards back online from remodeling or construction, only the contractors were completing walk-throughs. None of the hospital environmental and clinical staff performed walk-throughs to ensure a safe environment.

ITEM #2 - PHYSICAL PLANT MAINTENANCE

Based on observation and interview, the hospital staff failed to maintain the physical plant and furnishings in a safe manner and failed to mitigate ligature risks.

Failure to maintain safety in the physical plant and failure to mitigate ligature risk creates an unsafe environment for patients, staff, and visitors.

Findings included:

1. On 05/14/18 at 9:40 AM, Surveyor #2 toured ward C6 of the hospital. During the tour, the surveyor observed a torn mattress in room 305.

2. The ward administrator (Staff #203) confirmed the damage to the mattress and removed it from the ward.

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A 701	Continued From page 53 3. On 05/14/18 at 9:40 AM, Surveyor #2 toured ward C4 of the hospital. During the tour, the surveyor observed cracked tiles near the floor in a resident restroom. 4. At the time of the observation, a registered nurse 3 (Staff #204) confirmed the crack in the tiles. 5. On 05/14/18 from 10:45 AM to 11:45 AM, Surveyor #2 toured the treatment mall of the Central wards. During the tour, the surveyor observed 3 chairs with torn fabric, exposing the foam pad and internal materials of the chairs. 6. The therapy director (Staff #201) confirmed that the chairs were torn and had them removed from the treatment mall. 7. On 05/15/18 from 2:25 PM to 2:52 PM, Surveyor #2 toured ward E7. During the tour, the surveyor observed an approximate five foot section of chipped drywall below the window in room 133. 8. At the time of the observation, the ward administrator (Staff #205) confirmed the damage to the drywall. .	A 701		
A 710	LIFE SAFETY FROM FIRE CFR(s): 482.41(b)(1)(2)(3) (1) Except as otherwise provided in this 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,	A 710		

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A 710	Continued From page 54 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: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this 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: . Based on observation, interview, and document review, the hospital failed to meet the requirements of the 2012 edition of the Life Safety Code.	A 710		

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A 710	Continued From page 55 Findings included: Refer to the deficiencies written on the Medicare Life Safety inspection report dated 05/16/18 . .	A 710		
A 724	FACILITIES, SUPPLIES, EQUIPMENT MAINTENANCE CFR(s): 482.41(c)(2) Facilities, supplies, and equipment must be maintained to ensure an acceptable level of safety and quality. This STANDARD is not met as evidenced by: . ITEM #1 - EXPIRED BLOOD GLUCOSE TEST CONTROL SOLUTIONS Based on observation and document review, the hospital failed to have an effective quality control process in place to ensure that blood glucose test control solutions were dated and discarded after the manufacturer's beyond use date for 3 of 7 clinical nursing units inspected. Failure to ensure that blood glucose test solutions do not exceed manufacturer's beyond use date risks incorrectly treating patients based on incorrect blood glucose test results. Findings included: 1. Document review of the "ACCU-Check Inform II" manufacturer's instructions for use for glucose test solutions, dated 06/18/14, showed that the control solution is stable for 3 months from the date the bottle was opened or until the "Use by" date on the bottle label, whichever comes first.	A 724		

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2. During inspection of the Forensic medication rooms, Surveyor #3 found the following:

a. On 05/16/18 at 1:10 PM in clinical unit F-3, the surveyor observed two bottles of glucose test control solutions open and not dated in the glucometer storage case.

b. On 05/17/18 at 10:30 AM in clinical unit F-4, the surveyor observed two bottles of glucose test control solutions open and not dated in the glucometer storage case.

c. On 05/17/18 at 1:30 PM in clinical unit F-7, the surveyor observed two bottles of glucose test control solutions open and not dated in the glucometer storage case.

ITEM #2 - EXPIRED PATIENT CARE SUPPLIES

Based on observation, interview, and document review, the hospital failed to ensure that patient care supplies did not exceed their designated expiration dates.

Failure to ensure patient care supplies do not exceed their expiration dates places patients at risk of harm due to unsafe or ineffective equipment.

Findings included:

1. Document review of the hospital's undated document titled, "Interdepartmental Functions and Relationships," reference #1005, showed that the Central Service Department would ensure that adequate supplies were on hand for effective delivery of patient services, and would replace

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items in stock in patient care areas.

Document review of the hospital's Warehouse Operations document titled, "CIBS Warehousing and Consumable Inventory Procedures," dated 04/01/15, showed that staff are to monitor items with a shelf life, use-by, or expiration date to ensure they are used before they expire.

2. On 05/15/18 at 3:30 PM, during a tour of the Habilitative Mental Health (HMH) Unit with the HMH Program Manager (Staff #606), Surveyor #6 observed 2 packages of GE Silver Mactrode Plus electrocardiogram (ECG) electrodes in an unsealed plastic bag next to and ECG machine. One of the packages was opened and had a manufacturer expiration date of 2017-12.

3. At the time of the observation, Surveyor #6 interviewed Staff #606 and the Medical Nurse Consultant for W1S (Staff #607) about how staff manage electrode packages in the HMH units. Staff #607 stated that electrodes should be discarded by the manufacturer's expiration date.

4. On 05/14/18 at 9:34 AM, Surveyor #5 and the ward administrator (Staff #504) inspected the tub room located on ward C8. The observation showed one package of attends disposable washcloths with an expiration date of 01/03/17 and two 1.25 liter bottles of Provon hand wash liquid with a manufacturer's expiration date of 02/17.

5. On 05/14/18 at 9:54 AM, Surveyor #5 and the ward administrator (Staff #504) inspected the medication room located on ward C8. Surveyor #5 observed 30 packets of Juven Nutrition Protein with a manufacturer's expiration date of

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05/16.

6. At the time of the findings, Staff #504 confirmed the expiration dates and removed the expired items.

ITEM #3 - PROVISION OF PATIENT CARE SUPPLIES

Based on observation, interview, and review of policies and procedures, the hospital failed to maintain supplies in order to provide an acceptable level of safety and quality for patient care needs.

Failure to maintain patient care supplies could lead to unavailable, outdated, contaminated, or deteriorated supplies and risks harm to patients.

Findings included:

1. On 05/16/18 at 9:30 AM, Surveyor #8 reviewed the current medical record for Patient #809 with the registered nurse (RN)(Staff #807) and the psychologist (Staff #805). The patient had a history of Rhombencephalosynapsis (RS) (a congenital abnormality of the cerebellum with neurologic impairment). The patient received a feeding tube on 09/25/17 and again on 11/15/17. The RN stated that the patient's mother supplied the current feeding tube (1.5 Mic Key) as the hospital was not able to purchase this size. The psychologist also stated that the patient's family supplied the tube feedings.

2. Surveyor #8 asked for a policy that covered delineation of responsibilities for patient care supplies not provided by the hospital. The

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A 724	Continued From page 59 hospital was unable to locate a policy. ITEM #4- INSPECTION OF PATIENT-OWNED EQUIPMENT Based on observation, interview and review of policy and procedures, the hospital failed to ensure patient-owned equipment was not available for use until inspected and labeled as safe to use. Failure to ensure equipment supplied by a patient's family is inspected and deemed safe to use risks patient injury and harm. Findings included: 1. Record review of the hospitals policy titled, "Durable Medical Equipment Program," Policy #4.10, revised 10/17, showed that all patient owned equipment was to be reported to the medical equipment manager who would inspect the equipment and label it safe to use. 2. On 05/16/18 at 2:00 PM, Surveyor #8 toured the Habilitative Mental Health Treatment Program (HMH) with a psychologist (Staff #805). In the south treatment room, the observation showed a continuous positive airway pressure machine (CPAP) without a label to indicate the machine was safe for use. 3. On 05/17/18 at 1:30 PM, Surveyor #8 interviewed the Electrical Safety and Inspection Manager (Staff #806). Staff #806 stated that the machine should have a label to indicate it is safe to use. .	A 724		

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A 726	VENTILATION, LIGHT, TEMPERATURE CONTROLS CFR(s): 482.41(c)(4) 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: . ITEM #1- FOOD TEMPERATURES Based on observation, interview, and document review, the hospital failed to maintain food preparation temperatures consistent with the requirements of the Food and Drug Administration (FDA) Food Code. Failure to comply with FDA Food Code puts patients, staff, and visitors of the facility at risk from food borne illnesses. . ITEM #1a - COLD-HOLDING Findings included: 1. Document review of the hospital's policy titled, "Food Services," Policy 11.10, dated 08/17, showed that staff are to maintain perishable foods at a safe temperature until served; use a calibrated thermometer to verify the temperature; and maintain an internal temperature below 41 degrees Fahrenheit for cold food. Document review of the hospital's policy titled, "Food Service Infection Control," Policy 11.17, dated 08/17, showed that staff are to maintain a maximum temperature of 41 degrees Fahrenheit for cold food holding.	A 726		

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2. On 05/14/18 at 11:20 AM, Surveyor #2 used a thin-stemmed thermometer to measure the temperature of items in a refrigerator in the treatment mall of the Central wards. The observation showed that the internal temperatures for two pieces of string cheese were 43.9 and 43.1 degrees Fahrenheit.

At the time of the observation, the therapy director (Staff #201) confirmed the temperatures.

3. On 05/15/18 between 9:13 AM and 9:45 AM, Surveyor #2 toured ward E4. During the tour, the surveyor used a thin stem thermometer to measure the internal temperature of items in the kitchen refrigerator. The observation showed a container of hummus had an internal temperature of 50 degrees Fahrenheit and a carton of milk had an internal temperature of 47 degrees Fahrenheit.

At the time of the observation, the ward administrator (Staff #202) confirmed the temperatures.

4. On 05/15/18 at 10:00 AM, during a tour of Ward S9 with the ward administrator (Staff #603), Surveyor #6 used a thin-stemmed thermometer to assess the temperature of a half-pint container of 1 percent low fat milk in the ward refrigerator located in room #448. The milk temperature measured 47.7 degrees Fahrenheit, above the maximum allowable temperature of 41 degrees Fahrenheit.

A review of the temperature log sheet located on the refrigerator door showed that staff recorded a temperature of 40 degrees Fahrenheit on the same day (05/15/18) at 7:30 AM.

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At the time of the observation, Surveyor #6 interviewed a dietary supervisor (Staff #604) about cold holding temperatures. Staff #604 stated that she was not aware of any problems with cold holding temperatures in the ward S9 refrigerator and that she did not know whether staff checked the temperatures of potentially hazardous foods stored in the refrigerator.

Reference: 2009 FDA Food Code 3-501.16

5. On 05/16/18 at 2:15 PM, Surveyor #1 toured the dining room kitchen on E4 with the Ward Administrator (Staff #101). The observation showed that the refrigerator thermometer read 50 degrees Fahrenheit and that the refrigerator had an electronic temperature-monitoring device (Temp-Track) inside the unit.

During this observation, Surveyor #1 used a thin-stemmed thermometer to assess the temperature of the butter located on the top shelf of the refrigerator. The internal temperature of the butter was 46 degrees Fahrenheit, 5 degrees above the maximum cold-holding temperature of 41 degrees Fahrenheit as required in the Food and Drug Administration Food Code.

After assessing the temperature, the surveyor asked the ward administrator if he received notifications when the temperature is out of range. The ward administrator stated, "No."

6. On 05/17/18 at 2:00 PM, Surveyor #1 interviewed the dietary manager (Staff #102) and reviewed the Temp Track data temperature logs for the refrigerator on E4. The Temp Track temperature log dated 05/15/18 showed

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temperatures ranging from 45.9 to 50.5 degrees Fahrenheit between 8:15 AM and 10:45 AM, and temperatures ranging from 43.3 to 49.3 degrees Fahrenheit between 1:00 PM and 3:15 PM. The dietary manager stated that if the temperatures exceeded 41 degrees Fahrenheit for more than 2 hours, staff on the ward would receive notification.

7. On 5/18/18 at 12:00 PM, Surveyor #1 reviewed the Temp Track data logs for 30 refrigerators. The temperature data logs showed that from 05/15/18 through 05/16/18, 21 of the 30 refrigerators exceeded the maximum cold-holding temperature allowed by the Food and Drug Administration Food Code.

Reference: 2009 FDA Food Code 3-501.16
Reference: 2009 FDA Food Code 4-203.12

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ITEM #1b - HOT HOLDING

Findings included:

1. Document review of the hospital's policy titled, "Food Services," Policy 11.10, dated 08/17, showed that staff are to maintain prepared foods at a safe temperature until served; use a calibrated thermometer to verify the temperature; and maintain an internal temperature above 140 degrees Fahrenheit for hot food.

Document review of the hospital's policy titled, "Food Service Infection Control," Policy 11.17, dated 08/17, showed that staff are to maintain a minimum temperature of 135 degrees Fahrenheit for hot food holding, and that staff are to monitor and document temperatures on an appropriate

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temperature log.

2. On 05/14/18 at 9:30 AM, during a tour of the Food & Nutrition Department with the Director of Food & Nutrition (Staff 601), Surveyor #6 used a thin-stemmed thermometer to assess the temperature of chopped hamburger that was being hot-held prior to service. Servings of chopped hamburger measured 120, 128, and 130 degrees Fahrenheit, below the required 135 degrees Fahrenheit hot holding minimum temperature.

3. At the time of the observation, Surveyor #6 interviewed a cook (Staff #602) about the chopped hamburger. Staff #602 explained that the hamburger was a commercially pre-cooked, frozen product. At about 8:30 AM (1 hour before the observation), Staff #602 re-heated hamburgers to 160 degrees Fahrenheit, placed the burgers on buns, chopped and plated them. The prepared, chopped hamburgers were then moved to the hot-holding unit. Staff #602 stated that she had not documented times or temperatures.

At 10:00 AM, Staff #602 increased the temperature of the hot holding unit, reheated the chopped hamburgers, and started a temperature log.

Reference: 2009 FDA Food Code 3-501.16

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ITEM #1c- COOLING PROCEDURES

Findings included:

1. Document review of the hospital's food storage

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log titled, "Cold Storage Mandatory Temperature Log Sheet," Food Storage Log Form (March, 2006), showed that food temperature must cool from 140 degrees to 70 degrees in 2 hours. In the next 4 hours, temperatures must cool to 41 degrees.

Document review of the hospital's policies titled, "Food Services," Policy 11.10, dated 08/17, and "Food Service Infection Control," Policy 11.17, dated 08/17, showed that neither policy included cooling procedures. Surveyor #6 received these policies after a request for the hospital's dietary policy for cooling food.

2. On 05/14/18 at 10:20 AM, during a tour of the Food & Nutrition Department with the Director of Food & Nutrition (Staff #601), Surveyor #6 used a thin-stemmed thermometer to assess the temperature of ground beef in 5 roasting pans stored in Walk-In Refrigerator #127. The ground beef measured 51, 54, 55, 53, and 50 degrees Fahrenheit, above the maximum cold holding temperature of 41 degrees Fahrenheit required by the WA State Retail Food Code.

At the time of the observation, Surveyor #6 interviewed the lead cook (Staff #605) about the ground beef. Staff #605 provided the following information:

a. The previous day (05/13/18) between 8:30 AM and 10:30 AM, Staff #605 fried 236 pounds of raw ground beef.

b. Staff #605 placed the fried ground beef into 5 roasting pans and let them stand on the counter for about 35 minutes.

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c. At approximately 11:00 AM, Staff #605 used a digital food thermometer and measured the temperature of the ground beef at 155 degrees Fahrenheit.

d. Staff #605 wrapped the pans of ground beef with cloth covering (tablecloths) and placed them in the walk-in refrigerator.

3. On 05/14/18 at 11:10 AM, Surveyor #6 reviewed the cold storage log. The review showed that staff documented that on 05/13/18 at 10:10 AM, the ground beef had in internal temperature of 145 degrees Fahrenheit when they stored the cooked product in the refrigerator. Staff #605 initialed the log entry.

There were no other recorded temperatures during the cooling process. The dietary staff stated that the meat was for use in tacos scheduled for lunch service on 05/15/18.

4. On 05/14/18 at 11:15 AM, Staff #605 discarded the 5 roasting pans of ground beef.

Reference: 2009 FDA Food Code 3-501.14
Reference: 2009 FDA Food Code 3-501.15

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ITEM #2- SPECIMEN REFRIGERATOR TEMPERATURE MONITORING
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Based on observation, interview and review of documents, the hospital staff failed to monitor and document daily specimen refrigerator temperatures consistent with hospital policy.

Failure to ensure that specimen refrigerator temperatures are within industry standard ranges

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A 726	Continued From page 67 places patients at risk for unsafe care. Findings included: 1. Document review of the hospital's policy and procedure titled, "Temperature monitoring for on-ward refrigerator appliances," Procedure #240, dated 02/06, showed that the purpose of monitoring is early detection of temperatures outside an acceptable range and monitoring and documentation of temperatures serves as the quality control standard. 2. On 05/15/18 at 9:27 AM, Surveyor #5 and a ward administrator (Staff #515) inspected a dirty utility room on ward C3. The observation showed that for the past 3 months, staff documented the daily temperature in the refrigerator as 40 degrees Fahrenheit. Upon inspection, the surveyor found the thermometer inside the unit was broken and unusable. 3. At the time of the finding, Staff #515 verified the broken thermometer and removed it from service.	A 726		
A 749	. INFECTION CONTROL PROGRAM CFR(s): 482.42(a)(1) The infection control officer or officers must develop a system for identifying, reporting, investigating, and controlling infections and communicable diseases of patients and personnel. This STANDARD is not met as evidenced by:	A 749		

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ITEM #1 - CONTAMINATION OF LINENS

Based on observation, interview and document review, the hospital staff failed to prevent contamination of clean linen during the folding process.

Failure to prevent contamination of clean linen puts patients, staff, and visitors at risk of exposure to harmful pathogens.

References: Guidelines for Environmental Infection Control in Health-Care Facilities; Recommendations of CDC and Healthcare Infection Control Practices Advisory Committee (HICPAC) (2003) page 112 paragraph 2. Epidemiology and General Aspects of Infection Control: "Hygienically clean laundry carries negligible risk to health-care workers and patients, provided that the clean textiles, fabric, and clothing are not inadvertently contaminated before use."

Findings included:

1. On 05/17/18 at 11:15 AM, Surveyor #1 toured the laundry department with the supervisor of laundry services (Staff #103). During the tour, Surveyor #1 observed a patient (Patient #101) working in the facility folding linen. The observation showed that the patient allowed the linen to touch the ground during the folding process. The patient failed to use the provided linen table to fold the linen.

At the time of the observation, Surveyor #1 asked Staff #103 about the training process. The supervisor stated that the patient is from a

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community-based program (transitional skills program) and that he provided the training on site. Staff #103 was unable to provide documentation that showed patients in the program received infection control training.

2. On 05/18/18 at 9:00 AM, Surveyor #1 interviewed the vocational rehabilitation director (Staff #104). During the interview, the director stated that the patient was referred to the vocational rehabilitation program from the community program and that he would be able to provide documentation of training for the patient.

3. On 05/18/18 at 11:00 AM, Surveyor #1 reviewed documentation provided by the vocational rehabilitation director that showed Patient #101 received infection control training on 04/17/17.

4. Review of the hospital's policy titled, "Laundry Procedure Manual" dated January 2017, showed that this training did not include how to prevent contamination of linens during the cleaning process.

ITEM #2 - STORING PATIENT CARE ITEMS

Based on observation, interview and review of hospital policy and procedure, the hospital failed to ensure that patient hygiene items were stored appropriately in the clean utility room.

Failure to ensure that patient hygiene items are stored appropriately could lead to a risk of cross contamination and possible harm to patients.

Findings included:

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1. Document review of the hospital's policy and procedure titled, "Nursing Units," Chapter 8, revised 02/18, showed that patient care items in the clean utility room should not be stored in corrugated cardboard shipping boxes.

2. On 05/14/18 at 3:00 PM, Surveyor #9 inspected a clean utility room and found 3 boxes of hair brushes and 1 box of toothbrushes stored in their original shipping boxes of corrugated cardboard.

3. At the same time, Surveyor #9 discussed the observation with the registered nurse (RN) 3 (Staff #909), who stated that corrugated cardboard should not be used to store patient supplies. This was corrected at the time of the survey.

ITEM #3 - TUBERCULOSIS RISK ASSESSMENTS

Based on observation, interview, document review, and review of the hospital's policy and procedure, the hospital failed to implement and monitor its program for tuberculosis screening for 7 of 11 patients reviewed (Patient #502, #504, #505, #506, #510, #512, #513).

Failure to implement an effective tuberculosis screening and control program puts patients, staff and visitors at risk of illness from communicable diseases.

Findings included:

1. Document review of the hospital's policy and

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procedure titled, "Patient tuberculosis screening and follow up care," Policy # 6.03, effective 08/0/17, showed that all patients are to be screened for asymptomatic latent tuberculosis as part of the admission process. The admission medical provider will complete the "Washington State Adult Tuberculosis Risk Assessment".

2. On 05/15/18 at 9:55 AM, Surveyor #5, a registered nurse (Staff #509), and the ward administrator (Staff #515) reviewed the medical record of Patient #504, who was admitted on 08/18/17 for the treatment of paranoid schizophrenia and substance abuse. The record review showed:

a. The Physician Admission Tuberculosis Risk Assessment was blank.

b. There was no evidence that the patient was screened for asymptomatic latent tuberculosis at the time of admission.

c. There was a documented purified protein derivative skin test (a test that determines if you have tuberculosis) in the patient's record from a prior admission date of 09/23/16, but the "read" date and the test result were both missing.

3. At the time of the record review, Staff #509 and Staff #515 stated that it was the physician's responsibility to perform the risk assessment and order the appropriate tests.

4. Review of the medical records for Patient #502, #505, #506, #510, #512, and #513, admitted to the hospital after 11/17, showed no evidence that staff completed a tuberculosis risk assessment upon their admission.

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	504003	A. BUILDING _____ B. WING _____	05/25/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTERN STATE HOSPITAL	9601 STEILACOOM BLVD SW TACOMA, WA 98498

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5. On 05/22/18 at 10:00 AM, Surveyor #2 interviewed the Infection Preventionist (IP) (Staff #207) regarding patient screening for tuberculosis on admission. The IP stated that patients are screened for tuberculosis on admission by completing an assessment form. If patients meet a positive criterion on the assessment form, they are screened with a QuantiFERON screening test (a test to determine if someone is positive for tuberculosis infection). The IP stated that the assessment is handled by physicians on each ward during admission and that the infection control department is only notified of positive laboratory tests. The department would not be notified of a positive admission assessment.

ITEM #4- INFECTION RISK-FOLLOWING MANUFACTURER GUIDELINES

Based on observation, interview, and document review, the hospital staff failed to follow manufacturer's instructions and national standards for use, disinfection, and storage of semi-critical patient care devices in the hospital's dental procedure clinic.

Failure to adhere to the manufacturer's instructions and national standards for use, disinfection, and storage of semi-critical medical devices puts patients at risk from infection.

References:

U.S. Food and Drug Administration, "Multiple-Use Dental Dispenser Devices" (Updated 12/05/17): "Contamination or infection control issues arise for patients when the body or housing of

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multiple-use dental dispensers comes in contact with a previous patient's cheek or lips, or when the dispenser is handled by a dental practitioner whose gloves have become contaminated with previous patient's blood or saliva. According to the Centers for Disease Control and Prevention (CDC), devices that come in contact with mucous membranes of the mouth are classified as "semi critical" depending on the potential risk for infection associated with their intended use. CDC recommends that once a device in this category (such as a dental dispenser) becomes contaminated, it should be heat sterilized or subjected to immersion in a high-level chemical disinfectant. However, multiple-use dental dispensers cannot be reprocessed using heat sterilization (e.g., steam autoclave) or immersion in high-level disinfectants because this may damage the dispenser or material contained in the dispensers. Also, the FDA does not believe that these devices, once contaminated, can be adequately disinfected by wiping with a chemical disinfecting solution. Therefore, the FDA recommends disposal of contaminated multiple-use dental dispensers in order to avoid the risk of cross-contamination to patients .....DO: Apply disposable barrier sleeves/wraps over multiple-use dental dispensers before use with each patient. (Do) Use new, uncontaminated gloves when handling multiple-use dental dispensers. DO NOT: Reuse the multiple-use dental dispenser if it becomes contaminated. (DO NOT) Reprocess a contaminated multiple-use dental dispenser by using chemical wipes or disinfectants.

Findings included:

1. The hospital's policy and procedure titled,

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"Dental Clinic Infection Control," no policy number, revised 05/18, showed that standard precautions for blood, body fluids, non-intact skin and mucous membranes apply to all patients.

2. On 05/16/18 at 1:36 PM, Surveyor #5 and a dental hygienist (Staff #505) inspected the hospital's Dental Clinic. Surveyor #5 observed:

-One partially used syringe of flowable composite with a single use leur-lok curved blunt tipped needle with dried debris on the tip of the blunt needle and one partially used syringe of ultra-etch with sticky debris on the outside of the syringe located in a drawer with clean instruments and supplies.

3. At the time of the finding, Surveyor #5 asked Staff #505 about the dental clinics process for the cleaning and disinfection of syringes between patient uses. Staff #505 confirmed the blunt tip needle of the flowable composite was covered with dried debris and the ultra-etch syringe was covered in sticky debris. She told the Surveyor that this was not her area and that the dentist was responsible for the syringes.

During an interview with a dentist (Staff #516) immediately following the interview with Staff #505, the dentist confirmed the finding and stated that the blunt tipped needle should be changed between patients and that covers were used on the syringes between patients. The dentist did not know why these syringes were in the drawer.

ITEM #5- CLEANING PATIENT CARE EQUIPMENT AND ENVIRONMENT

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A 749	Continued From page 75 Based on document review, interview and observation, the hospital staff failed to maintain cleanliness of patient care areas and equipment. Failure to maintain cleanliness of patient care areas and equipment puts patients at risk of harm from infectious disease, including extended hospital stays, increased healthcare costs, and death. Findings included: 1. Document review of the hospital's policy and procedure manual titled, "Infection Prevention and Control Manual, Chapter 8 Nursing Units," revised 02/18, showed that seclusion rooms are to be cleaned after each use including the mattresses, walls, windows, and floors. 2. On 05/17/18 at 3:30 PM, Surveyor #5 and the ward administrator (Staff #517) inspected two restraint and seclusion rooms on ward C6. Surveyor #5 lifted the mattresses off the frames and observed significant rust on the flat surfaces and moist organic debris grossly built up in corners of the beds. 3. At the time of the observation, Staff #517 confirmed the findings and stated he would place a work order to have the beds removed or fixed. .	A 749		