CMS Unveils Hospital Violations Database

***Cheryl Clark, for HealthLeaders Media* , March 18, 2013**

For the first time, providers, payers, and patients now have an enormous searchable database containing documents detailing about 8,000 serious federal safety rule violations—many of which have caused serious patient harm or death—at about 1,000 U.S. hospitals since January, 2011.

The documents, which resulted from federally authorized complaint investigations and are called "2567s," were released over the weekend by the Centers for Medicare & Medicaid Services after a long-standing request from and collaboration with the Association of Health Care Journalists. The AHCJ has organized the document files on a searchable website on its site, **hospitalinspections.org**.

AHCJ president Charles Ornstein, a senior reporter at ProPublica in New York, made the announcement about the database during a news conference Saturday at the organization's annual meeting in Boston. He said the documents "show deception, fraud, falsification, and medical errors that are inexcusable."

Also, he said, now members of the public can find out not only which hospitals in their cities or regions had incidents serious enough to prompt such investigations, but how often errors of a particular type occurred in any facility to receive such a federal investigation report in the last 26 months.

For example, hospital deficiencies may now be searched by keyword or phrase, such as "wrong site," "wrong patient," "infection," "sponge," "transfusion," or "falsified," to catalogue types and frequency of hospital errors, and often whether a patient death was involved. Some of the violations involved a declaration of immediate jeopardy, which are so serious and immediately threatening to patients or workers that the situation must be resolved within 24 hours.

Prior to CMS's release, these documents were available only after members of the public or news media filed Freedom of Information Act or state public records requests.

"It was a time-consuming process, and there would be no way to compare (various hospitals or regions of the country) except by spending a lot of time and spending many hours creating spreadsheets, and creating data tools to do that," Ornstein says. "What we wanted to do was make this easy for the public to access these reports."

The new database does not include documents about results of complaint investigations involving psychiatric hospitals or long-term care facilities. Routine inspection reports are also not included. However Ornstein's group said it was working to get disclosure of those files as well.

Ornstein also said that the database would be updated quarterly.

In response to questions on Saturday, CMS spokeswoman Kathryn Ceja said in an e-mail, that the agency released the data with AHCJ because the government wants to "promote an informed citizenry, patient engagement in healthcare, quality improvement on the part of providers, and transparency in government."

She added that the release of these reports about acute care, including critical access hospitals, follows the release last year of a similar searchable database on nursing homes.

AHCJ uploaded CMS's responses to various questions about the database on a section of its website. For example, the agency explains the process that can result in a 2567. And it explains that state health department teams usually perform inspections at the request of CMS when a complaint seems serious enough to jeopardize federal reimbursement to a hospital.

Elizabeth Lietz, spokeswoman for the American Hospital Association who attended the meeting, said her organization was not told in advance by CMS that it was releasing this electronic database of 2567 documents.

The American Hospital Association plays down the value of having the public documents be more accesible. "Despite our hope that these data would help inform the public, the public has not found the data as useful as we anticipated... it is hard even for a seasoned healthcare policymaker to understand the CMS documents or thoughtfully apply them to making informed decisions," said Nancy Foster, quality and patient safety vice president of the American Hospital Association.

One important deficiency in the new electronic database is that hospitals' plans of correction—required if a hospital is to continue to receive reimbursement for care of Medicaid and Medicare patients—were not included because of technical difficulties. Those may still be provided to the public, but only through a federal or state information or public records act request.

Ceja explained why in an e-mail response: "CMS' efforts to make plans of correction available in a national, searchable electronic database are suspended indefinitely until there is more clarity with respect to the federal budget. Development of such capability requires a multi-year effort and design safeguards that can adequately maintain security in a system that imports data from thousands of external parties."

Ornstein said the journalism association has also put pressure on The Joint Commission to release results of its accreditation surveys of hospitals. "Given the government's steps to increase transparency around these vital reports, we once again call on The Joint Commission to do the same," Ornstein said in a letter March 13 to TJC president Mark Chassin, MD.

"In our previous exchanges, you have expressed concerns that the public release of The Joint Commission's inspection reports would compromise your efforts to improve hospital quality," he wrote. "The AHCJ board cannot accept the notion that patients are best protected by keeping hospital problems secret. Such reasoning also flies in the face of growing consensus among healthcare leaders and policy makers about the importance of transparency to improve medical care quality."

A spokeswoman for TJC, Elizabeth Zhani, who also attended the journalism meeting, said that Chassin is studying the AHCJ's request.

Funding for the AHCJ's website was provided by the Ethics and Excellence in Journalism Foundation.

Cheryl Clark is senior quality editor and California correspondent for HealthLeaders Media.

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A Q&A with CMS: Getting up to speed on inspection reports

The Centers for Medicare and Medicaid Services answers questions about the inspection process and the 2567 forms used to complete the inspections. Quick links to answers below:

- Are there federal fines against hospitals that violate CMS Conditions of Participation?

These reports have always been available to the public, right? Until now, how could someone get a copy of a hospital's inspection report?

Correct. Until now, a request for an inspection report (or, in federal parlance, a survey) conducted on behalf of the Centers for Medicare and Medicaid Services (CMS) could be made to the state agency that conducts inspections on behalf of CMS, which we refer to as a local state survey agency, or CMS regional office.

This process is described in a CMS memo entitled "Release of Form CMS-2567 (Statement of Deficiencies) by State Survey Agencies (SAs)," available here.

See also 42 Code of Federal Regulations § 401.133, available here.

These reports, as we understand it, are called 2567 forms. How did they get this name?

A number is typically assigned to the official forms a federal agency uses. The "official" name for this document is "Form CMS-2567, Statement of Deficiencies and Plans of Correction."

How are the 2567 forms derived?

When state survey agencies conduct surveys of acute hospitals and critical access hospitals (CAHs) on behalf of CMS, they are assessing compliance with Medicare health and safety regulations for acute or critical access hospitals, the "Conditions of Participation (CoPs)." The surveyors prepare their survey report on an electronic version of the Form CMS-2567 available in a CMS data system that supports survey work. This system contains the text of the regulations, broken down by surveyors into smaller sections called "tags"to facilitate the work of the surveyors to identify regulatory deficiencies and choose the applicable tag. The system generates a Form CMS-2567 with the regulatory text associated with that tag, and then surveyors enter a summary of the evidence for the noncompliance they observed. The survey report is released to the acute or critical access hospital which, depending on the survey findings, may be required to return the Form CMS-2567 with a plan of correction for each area of deficiency.

When are Plans of Correction (POCs) Required?

Non-deemed hospitals always have to do plans of correction.

Deemed hospitals generally do them only when they have condition-level deficiencies.

However, some deemed hospitals choose to do a POC even when not required, because they are aware the 2567 can be released and they want their POC released as well.

Does CMS inspect all hospitals in the U.S.? If not, please explain.

No. Only acute or critical access hospitals that choose to participate in Medicare and/or Medicaid are subject to federal surveys to assess compliance with the CMS Conditions of Participation (CoPs). Medicaid regulations require hospitals to comply with the Medicare CoPs. Veterans Administration,

military and prison hospitals may not participate in Medicare or Medicaid, and therefore are also not inspected by CMS.

In addition, federal law permits participating acute or critical access hospitals that are accredited by a CMS- approved Medicare accreditation program to be "deemed" to be in compliance with the CMS CoPs. Eighty-five percent of acute hospitals and 32 percent of critical access hospitals participate in this manner. They are surveyed by their accrediting organization at regular intervals.

Generally surveys of non-accredited acute or critical access hospitals to assess compliance with the Medicare CoPs are performed by a state survey agency on CMS's behalf. CMS may also direct the state survey agency to conduct a survey in an accredited acute or critical access hospital in certain situations, such as when complaints allege serious deficiencies.

Since most hospitals have deemed status on the basis of their accreditation, the vast majority of the survey reports being made available were generated from focused surveys responding to serious complaints.

By law, reports generated by accrediting organizations are not considered public records.

How often are hospitals inspected?

On average acute or critical access hospitals are reassessed every three to four years for their compliance with all of the CoPs.

Focused surveys to investigate complaints may occur at any time.

Is there any variation by state? If so, please explain.

There are uniform national policies in place for surveys conducted to assess compliance with the CoPs. CMS conducts training and other activities on an ongoing basis to improve consistency and reduce local or regional variation in how these federal policies are implemented.

It should be noted that many of the state survey agencies that conduct surveys on behalf of CMS under federal law are also responsible for enforcing their individual state licensure laws, which vary. States may use the same survey to assess both federal and state regulatory compliance. However, they must report their federal survey findings separately.

What types of problems do you look for in hospitals?

On the periodic surveys, compliance with all of the acute or critical access hospitals' CoPs are to be assessed. The CoPs address areas such as nursing services, infection control, medical staff requirements, emergency services, pharmaceutical services, physical plant safety and maintenance, etc. In a survey done to investigate a complaint, the areas assessed depend on the nature of the complaint.

Are there differences in the level of seriousness or a rating system akin to what is used for nursing home violations?

For acute or critical access hospitals the statutory and regulatory requirements are that they be in"substantial" compliance with each Condition of Participation (CoP). There are two different types of citations that CMS can issue. The more serious, known as "condition-level" mean that a hospital is not

in substantial compliance with the CoP. A "standard-level" deficiency means that the hospital may be out of compliance with one aspect of the regulations, but is considered less severe than condition-level. There is an additional level of non compliance called "immediate jeopardy" that arises when surveyors determine that the hospital's deviation from regulatory standards constitutes an immediate threat to patients' health and safety. An immediate jeopardy determination forces a hospital to correct the underlying problems quickly. Termination from participation in Medicare and Medicaid can result in 23 days if the hospital fails to correct the problems.

If an acute or critical access hospital is not in substantial compliance, the only enforcement remedy, if the facility fails to make timely correction, is termination of its participation in Medicare and Medicaid. There is no authority to issue civil monetary penalties based on a detailed rating of the scope and severity of deficiencies, as exists for nursing homes.

What is the difference between a standard-level deficiency and one that is labeled as condition-level?

As indicated above, a condition-level deficiency means that for that particular CoP the acute or critical access hospital is not in substantial compliance. There can be noncompliance with a CoP regulatory standard that does not rise to the level of substantial noncompliance with the condition. The manner and degree of the noncompliance is considered to determine whether there is substantial compliance or not.

What is an immediate jeopardy?

42 CFR §489.3 defines immediate jeopardy as "a situation in which the provider's non-compliance with one or more of the requirements of participation has caused or is likely to cause, serious injury, harm, impairment, or death ..." When investigating a potential immediate jeopardy situation, surveyors must find that serious harm has occurred or has the potential to occur, that the threat of future harm is immediate, and that there is facility culpability that resulted in the situation.

As we understand it, deficiencies can be identified during regular inspections (known as surveys), as well as complaint visits. What's the difference between the two? And are both included in the data being released by CMS?

To clarify, any on-site inspection is considered a survey. A complaint survey is a more focused survey to investigate compliance with CoPs related to the nature of the complaint. As stated above, surveys of compliance with all CoPs occur on average every three to four years for non-deemed hospitals. Each year, CMS also directs the state survey agencies to conduct full surveys of a sample of accredited acute or critical access hospitals as part of its assessment of performance of acute or critical access hospitals accreditation organization.

Currently CMS has plans only to release deficiencies cited on complaint surveys.

Does CMS have a team of inspectors that visit hospitals? If not, who does the agency rely on to conduct inspections on its behalf?

CMS has an agreement with each state to conduct federal surveys in that state, and the majority of federal surveys are performed by state survey agencies. In some situations, staff from a CMS regional office or contractors are assigned to conduct survey activities.

If a state conducts an inspection on behalf of CMS, is it still considered a federal inspection?

Yes.

What constitutes a complaint? Does a person have to fill out a form to complain?

A complaint is an allegation of noncompliance with federal and/or state requirements. Complaints regarding the care, treatment and services provided to patients can come from a variety of sources, including the patients themselves, family members, staff in acute or critical access hospitals, other hospitals, concerned citizens, other public agencies, or media reports. Complaints may be submitted by phone or in writing anonymously.

While some state survey agencies may have developed their own forms to document complaints, federal complaints need not be in writing and no form is required.

If a patient files a complaint with an accrediting group, i.e. The Joint Commission, will the reports you're releasing include information on that? If not, why not?

No. By law, with the exception of Home Health Agencies, CMS may not release the results of an accreditation organization survey unless it is using those results in order to take enforcement action against the hospital. CMS generally takes enforcement action based on state survey agency surveys. If an accreditation organization informs CMS of serious quality of care issues in an acute or critical access hospital, CMS directs the state survey agency to conduct a survey and takes enforcement action if needed on the basis of that survey.

When an inspection is complete, is a hospital given a chance to respond? If so, how long?

The hospital must submit a plan of correction for any identified deficiencies within 10 calendar days of receiving the Form CMS-2567 report.

If a hospital believes a finding is in error, how would it challenge the finding?

If an acute or critical access hospital believes a survey finding was factually inaccurate, it may include supporting documentation for its claim in its plan of correction. CMS may revise the Form CMS-2567 if it agrees the original finding was not factually supported.

Are hospitals' plans of correction included in the data you've released? If not, how should a reporter or member of the public get them?

Hospitals' plans of correction are not currently included. Those plans can be obtained from the hospitals or from the state survey agencies.

What is the approval process for a plan of correction?

The acute or critical access hospital submits its plan of correction for review. If it is not acceptable, it is asked to submit a revised plan. Note that an accredited acute or critical access hospital is not required to submit a plan of correction in response to a survey with only standard-level findings, although it may voluntarily do so. Such voluntary plans are not reviewed for acceptability.

What's the process for inspection findings to go from a state agency to the feds?

For non-accredited acute or critical access hospitals the state survey agency's findings are final; for an accredited acute or critical access hospital where the state survey agency finds condition-level deficiencies, the CMS regional office must review the report and make the determination whether or not there is substantial noncompliance. The state agency enters these findings into the federal database.

Are there federal fines against hospitals that violate CMS Conditions of Participation?

No. CMS has the legal authority to terminate a hospital's Medicare agreement if it does not comply with one of more of the CoPs, but there is no statutory authority to levy civil monetary penalties.

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Facilities in Massachusetts

All cities Filter by city

Hospital	City	State	Ownership type	Complete reports (?)	Missing reports (?)	Violations
ANNA JAQUES HOSPITAL	NEWBURYPORT	MA	Voluntary non-profit - Private	3	0	5
BAYSTATE FRANKLIN MEDICAL CENTER	GREENFIELD	MA	Voluntary non-profit - Private	1	0	1
BAYSTATE MEDICAL CENTER	SPRINGFIELD	MA	Voluntary non-profit - Private	2	1	6
BERKSHIRE MEDICAL CENTER INC	PITTSFIELD	MA	Voluntary non-profit - Other	1	0	2
BETH ISRAEL DEACONESS MEDICAL CENTER	BOSTON	MA	Voluntary non-profit - Private	4	0	6
BRIGHAM AND WOMEN'S HOSPITAL	BOSTON	MA	Voluntary non-profit - Private	9	0	13
	CAMBRIDGE	MA		1	0	1

Hospital	City	State	Ownership type	Complete reports (?)	Missing reports (?)	Violations
CAMBRIDGE HEALTH ALLIANCE			Government - Local			
CAPE COD HOSPITAL	HYANNIS	MA	Voluntary non-profit - Private	2	0	2
CARNEY HOSPITAL	BOSTON	MA	Proprietary	2	0	6
COOLEY DICKINSON HOSPITAL INC,THE	NORTHAMPTON	MA	Voluntary non-profit - Private	1	0	2
DANA-FARBER CANCER INSTITUTE	BOSTON	MA	Voluntary non-profit - Private	1	0	2
EMERSON HOSPITAL	W CONCORD	MA	Voluntary non-profit - Private	2	1	5
FAULKNER HOSPITAL	BOSTON	MA	Voluntary non-profit - Private	3	0	9
GOOD SAMARITAN MEDICAL CENTER	BROCKTON	MA	Proprietary	2	0	9
HARRINGTON MEMORIAL HOSPITAL	SOUTHBRIDGE	MA	Voluntary non-profit - Private	2	0	3
HEALTHALLIANCE HOSPITALS, INC	LEOMINSTER	MA	Voluntary non-profit - Other	2	0	7
HOLY FAMILY HOSPITAL	METHUEN	MA	Proprietary	1	0	1
JORDAN HOSPITAL INC	PLYMOUTH	MA	Voluntary non-profit - Private	1	0	1
LAHEY CLINIC HOSPITAL	BURLINGTON	MA	Voluntary non-profit - Private	4	0	12
LAWRENCE GENERAL HOSPITAL	LAWRENCE	MA	Voluntary non-profit - Private	3	0	5
LOWELL GENERAL HOSPITAL	LOWELL	MA	Voluntary non-profit - Private	0	1	2

Hospital	City	State	Ownership type	Complete reports (?)	Missing reports (?)	Violations
MARLBOROUGH HOSPITAL	MARLBOROUGH	MA	Voluntary non-profit - Private	3	1	7
MASSACHUSETTS GENERAL HOSPITAL	BOSTON	MA	Voluntary non-profit - Private	1	0	1
MERCY MEDICAL CENTER	SPRINGFIELD	MA	Voluntary non-profit - Private	1	0	1
MERRIMACK VALLEY HOSPITAL	HAVERHILL	MA	Proprietary	2	0	8
METROWEST MEDICAL CENTER	FRAMINGHAM	MA	Voluntary non-profit - Private	2	0	5
MILFORD REGIONAL MEDICAL CENTER	MILFORD	MA	Voluntary non-profit - Other	3	0	7
MILTON HOSPITAL INC	MILTON	MA	Government - Federal	1	0	1
MORTON HOSPITAL	TAUNTON	MA	Proprietary	4	0	14
MOUNT AUBURN HOSPITAL	CAMBRIDGE	MA	Voluntary non-profit - Private	1	0	2
NASHOBA VALLEY MEDICAL CENTER	AYER	MA	Proprietary	1	0	4
NEWTON-WELLESLEY HOSPITAL	NEWTON	MA	Voluntary non-profit - Other	1	0	3
NOBLE HOSPITAL	WESTFIELD	MA	Government - Federal	2	0	4
NORTH ADAMS REGIONAL HOSPITAL	NORTH ADAMS	MA	Voluntary non-profit - Private	1	0	1
NORTH SHORE MEDICAL CENTER	SALEM	MA	Voluntary non-profit - Private	1	0	1
NORWOOD HOSPITAL	NORWOOD	MA	Proprietary	4	0	11

Hospital	City	State	Ownership type	Complete reports (?)	Missing reports (?)	Violations
QUINCY MEDICAL CENTER	QUINCY	MA	Proprietary	2	1	7
SAINT ANNE'S HOSPITAL	FALL RIVER	MA	Proprietary	2	0	3
SAINTS MEDICAL CENTER INC	LOWELL	MA	Voluntary non-profit - Church	2	0	4
SIGNATURE HEALTHCARE BROCKTON HOSPITAL	BROCKTON	MA	Voluntary non-profit - Other	1	0	2
SOUTH SHORE HOSPITAL	SOUTH WEYMOUTH	MA	Voluntary non-profit - Private	5	0	10
SOUTHCOAST HOSPITAL GROUP, INC	FALL RIVER	MA	Voluntary non-profit - Private	7	1	10
ST ELIZABETH'S MEDICAL CENTER	BRIGHTON	MA	Proprietary	4	0	8
ST VINCENT HOSPITAL	WORCESTER	MA	Proprietary	4	0	8
STURDY MEMORIAL HOSPITAL	ATTLEBORO	MA	Voluntary non-profit - Other	1	0	3
TUFTS MEDICAL CENTER	BOSTON	MA	Voluntary non-profit - Private	1	1	5
UMASS MEMORIAL MEDICAL CENTER INC	WORCESTER	MA	Voluntary non-profit - Private	6	0	18

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The information below comes from the statement of deficiencies compiled by health inspectors and provided to AHCJ by the Centers for Medicare and Medicaid Services. It does not include the steps the hospital plans to take to fix the problem, known as a plan of correction. For that information, you should contact the hospital, your state health department or CMS. Accessing the document may require you to file a Freedom of Information Request. Information on doing so is available here.

CARNEY HOSPITAL **2100 DORCHESTER AVENUE BOSTON, MA 2124** **Dec. 15, 2011**

VIOLATION: *MAINTENANCE OF PHYSICAL PLANT* **Tag No:** A0701

Based on a review of the completed monthly Pharmacy Floor Inspections and the Floor Inspections log and interviews, the Hospital failed to ensure that the patient care medication areas were inspected on a regular basis.

Findings include:

1) According to the Pharmacy Floor Inspections Log, less than 50% of monthly patient care area inspections were checked off as having been completed.

2) A review of the actual Floor Inspection forms for January through June of 2011 revealed that 15 inspection forms, listed on the Log as having been completed, were not in the notebook. [Monthly inspections are an opportunity to ensure that special labeling and packaging are being done throughout the institution.]

VIOLATION: *MEDICAL STAFF ACCOUNTABILITY* **Tag No:** A0347

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY

Based on review of the medical record, Medication Administration Record [MAR] and staff interviews, for one Patient (#8) out of a total sample of 11, the Attending Psychiatrist failed to order Patient # 8's regularly prescribed medications that included prednisone, methotrexate and glipizide, which resulted in the patient not receiving those

medications during a 12 day hospitalization .

Findings include:

Patent #8 was admitted to the psychiatric unit for sexual behaviors and combativeness at the hospital on [DATE]. Patient # 8's medical history included dementia, diabetes and rheumatoid arthritis.

Review of Patient #8's form for Current Home Medication List indicated that prednisone, methotrexate and glipizide were prescribed medications that Patient #8 received at his/her nursing home and the Attending Psychiatrist reconciled, timed and dated the form on 11/7/11 at 6:00 P.M.

Review of Physician Orders and Medication Summary records dated 11/4/11-11/16/11 indicated that the Attending Psychiatrist did not write orders for prednisone, methotrexate and glipizide.

Review of the Hospital's policy and procedure for Medication Reconciliation indicated that a list of current home medications shall be documented as soon as possible during the intake process, but no later than 24 hours after admission. The policy/procedure indicated the unit secretary will fax the Current Home Medication List to the Pharmacy once the RN signs the form verifying that the list was reviewed with the patient/family.

The Patient Care Director for In/Out Patient Psychiatry was interviewed in person on 12/14/11 at 11:25 A.M. and 12:20 P.M. The Patient Care Director said he received a complaint from the nursing home indicating that Patient #8 was not receiving prednisone, methotrexate and glipizide during hospitalization .

The Risk Manager was interviewed throughout the on-site investigation. The Risk Manager said she reviewed Patient #8's medical record and compared the medical reconciliation form and the computerized provider order entry (CPOE) form and concluded the Patient's regularly prescribed medications were not ordered for Patient #8.

The Vice President [VP] for Medical Affairs was interviewed on 12/13/11 at 7:70 AM and on 12/15/11 at 12:15 P.M. The VP said that he discussed the care provided to Patient #8 with the Chief Executive Officer and the Attending Psychiatrist. The VP said that a medical peer review process was conducted and the recommendation for action (as outline in Article 4., Section 4.3 Summary Suspension and Article 5 Hearing and Appellate Review Procedure in the Medical Staff By-Law) was provided to the Attending Psychiatrist and he was waiting for the Attending Psychiatrist's response to the recommendation..

VIOLATION: *ADMINISTRATION OF DRUGS* **Tag No:** A0405

Based on observations, record review, interviews and review of Hospital policy, the Hospital failed to ensure that accepted standards of nursing practice were incorporated in the Hospital's policies/procedures for the administration of medications.

Findings include:

1) Observations made in the Emergency Department on 12/13/11 at 9:45 to 9:55 A.M. included a medication pass to Patient #2. Patient #2 was administered an oral antibiotic at 9:55 A.M. by an Emergency Department [ED] nurse

using the 5 rights of medication administration

2) Review of the Hospital policy titled Medication Administration Policy did not indicate that the nurse will administer medications to patients using the 5 rights of medication administration.
3) According to the The U.S. Department of Health and Human Services the five rights, as an important goal for safe medication practices include: 1) the right patient, 2) the right drug, 3) the right dose, 4) the right route and 5) the right time. The 5 right's form the foundation for safe medication administration and error reduction.
4) The Risk Manager and the Patient Care Director of the ED/Intensive Care Unit reviewed the Hospital's medication administration policy with this Surveyor and they did not identify the 5 right's in the policy/procedure.

VIOLATION: *CONTENT OF RECORD* **Tag No:** A0449

Based on review of the medical record and interviews, the Hospital failed to ensure that the disclosure and discussion regarding a medication error that occurred on 11/7/11 was documented in 1 of 11 patient records reviewed, for Patient #1, as required by Hospital policy.

Findings include:

Review of Patient#1's medical record dated 11/7/11 indicated that ED Patient #1 received Vecuronium instead of the prescribed Vancomycin. ED record documentation indicated that Patient #1's primary language was not English

The Risk Manager was interviewed intermittently during the on-site investigation. The Risk Manager said the error was disclosed to the Patient #1's family shortly after the error occurred.

The Patient Care Director of the ED/ICU was interviewed intermittently during the on-site investigation. The Patient Care Director said he discussed the medication error with Patient #1's family. Patient #1's family requested that Patient #1 be informed of the medication error after he/she was removed from mechanical ventilation. The Patient Care Director said he discussed the medication error with Patient #1 and a family member with an interpreter.

Review of the Hospital's policy/procedure regarding Communication of Unanticipated Outcomes indicated that the disclosure discussion should be documented in the patient's medical record. The documentation should include a brief summary of the discussion, when the discussion occurred and who was present during the discussion.

Review of patient care notes in Patient #1's medical record dated 11/7/11-11/11/11 indicated that the discussion regarding the medication error was not documented in Patient #1's record as required per hospital policy.

VIOLATION: *PHARMACY ADMINISTRATION* **Tag No:** A0491

Based on a review of the completed monthly Pharmacy Floor Inspections and the Floor Inspections log and interviews, the Hospital failed to ensure that the patient care medication areas were inspected on a regular basis.

Findings include:

1) According to the Pharmacy Floor Inspections Log, less than 50% of monthly patient care area inspections were checked off as having been completed.

2) A review of the actual Floor Inspection forms for January through June of 2011 revealed that 15 inspection forms, listed on the Log as having been completed, were not in the notebook. [Monthly inspections are an opportunity to ensure that special labeling and packaging are being done throughout the institution.]

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CARNEY HOSPITAL	2100 DORCHESTER AVENUE BOSTON, MA 2124	Jan. 19, 2011

VIOLATION: *EMERGENCY SERVICES POLICIES* **Tag No:** A1104

Based on record review, physician and staff interview one of one applicable Patient #1's eloped from the Emergency Department (ED)after an appropriate medical screening in December 2010. The ED staff failed to implement a Code Amber for the Patient's elopement as per Hospital Policy.

The findings are as follow:

Patient #1 had eloped from a long-term care facility earlier the same day on 12/31/10.

Review of the Emergency Medical Service (EMS) Trip Report dated 12/31/10 indicated Patient #1 walked into a police station and requested an ambulance. Patient #1 reported having abdominal pain for a year with nausea and vomiting. The EMS Report indicated Patient #1 had been evaluated in the ED on 12/30/10. Patient #1 returned to the long-term care facility following the evaluation on 12/30/10. On 12/31/10, the EMS Report indicated Patient #1's abdomen was soft and non-tender. Patient #1 reported being a diabetic on insulin and having hypertension. Patien #1t's vital signs were recorded as a blood pressure of 182/50, heart rate of 88 beats per minute and respirations 16 breaths per minute. Patient #1 arrived to the ED on 12/31/10 without incident.

Continued review of the ED Record indicated Patient #1 had a legal guardian.

Review of Patient #1's ED Nursing Triage Record dated 12/31/10 at 11:30 AM indicated Patient #1 had eloped from a nursing home and was seen in the ED 12/30/10. The ED Triage Record indicated Patient #1 complained of having a hernia and a growth in the belly. Patient #1 reported having a mild pain level rated a 4 out of 10. The ED

Triage Record indicated Patient #1 was alert and uncooperative. The ED Triage Record indicated Patient #1's abdomen was tender with flank pain. Patient #1 denied abuse or any incidents of physical assault. The ED Registered Nurse #1 indicated Patient #1 was placed on close observation in the corridor.Patient #1was later moved to a back corridor.

Review of the Hospital's Code Amber Policy dated November 2010 indicated the purpose of the policy was to provide guidelines to staff to ensure an appropriate response to an elopement event when the eloped patient is a safety risk to him/herself or others. The policy indicated all staff were to participate in the Code Amber to report possible sightings. The policy indicated the local police, Hospital's Risk Manager and the Administrator-On-Call were to be notified.

Registered Nurse #1 was interviewed in person on 01/19/11. RN #1 said Patient #1 complained of pain in the lower abdomen and that something was growing. RN #1 said Patient #1 was placed on a stretcher in front of the nursing station. RN #1 said Patient #1 was placed on close observation. RN #1 said Patient #1 was oriented, cooperative, normal looking, well dressed and well groomed. RN #1 said Patient #1 was evaluated by ED Attending Physician #1 on 12/31/10 at 1:30 PM. RN #1 was aware Patient #1 had been evaluated in the ED the night before and that Patient #1 resided in a nursing home. RN #1 said the nursing home was not called until Patient #1 was discharged and arrangements were made to send Patient #1 by ambulance. RN #1 said at 3:45 PM, the EMTs arrived and spoke to Patient #1. Patient #1 did not want to return to the nursing home but was not questioned as to why. RN #1 said Patient #1 requested to go to the bathroom which was located in the center of the ED and in front of the nursing station. RN #1 said there were three security officers located within the area just outside of the bathroom. RN #1 denied alerting security of any concerns with Patient #1. RN #1 said Patient #1 was missing within minutes. RN #1 said the security officers approached Patient #1 at the bus stop but they had no reason to stop Patient #1 from boarding the bus. It was not clear how the security officers were alerted to Patient#1's exit from the ED.

The Hospital's Risk Manager and Director of Quality and Patient Safety were interviewed on the day of survey. The Hospital's Risk Manager was unaware of Patient #1's elopement incident dated 12/31/10. The Hospital's Risk Manager said an incident report should have been filed by both RN #1 and security. The Hospital Risk Manager was unable to identify the security officers who approached Patient #1 at the bus stop located near the entrance to the Hospital. The Hospital Risk Manager said there were no specific policies for an episode of elopement; so a policy had been developed and implemented on 12/06/10. The Hospital Risk Manager said staff training was primarily offered on the inpatient units in September of 2010.

RN #1, RN #2, RN #3 and a security officer interviewed in the ED on 01/19/11 at 12 PM were unfamiliar with the alert name for a patient elopement. RN #2 needed to refer to a poster in the ED for the Code to call. The Security Officer interviewed said it was called Code Pink which was used for a child abduction.

The Chief of the ED was interviewed in person on 01/19/11 at 10:45 AM. The Chief of the ED said many patients elope from the ED. The Chief of the ED said the distinction was whether or not the patient was safe. The Chief of the ED said it would have been appropriate to detain the Patient and complete a Section 12 for a psychiatric evaluation or possibly case management consultation. The Chief of the ED said the ED Attending Physician should have been informed of Patient #1's elopement.

ED Attending Physician #2 was interviewed in person on 01/19/11 at 4 PM. ED Attending Physician #2 said report

was given by the ED Attending Physician #1 who evaluated and discharged Patient #1 at approximately 4 PM. ED Attending Physician #2 said Patient#1 was to return to a long-term care facility. ED Attending Physician #2 denied being informed Patient #1eloped from the ED.

The Interim ED Nurse Manager was interviewed on 01/19/11 at 12:40 PM. The Interim ED Nurse Manager was unaware of Patient #1's elopement incident.The ED Interim Nurse Manager said there had been discussions regarding the new Code Amber over two to three months. The ED Interim Nurse Manager said there had not been a Code Amber since the policy had been implemented on 12/06/10.

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Home -> Massachusetts -> GOOD SAMARITAN MEDICAL CENTER -> Report No. 1026

The information below comes from the statement of deficiencies compiled by health inspectors and provided to AHCJ by the Centers for Medicare and Medicaid Services. It does not include the steps the hospital plans to take to fix the problem, known as a plan of correction. For that information, you should contact the hospital, your state health department or CMS. Accessing the document may require you to file a Freedom of Information Request. Information on doing so is available here.

GOOD SAMARITAN MEDICAL CENTER	235 NORTH PEARL STREET BROCKTON, MA 2301	Oct. 11, 2012

VIOLATION: *TRANSFER OR REFERRAL*

Tag No: A0837

Based on one of ten (Pt. #1) patient records reviewed, the Hospital failed to ensure accurate prescription medication was prescribed for Pt. #1 when he/she was transferred from the Hospital to the skilled nursing facility (SNF), resulting in Pt. #1 receiving those medications which caused him/her to become unresponsive and required an acute transfer from the SNF to the Hospital.

Findings include:

The Hospital's Internal Investigation regarding Pt. #1 and Pt. #1's Discharge Medication Reconciliation Form, dated 9/18/12 indicated that 12 additional prescriptions were transcribed from another patients home medication list (that was incorrectly labeled and placed in Pt. #1's medical record) to prescribed discharge prescriptions that were inaccurate.

VIOLATION: *RN SUPERVISION OF NURSING CARE*

Tag No: A0395

Based on observations and record review the Hospital failed to ensure the nursing staff followed the policy related to Intravenous (IV) therapy.

The Hospital's policy and procedure indicated that all peripheral IV primary administration sets are changed every

72 hours. Primary secondary intermittent administration sets shall be changed every 24 hours. All IV tubing shall be labeled with a registered nurses (RN) initials, the date and time the tubing was hung and when the tubing expires. IV fluids will be labeled with a RN's initials and labeled with a patient name, the additives to the IV fluid, the date and time the IV fluid was hung.

During observation of a medication pass conducted on 10/9/12 at 8:30 A.M. revealed that Pt. #3's IV tubing was not dated and timed as required by Hospital policy and procedure. The label on the bag of IV fluid identified only Pt. #4's name. The label was not completed according to Hospital policy.

VIOLATION: *LIST OF HOME HEALTH AGENCIES* **Tag No:** A0823

Based on interviews and record review the Hospital failed to ensure that the listing of facilities used by the Hospital as referral sources was provided for one of ten (Pt. #3) patient records reviewed.

Findings include:

During a tour of the medical/surgical unit conducted on 10/11/12 at 10:30 A.M. a case manager (Case Manager #2) was interviewed. Case Manager #2 said she verbally reviewed with Pt. #3 the skilled nursing facilities that were based on Pt. #3's insurance and where Pt. #3's attending physician had admitting privileges. Case Manager #2 said she did not document or provide in writing the list to Pt. #3 or his/her family.

Pt. #3 was interviewed on 10/11/12, during the tour of the Medical/Surgical Unit. Pt. #3 said he/she was preparing for discharge and did not want to return to the skilled nursing facility. Pt. #3 said he/she was not provided a list of other skilled nursing facilities.

VIOLATION: *PATIENT RIGHTS: CARE IN SAFE SETTING* **Tag No:** A0144

Based on review of four (Pt. #1, #2, #3 and #5) of 10 patient records, the facility failed to ensure the nursing staff followed the Hospital's medication reconciliation process.

Findings include:

The Hospital's Medication Reconciliation Policy indicated that in the Emergency Department (ED) a licensed nurse or other licensed staff member during the intake process shall obtain a list of pre-hospital medications. If the patient or family have a copy of the medications, the list should have a patient identification label affixed to the medication list. The list then shall be stapled to the Medication Reconciliation Current (pre-hospital) List and reviewed with the patient/family and changes will be documented. The completed Medication Reconciliation Form will be scanned/faxed to the pharmacy and the date and time of the fax should be placed on the form. The policy and procedure also indicated that the completed Medication Reconciliation Form form should be reviewed, signed, dated and timed by the admitting nurse attesting to its accuracy and completeness.

Pt. #1's medication reconciliation Current Medication List Form, dated 9/13/12, indicated that the Form was not faxed to the Pharmacy when he/she was admitted to the Hospital as required by Hospital policy and procedure. The admitting nurse failed to document she reviewed Pt. #1's medication list with Pt. #1 and or his/her family as required by Hospital policy and procedures and completed the medication reconciliation process.

Pt #2's Medication Reconciliation Current (Pre-Hospital) Medication List Form, dated 9/12/12, indicated that the Form was not faxed to the Pharmacy as required by Hospital policy and procedure.

Pt #3's Medication Reconciliation Current (Pre-Hospital) Medication List Form, dated 8/15/12, indicated that the faxed list was not dated and timed as required by Hospital policy and procedure.

Pt #5's Medication Reconciliation Current (Pre-Hospital) Medication List Form, dated 10/5/12 indicated that the list was not faxed to the Pharmacy. The spaces on the form for date and time were blank.

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GOOD SAMARITAN MEDICAL CENTER	**235 NORTH PEARL STREET BROCKTON, MA 2301**	**Feb. 27, 2012**

VIOLATION: *PATIENT RIGHTS: CARE IN SAFE SETTING*

Tag No: A0144

Based on review of the medical record and staff interviews, the Hospital failed to ensure that one of one applicable Patients, Patient #1 was closely monitored to prevent the development of multiple pressures ulcers on the right foot. A Controlled Ankle Movement (CAM) walking boot was applied because of a non-displaced fracture on 01/09/12. There was no evidence that the walking boot was removed to assess Patient #1's skin for five days between the dates of 01/09/12 to 01/14/12 by either the orthopedic physician assistants, the nursing staff or the physical therapist after Patient #1 complained of continued right foot pain. Patient #1 developed multiple pressure ulcers as a result of wearing the CAM boot for 5 continuous days.

Findings include:

Background Information:
Review of the Emergency Department (ED) Medical Record dated 01/07/12 indicated that Patient #1 complained of feeling dizzy and fell . Patient #1 was not able to stand secondary to right leg and ankle pain. Patient #1 was admitted to a Telemetry Unit for cardiac monitoring. The ED Attending Physician indicated that Patient #1 had a ankle sprain. However, a Computerized Tomography (CT) of the right ankle indicated Patient #1 had a non-displaced fracture of the right ankle. An ace bandage was applied to the right ankle.

The Director of Quality and Patient Safety accompanied the Surveyor on two days of survey and the Hospital's Risk Manager was interviewed in person on 02/22/12 from 11:20 A.M. to 12:00 P.M. Both said that Patient #1 continued with hemodialysis three times a week while hospitalized . Both said Patient #1 experienced some

confusion following each dialysis treatment on return to the inpatient unit. Both said that on 01/09/12, Patient #1 had the CAM boot applied by an outside vendor, the Ortotist. Both said that the Ortotist gave instructions and literature to Patient #1, but the information was not added to Patient #1's plan of care.

Review of the manufacturer's literature provided by the Hospital for the Controlled Ankle Movement (CAM) walking boot indicated the ankle hinge of a CAM walking boot adjusts to allow as much or as little movement as the treating orthopedist, physical therapist or orthotic feels is appropriate to the patients condition. Patients were instructed not to change the settings, but to report any discomfort and ask for professional adjustment. The literature indicated that the patient was to follow instructions, particularly to remove the CAM for sleep and bathing. Patients were instructed to frequently inspect the skin covered by the CAM boot frequently for signs for pressure or irritation.

Review of the Physical Therapy Evaluation dated 01/10/12 indicated that Physical Therapist #1 documented that the right lower ankle was not evaluated because the CAM boot was on.

The Physical Therapist failed to adequately assess Patient #1's right foot because she never removed the CAM boot to assess the foot.

Review of the Nurses Note dated 01/14/12 indicated that Patient #1 had a necrotic area on the right foot.

Review of the Physician Orders dated 01/14/12 indicated that the Hospitalist ordered a consultation with the Wound Nurse.

The Wound Nurse was interviewed on 02/22/12 from 1:25 P.M. to 2:00 P.M. The Wound Nurse said she reviewed the other consultations for Patient #1, but did not conduct an assessment. The Wound Nurse failed to conduct as assessment following an ordered consultation by a physician.

Review of the medical record indicated that the Physician's Assistant, Physical Therapist, Wound Nurse and the nursing staff failed to adequately assess Patient #1 for the complaint of pain in the right foot.

Patient #1 developed multiple pressure ulcers as a result of wearing the CAM boot for 5 continuous days.

Refer to A-0347, A-0353, A-0395 and A-0396.

VIOLATION: *MEDICAL STAFF ACCOUNTABILITY*

Tag No: A0347

Based on medical record review, physician and physician assistant interview, the orthopedic services failed to evaluate one of one Patients, Patient #1 who developed pressure ulcers beneath a CAM walking boot. The CAM boot remained on for five days from 01/09/12 to 01/14/12.

Findings include:

Review of the History and Physical (H & P) Examination dated 01/07/12 indicated that Patient #1 had cardiac

disease, rheumatoid arthritis, diabetes mellitus with neuropathy (loss of sensation of the lower extremities) and end stage renal disease requiring hemodialysis. However, the H & P lacked documentation that Patient #1 had a history of peripheral vascular/arterial disease with a fifth digit amputation on the left foot secondary to ischemia.

Review of the Physician's Orders dated 01/08/12 indicated that a Physician's Assistant (PA) ordered that Patient #1 wear a CAM/tall walking boot, apply an ace bandage and to elevate the right foot. There were no orders for the management of Patient #1's CAM boot, which included data for the removal of the boot for circulation check, skin inspection, washing and to remove the boot while sleeping.

Review of the Physician's Orders dated 01/11/12 at 2 P.M. indicated that the Orthopedic Service was called for another consultation. The Hospitalist ordered an orthopedic consultation regarding Patient #1's complaint of severe intractable pain in the right ankle.

Review of Physician's Assistant (PA) #1 Progress Note dated 01/11/12 indicated Patient #1 was seen for the evaluation of right knee pain, which was a new complaint. However, PA #1 indicated that pain in the right ankle was tolerable at the time of the evaluation.

PA #1 was interviewed in person on 02/27/12 from 8:40 A.M. to 8:50 A.M. PA #1 said he evaluated Patient #1 on 01/11/12 at 4 P.M. after dialysis. PA #1 said the orthopedic consultation was for a complaint of right ankle pain. However, Patient #1's complaint was pain in the right knee. PA #1 did not remove the CAM boot, nor did he review the consultation note written by the Hospitalist. PA #1 said the walking boot should be removed when the patient is in bed. PA #1 was not aware that the boot was kept on Patient #1 continuously for 5 days. PA #1 failed to evaluate Patient #1's foot according to the requested consultation.

Review of the Vascular Consultation dated 01/14/12 indicated that after removal of the CAM boot, there were three pressure ulcers noted: a linear 2 x 8 centimeter area of ecchymosis on the lateral aspect of the foot, a slightly discolored stage one (reddened area)pressure ulcer on the dorsum of the foot and a Stage 2 (partial thickness loss which may be intact, open or present as a blister) pressure ulcer at the lateral malleolus with dark eschar and Stage one pressure ulcer on the medial malleolus. The right foot was warm with no palpable pulses. The Vascular Surgeon indicated that the ischemic changes to the right foot were a result of consistent pressure from the compression boot.

Review of the medical record indicated that Patient #1 complained of pain in the right ankle after the application of a CAM walking boot and was not evaluated by the PA's for the condition of Patient #1's skin beneath the CAM boot for five days.

Refer to A-0144 and A-0353.

VIOLATION: *MEDICAL STAFF BYLAWS*

Tag No: A0353

Based on medical record review and interview with physicians and the physician assistants indicated that the Hospital failed to ensure that the orthopedic supervising physician reviewed the care and co-signed the physician assistant progress notes, as outlined in the By-Laws and Delineation of Privileges for one of one applicable

Patients, Patient #1 in January 2012.

Findings include:

Medical record review indicated that there was no documentation that the orthopedic service supervising physician reviewed the PA's treatment plan for Patient #1.

Medical record review indicated that there was no documentation that the PA's contacted the supervising physician for Patient #1's a new complaint of right knee pain. There was no documentation that the PA notified the supervising physician of a new consultation request by the Hospitalist for Patient #1's complaint of intractable right ankle pain on 01/11/12. PA #1 did not remove the CAM boot and evaluate the condition of Patient #1's right foot.

Review of the Progress/Consultation Notes by the PA on 01/11/12, 01/12/12, 01/13/12 and 01/14/12 indicated that there were no co-signatures by the supervising physician within 24 hours as outlined in the Delineation of Privileges for PA's in the Medical Staff By-Laws.

The medical staff failed to adequately coordinate the orthopedic needs and services provided to Patient #1 to prevent the development of pressure ulcers following the application of a CAM boot.

There was no documentation that the supervising physician of the orthopedic service evaluated Patient #1 after the application of the CAM/walking boot.

VIOLATION: *RN SUPERVISION OF NURSING CARE*

Tag No: A0395

Based on record review and staff interview, the registered nurse failed to evaluate the care provided to one of one applicable Patients, Patient #1, and implement appropriate nursing measures to prevent the development of pressure ulcers on the right foot following a fracture.

Findings include.

Refer to A-0144 and A-396.

Review of the manufacturer's literature provided by the Hospital for the Controlled Ankle Movement (CAM) walking boot indicated the ankle hinge of a CAM walking boot adjusts to allow as much or as little movement as the treating orthopedist, physical therapist or orthotist feels is appropriate to the patients condition. Patients were instructed not to change the settings, but to report any discomfort and ask for professional adjustment. The literature indicated that the patient was to follow the professional instructions, especially for removal of the CAM for sleep and bathing. Patients were instructed to inspect the skin covered by the CAM boot frequently for signs for pressure or irritation.

Review of the Nursing Interventions and Assessments between the dates of 01/09/12 to 01/13/12 did not include any documentation that Patient #1 was in an ortotic device/ CAM boot. There was no documentation that Patient #1's right foot was assessed for skin irritation or skin breakdown. There was no documentation in the nursing

assessments that Patient #1 had an amputated fifth digit on the left foot. There was no documentation that the CAM walking boot was removed during that time frame to assess Patient #1's skin.

RN #1 was interviewed in person on 02/22/12 from 1 P.M. to 1:20 P.M. RN #2 was interviewed on 02/27/12 from 9:00 A. M to 9:30 A.M. RN #1 said Patient #1 was screaming and complaining of right ankle pain. Both said on 01/13/12, Patient #1's CAM boot was removed from the right foot, but the ace bandage was not removed to properly assess the skin condition of the right foot.

The nursing staff failed to adequately assess Patient #1 for the complaint of pain in the right foot. The nursing staff failed to adequately assess Patient #1's skin on the right foot. Instead, both RN #1 and RN #2 said they never removed the ace bandage because the application of the ace bandage looked as though it was professionally applied. Both said that they did not routinely care for orthopedic patients on the telemetry unit and were unfamiliar with the management of a patient who was in a CAM walking boot.

RN #2 said she removed both the CAM boot and ace bandage on 01/14/12 and observed a necrotic area on the right foot. RN #2 said she did not put the CAM boot back on.

The nursing staff failed to develop a nursing care plan and obtain orders for the management of a CAM/walking boot.

VIOLATION: *NURSING CARE PLAN*

Tag No: A0396

Based on medical record review and staff interview, the nursing staff failed to develop, implement and revise an individualized plan of care for one of one applicable Patients, Patient #1, that developed multiple pressure ulcers beneath a CAM/walking boot in January 2012.

Findings include:

Refer to A-0144 and A-0395.

Review of the Hospital's Policy for Diabetic Foot Care indicated that the purpose of the policy was to provide basic guidelines for the proper care of the diabetic. The Policy indicated patients with diabetes were at a higher risk for foot problems. Diabetic patients may experience sensitivity to heat, cold and may have numbness or increased pain in their feet. These changes can lead to an increased rate of neuropathy, slow healing of cuts, foot ulcers and infection.

Review of the Nursing Plan of Care indicated that Patient #1 had significant mobility limitations, sensory deficits, lack of knowledge of environmental hazards and safety precautions.

The nursing staff failed to develop, implement and revise an appropriate plan of care for Patient #1 who sustained a fracture and required the application of a CAM/walking boot. As a result, Patient #1 developed multiple pressure ulcers on the right foot.

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Home -> Massachusetts -> HOLY FAMILY HOSPITAL -> Report No. 996

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HOLY FAMILY HOSPITAL	70 EAST STREET METHUEN, MA 1844	Feb. 7, 2012
VIOLATION: *PATIENT RIGHTS: CARE IN SAFE SETTING*		**Tag No:** A0144

Based on review of the medical record, physician and staff interviews, the Hospital failed to ensure that one of one applicable Patients, Patient #2, was maintained in a safe environment and not able to access sharps and other harmful contraband on 12/28/11, 01/04/12 and 01/24/12. Because Patient #2 was able to access contraband, multiple self-inflicted cuts were made on Patient #2's chest and abdomen which required 97 staples for closure.

Findings include:

1. Background: It was reported that Patient #2 was admitted to an inpatient psychiatric unit. Mental Health Counselor (MHC) #1 became concerned when Patient #1 spent considerable time in the bathroom. Patient #2 was observed to have multiple self-inflicted multiple lacerations to the chest and abdomen from a jagged disposable razor on 12/28/11 at 10:30 P.M. Patient #2 required the placement of 97 staples to close multiple superficial and deep lacerations on the chest and abdomen. Patient #1 also had superficial facial lacerations.

2. MHC #1 was interviewed in person on 02/06/12 from 3:16 P.M. to 3:34 P.M.and MHC #2 was interviewed in person on 02/06/12 from 3:36 P.M. to 3:58 P.M. respectively. Both said that Patient #2 was in the bathroom between 10 P.M. to 10:30 P.M. for two of the consecutive fifteen minute checks. When MHC #1 called out to ask if she/he was alright, Patient #2 reported to MHC #1 that he/she was fine. MHC #1 became suspicious and spoke to MHC #2 and Licensed Practical Nurse #1. Both MHC #1 and #2 returned to Patient #2's room and found him/her sitting on the bed, covered in blood from multiple lacerations on the face, chest and abdomen. A broken and jagged razor was found on the floor. Additional contraband including sharps, open paper clips, three plastic sharp

tipped single use dental floss sticks and two razors were found in the room and within Patient #2's possessions. Patient #2 was evaluated by the Hospitalist and taken to the Emergency Department (ED) for treatment and closure of the wounds.

3 Patient #2 was observed to have self-inflicted chest and abdominal wounds measuring 90 centimeters in a criss cross pattern. Review of the ED Record indicated that Patient #2's wounds were closed with 97 staples. On 12/29/11 at 2:10 A.M., Patient #2 returned to the psychiatric unit.

4. Registered Nurse (RN) #1 was interviewed in person on 02/07/12 from 2:07 P.M. to 2:41 P.M. and RN #2 was interviewed in person on 02/07/12 from 4:00 P.M. to 4:25 P.M. respectively. RN #1 said that Patient #2's duffel bag had been given to him/her during the day. RN#1 said that sharp objects were found among the Patient's personal belongings and they were removed, documented on a list and the items were stored in pink plastic bins within a locked cabinet. RN #2 said that she offered Patient #2 the pink bin with the sharp items because Patient #2 requested to have a CD to listen to music with a headset. RN #2 said Patient #2 may have taken the razors at that time, but she did not recall the specific date.
There were no orders, nor specific directives for the use of CD's to listen to music with a headset. CD's were listed in the Hospital Center for Behavior Medicine Policy as a restricted item and required a physician's order for patients to use them.

5. Review of Patient #2's Valuables and Belongings List dated 12/19/11 on admission indicated that Patient #2 had 5 CDs, eight razors, a belt and styling gel. The sharp tipped, plastic dental floss container was not listed on the Valuables and Belongings List.

6. Review of both the Psychiatrist's Progress Note and Mental Health Clinician's Referral for Continued Care Note dated 01/04/12 indicated that Patient #2 was again found hoarding paper clips and tea bags for overconsumption of caffeine.

7. Review of the Nurses Note dated 01/10/12 indicated that "stay awake"caffeine pills were discarded as directed by the psychiatrist. The Nurses Note indicated Patient #2 had 29 out of 60 tablets remaining in the bottle. The documentation was unclear as to when Patient #2 had possession of the contraband. The "stay awake" caffeine pills were not listed on Patient #2's Valuables and Belongings List dated 12/19/11. On 01/23/12, Patient #2 signed a Treatment Plan to limit coffee consumption, to use the CD player in a public area and not hurt himself/herself or others. The Nurses Note dated 01/24/12 indicated that Patient #2 was suspected of having possession of a razor confiscated from another patient.

8. The Behavioral Health staff failed to ensure the safety of Patient #2 following an incident of self-inflicted injury by cutting because additional contraband continued to be found in Patient #2's possession despite documentation that Patient #2 had been assigned a one to one observer since 12/28/11.

9. The Behavioral Health staff failed to conduct an appropriate search of Patient #2's belongings on admission and failed to ensure that Patient #2 did not have access to additional contraband during his/her hospitalization .

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Home -> Massachusetts -> MERRIMACK VALLEY HOSPITAL -> Report No. 1047

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MERRIMACK VALLEY HOSPITAL	**140 LINCOLN AVENUE HAVERHILL, MA 1830**	**Oct. 31, 2012**

VIOLATION: *MEDICAL SCREENING EXAM*

Tag No: A2406

Based on interviews, record review, observations and a review of the Hospital Internal Investigation, it was determined that Hospital Emergency Department (ED) #1 failed to provide a medical screening examination for Patient (Pt.) #1 after a request for care was made on behalf of Pt. #1 by the Police Department (PD) Officer. Nurse #1 did not direct the PD Officer to bring Pt. #1 into the ED for triage and a medical screening exam. Nurse #1 directed PD Officer to do what was best for Pt. #1 without a direct assessment being done.

Findings include:

1) The Emergency Medical Services (EMS) ambulance trip record, dated 10/22/12 at 6:13 P.M, indicated that EMS personnel arrived at Pt. #1's home. The EMS trip record indicated that Pt. #1 required psychiatric care.

The Triage Assessment, (sorting patients and setting priorities for their treatment in urgent care settings), dated 10/22/12 at 6:30 P.M., indicated that Patient (Pt.) #1 presented to Emergency Department (ED) #1 at 5:23 P.M. for a psychiatric evaluation. The Triage Assessment indicated that earlier that day, Pt. #1 was discharged from a psychiatric hospital and went to his/her mother's house. Pt. #1 began throwing around medications and the Police were called. At ED #1, Pt. #1 was immediately triaged as a Emergency Severity Index [ESI] Level 3. (Emergency Severity Index, ranging from one to five, is a severity rating system utilized during triage to determine the level of emergency care the patient needed. Severity Level 3 indicates that 2 or more resources are required and the patient needs treatment within 1 to 3 hours. The Triage Assessment indicated that Pt. #1 denied having suicidal intentions.

2) ED Nurse #1 was interviewed on 10/31/12. ED Nurse #1 said that when Pt. #1 arrived, Pt. #1 was asked to sit in a chair near the nursing station because no bed was available. ED Nurse #1 said that about five to ten minutes later, Pt. #1 became aggressive and tried to start a fight with another patient near him/her. ED Nurse #1 said he tried to calm Pt. #1. ED Nurse #1 said Pt. #1 requested a bed and was informed he/she would have to wait until a bed became available. Nurse #1 said Pt. #1 was upset with the wait and walked out of the ED.

3) The Director of Quality Improvement was interviewed on 10/31/12 at 8:15 A.M. The Director of Quality Improvement said that after Pt. #1 left the ED, he/she went to the Hospital's lobby area where the switchboard was located. The Director of Quality Improvement said that Pt. #1 demonstrated aggressive behavior with the Switchboard Operator and was demanding a bed and ripping up papers on her desk. The Switchboard Operator called the Security Guard .

4) Security Guard #1 was interviewed on 10/31/12 at 11:40 A.M. Security Guard #1 said that he was called to the main desk in the lobby at 6:52 P.M.. Security Guard #1 said that Pt. #1 reported the he/she wanted a bed NOW!. Security Guard #1 said Pt. #1 reported that he/she didn't want to wait for an evaluation in the ED, he/she just wanted a bed. Security Guard #1 said that he explained to Pt. #1 that he/she needed to be seen in the ED to be assigned a bed. The Security Guard #1 said that Pt. #1 ran out of the Hospital, threw a rock at the glass entrance and then ran to the street, into oncoming traffic. Police Officers responded and apprehended Pt. #1 and placed him/her in handcuffs and transported Pt. #1 back to ED #1 in the Police Cruiser.

5) ED Nurse #1 said the Police Officer came into the ED and reported that Pt. #1 was outside in the Police Cruiser. The PD Officer entered the ED and informed Nurse #1 that Pt. #1 was in the Cruiser and asked what he should do. Nurse #1 told the PD Officer that he should do what was best for Pt. #1. Nurse #1 did not ensure that Pt. #1 was brought back into the ED to be triaged or provided with a medical screening examination.

The PD Officer left the ED and spoke with Pt. #1 who said that he/she wanted to go to another ED for a psychiatric evaluation. An ambulance was summoned to the parking lot of ED #1 and Pt. #1 was transported to Hospital ED #2.

6) The Hospital's Internal Investigation indicated Pt. #1 did not receive a medical screening examination and the PD Officer arranged for ambulance transfer from Hospital #1's property to Hospital #2's ED.

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MORTON HOSPITAL **88 WASHINGTON STREET TAUNTON, MA 2780** **Oct. 31, 2011**

VIOLATION: *NURSING CARE PLAN* **Tag No:** A0396

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY

Based on observation, record reviews and staff interviews, for six of 32 inpatients reviewed, (Patients # 2, 9, 15, 18, 27 and 32) and 1 non-sampled patient B, the Hospital failed to ensure that the nursing staff developed and implemented an adequate, current nursing care plan for each patient.

For Patients # 9, 15, 18 & non-sampled patient B (# NSB), plans of care were not developed and implemented to ensure nursing services were provided for the maintenance of intravenous devices

For Patient #32, who staff knew from previous admissions to the hospital, the nursing staff failed to develop a plan to address the patient's urinary tract infection and behaviors.

For Patients #2 and #27, the nursing staff failed to monitor and assess weight changes to ensure appropriate nutrition and medical interventions would be provided.

1. The medical record review for Patient #18 was started on 10/19/11 at 8:15 A.M. After treatment in the Hospital's Emergency Department on 10/10/11, the patient was admitted as an inpatient to the Hospital's Intensive Care Unit at 7 P.M. on 10/10/11. The patient was admitted with a central line catheter in the right chest that was used for

hemodialysis. There was no evidence in the medical record that the staff of the hospital provided ongoing assessment and care to the central line from the time of admission to the time of surveyor record review on 10/19/11.

Specific findings follow:

The patient was transported to the Hospital's Emergency Department by paramedics. The patient had been found by dialysis transport employees sitting on the bathroom floor at her home.

There was a notation on the Emergency Department's report that the physician in the Emergency Department called the patient's nephrologist. The subsequent notation by the Emergency Department physician indicated that after discussing the case with the nephrologist, the nephrologist "would prefer that the patient be dialyzed less urgently since no CHF, Hyperkalemia, AG Acidosis."

The Emergency Department report also indicated that the patient had a "right dialysis catheter."

The patient was transferred from the Emergency Department to the Intensive Care Unit with the clinical impression of Dehydration and Hyperglycemia.

The initial nurse's note written on 10/10/11 at 11:57 P.M. by the nurse in the Intensive Care Unit indicated that the patient arrived at approximately 7:00 P.M. and that a "dialysis catheter is seen in the right chest. This is intact with a DSD in place." This was the only entry related to the central line catheter by the nursing staff while the patient was being cared for in the Intensive Care Unit.

The nurse's note of 10/11/11 at 2:19 P.M. recorded that the patient was transferred to the PCU (Progressive Care Unit.)

The initial nurse's note by the staff in the PCU was written on 10/11/11 at 5:17 P.M. The note failed to make any mention of the patient having a central line in her right chest.

The next note by the PCU nursing staff was on 10/11/11 at 10:35 P.M. This nurse wrote that the patient had a "tesio (central line) to (the) right chest wall, new dialysis pt.." There was no additional information related to the status of the catheter including dressing appearance, drainage, the last time the dressing was changed or the last time the catheter/ports were flushed to maintain patency.

On 10/12/11 at 3:02 A.M. the nurse caring for the patient in the PCU wrote that there was a "Tesio cath to R chest, dsg C/D/I." (dressing clean, dry, intact.) There was no additional information in this nursing note related to the care of this central line.

On 10/13/11 at 7:14 A.M. the nurse in the PCU noted that the patient had "Tesio to right chest. Drsg C/D/I"

The patient was transferred to the S1 unit on 10/13/11 at 12:52 P.M.. The first entry by the nursing staff on S1 related to the patient having a central line catheter was on 10/14/11 at 2:18 A.M. The nurse wrote: "pt aware of dialysis in A.M." and "drsg. to rt. chest dialysis catheter intact."

On 10/14/11 at 2:28 P.M., the nurse wrote that the patient indicated that, "I am ready to go home. I will go to my own dialysis center."

A review of the nephrologist's note in the patient's medical record dated 10/13/11 indicated, "some recovery of renal function, to defer dialysis, to observe as outpatient."

It was unclear why the night nurse on 10/14/11 indicated that the patient was going to be dialyzed in the morning when the nephrologist had determined on 10/13/11 that dialysis was being deferred.

It was determined through interview with the contracted dialysis staff that this patient had not been dialyzed in this hospital during this admission.

The next nursing entry related to the care of this patient's central line was on 10/18/11 at 3:14 A.M. when the nurse wrote, "dialysis cath dressing needs changing - Pt refused at present. Would let R.N. secure with tape."

On 10/19/11 at 2:06 A.M. the nurse indicated in the nursing entry, "Drsg to dialysis catheter intact."

On 10/19/11 at 10:00 A.M. the patient's medical record was reviewed and discussed with Nursing Supervisor #1. The surveyor initially discussed the lack of care provided to the patient's central line. Nursing Supervisor #1 immediately responded: "We do not touch Tesio catheters here." The surveyor asked for a hospital policy related to this statement and was told that it was understood by nursing staff that they do not provide care to Tesio catheters. Nursing Supervisor #1 indicated that it has been a long standing hospital policy that the nursing staff does not care for central lines designated for use in the patient's dialysis treatment.

The surveyor explained to Nursing Supervisor #1 that this patient was admitted on [DATE], had been cared for in the Intensive Care Unit, the Progressive Care Unit and on S1 (a medical/surgical unit), and there was no evidence in the patient's medical record that the nursing staff had provided care to this device and/or arranged to have care provided to this device. It was also explained that there was no indication that the patient had been dialyzed while hospitalized ; therefore, there had been no assessment or care provided to the central line by the contracted dialysis staff.

The hospital utilized an electronic medical record system. Survey staff asked Nursing Supervisor #1 to locate any information in the patient's medical record related to the care of the patient's central line that may have been overlooked by the surveyor. Nursing Supervisor #1 asked the Nursing Informatics Manager to assist in the search of the electronic medical record. There was no additional information regarding the assessment and care provided to this patient's central line that was brought to the attention of the surveyor by either of these two individuals.

Nursing Supervisor #1 was asked if the nurse assigned to the patient's care that day (10/19/11 on the day shift) had any plan regarding the care she would be providing to the patient's central line. Nursing Supervisor #1 located R.N. #14 who was caring for Patient #18 during that shift. When asked about the Patient's central line, R.N.#14 indicated that she was aware that this patient had a central line in place for dialysis. R.N. #14 was asked by the surveyor what the plan was for providing care to this central line. R.N. #14 offered that she thought that "was a good question." R.N. #14 also indicated that the insertion site of the central line could not be assessed because the dressing covering the area was not transparent.

Following the conversation with R.N.#14, Nursing Supervisor #1 indicated that she was going to direct R.N. #14 to contact the Patient's nephrologist regarding direction for the care of the central line.

The surveyor requested to be informed of the orders obtained from the nephrologist. In the event that the nephrologist ordered that the dressing to the central line site was to be changed and the lines of the device were to be flushed, survey staff requested to be present for these procedures. Nursing Supervisor #1 indicated that she understood the request and would contact the surveyor prior to any care being provided to the central line.

The surveyor returned to the S1 unit at 1 P.M. on 10/19/11. R.N. #14 was asked about the status of the patient's central line care. R.N. #14 indicated that the covering nephrologist had written medical orders for the dressing change at the site of the central line and for the flushing of the line. R.N. #14 indicated that she had to contact the nephrologist for clarification of the frequency these procedures were to be done. The surveyor was told that following this clarification, the dressing change and line flushing would be done. R.N. #14 would contact the surveyor prior to the care to the central line being done.

Approximately 3 minutes later, R.N. #14 approached the surveyor and indicated that the care of the central line for this patient had already been done. R.N. #14 indicated that she had just been informed that the contracted dialysis nurse had changed the central line dressing, flushed the lines and instilled heparin into the ports. R.N. #14 indicated that the contracted dialysis nurse had not communicated with any staff on the unit, including R.N.#14, regarding the patient's condition, the indication for the patient to be on contact precautions (positive for methicillin resistant staph aureus), obtaining supplies needed to perform the dressing change and flushing procedures, the condition of the insertion site, the status of the ports of the catheter, the patient's acceptance of the procedure and any reaction the patient may have experienced.

The patient's medical record was then reviewed with Nursing Supervisor #1 and Nurse Manager #2 in an effort to determine if the contracted dialysis nurse had entered any information in the patient's medical record regarding the procedures she had just completed. As the contracted dialysis staff cannot enter information in the electronic medical record, the paper record was reviewed. It was confirmed that the contracted dialysis nurse had not made any entries in the patient's medical record regarding the procedures that she performed related to the central line.

It was then determined that the Nurse Manager would accompany the surveyor to the three station dialysis unit the Hospital operated through a contract with a provider of hemodialysis services. (Please refer to A-398)

Following the surveyors visit to the dialysis room on 10/19/11 at 3:00 P.M., a discussion was held with the CNO (Chief Nursing Officer) and Nursing Supervisor #1 to review the lack of care provided to Patient #18's central line, and the multiple issues regarding the contracted dialysis services. The CNO indicated that she had been informed of the issue of the Hospital nursing staff not providing care to the patient's central line, and the contracted dialysis nurse inappropriately providing care to the patient. The surveyor informed the CNO and Nursing Supervisor #1 of the supply of Heparin that had been found in the dialysis room. They both expressed their understanding of the issues and did not offer any additional information other than indicating that the Hospital had a policy and procedure for the care of central lines which they would supply to the survey team.

2. Clinical record review on 10/19/11 at 10 A.M. revealed Patient #15 was admitted on [DATE]. According to the initial nursing assessment completed on 10/15/11 at 11:43 P.M., the patient had a past medical history of [DIAGNOSES REDACTED]

On 10/17/11 at 11:37 P.M. nursing documentation in the electronic medical record revealed the patient had a portacath (implanted small medical appliance installed beneath the skin, used for chemotherapy) in the left upper arm. There was no mention of this device in the initial nursing assessment of 10/15/11.

The above findings were reviewed with Nurse Manager #3 on 10/19/11 at approximately 2 P.M. The Nurse Manager acknowledged there were no other entries prior to 10/17/11 regarding the portacath. Nurse Manager #3 reviewed the electronic medical record with the nurse assigned to the patient for a nursing plan of care for the portacath. There was no plan; nor alerts for the nursing staff to not use this arm for blood pressure or obtaining blood samples. When asked how this information would be communicated to the nursing staff including the CNA's assigned to the unit, the Nurse Manager stated the information should be noted on the dry/erase board in the patient's room. (These were boards mounted on the wall of patients' rooms that were visible to other patients as well as visitors and were not an appropriate forum for communicating personal care needs.) Nurse Manager #3 accompanied the surveyor to the patient's room. It was noted on the dry/erase board not to use the patient's left arm for these procedures. Nurse Manager #3 acknowledged that the nursing plan of care should have identified the presence of this device and care interventions needed to be in the plan.

3. The Elder Behavioral Health Unit was a unit the Hospital operated through a contract with a provider of acute behavioral health services. On 10/18/11 at approximately 4:45 P.M., RN survey staff went to the Elder Behavioral Health Services (EBHS) unit to assess two patients, Patient #9 and non-sampled Patient B who had intravenous devices, at the request of Social Work survey staff.

Upon arriving on the Unit, non-sampled Patient B was observed sitting in the day room. The patient was observed with an intravenous saline lock in his right hand. The nurse, RN #19 from the Behavioral Health contract company, stated that the patient had returned to the unit on 10/17/11 at 2:15 P.M. after surgery with the device and it would need to be flushed every shift. RN #19 also stated the device would be left in for approximately 24 hours post-operatively and if the patient was tolerating food and liquids it would be discontinued. RN #19 stated that "it could probably be pulled now."

RN #19 accessed the electronic medication administration record to obtain information regarding the flushing of the device. RN #19 stated there was no evidence that the device had been flushed since the patient returned to unit nor physician's orders for the maintenance of the device.

At 5 P.M., Patient #9 was observed lying in bed, with oxygen via a nasal cannula, and had an intravenous device in his left hand. According to RN #19 the patient had pneumonia and was receiving intravenous antibiotics and intravenous fluids. When asked by survey staff as to the amount of fluids the patient had received since the initiation of the intravenous, the nurse was unable to locate the information in the electronic medical record or in the written medical record. RN #19 stated she would look at the time tape which was affixed to the intravenous solution bag for the amount infused and brought the time tape to survey staff to see. RN #19 acknowledged there should be a way to retrieve this information from the clinical record.

At 6 P.M. RN #15, also from the Behavioral Health contractor, provided survey staff with a nurse's note from 10/18/11 1:51 P.M. written by RN #16 (also from the Behavioral Health contractor.) According to the note, RN #16 documented that the intravenous was started by another RN, not RN #16. Documentation from the electronic medical record revealed an entry by RN#16 in the intravenous insertion section of the record that she had inserted

the intravenous device. There was no documentation that the nursing staff could provide or locate by the nurse identified as inserting the intravenous as noted by RN#16 in the nurse's note. Additionally, record review on 10/18/11 revealed that although the patient was admitted on [DATE] and a psychiatric initial assessment had been completed, no history or physical had been completed by the medical physician. (Refer to A 358).

At 6:15 P.M., survey staff met with the CNO to discuss the above findings,observations and concerns regarding Patient #9's medical condition. The CNO stated that based on the patient's current condition, the patient would be evaluated to see if his medical condition was stable so he could remain on the EBHS unit or be transferred to to a medical unit in the Hospital. On 10/19/11, the CNO informed survey staff that Patient #9 had been transferred to a medical unit later in the evening on 10/18/11.

4. Per 10/26/2011 at 10:30 AM review of the medical record, Patient #32 was an elderly patient who was readmitted to the Hospital via the emergency room (ER) on 10/17/11. The Patient had arrived at the Hospital ER via ambulance at 7:22 AM. Twenty minutes later, at 7:42 AM, the nurse documented that the patient was "consistently" complaining of left sided abdominal pain, was stating she was confused and anxious, and was unable to state her birthday.

Patient #32 was seen by the physician at 7:54 AM. The physician documented that the Patient had been seen in the ER three days prior, was diagnosed with [DIAGNOSES REDACTED].

The ER nurse documented that the patient voided a large amount in the bedpan at 11:30 AM., and that at 1 PM the patient was medicated with the antibiotic medication, Rocephin, for a "UTI" (urinary tract infection.) At 1:38 PM the physician ordered Sodium Cl 0.9% IV (NS 0.9% IV) at a rate of 100 mls per hour for parenteral fluid replacement. Patient #32 was transferred and admitted to the S1 inpatient unit at 2:40 PM.

The initial assessment by the nursing staff on the S1 unit was recorded at 5:29 PM and noted that Patient #32 had a bilateral, below the knee amputation, had an IV/Saline/Heparin Lock, had frequency of urination, was confused, disoriented and required toileting every two hours. Additionally, the assessment noted the patient was a high fall risk and required assistance of two with mobility.

The nursing plan of care developed on 10/17/2011 indicated Patient #32 was "on bed rest with bathroom privileges." The plan of care noted the patient was a fall risk and the "fall prevention care plan" would be implemented.

The Hospital's Falls Prevention and Management Protocol, effective 10/7/11, directed staff to complete the following:

- Assess coordination and balance before transferring or mobility activities
- Provide frequent toileting to decrease urgency and incontinence
- Use rubber sole shoes, slippers or traction socks
- Lock all moveable equipment before transferring patients

- Individualize assistive devices to patient needs
- Place patient care articles within reach
- Provide physically safe environment
- Provide adequate lighting
- Review medications for potential impact on fall risk
- Actively engage patient and family in fall prevention

Additionally, for patients' assessed to be at high risk (including Patient #32) staff were directed to:

- Post a falling star on the door
- The patient was to wear yellow socks and a yellow arm band
- Low beds would be provided where available
- Bed and Chair alarms
- Move the patient closer to the nursing station
- Consider an observation attendant if above interventions not effective.

However, the nursing plan of care developed on 10/17/2011 for Patient #32 did not address nor plan interventions for the patient's known urinary tract infection, confusion, disorientation, diagnosed mood disorder nor dementia.

Continued medical record review revealed that at 9:18 PM on 10/17/11 the nurse documented that Patient #32 had voided on the bedpan on two occasions.

The following morning, on 10/18/11 at 7:53 AM, the nurse documented the patient had complained about pain during the night shift, the doctor had been called and had ordered "Morphine 1 - 2 milligrams IV;" however, the morphine was not available in Pyxis. Also, that the patient was receiving her second bag of normal saline via an intravenous device that was infusing at 100 milliliters an hour. At 9:09 AM the nurse documented "morphine given for pain."

At 1:00 PM the nurse documented that Patient #32 was found sitting on the floor. Subsequent radiographs revealed the patient, who was a bilateral amputee, had a supracondylar fracture of the right femur.

RN #22, who had cared for Patient #32 at the time of the fall, was interviewed on 10/26/11 at 2 PM. The nurse stated that she knew Patient #32 from previous admissions. The nurse said that Patient #32 was on medication for a urinary tract infection and had used the bedpan earlier in the morning without incident. The nurse stated that, to her knowledge, Patient #32 had never attempted to get out of bed in the past. However, Patient #32 had "difficulty waiting for care," and "would yell rather than use the call bell." Also, that Patient #32 would refuse to take her medication at times, stating: "I no take them." The nurse acknowledged that the patient was a high fall risk and stated: "we had implemented all the fall interventions in the protocol." The nurse stated that the "falling star" was on the door. However, as the patient was a bilateral amputee and had no feet, the nurse stated that the staff were uncertain how to implement the use of the non-skid "yellow slippers" required in the Hospital's fall protocol . The nurse stated that (in an attempt to adhere to the Hospital's protocol,) staff had placed yellow slippers over the top of the posts at the end of the patient's bed. It was unclear how the nurse determined that action would prevent a fall.

Nursing Assistant #1 (NA #1) who was caring for Patient #32 at the time of the fall was interviewed on 10/27/11 at

7:30 AM. The Nursing Assistant said she knew (Patient #32) "by heart as he/she has been on my floor many times." NA #1 stated the patient could be "combative" if she didn't get what she wanted immediately, so if her buzzer went on, the NA responded quickly. NA #1 said she offered the patient the bedpan; however, the patient "was screaming and yelling no." The NA stated the nurse had been in the room; however, had been called to the desk at that time. The NA stated she offered the commode and the patient pushed it against her hands, stating "banyo" (bathroom.) The NA stated she knew the patient had no legs so she left to get the wheelchair.

RN #22, confirmed on 10/26/11 at 2 PM that she had told the NA "maybe we could get her into a wheelchair." The nurse stated that she had heard a commotion in the room and entered to find the patient on the floor. The nurse stated the NA arrived moments later with the commode. The NA stated she had arrived moments later with a wheelchair.

Observation of the S1 unit's physical layout, on 10/26/11 at 8:30 AM, revealed that Patient #32's assigned room was located at one end of the unit and at a significant distance from the equipment storage area. Accessing the equipment storage closet required walking the length of the corridor, turning around a corner and traveling down an adjacent corridor. At the request of surveyors, the CNO had the distance from Patient #32's room to the storage closet measured. The hospital CNO reported on 10/26/11 at 11:15 AM that the distance from Patient #32's room to the equipment closet was 156 feet each way (312 feet round trip.)

The Nursing Staff failed to ensure that necessary patient care equipment (including commode and/or wheelchair) for Patient #32 was readily available. The nursing staff rigidly adhered to a generic falls protocol that was not appropriate to the needs of Patient #32 who was a bilateral amputee ("yellow slippers"), and failed to develop an adequate plan of care to address Patient #32's impulsive behavior and urinary tract infection. Failure to develop an adequate plan of care for Patient #32 resulted in the patient's fall and resulting fracture.

5. The medical record of Patient #27, including both the written and electronic recordings, was reviewed on 10/18/11.

Record review revealed the patient was admitted on [DATE] after treatment in the emergency room for a recent fall, with question of early dementia or [DIAGNOSES REDACTED]. The patient was admitted to the S1 unit for mild dehydration and anemia, with plans for neuropsychological, dermatology and ophthalmology consultations. Admission data noted the patient's height was 5' 4" and weight was 144 pounds; with presence of a stage II skin area to buttock. Additionally, the patient had medication orders for insulin and a 75 gram Carbohydrate, 1800 calorie diet. The diet was subsequently changed to a No Concentrated Sweets diet on 10/13/11.

The 10/14/11 nutrition progress note by the dietitian indicated the resident's Ideal Body Weight was approximately 130 lbs. Laboratory values included a blood urea nitrogen level (BUN) of 25 (slight elevation) and iron (Fe) level at 34 (low abnormal). Blood glucose levels were followed before meals and at night with sliding scale insulin coverage. Recorded meal intakes for this patient ranged from 50 to 100 %. The nutrition goal read to monitor intake, blood sugar levels and weight. This patient was transferred from the S1 unit to the Elder Behavioral Health Services (EBHS) unit. On 10/17/11 the patient's weight was documented as 134.4 pounds; a 9.6 pound loss.

On 10/19/11, at 9:30 A.M., the surveyor interviewed the EBHS Program Manager about the resident's weight changes. According to the Program Manager, the patient's 134.4 pounds was the only recorded weight available for review. The program manger proceeded to search the electronic medical record for nursing documentation from the S1 unit where this patient was first admitted and could not access the nursing documentation. The EBHS Nurse Program Manger's explanation as to why the admission nursing documentation from the S1 unit could not be reviewed by the staff on EBHS caring for the patient was due to security limits of patient information on the EBHS unit. However, the patient's admission weight was recorded on the dietary report listing for hospital patient census; with pertinent patient nutritional information such as diet order, height, weight, allergies, etc.

Further interview with the EBHS Program Manager indicated that the weight method used on the EBHS unit was a chair scale. The EBHS Program Manager was not aware of the patent's admission weight of 144 pounds. There was no way to determine if the patient's weight variance was due to the difference in equipment (bed scale), an actual weight loss, or a combination of both factors.

Per interview on 10/18/11, the Clinical Dietitian Manager was not aware of the 9 to 10 pound weight (loss) change since the patient's 10/12/11 admission weight. According to clinical nutrition assessment criteria, this patient was not due to for a follow-up review until 10/20/11. Per interview with the RN#13 on 10/18/11 at 2 P.M., the RN was not aware of a hospital nursing/weight assessment policy.

An outdated policy dated 5/09 for Patient Care Services/Nutrition Services was provided at 2:30 P.M. on 10/18/11,. The policy stated that the admission nurse was responsible for obtaining a patient's weight. Additionally, the weights and patient reweighs were to be done on the same scale and documented accordingly.

Patient #27's weight change went unnoted and the data recording for patient weight information was limited..

6. Patient # 2 was reviewed on 10/18/11. Patient #2 was admitted to the hospital for acute intervention with multiple medical conditions which included aspiration with esophageal impaction, respiratory failure, congestive heart failure, diabetes, [DIAGNOSES REDACTED]and end stage renal disease with dialysis treatments.

Admission data for this patient included height of 5' 11" and weight at 180.39 pounds. The initial nutritional assessment reported this patient at risk due to a clear liquid diet, poor protein stores and high risk due to skin breakdown. Speech therapy determined the patient was unable to swallow safely and remained NPO (fed nothing by mouth). Tolerance and risk of fluid/metabolic imbalances and gastric residuals limited the advancement of enteral feedings. The patient's condition evidenced extreme low albumin levels and edematous extremities despite dialysis treatments. The dietician's nutritional assessment calculated the patient's estimated caloric and nutrient needs could be met with the formula administration at 55 ml/hour. The patient received intravenous fluids, and was determined unable to safely swallow foods; therefore, a nasogastric tube provided the nutrition formula at a slow rate.

The patient's weight measurements were recorded in the medical record and included significant variances of 20 to 22 pounds on two occasions; without evidence of nursing assessment or reweigh according to hospital policy.

Review of printed medical record information identified this patient's weight on 9/30/11 and 10/1/11, data from a previous hospital stay, at 180.34 pounds. On the date of admission, 10/5/11, the patient's documented weight was

reported as 180.34, which was recorded for 10/7/11. On 10/8/11, the patients weight was reported at 182 pounds. It was difficult to determine if the admission weight was accurate, and whether the current weight was valid.

Review of weight documentation noted the patient was weighed on a bed scale on 10/9/11, at 203 pounds (an increase of 22 pounds). The patient received dialysis while in the intensive care unit (ICU) with pre and post treatment weight measurements recorded in kilograms with the dialysis services documentation, separate from the electronic medical record.

During 10/18/11 at 12:30 P.M. interview, RN #1 reviewed the documentation and could only correlate the increase with intravenous fluids received on 10/7/11 and 10/8 /11 respectively (3 plus liters and 4 liter intakes via intravenous/enteral fluids with little to no output.) Discussion with RN #1 revealed that weight inaccuracies would be likely if the patient's bed contained additional items that were not accounted for, or that the bed scale weight was not obtained correctly.

A nutrition progress note dated 10/10/11 had questioned the patient's weight difference of 20 pounds in two days. Also, the nutrition progress note noted concern with the laboratory blood value for the patient's albumin (1.9) as extremely low and questioned possible fluid overload status/anasarca. However, there was no nursing documentation that indicated the increased weight was reassessed at that time.

On 10/13/11, the patient's weight was noted at 224 pounds (21 pound increase). These weights were obtained via bed scale within the patient's ICU bed. The nutrition progress notes of 10/16 and 10/17/11 recommended protein repletion was needed and questioned whether the patient's weight gain was related to fluid. The recommendation was to resume enteral feeding as soon as possible and/or consider gastrostomy placement or total parenteral nutrition. Although this patient was followed by dialysis services, the patient' dialysis pre and post weights were not documented in the weight data collection area of the electronic record; comprehensive review of data collection was limited.

Discussion with RN #13 on 10/18/11 at 2:30 P.M. revealed that the hospital had provided education/competency for bed scale weight measurements during November 2010 for licensed and certified nurse aide staff. The information directed staff to compare the previous weight in electronic medical documentation to the current day's weight. There was no evidence that patients' weights were reviewed by nursing at the time of recording in the electronic medical record with comparison with the previously documented weight to address the significant variances.

The Hospital failed to ensure that the weight monitoring system in use was effective and implemented correctly for these two patients.

VIOLATION: *PATIENT CARE ASSIGMENTS* **Tag No:** A0397

Based upon record reviews and staff interviews, the Hospital failed to ensure that a Registered Nurse supervised the care of each patient by directing the assignments and care provided by the nursing assistants. The findings are:

On the first day of survey, 10/17/11 during the initial tour, the surveyor was informed by RN #6 that the "charge

nurse" on the S1 unit takes a full patient assignment. During the initial tour on the S2 unit on 10/17/11 at 9 AM, the "charge nurse" had a three patient assignment. On 10/18/11 at 8 AM, the "charge nurse" on S2 unit had a three patient assignment.

Review of the S2 assignment/roster sheet used by the nursing assistants on 10/18/11 at 9 AM revealed 7 of the 28 patients on the S2 unit had no information documented on the roster sheet to direct the nursing assistants other than the name of the nurse assigned to the patient.

Review of the S1 assignment/roster sheet used by the nursing assistants on 10/20/11 at 9 AM revealed 13 of the 19 patients on the S1 unit had no information documented on the roster sheet to direct the nursing assistants other than the name of the nurse assigned to the patient.

On 10/26/11 at 9:30 AM, Nurse Manager #3 was interviewed and asked to explain the process for communicating nursing assistants' assignments. The Nurse Manager stated that the on-coming day shift nursing assistants met with the out-going night shift nursing assistants to "update each other" on the patients. This nurse aide to nurse aide meeting occurred at the same time the Registered Nurses were meeting. On the unit where Nurse Manager #3 worked, there were three nursing assistants on the day shift; and according to Nurse Manager #3, the nursing assistants did not have a specific assignment. According to Nurse Manager #3, the three nurse aides "work together." Nurse Manager #3 stated that the nurse was responsible to "touch base" with the assistant, and would write specific instructions for individual patients on a daily bed roster. Also, the nurse would write information on the "white board" located in each patients' room. (These were boards mounted on the wall of patients' rooms that were visible to other patients as well as visitors and were not an appropriate forum for communicating personal care needs.) The surveyors requested to view a nurse aide roster sheet. The surveyors were provided with a copy of the sheet being used by Nurse Aide #3 to direct her care at approximately 9:45 AM on 10/26/11. The sheet listed all of the patients on the unit on 10/26/11; and, next to each patient's name were initials of the nurse assigned to the patient. It was approximately three hours into the shift at the time of review and there was no additional documented information to guide/direct the nurse aide in the care of the patients on the roster sheet.

On 10/26/11 at 11:25 AM, staff nurse (RN #20) was interviewed. RN #20 was asked to explain the process for communicating patients' care needs to the nursing assistants. RN #20 stated the day shift nursing assistants "pass along" information directly to the evening shift nursing assistants. RN #20 also stated the nursing assistants are not assigned to specific patients.

On 10/26/11 at 1:00 PM, staff nurse (RN #21) was interviewed. RN #21 stated there are usually two nursing assistants on her unit. RN #21 stated the nursing assistants talk before the start of the shift with the out-going night aide "for direction."

Staff Nurse (RN #22) was interviewed on 10/26/11 at 2 PM and stated her unit has two nursing assistants and each assistant takes "a side, typically ten patients each." RN #22 said she would personally direct the nurse assistants assigned to her patients; however, RN #22 was only responsible for four of the patients.

On 10/27/11 at 7:30 AM, Nursing Assistant (NA #1) was interviewed. NA #1 stated she would receive a list of the patients from the nurse and would "try to get a report the best I can from the night aide." NA #1 went on to explain that there is only one nursing assistant on the night shift, and that person is very busy so it is difficult to obtain a report at times. NA #1 stated her assignment at times is 13 patients. "I know I don't do medications or

assessments, but some nurses want me to."

Nursing Assistant (NA #2) was interviewed on 10/27/11 at 9:05 AM. NA #2 stated she received report from the night shift nursing assistants, and that the nursing assistants decided how to divide the work load amongst themselves. The assistant was asked how they would know what patients needed feeding assistance? NA #2 stated: "that's a tough one, because there is no meal on 11 to 7, so the night aides don't always know." NA #2 went on to explain that sometimes information is passed along from the 3 to 11 shift nursing assistants; and other times the nurse aide just observes the patient to decide if they need assistance to eat.

Nursing Assistant (NA#3) was interviewed on 10/27/11 at 10:15 AM. NA #3 stated she met with the night aides to receive report and the nurse would tell her anything else she needed to know. (As noted above, the surveyors had reviewed the roster used by NA #3 on 10/26/11 and it contained no specific directions from the nursing staff.)

NA #3 stated her usual tasks included application of immobilizers. When asked how she would know the plan for a specific patient included application of an immobilizer, NA #3 stated: "if I find one in the room, then I know to apply it." "There are white ones and there's another one." "The other ones have a setting, but it would already be set." NA #3 stated she was familiar with Femoral Blocks. When asked what her responsibility would be, NA #3 stated: "it's just a matter of rearranging the furniture in the room." When asked how she would know to do that, NA #3 stated: "Because it is a different IV Pole and the liquid in the tube is yellow."

The above findings were reviewed with the Chief Nursing Officer (CNO) on 10/27/11 at 12:15 PM. The CNO confirmed that the charge nurses have a full patient assignment and the Nurse Managers have responsibility for multiple areas. The CNO confirmed the S1 Nurse Manager position was vacant. The CNO stated she had wanted to create a "true" charge nurse/resource nurse position to provide direction for staff on each unit; however, the Hospital had been unable to fund that position within the budget.

The Hospital failed to implement an adequate system to ensure that a Registered Nurse was directing the care provided by nursing assistants.

VIOLATION: *UNSPECIFIED CATEGORY* **Tag No:**

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY

Based on record review and staff interviews, for one patient (Patient #31) from a total sample of thirty-two patients reviewed, the Hospital failed to ensure that analgesic medications were administered in accordance with the physician's orders and according to accepted standards of practice for medication administration by the Registered Nurse.

Pursuant to Massachusetts General Law (M.G.L.), chapter 112, individuals are given the designation of registered nurse and practical nurse which includes the responsibility to provide nursing care. Pursuant to the Code of Massachusetts Regulation (CMR) 244, Rules and Regulations 3.02 and 3.04 define the responsibilities and functions of a registered nurse and Practical nurse respectively. The regulations stipulate that both the registered nurse and practical nurse bear full responsibility for systematically assessing health status and recording the related health data. They also stipulate that both the registered nurse and practical nurse incorporate into the plan

of care, and implement prescribed medical regimens. The rules and regulations 9.03 define standards of Conduct for Nurses where it is stipulated that a "nurse licensed by the Board shall engage in the practice of nursing in accordance with accepted standards of practice."

The findings are:

1. Per 10/26/2011 at 10:30 AM review of the medical record, Patient #31 was an elderly patient who was admitted on [DATE] following a total arthroplasty of the right knee at approximately 8 AM that morning.

According to the anesthesia record, at 7:42 AM on 10/17/11 anesthesia was started. At 10:00 AM it stopped. The anesthesia record also indicated that the patient had an ultrasound guided, Femoral Nerve Catheter Nerve Block placed prior to the procedure. The Post-operative Anesthesia Continuous Peripheral Nerve Block Order indicated the catheter was placed at the right femoral nerve and the medication was Bupivacaine 0.125 % (B1/8) in 100 milliliters (ml) of normal saline and was to infuse a 6 milliliters per hour for 48 hours and then to be discontinued on 10/19/11 at 6:00 AM. The post anesthesia evaluation note, completed at 11:45 AM on 10/17/11, noted that the patient was "receiving a long-acting regional anesthesia: full recovery had not occurred and is not expected within the 48 hour timeframe."

The Chief of Anesthesia was interviewed on 10/26/11 at 1:50 PM and explained that, although the Femoral Nerve Block provided excellent pain relief, the quadriceps muscle can be weakened for 6 to 24 hours following removal of the catheter. The Chief of Anesthesia stated that all nurses had been trained on Femoral Nerve Catheter Blocks prior to the Anesthesia Department's initiation of their use for that reason.

Further clinical record review revealed that, at 11:10 AM on 10/17/11 the physician ordered a PCA (Patient Controlled Anesthesia) Pump for Patient #31. The PCA is a device that allows the patient to self-administer pain medication with built-in limits. The order for Patient #31's PCA indicated that the pump would be loaded with IV Morphine at a concentration of 5 milligrams per milliliter. The pump would be set to dose the Morphine at 1 milligram intravenously, every 7 minutes, with a maximum of 8 injections in an hour. These settings reflected that, no matter how often the patient pushed the button on the pump, the maximum dose of Morphine the patient could receive would be 8 milligrams an hour.

Patient #31 was transferred out of the post anesthesia care unit and to the S2 nursing unit on 10/17/11. The nurses noted that the patient had a Femoral Nerve Block Catheter in the upper right thigh/groin that was infusing at 6 cubic centimeters an hour. Additionally, the patient had a CPM (Continuous Passive Motion) Machine that had been applied in the "recovery room." The plan was for the nurses to remove the CPM machine when required.

An initial nursing assessment, documented on 10/17/11 at 2:09 PM, indicated the patient had neither chronic nor acute pain. The plan of care, developed at 2:23 on the 10/17 noted a problem with alteration in comfort, and a plan to complete a pain assessment, initiate and maintain a PCA pump, medicate as ordered and evaluate effect.

At approximately 8:00 PM, Patient #31 complained of fever, shaking and chills. The nurse documented that the patient had a temperature of 102.7, that she administered 650 milligrams of Tylenol, and would "recheck temp. in 1 hr." At 9:45 the patient's temperature was 102.1, but the patient denied shaking or chills. The nurse encouraged the patient to cough/deep breathe. At 1:30 AM the patient's temperature was 100.7. The physician's assistant was notified but gave no new orders.

The following morning, 10/18/11 at 8:23 AM, the nurse documented that the patient was on and off the bedpan, complaining of a full bladder and the Femoral Nerve Block Catheter was found in the bed. The physician assistant was notified and ordered a Foley catheter be inserted. On 10/18 at 10:35 AM the nurse documented an assessment of the patient's pain as "N" (none). At 10:41 AM the nurse documented that Anesthesia came to see the patient as the Femoral Nerve Block was "out" and that the Femoral Nerve Block had been discontinued. There was no documentation to indicate how much of the nerve block was received. Also the nurse wrote that the patient "uses PCA morphine sparingly - 1/7/8", the settings ordered by the physician.

At 1:21 PM on 10/18/11 the physician's assistant ordered the analgesic medication, Percocet 5/325 (oxycodone 5 milligrams/ acetaminophen 325 milligrams) 1 to 2 tablets, by mouth, every four hours as needed for pain.

On 10/18/11 at 1:25 PM, the nurse assessed the patient's pain and documented "N" (none.)

According to the medication administration records in the clinical record, at 2:41 PM, the nurse administered two Percocet 5/325 tablets to the patient.

At 3:24 PM the physical therapist visited the patient and applied the CPM machine. The machine was scheduled to shut off at 5 PM.

At 3:30 PM on 10/18/11, Patient #31 was found sitting on the floor by the nursing assistant who initiated a staff emergency. The patient was "confused," and unable to recall the circumstances of the fall.

RN #20 was interviewed on 10/26/11 at 11:25 AM stated she had responded to the staff emergency. The RN stated the patient had removed her leg from the CPM machine herself. The RN stated the patient's wound had "totally dehisced" and was bleeding. The RN stated that the patient "denied pain throughout the fall." The RN stated that the patient was unable to state what happened or why.

The physician assistant (PA #1) who cared for patient #31 was interviewed on 10/26/11 at 12:30 PM. PA #1 stated he had responded to the emergency call from the nurses and determined "it was a running stitch. The whole thing broke open." He contacted MD #3 who stated the patient needed to return to the OR. When asked regarding the discontinuation of the PCA pump and the order for the Percocet, PA #1 stated he could not recall why he had ordered the Percocet.

The patient's surgeon, MD #3, was interviewed on 10/26/11 at 12:05 PM. MD #3 stated the patient had previously had the same procedure on the other knee and was the "model patient." When asked, MD #3 stated that although the CPM device can be challenging to apply/remove; the patient was familiar with the device from her previous surgery.

RN #21, who cared for the patient on the day-shift of 10/18/11 was interviewed on 10/26/11 at 1 PM. RN #21 stated that Patient #31 "didn't like the PCA - made her loopy." Further, that Patient #31 told the Physician Assistant that she wanted Percocet. RN #21 stated that when the Physician Assistant came to see the patient he discontinued the PCA and ordered Percocet. When asked about the Percocet administered at 2:41 PM, RN #21 stated that it was administered because the patient wanted it. RN #21 was asked how much PCA Morphine the patient had self-administered on her shift. RN #21 answered: "the PCA was discontinued." The RN was asked

again, and continued to state the PCA was discontinued.

The Physical Therapist (PT #1) who had cared for Patient #31 was interviewed on 10/26/11 at 3:15 PM. PT #1 said that although the patient's Femoral Nerve Block had "fallen out," she was not complaining of pain. He stated she was unusual, stating: "she never complained of pain greater than 3." He assisted her back to bed and found she required "moderate assistance" adding, she was putting weight on her leg, and tolerating it, so I was happy." She was placed on the machine at 3 PM, "was awake, alert, talking to me."

There was no further documentation in the clinical record regarding the amount of morphine self-administered by Patient #31 while utilizing the PCA pump. The Nursing Infomatics Manager was interviewed at 9:15 AM and reviewed Patient #31's electronic and written clinical record together with the surveyors. Following this review, the Infomatics Manager stated that although "initiate and maintain" forms existed in the Hospital's electronic medical record for both the PCA pump and Femoral Nerve Block Catheters, the Manager confirmed that neither form had been completed for Patient #31. Therefore there was no documentation to indicate the amount and timing of self-administered morphine used by Patient #31 and or that the morphine was tracked and evaluated, and there was no documentation of the monitoring of the Femoral Nerve Block as required by Hospital policies and procedures.

At 11:30 AM on 10/27/11 the surveyors interviewed the Director of Pharmacy, Director of Nursing Education and the Chief Nursing Officer regarding the above. The Director of Pharmacy stated that the pharmacy could track the total amount of morphine used during the time the patient had the pump and reported it was a total of 26 milligrams over 26 hours. However, as nursing staff had not completed the tracking forms, neither pharmacy nor nursing could determine when during those 26 hours the patient had received the morphine.

The nurse administered the maximum ordered dose of Percocet at 2:41 PM, with no evidence the patient was in pain nor that the dose and timing of morphine was assessed/documented and there was no assessment of sensory and motor function from the femoral nerve catheter before the Percocet tablets were administered. The patient fell from her bed at 3:30 PM and sustained a dehiscence of her surgical wound.

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MORTON HOSPITAL	88 WASHINGTON STREET TAUNTON, MA 2780	Aug. 30, 2011

VIOLATION: *UNSPECIFIED CATEGORY* **Tag No:**

Based on review of the Physician's orders, the MAR and the Pharmacist's acknowledgment of the order for dispensing the medication, Lamictal, it was determined that Patient #1 received 800 mg of Lamictal daily on 7/6-7/9/11. The doses were not administered by the nursing staff with consistent accepted standards of practice.

Findings include:

1) See also Tag 490 Condition for Pharmacy Services

2) Review of Hospital policies and procedures related to the administration of medication indicated that personnel administering medications are responsible for knowing the actions, effects of the medication and normal doses.

3) Review of Patient #1's medical record indicated she/he received 9 doses of Lamictal that was ordered, prescribed and administered outside the normal dose range.

VIOLATION: *PHARMACEUTICAL SERVICES* **Tag No:** A0490

The condition for Pharmacy Services was not met.

Findings include:

Based on observations, record review and interview with nursing staff, the Director of Pharmacy and the Vice President/Chief Information & Innovation Officer, the pharmaceutical service was not aware that the drug dosage alert was deactivated when electronic documentation was incorporated into the Hospital's Computer System and as a result one of one sampled patients (Patient #1) received higher than normal dosages of Lamictal on 7/6-7/9/11. The facility failed to have policies/procedure in place to ensure clarification was obtained when dispensing medications that are prescribed outside/beyond the normal dosing range.

1.) Review of computerized provider order entry (CPOE) dated 7/5/11 at 4:48 PM indicated Hospitalist #1 ordered 400 mg of Lamictal twice a day for Patient #1.

2.) Review of the Hospital's data source for dosing information for Lamictal was normal dose = 300 milligrams (mg)-500 mg per day in 2 divided doses, or a maximum daily dose of 500 mg up to 700 mg. Patient #1 received 800 mg daily during her hospitalization .

3.) Review of Patient #1's medical record dated 7/11/11 indicated a neurology consult was obtained and it was determined that Patient #1 was receiving more than her baseline of Lamictal. Patient #1 reported to the neurologist he/she took 200 mg twice a day.

4.) Review of the Medication Administration Record documentation indicated Patient #1 received 400 mg of Lamictal on 7/5/11 at 7:46 PM; 400 mg on 7/6/11 at both 8:34 AM and 8:35 PM; 400 mg on 7/7/11 at both 8:31 AM and 8:14 PM; 400 mg on 7/8/11 both at 8:32 AM and 9:08 PM; and 400 mg on 7/9/11 at both 8:37 AM and 8:38 PM.

5.) The Director of the Pharmacy was interviewed in person on 8/24/11 at 2:00 PM and on 8/25/11 at 10:55 AM. The Director said the CPOE system was used to identify patient's at home list/prescribed medications and ensure all information regarding those medications were included/updated in the automated patient information system. The Director said the computerized system has integrated drug safety alerts. An example would be drug to drug interactions and the interactions are categorized according to different severity levels. A pharmacist can then document electronically in a comment field if a drug to drug to drug interaction was noted and the final decision/recommendation made by the pharmacist if the drugs were allowed for clinical administration. The Director of the Pharmacy said she was not aware, until this Surveyor asked for drug and dose information during the onsite investigation, that the computer's dose range alert was not live (turned on) and was noted to be inactivated (turned off) when the automated physician ordering system was implemented. The Director of the Pharmacy said if the dose alert had been activated, a pharmacist who saw the out of range dose alert, would comment what action to take before dispensing a medication on the intervention screen.

6) The VP Chief Information and Innovation Officer was interviewed in person on 8/29/11 at 9:00 AM. The VP Chief Information and Innovation Officer said there was an informal discussion in the beginning of the implementation process in the fall of 2010 regarding the automated computerized provider order entry to deactivate the dose range alerts (electronic support system that identify drug dosage warnings). The dose range alert was off for all staff involved in the administration of medications to patients because an informal decision was made to turn the alert off without obtaining the approval of the Executive Leadership the hospital.

VIOLATION: *PATIENT RIGHTS: NOTICE OF GRIEVANCE DECISION* **Tag No:** A0123

Based on review of 2 of 3 randomly selected complaints, Patient #14 and Patient #15 and the Hospital's response to the complaints, it was determined the Hospital failed to address each point raised in the Complainant's letter as part of the investigation of the grievance.

Findings included:

1) Review of the complaint file for Patient #14 indicated that a complaint letter, dated 5/4/11, was received by the Hospital. The complaint was regarding medical care received in the Hospital's ED on 4/17/11 and in addition, the co-pay for the ED visit. Documentation indicated an acknowledgement letter was sent to the complainant on 5/9/11 and stating that an investigation would be performed. The letter/written response to the Complainant from the chief of Emergency Medicine did not include what the outcome of the investigation was regarding the quality of medical care. The response addressed the co-pay issue.

2) Review of the complaint file for Patient #15 indicated a complaint letter, dated 5/2/11, was received regarding the quality of medical care received in the ED on 2/25 and 2/26/11 and a dispute regarding the co-payment. Documentation indicated an acknowledgement letter was sent to the complainant on 5/3/11. The letter/written response to the complainant on 5/4/11 from the Chief of Emergency Medicine addressed the co-pay issue and not the quality of medical care that was provided.

VIOLATION: *PATIENT RIGHTS: CARE IN SAFE SETTING* **Tag No:** A0144

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY

Based on observations on 8/24/11 at 8:10, interviews and record review regarding patient safety measures such as A-medication alerts, B -patient on aspiration precautions, C-infection control and D- Fall precautions, it was determined the Hospital failed to ensure safety measures were implemented to protect patients from identified safety risk factors.

Findings include:

A. Medication Alerts: The Director of the Pharmacy was interviewed in person on 8/24/11 at 2:00 PM and on 8/25/11 at 10:55 AM. Please refer to Tag 490 Condition for Pharmacy Services for additional information,

The VP Chief Information and Innovation Officer was interviewed in person on 8/29/11 at 9:00 AM. The VP Chief Information and Innovation Officer said the automated computerized provider order entry (CPOE) was deactivated for the dosage range alert (electronic support system that identified drug dosage warnings).

B. Patient on Aspiration Precautions

During a tour of S2 on 8/24/11 at 8:10 AM, it was observed that CNA #2 was feeding Patient #13 who was on aspiration precautions without using safe swallowing strategies. CNA #2 was standing to the side above the patient, rather than at eye level, and did not watch, look and assess that Patient #13 swallowed before more food was provided to the patient.

Review of CNA #2's education and personnel file did not contain documentation of competencies for feeding patients on aspiration precautions.

C. Infection Control

During a tour of S2 on 8/24/11 at 8:10 AM, it was also observed that a sink in the medication room had dried spillage and rust stains. Surface dust was seen on stacked plastic storage containers and there was a buildup of dirt along the edges of the floor.

D. Fall Precautions

Medical record review of Patient #1's admission assessment dated [DATE] indicated that Patient #1 was alert and oriented and assessed at risk for falls with a score of 60 points, which according to the assessment tool used, classified Patient #1 as high risk. Review of Nurse #4's note dated 7/9/11 indicated that Patient #1 was found repeatedly attempting to get out of bed, did not call for assistance when getting out of bed to the commode to void, was observed to be unsteady and wobbled side to side, needed to be supported while sitting on the commode and complained of feeling dizzy. Review of Nurse #4's note dated 7/10/11 at 5:24 AM indicated Patient #1 was found lying face down on the floor next to her/his bed.

Nurse #4, who cared for Patient #1 during the night shift from 7/8 into 7/9/11 and 7/9 into 7/10/11 was interviewed in person on 8/25/11 at 7:15 AM. Nurse #4 said Patient #1 would get up out of bed without calling for assistance. Nurse #4 said Patient #1 told her that she/he had a commode at her/his bedside at home because of frequency and urgency with voiding. Nurse #4 said the first night she cared for Patient #1, she moved the commode from the bathroom to Patient #1's bedside. Nurse #4 said the second night she cared for Patient #1, the commode was moved from the bedside to the corner of Patient #1's room. Nurse #4 said because of Patient #1's impulsivity and high risk for falling, Nurse #4 thought Patient #1 needed 1:1 supervision (safety sitter) because of the increased potential for a fall. Nurse #4 said she did not ask/report to the charge nurse or the nursing supervisor of the need for the 1:1 supervision for Patient #1 because former requests were met with resistance.

Hospital policies/procedures related to fall risk/prevention indicated that if a patient was identified to be a high risk for falls, then the need for an Observation Assistant (1:1) supervision will be considered. The policy did not address a protocol for determining the need for 1:1.

CNA #1, who cared for Patient #1 during the night shift from 7/9 into 7/10/11, was interviewed in person on 8/25/11 at 3:15 PM. CNA #1 said Patient #1's commode was at Patient #1's bedside. CNA #1 denied he moved Patient #1's commode from the bedside to the corner of the room. CNA #1 said heard there had been shortages of safety sitters.

VIOLATION: *UNSPECIFIED CATEGORY* **Tag No:**

Based on review of documentation regarding patient fall data, the hospital's internal investigation and interviews, the Hospital failed to ensure that data collected related to falls which is used to identify opportunities for patient improvement were thoroughly analyzed and was accurate.

Findings include:

Review of the incident report, dated 7/10/11, indicated that Patient #1 was found laying face down on the floor next to her/his bed minutes after being assisted to bed from using a commode. The incident report failed to identify Patient #1's fall risk status and nursing falls risk assessment data.

Review of nursing assessments dated 7/5/11, 7/6/11, 7/8/11 indicated Patient #1 was identified to be at high risk for falls using the Morse Falls Risk Assessment Tool.

Quality Improvement Nurse #2 was interviewed in person on 8/24/11 at 12:15 PM. Quality Improvement Nurse #2 said the incident report regarding Patient #1's fall on 7/10/11 was not complete nor accurate. Quality Improvement Nurse #2 said she reviews all reports related to falls and if the reports are not completed, she will at times, edit/enter the data to complete the reports. Quality Improvement Nurse #2 said information from the incident reports generate summary data for falls.

Review of the Hospital's data summary for falls, dated 7/1/11 to 7/31/11 indicated the data from incident reports, but review of the incident report regarding Patient #1's fall indicated it was not complete and accurate.

Review of documentation for the Hospital's internal investigation/ root cause analysis regarding Patient #1's fall indicated a meeting was held on 7/16/11 and the pharmacy staff were not asked to attend and as a result, not all of Patient #1's medications and dosages were reviewed by a pharmacist to determine if medications and dosages were a factor in placing the patient at increased risk for falls.

The Hospital's root cause analysis failed to identify the following issues: 1) Patient #1 began to get up without calling for assistance and no additional nursing measures were implemented/documented to protect Patient #1's safety after identifying non-compliance with requesting assistance in ambulating. Nursing staff failed to request 1:1 observation for safety. 2) The incorrect information was conveyed to the medical team that Patient #1 had a 3 centimeter subarachnoid hemorrhage, when in fact it was a very small 3 millimeter sized hemorrhage. As a result, additional concerns for Patient #1's neurological status were implemented such as med-flighted the patient to a Tertiary Care Hospital. 3.) Pharmacy staff/Director of the Pharmacy was not asked to attend the root cause analysis meeting. There was no active discussion during the RCA which may have identified the above therapeutic dose of Lamictal ordered for Patient #1.

VIOLATION: *NURSING CARE PLAN* **Tag No:** A0396

Based on interview, documentation and medical record review for 6 out of a total of 10 patients records sampled from the list of patient falls, [Patient #1, #2, #5, #8, #9, #10] the Hospital failed to ensure that the nursing staff developed and kept current, plans of care for each patient.

Findings included:

1.) Review of Patient #1's medical record documentation dated 7/5/11-7/10/11 indicated the patient had a problem of urinary incontinence and frequency, especially at night. Patient #1 was admitted after falling at home while

rushing to a commode/bathroom during the night to void. A urinary drainage catheter was placed at admission and was discontinued 7/7/11. However, Patient #1's plan of care did not identify a revised plan to ensure increased monitoring based on discontinuing the urinary catheter. A nursing care plan dated 7/5/11 indicated Patient #1's mobility deficit was identified, but the interventions were not individualized to the patient's specific needs and issues.

2.) Review of Patient #2's medical record documentation, dated 5/10/11, indicated Patient #2 resided in a nursing home with a history of falls, came to the ED and was then admitted to the Hospital at 10:38 PM. Shortly after admission, at 11:00 PM, Patient #2 was found on the floor. Review of Patient #2's plan of care indicated a problem list that identified an Alteration in Activities of Daily Living. Review of the nursing interventions listed were to perform a fall risk assessment, but plan of care was not individualized for Patient #2.

3.) Review of Patient #5's medical record documentation, dated 6/26/11- 6/30/11, indicated Patient #5 was alert, but confused at times. Patient #5 had weakness and used a bedside commode. On 6/28/11, Patient #5 was found trying to get out of bed unassisted. On 6/30/11, Patient #5 attempted to stand without nursing assistance and was found on the floor on her/his right knee. Review of Patient #5's plan of care indicated a problem list that identified an Alteration in Activities of Daily Living. The nursing intervention listed was to perform a fall risk assessment. The plan of care was not individualized for Patient #5 needs.

4.) Review of Patient #8's medical record documentation, dated 7/6-7/18/11, indicated Patient #8 was admitted to the hospital with a history of being unsteady on his/her feet with falls and being totally dependent for personal care needs. Review of Patient #8's plan of care did not include nursing interventions required to meet activities of daily living for Patient #8 specific needs. Documentation dated 7/17/11 indicated Patient #8 was found sitting on the floor. Patient #8 stated he/she needed to go to the bathroom and tried to get his/her walker, but instead tripped over it. Patient #8 stated he/she hit their head on the wall.

5.) Review of Patient #9's medical record documentation, dated 7/23-7/26/11 and review of Patient #10's medical record, indicated that both Patient #9's and Patient #10's plan of care was not individualized and updated after their falls to reflect increased safety measures.

VIOLATION: *PHARMACIST RESPONSIBILITIES*

Tag No: A0492

Based on review of documentation, the Physician's medication order, the MAR and interviews, the Hospital failed to ensure that Pharmacy Services informed Hospitalist #1 regarding a high dose of Lamictal that was ordered for one of ten sampled patients (Patient #1).

Findings include:

The Pharmacy's policies/procedures related to clarifications of medication orders indicated that any questionable medication orders (unclear, illegible or incomplete) are clarified with the prescriber before any medication is dispense from the pharmacy. The policy/procedure did not include that the responsibility shall also include questioning the dispensing of medications outside of normal dose range/a high dose and along with documentation of actions taken by the pharmacist.

Review of the CPOE documentation indicated that Hospitalist #1 orders, dated 7/5/11 for Patient #,1 included Lamictal 400 milligrams (mg) twice a day, was acknowledged by a pharmacist. However, there was no evidence that the Pharmacist alerted Hospitalist #1 and/or took actions to clarify the medication dose ordered which was outside the normal dosing range/ high dose.

VIOLATION: *DELIVERY OF DRUGS* **Tag No:** A0500

Based on review of documentation, the MAR and interviews, the Hospital failed to ensure that a higher than therapeutic dose of Lamictal and other medications ordered with a high dosage range were clarified and cleared by a Pharmacist before the medications were dispensed from the Pharmacy.

Findings include:

The Director of the Pharmacy was interviewed in person on 8/24/11 at 2:00 PM and on 8/25/11 at 10:55 AM. The Director of the Pharmacy said the dose range alert was not live (turned on), it was inactivated (turned off) when the automated physician ordering system was implemented. The Director of the Pharmacy said if the dose alert had been activated, a pharmacist who saw the out of range dose alert would comment what action they took (when viewing, acknowledging and dispensing a medication with a dose alert) on the intervention screen.

Review of the electronic documentation dated 7/5/11 at 4:48 PM indicated Lamictal 400 mg twice a day, was ordered for Patient #1 and was acknowledged by a pharmacist at 5:21 PM. There was no documentation/comment by a pharmacist that dispensed the medication from the pharmacy that this drug was outside the normal dosing range.

The information below comes from the statement of deficiencies compiled by health inspectors and provided to AHCJ by the Centers for Medicare and Medicaid Services. It does not include the steps the hospital plans to take to fix the problem, known as a plan of correction. For that information, you should contact the hospital, your state health department or CMS. Accessing the document may require you to file a Freedom of Information Request. Information on doing so is available here.

MORTON HOSPITAL **88 WASHINGTON STREET TAUNTON, MA 2780** **Feb. 8, 2011**

VIOLATION: *EMERGENCY SERVICES POLICIES* **Tag No:** A1104

Based on interview it was determined the Hospital failed to ensure emergency department policies and procedures were current and revised as necessary.

Findings included:

I. Clinical Record review indicated Patient #1 presented to the ED and during triage (the process of determining the order in which individuals will be seen by a medical care provider based on their need for immediate medical treatment.), at 6:30 PM, reported experiencing a bad reaction to medication that had been taken three months prior to the visit. Patient #1 reported it felt like his/her heart was going to burst since taking the medication and was in need of medication to calm down. Patient #1's heart rate upon initial assessment was 137 (normal range 60-90) and at the end of the triage process had decreased to between 109-119. The Triage Nurse noted Patient #1 was manic with pinpoint pupils and was out of control while in the triage area. Patient #1 was assigned a triage Priority Level of III (Triage Priotiy Levels include Levels I to V; with I being the most acute/urgent.), and sent to the waiting area. Patient #1, while in the waiting area made rude hand gestures and used foul language toward nursing staff members. At 7:48 PM the Nursing Supervisor was notified of the behavior Patient #1 was exhibiting in the waiting room and Hospital security staff escorted Patient #1 off of Hospital Property. Documentation indicated Patient #1's had left without being seen.

The Hospital Policy that addressed patients who leave the emergency department without being been by a physician was reviewed. The policy was last reviewed and signed off as approved on August 13, 2007. The policy stated If the patient chooses to leave without being seen by a physician he/she will receive a follow-up telephone call the next day shift from the Emergency Department Patient Advocate. During this call the patient will again be encouraged to return to the hospital for medical treatment of the illness or injury. A variance report will be made out by the charge nurse and forwarded to the Director of Emergency and Outpatient Services. The follow-up call will be documented on the ED Patient Call Back Sheet and will be kept in a file in the Emergency Department Patient Advocate's office.

The Director of Quality and Safety (Director) was interviewed in person and by telephone at various times during the Survey. The Director said there was no longer a ED Patient Advocate and the call backs to patient's leaving without being seen, in some cases were made by an ED Physician Assistant, but this was not happening consistently and had not happened in regard to Patient #1. In addition no variance report had been made out related to Patient #1's leaving the ED without being seen. There was no documentation to indicate all cases involving a patient who leaves the ED without being seen were forwarded to the Director of the ED.

II. The Hospital policy that addressed evaluation of crisis patients was reviewed. The policy stated a patient presenting in need of crisis evaluation represents a potentially unstable and fatal condition. Crisis patients are classified as Priority II (urgent) and will be evaluated by an Emergency Department attending physician to determine suicide risk, as soon as possible after all Priority I (emergency) patients are stable.

Review of Patient #5's medical record documentation indicated Patient #5 presented to the Hospital ED with a chief

complaint of severe depression, suicidal ideation and uncontrollable temper rage. Patient #5 was classified as a crisis patient in need of a crisis evaluation. Patient #5 at triage was classified as a Priority III. Patient #5 left without being seen after waiting room for one hour.

Review of Patient #9's medical record documentation indicate Patient #9 presented to the ED with the chief complaint of alcohol withdrawal and was classified as a crisis patient in need of a crisis evaluation. Patient #9 left without being seen after waiting over 2 hours.

Review of Patient #10's medical record documentation indicated Patient #10, who had a history of attention deficit disorder and bi-polar/mood disorder, presented to the Hospital ED and reported increased aggression, that they had been off medication to treat the bi-polar/mood disorder for a year and had requested to be started back on the medications. Patient #10 reported feeling the desire to act out. Patient #10 was assessed as needing a crisis evaluation, classified as a Priority III and sent to the waiting room. When Patient #10's name was called over two hours later it was determined Patient #10 had left without being seen.

Review of Patient #13 medical record documentation indicated Patient #13, who had been diagnosed as bi-polar and a post traumatic stress disorder and who had a long history cutting, presented to the Hospital's ED with healing lacerations on the left forearm and reported he/she felt suicidal. When triaged Patient #13 was classified as a crisis patient in need of a crisis evaluation. Patient #13 was evaluated and classified as a Priority III by the triage nurse. Patient #13 left the ED without being seen after waiting 2 hours.

Also refer to EMTALA deficiency: Tag A-2406.

The information below comes from the statement of deficiencies compiled by health inspectors and provided to AHCJ by the Centers for Medicare and Medicaid Services. It does not include the steps the hospital plans to take to fix the problem, known as a plan of correction. For that information, you should contact the hospital, your state health department or CMS. Accessing the document may require you to file a Freedom of Information Request. Information on doing so is available here.

MORTON HOSPITAL **88 WASHINGTON STREET TAUNTON, MA 2780** **Feb. 7, 2011**

VIOLATION: *STABILIZING TREATMENT* **Tag No:** A2407

Based on documentation review it was determined Pateint #1's received no stabilizing treatment for an emergency medical condition prior to being escorted off Hospital property.

Findings included:

Clinical Record review indicated Patient #1 presented to the ED and during triage reported experiencing a bad reaction to medication that had been taken three months prior to the visit; feeling like his/her heart was going to burst since taking the medication and being in need of medication to calm down. Patient #1's heart rate upon initial assessment was 137 (normal range 60-90) and at the end of the triage process had decreased to between 109-119. The Triage Nurse noted Patient #1 was manic with pinpoint pupils and was out of control while in the triage area. While in the waiting area Pateint #1's was disruptive, making rude hand gestures and using foul language. The Nursing Supervisor was notified of Patient #1 behavior and Hospital security staff escorted Patient #1 off of Hospital Property.

Documentation did not indicate an appropriate medical screening and behavioral health assessment were provided and that Patient #1's emergency medical condition was stabilized before being escorted off of the Hospital Property.

VIOLATION: *MEDICAL SCREENING EXAM* **Tag No:** A2406

Based on interview and documentation review, it was determined the Hospital failed to ensure that all individuals presenting to the emergency department seeking treatment were provided with an appropriate medical screening examination in five (Patient #1, Patient #5, Patient #9, Patient #10 and Patient #13,) of 21 medical records reviewed.

Findings included:

I. Clinical Record review indicated Patient #1 presented to the ED and during triage (the process of determining the order in which individuals will be seen by a medical care provider based on their need for immediate medical treatment.), at 6:30 PM, reported experiencing a bad reaction to medication that had been taken three months prior to the visit. Patient #1 reported it felt like his/her heart was going to burst since taking the medication and was in need of medication to calm down. Patient #1's heart rate upon initial assessment was 137 (normal range 60-90) and at the end of the triage process had decreased to between 109-119. The Triage Nurse noted Patient #1 was manic with pinpoint pupils and was out of control while in the triage area. Patient #1 was assigned a triage Priority Level of III (Triage Priority Levels include Levels I to V; with I being the most acute/urgent.), and sent to the waiting area. Patient #1, while in the waiting area made rude hand gestures and used foul language toward nursing staff members. At 7:48 PM the Nursing Supervisor was notified of the behavior Patient #1 was exhibiting in the waiting room and Hospital security staff escorted Patient #1 off of Hospital Property. Documentation indicated Patient #1's had left without being seen.

Security Officer #1 was interviewed in person on 2/7/2011 at 3:35 PM with the Director of Quality and Safety present. Security Officer #1 said a call was received from the Charge Nurse,at 7:20 PM , who reported Patient #1 was yelling, swearing and making a scene in the ED waiting room. The Charge Nurse instructions were to escort Patient #1 off of the property.

Security Officer #2 was interviewed in person on 2/7/11 at 7:15 AM with the Director of Quality and Safety present. Security Officer #2 said the Security officers had talked with the Charge Nurse and the Charge Nurse had stated that during a conversation with the Nursing Supervisor it was determined it was okay to ask Patient #1 to leave.

Security Officer #3 was interviewed in person on 2/7/11 at 3:10 PM with the Director of Quality and Safety present. Security Officer #3 said Security Officer #1 had reported the Charge Nurse wanted Patient #1 to leave if he/she could not be cooperative.

Review of 1/19/11 security documentation indicated a call was received, at 7:20 PM from the Charge Nurse regarding Patient #1 yelling, swearing and making a scene if front of small children in the ED waiting room. The Charge Nurse informed security Patient #1 needed to be escorted off Hospital property due to this behavior. Patient #1 was brought from the ED waiting room through the side door and escorted off the property via the ambulance bay.

II. The Hospital policy that addressed evaluation of crisis patients was reviewed. The policy stated a patient presenting in need of crisis evaluation represents a potentially unstable and fatal condition. Crisis patients are classified as Priority II (urgent) and will be evaluated by an Emergency Department attending physician to determine suicide risk, as soon as possible after all Priority I (emergency) patients are stable.

Review of Patient #5's medical record documentation indicated Patient #5 presented to the Hospital ED with a chief complaint of severe depression, suicidal ideation and uncontrollable temper rage. Patient #5 was classified as a crisis patient in need of a crisis evaluation. Patient #5 at triage was classified as a Priority III. Patient #5 left without being seen after waiting room for one hour.

Review of Patient #9's medical record documentation indicate Patient #9 presented to the ED with the chief complaint of alcohol withdrawal and was classified as a crisis patient in need of a crisis evaluation. Patient #9 left without being seen after waiting over 2 hours.

Review of Patient #10's medical record documentation indicated Patient #10, who had a history of attention deficit disorder and bi-polar/mood disorder, presented to the Hospital ED and reported increased aggression, that they had been off medication to treat the bi-polar/mood disorder for a year and had requested to be started back on the medications. Patient #10 reported feeling the desire to act out. Patient #10 was assessed as needing a crisis evaluation, classified as a Priority III and sent to the waiting room. When Patient #10's name was called over two hours later it was determined Patient #10 had left without being seen.

Review of Patient #13 medical record documentation indicated Patient #13, who had been diagnosed as bi-polar and a post traumatic stress disorder and who had a long history cutting, presented to the Hospital's ED with healing lacerations on the left forearm and reported he/she felt suicidal. When triaged Patient #13 was classified as a crisis patient in need of a crisis evaluation. Patient #13 was evaluated and classified as a Priority III by the triage nurse. Patient #13 left the ED without being seen after waiting 2 hours.

Also refer to The Conditions of Participation deficiency Tag A-1104

The information below comes from the statement of deficiencies compiled by health inspectors and provided to AHCJ by the Centers for Medicare and Medicaid Services. It does not include the steps the hospital plans to take to fix the problem, known as a plan of correction. For that information, you should contact the hospital, your state health department or CMS. Accessing the document may require you to file a Freedom of Information Request. Information on doing so is available here.

NASHOBA VALLEY MEDICAL CENTER	**200 GROTON ROAD AYER, MA 1432**	**Feb. 10, 2011**

VIOLATION: *PATIENT RIGHTS: CARE IN SAFE SETTING* **Tag No:** A0144

Based on record review and staff interview, one of one applicable Patient's (#1) was not provided with the opportunity for prompt intubation and airway support management while in the Intensive Care Unit (ICU). Instead, the ICU staff called the operating room for Anesthesiologist #1 who was not immediately available.

The findings are as follow:

Patient #1, a young adult, was evaluated in the Emergency Department (ED) for shortness of breath.

Review of the ED Record dated 01/31/11 at 10:30 AM indicated ED Attending Physician #1 documented Patient #1 had been briefly hospitalized the previous year of asthma at another facility. Patient #1 was awake on arrival, anxious and unable to speak secondary to respiratory distress. ED Attending Physician #1 indicated Patient #1 was unable to provide a medical history secondary to respiratory difficulty. Patient #1 had decreased breath sounds at both bases and was positive for wheezing both anterior and posterior on inspiration and expiration. ED Attending Physician #1 indicated symptoms had occurred within hours and were severe Patient #1's vital signs were recorded as a temperature of 98 degrees Fahrenheit, blood pressure 170/94, heart rate 162 to 177 beats per minute, respirations 35 breaths per minute with an oxygen saturation level of 85%. Patient #1's initial arterial blood gases (ABG's) were recorded as a pH of 7.36, a low PO2 76, and PCO2 40.

ED Attending Physician #1 was interviewed in person on 02/09/11 at 1:40 PM. ED Attending Physician #1 said Patient #1 was very ill and required whatever we needed to do to improve Patient #1's breathing. Pulmonologist/Hospitalist #1 was consulted and evaluated Patient #1 while Patient #1 was in the ED. ED Attending Physician #1 said Patient #1 did not have an impressive infiltrate. ED Attending Physician #1 said Patient #1 was administered continuous nebulizers (DuoNeb and Albuterol) via a facial mask, intravenous steroids (SoluMedrol), Magnesium and antibiotics Rocephin and Azithromax). Patient #1 was not able to tolerate continuous positive pressure airway pressure (CPAP)as a respiratory treatment. ED Attending Physician #1 said Patient #1 improved at the time of transfer into ICU.

Review of the Respiratory Care Treatment Flow Sheets between 10:35 AM and 11:25 AM while Patient #1 was in the ED indicated Patient #1's vital signs both before and after nebulizer treatment were recorded as a heart rate of 160 to 179 beats per minute, with a pulse oxymetry of 93% to 94%. Respiratory Therapist #1 indicated Patient #1's lung sounds were tight. Between 11:10 AM to 11:25 AM, Respiratory Therapist #1 indicated Patient #1 improved following the nebulizer treatments.However, Patient #1's respiratory rate increased to 42 to 44 breaths per minute. There was no further documentation by Respiratory Therapist #1 after 11:25 AM.

Respiratory Therapist #1 was interviewed in person on 02/10/11. Respiratory Therapist #1 said Patient #1 had shortness of breath, a rapid heart rate and lung sounds were very wheezy. Respiratory Therapist #1 said Respiratory Therapist #2 assumed the care of Patient #1.

Continued review of the ED record dated 01/31/11 at 12 PM indicated Patient #1' temperature was 102.4 degrees

Fahrenheit, blood pressure 128/59, heart rate 172 beats per minute and respirations 38 breaths per minute. Patient #1 remained on 55% Vente Mask at 6 liters per minute with an oxygen saturation level of 91%.

Review of Patient #1's ABG's taken at 1:15 PM in the ED by Respiratory Therapist #2 recorded the results as a low pH of 7.24, low P02 of 77, elevated PC02 53 (from 40 done at 10:35 AM) and oxygen saturation level of 92% on 55% Vente mask and 6 liters of oxygen by nasal cannula. Respiratory Therapist #2 notified Pulmonologist #1.

Patient #1 was admitted to ICU at 1:30 PM.
Review of the ICU Patient Notes indicated Patient #1 barely able to stand or sit on the bed. Patient #1's respiratory rate was between 34 to 40 breaths per minute with an oxygen saturation level 90%. Patient #1 using accessory muscles and was unable to talk. Respiratory Therapist #2 called for a nebulizer treatment. At 2 PM, Patient #1 continues to work to breathe, Pulmonologist #1 at the bedside. Registered Nurse #3 documented Patient #1 was unable to comprehend teaching secondary to extreme shortness of breath.

Documentation indicated att 2:10 PM, a nebulizer (Albuterol) treatment was administered. Patient #1's vital signs post treatment were recorded as a blood pressure 162/82, heart rate 162 beats per minute with respiratory rate of 36 breaths per minute with a 93%-91% oxygen saturation level. Respiratory Therapist #2 documented Patient #1 was improved after treatment.

Documentation indicated at 3:10 PM, by Pulmonologist #1 in a progress note indicated Patient #1 had status asmaticus with failed CPAP. Pulmonologist #1 indicated Patient #1 did not require mechanical ventilation at this time.

Review of the ICU Patient Notes indicated at 4 PM Patient #1 continued to work (to breathe). Patient #1's respiratory rate was 34 to 39 breaths per minute with an oxygen saturation level of 91%.

Review of the Respiratory Therapist #2 electronic Progress Note at 4:45 PM indicated Patient #1's vital signs were recorded as a blood pressure 154/69, heart rate 143 beats per minute and respirations 39 breaths per minute with an oxygen saturation level of 94%. Patient #1 remained on 55% Vente Mask with 6 liters of oxygen via nasal cannula.

Continued review of the ICU Patient Notes at 5 PM indicated Patient #1's condition not improving. Registered Nurse #3 said Pulmonologist #1 decided Patient #1 needed to be intubated. Registered Nurse #3 indicated an anesthesiologist would intubate Patient #1at the completion of a surgical case in the operating room.

There was no documentation of further contact with a physician.

Respiratory Therapist #2 documented in a late entry at 5 PM and 6 PM nebulizer treatments were administered to Patient #1. Patient #1's respiratory rate was 36 to 44 breaths per minute and oxygen saturation levels ranged between 90 to 92%. At approximately 6:10 PM, Patient #1 was changed to a non-rebreather mask and 6 liters of nasal cannula with a oxygen saturation level documented as 97%.

There was no documentation Pulmonologist #1 re-evaluated Patient #1 between 3:10 PM and 6:20 PM.

Pulmonologist #1 was interviewed in person on 02/09/11 at 9:50 Am. Pulmonologist #1 evaluated Patient #1 in the ED. Pulmonologist #1 said Patient #1 had a rapid heart rate of 170's to 180's and a low oxygen saturation level in the mid 90's. Pulmonologist #1 said Patient #1 was alert and conscious however not able to speak. Pulmonologist #! said Patient #1' ABG's had a low oxygen level and oxygen delivery was changed to a non-rebreather mask. Pulmonologist #! said Patient #1 improved and did not need to be intubated. Pulmonologist #1 said intubating Patient #1 would have placed the patient at risk for pneumonia. Pulmonologist #1 said Patient #1's lungs looked fairly good. Pulmonologist #1 said Patient #1 declined around 4 PM. Pulmonologist #1 said it was determined Patient #1 would have an elective intubation but it was not urgent. Pulmonologist #1 decided not to intubate Patient #1 because of a narrow throat and short tongue. There was no documentation of the Patient's oral cavity nor decision not to intubate. Pulmonologist #1 referred Patient #1 to anesthesia for intubation. Pulmonologist #1 said Anesthesiologist #1 came to the ICU and decided to transfer Patient #! into the operating room. Pulmonologist #1 said the OR was a more controlled environment and the intubation was not urgent. Pulmonologist #1 said Patient #1's oxygen saturation level was 97%. Pulmonologist #1 went to the operating room and assisted Anesthesiologist #1. Pulmonologist #1 said Anesthesiologist #! had no problem passing the endotracheal tube. Pulmonologist #1 said Patient #1 had inflamed airways and a lot of swelling with thick mucus. Pulmonologist #1 passed a bronchoscope. Pulmonologist #1 said Patient #1 started destating (dropping oxygen levels) and a code was called and despite a lengthy code Patient #1 expired.

Continued review of Patient #1's medical record indicated Anesthesiologist #1 examined Patient #1 on 01/31/11 at 6:20 PM. Anesthesiologist #1 arrived in ICU to assist with an urgent intubation of Patient #1 who was in acute

respiratory distress. Anesthesiologist #1 indicated Patient #1's oxygen saturation levels on room air were recorded as 84% with a respiratory rate of 40's. Anesthesiologist #1 indicated Patient #1's tongue was swollen and Patient could not talk. Anesthesiologist #1 indicated Patient #1 was a Mallampati 4 (a nonvisual airway and difficult to intubate). At 6:40 PM, Anesthesiologist #1 indicated Patient needed to be taken to the operating room for an emergency airway.

Anesthesiologist #1 was interviewed in person on 02/09/11 at 12 PM. Anesthesiologist #2 was scheduled for elective cases until the evening of 01/31/11. Anesthesiologist #1 was called by RN #3 regarding Patient #1who needed an airway. Anesthesiologist #1 said the surgical cases were elective and if it had been known that the need to intubate was emergent the last case in the operating room could have been cancelled. Anesthesiologist #1 said after arrival into the ICU, Patient #1 was breathing at a rate of 40 to 60 breaths per minute with tight wheezes and oxygen saturation levels ranging 83 to 86%. The operating room was ordered be set up immediately. Anesthesiologist #1 said Patient #1 needed to be taken to the OR because of the anesthesia equipment and skilled staff available in the operating room. Anesthesiologist #1 said Pulmonologist #1 was in the ICU and later came to assist in the operating room. Anesthesiologist #1 said Patient #1 was at the point of not being able to breathe. Anesthesiologist #1 said the intubation was successful on the first attempt however, Patient #1' lungs prohibited any pressure applied to Ambu/aerate the lungs. Anesthesiologist #1 said despite the resuscitative efforts the Patient expired.

VIOLATION: *UNSPECIFIED CATEGORY*

Tag No:

Based on record review and staff interview, one of one applicable Patient's (#1) was not provided with the opportunity for prompt intubation and airway support management while in the Intensive Care Unit (ICU). Instead, the ICU staff called the operating room for Anesthesiologist #1 who was not immediately available.

The findings are as follow:

Refer to A-Tag 144.

The President of the Medical Staff was interviewed in person on 02/10/11 at 9 AM. The President of the Medical Staff said Patient #1 should havebeen intubated when the second set of ABG's were drawn at 1:15 PM. The President of the Medical Staff said neither the ED Physician or the Pulmonologist had been interviewed. The President of the Medical Staff said an ED Physician should have been called to intubate Patient #1, if the anesthesiologist was not available.

There was no documented evidence the Hospital had addressed the concerns regarding the medical management and lack at attempt of intubation for Patient #1 in the QA/PI Program.

VIOLATION: *CONTENT OF RECORD - OTHER INFORMATION*

Tag No: A0467

Based on record review, physician and staff interview, Pulmonologist #1, Registered Nurse #3 and Respiratory Therapist #2 failed to adequately document Patient #1' change in medical condition and response to treatment in January 2011.

The findings are as follow:

Registered Nurse #3 documented on 01/31/11 at 5 PM Patient #1's condition was not improving. Registered Nurse #3 called Pulmonologist #1 who reported Patient #1 needed to be intubated.

Patient #1's medical record lacked a physician's assessment at the time of the Patient #1's change in condition. There was no documentation by Pulmonologist #1 that intubation was to be deferred to an anesthesiologist or the reasons why the physician chose to defer the care of Patient #1 to the anesthesiologist.

Pulmonologist #1 was interviewed in person on 02/09/11 at 9:50 Am. Pulmonologist #1 evaluated Patient #1 in the ED. Pulmonologist #1 said Patient #1 had a rapid heart rate of 170's to 180's and a low oxygen saturation level in the mid 90's. Pulmonologist #1 said Patient #1 was alert and conscious however not able to speak. Pulmonologist #1 said Patient #1' ABG's had a low oxygen level and changed to a non-rebreather mask. Pulmonologist #1 said Patient #1 improved and did not need to be intubated. Pulmonologist #1 said intubating Patient #1 would have placed the patient at risk for pneumonia. Pulmonologist #1 said Patient #1's lungs looked fairly good. Pulmonologist #1 said

Patient #1 declined around 4 PM and the heart rate raised. Pulmonologist #1 said it was determined Patient #1 would have an elective intubation but it was not urgent. Pulmonologist #1 decided not to intubate Patient #1 because of a narrow throat and short tongue. There was no documentation of the Patient's oral cavity nor decision not to intubate. Pulmonologist #1 referred Patient #1 to anesthesia for intubation. Pulmonologist #1 said Anesthesiologist #1 came to the ICU and decided to transfer Patient #1 into the operating room. Pulmonologist #1 said the OR was a more controlled environment and the intubation was not urgent. Pulmonologist #1 said Patient #1's oxygen saturation level was 97%. Pulmonologist #1 went to the operating room and assisted Anesthesiologist #1. Pulmonologist #1 said Anesthesiologist #! had no problem passing the endotracheal tube. Pulmonologist #1 said Patient #1 had inflamed airways and a lot
of swelling with thick mucus. Pulmonologist #1 passed a bronchoscope. Pulmonologist #1 said Patient #1 started destating (dropping oxygen levels) and a code was called and despite a lengthy code Patient #1 expired.

Continued review of Patient #1's medical record indicated Anesthesiologist #1 examined Patient #1 on 01/31/11 at 6:20 PM. Anesthesiologist #1 arrived in ICU to assist with an urgent intubation of Patient #1 who was in acute respiratory distress. Anesthesiologist #1 indicated Patient #1's oxygen saturation levels on room air were recorded as 84% on room air and a respiratory rate of 40's. Anesthesiologist #1 indicated Patient #1's tongue was swollen and Patient could not talk. Anesthesiologist #1 indicated Patient #1 was a Mallampati 4 (a nonvisual airway and difficult to intubate. At 6:40 PM, Anesthesiologist #1 indicated Patient needed to be taken to the operating room as an emergency airway case

Anesthesiologist #1 was interviewed in person on 02/09/11 at 12 PM. Anesthesiologist #1 was scheduled for elective surgical cases until the evening of 01/31/11. Anesthesiologist #1 was called by RN #3 regarding a Patient(#1 who needed an airway. Anesthesiologist #1 said the cases were elective and if it had been known that the need to intubate Patient #1 was emergent, the last case in the operating room could have been cancelled.. Anesthesiologist #1 said after arrival into the ICU, Patient #1 was breathing at a rate of 40 to 60 breaths per minute with tight wheezes and oxygen saturation levels ranging 83 to 86%. The operating room was ordered to be set up immediately. Anesthesiologist #1 said Patient #1 needed to be taken to the OR because of the anesthesia equipment and skilled staff available in the operating room. Anesthesiologist #1 said Pulmonologist #1 was in the ICU and later came to assist in the operating room. Anesthesiologist #1 said Patient #1 was at the point of not being able to breathe. Anesthesiologist #1 said the intubation was successful on the first attempt however, Patient #1' lungs prohibited any pressure applied to Ambu/aerate the lungs Anesthesiologist #1 said despite the resuscitative efforts the Patient expired.

Between the hours of 4 PM to 6:20 PM, there was no documentation for Patient #1's response to treatment by either nursing or respiratory services.

VIOLATION: *INTEGRATION OF EMERGENCY SERVICES* **Tag No:** A1103

Based on medical record review, physician and staff interview, Patient #1' emergent intubation was unnecessarily delayed because the anesthesiologist was in the operating room.

Refer to A- Tag 144.

The findings are as follow:

Patient #1, a non-surgical patient required emergent intubation while in the Intensive Care Unit.. Instead Patient #1 was brought into the operating room for intubation.

Registered Nurse #3 documented and said Anesthesiologist #1 was in the operating room with a patient and would arrive at the completion of the surgical case.

There were no other emergent provisions made to ensure Patient #1 was intubated in a timely manner. Instead, Between 4 PM and 6:20 PM, Patient #1' condition changed and there was no documentation Patient #1 was evaluated by a physician.

Anesthesiologist #1 was interviewed in person on 02/09/11 at 12 PM. Anesthesiologist #2 was scheduled for elective surgical cases until the evening of 01/31/11. Anesthesiologist #1 was called by RN #3 regarding Patient #1 who needed an airway. Anesthesiologist #1 said the surgical cases were elective and if it had been known that the need to intubate Patient #1 was emergent the last surgical case in the operating room could have been cancelled. Anesthesiologist #1 said after arrival into the ICU, Patient #1 was breathing at a rate of 40 to 60 breaths per minute with tight wheezes and oxygen saturation levels ranging 83 to 86%.The operating room was ordered to be set up

immediately. Anesthesiologist #1 said Patient #1 needed to be taken to the OR because of the anesthesia equipment and skilled staff available in the operating room. Anesthesiologist #1 said Pulmonologist #1 was in the ICU and later came to assist in the operating room. Anesthesiologist #1 said Patient #1 was at the point of not being able to breathe. Anesthesiologist #1 said the intubation was successful on the first attempt however, Patient #1' lungs prohibited any pressure applied to Ambu/aerate the lungs Anesthesiologist #1 said despite the resuscitative efforts the Patient expired.

There was an unnecessary delay in Patient #1's intubation because there were no emergent provisions implemented for the lack of availability of the anesthesiologist who was in the operating room.

The information below comes from the statement of deficiencies compiled by health inspectors and provided to AHCJ by the Centers for Medicare and Medicaid Services. It does not include the steps the hospital plans to take to fix the problem, known as a plan of correction. For that information, you should contact the hospital, your state health department or CMS. Accessing the document may require you to file a Freedom of Information Request. Information on doing so is available here.

NORWOOD HOSPITAL **800 WASHINGTON STREET NORWOOD, MA 2062** **July 18, 2012**

VIOLATION: *PATIENT RIGHTS* **Tag No:** A0115

Based on documentation review, interviews and observations of Emergency Department (ED) patients, Immediate Jeopardy was determined because the Hospital failed to ensure that:
1.) items posing potential danger to a suicidal patient were removed from 1 of 8 ED behavioral health patients deemed suicidal in accordance with the Hospital's policy/procedure titled "Homicidal/Suicide Precautions in a Non-Psychiatric Setting" resulting in a drug overdose.
2.) 6 of 8 ED behavioral health patients deemed suicidal were supervised in accordance with the Hospital's policy/procedure titled "Homicidal/Suicide Precautions in a Non-Psychiatric Setting".
3.) a physician or other licensed independent practitioner's order was obtained for the application of 1 of 3 ED behavioral health emergency physical restraint applications.
4.) a patient in simultaneous restraint and seclusion (Patient #1) was continually monitored face-to-face or by both video and audio equipment.

Please refer to Tags A-0144, A-0168 and A-0183 for details.

VIOLATION: *PATIENT RIGHTS: CARE IN SAFE SETTING* **Tag No:** A0144

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY

Based on documentation review, interviews and observations of Emergency Department (ED) patients, it was determined that the Hospital failed to ensure that:
1.) items posing potential danger to a suicidal patient were removed from 1 of 8 ED behavioral health patients deemed suicidal (Patient #2) in accordance with the Hospital's policy/procedure titled "Homicidal/Suicide Precautions in a Non-Psychiatric Setting" resulting in a drug overdose.
2.) 6 of 8 ED behavioral health patients deemed suicidal (Patient's #1, #2, #5, #6, #7 and #8) were not supervised in accordance with the Hospital's policy/procedure titled "Homicidal/Suicide Precautions in a Non-Psychiatric Setting".

Findings include:

The Hospital's policy/procedure titled "Homicidal/Suicide Precautions in a Non-Psychiatric Setting" indicated that patients expressing suicidal ideation are to be placed on constant visual observation, within arm's length of a staff member, at all times (including when the patient is in the bathroom). The physician is to order the observation and a psychiatric consultation. The policy/procedure also indicated that items posing a potential danger to the patient were to be removed from the patient and environment.

PATIENT #1:

An Ambulance Trip Report dated 6/23/12 indicated that Emergency Medical Service (EMS) personnel were summoned at 2:30 A.M. because Patient #1 was found intoxicated and with facial trauma by police. Patient #1 was combative and stated that he/she was going to kill himself/herself. Patient #1 was transported to the Hospital's ED.

ED Triage documentation dated 6/23/12 at 3:14 A.M. indicated that Patient #1 was agitated and anxious. Patient #1 answered no when asked if he/she had tried to hurt himself/herself and denied doing so in the past.

A Confidential Patient Observation/Restraint Form dated 6/23/12 indicated that Patient #1 was placed on Observation at 3:15 A.M. by ED Registered Nurse (RN) #1 because Patient #1 exhibited serious suicidal ideation and/or behavior. Documentation on the Form indicated that the observation was to be provided by Security staff and the security officer was to remain outside the room. Patient #1 could use the bathroom but if he/she attempted to leave the ED, he/she was to be physically restrained and ED staff were to be notified. The documentation also indicated that the room was cleared of all possible hazards, Patient #1 was searched and placed in a hospital gown, and Patient #1's belongings were removed from the room and secured.

ED Physician documentation dated 6/23/12 indicated that Patient #1 was evaluated by ED Physician #1 at 3:20 A.M. Patient #1 was awake and angry and indicated that he/she wanted to die. Patient #1 had bruising on the nose and forehead and a small laceration through the right eyebrow. ED Physician #1 ordered diagnostic and treatment interventions and completed an Application for and Authorization of Temporary Involuntary hospitalization (commonly known as a Section 12a; a form that when properly completed mandates an involuntary hospitalization until a formal psychiatric evaluation is completed). The Section 12a Form indicated that Patient #1 was at substantial risk of physical harm secondary to suicidal ideation and impaired judgement.

A review of Patient #1's ED Physician Orders did not evidence an order for a specific type or level of Patient Observation.

ED Physician documentation dated 6/23/12 indicated that Patient #1 was diagnosed with alcohol intoxication, facial fractures and suicidal ideation. Patient #1 was medically cleared for a psychiatric evaluation at 7:00 A.M.

ED Nursing documentation dated 6/23/12 indicated that a clinician from the Contracted Psychiatric Service tried to evaluate Patient #1 sometime prior to 10:30 A.M., but Patient #1 was too sleepy. At 10:30 A.M., Patient #1 asked for his/her underwear and a security officer provided his/her belongings bag. Patient #1 put on underwear and a pair of shorts and proceeded to leave the ED. Patient #1 was ordered to stop, but took flight. Patient #1 was apprehended by a security officer and put in 4-point leather restraints. Patient #1 was evaluated by ED Physician #2 and administered intramuscular Ativan (an anti-anxiety/sedative medication).

Patient #1's 6/23/12 Confidential Patient Observation/Restraint Form was not updated to indicate that he/she was a significant flight risk.

ED Nursing documentation dated 6/23/12 indicated that all of Patient #1's restraints were removed by 11:20 A.M.

A Psychiatric assessment dated [DATE] indicated that Patient #1 was evaluated by the Contracted Psychiatric Service at 12:20 P.M. Patient #1 was cooperative and indicated that he/she wanted to go home. The psychiatric clinician assessed Patient #1 to be at a low risk for suicide and discussed discharge planning with an (un-named) ED physician. The ED physician indicated that he wanted Patient #1 admitted for safety and containment. The Section 12a was continued and an inpatient psychiatric bed search was initiated.

ED Nursing documentation dated 6/23/12 indicated that Patient #1 eloped from the ED at 6:24 P.M. The documentation also indicated that security staff were busy with another behavioral health patient at the time of Patient #1's elopement.

ED Nursing documentation dated 6/23/12 indicated that Patient #1 was located by local police and returned to the ED under a Section 12a at 8:43 P.M. Patient #1 was unharmed.

The Hospital's Risk Manager was interviewed in person on 7/17/12 at 8:20 A.M. The Risk Manager said a Hospital Internal Investigation was conducted regarding Patient #1's 6/23/12 ED care/elopement.

A review of the Hospital Internal Investigation revealed it determined that ED security staff/behavioral health patient ratios were often high and that this made effective constant observation impossible. The Investigation also determined that there were hand-off communication issues related to Patient #1's flight risk. A Corrective Action Plan was not developed/implemented.

The Hospital Internal Investigation did not determine that: a.) Patient #1 was not supervised in accordance with the Hospital's policy/procedure titled "Homicidal/Suicide Precautions in a Non-Psychiatric Setting", b.) ED Physician #1 did not order a specific type or level of observation for Patient #1 and c.) the security officer did not consult with Patient #1's nurse regarding giving Patient #1 his/her belongings bag.

PATIENT #2:

ED Triage documentation dated 6/21/12 indicated that Patient #2 was brought to the ED by EMS personnel and police at 10:59 P.M. because he/she had been drinking alcohol and fell sustaining an ankle injury. The police indicated that Patient #2 may have also been using cocaine and that he/she had texted suicidal messages to a family member. Patient #2 answered no when asked if he/she had tried to hurt himself/herself and denied doing so in the past.

An ED Nursing assessment dated [DATE] indicated that Patient #2 had a history of anxiety and depression.

The ED RN assigned to Patient #2 (ED RN #1) was interviewed in person on 7/17/12 at 3:00 P.M. ED RN #1 said that she questioned Patient #2 about being suicidal and Patient #2 denied suicidal ideation. ED RN #1 said that Patient #2 indicated that he/she was having marital problems and following an altercation with his/her spouse, he/she texted a family member and said something like he/she was ready to kill himself/herself. ED RN #1 said that Patient #2 indicated that he/she was not serious about killing himself/herself and that he/she would never do such a thing as he/she had 3 young children.

ED RN #1 reported getting Patient #2 settled and giving a verbal report regarding Patient #2 to ED RN #2.

Documentation completed by ED Physician #3 on 6/21/12 (time not indicated) indicated that Patient #2's spouse and sibling said that Patient #2 had been exhibiting self-injurious behaviors. ED Physician #3 ordered diagnostic procedures and completed a Section 12a. The Section 12a was timed 11:35 P.M. and indicated that Patient #2 was at substantial risk of physical harm secondary to suicidal ideation.

A review of Patient #2's ED Physician Orders did not evidence an order for a specific type or level of Patient Observation.

Laboratory testing dated 6/22/12 indicated Patient #2 tested positive for cocaine (a narcotic) and benzodiazepines (a class of anti-anxiety/sedative medications).

ED RN #2 was interviewed in person on 7/18/12 at 8:00 A.M. ED RN #2 said that she received a verbal report regarding Patient #2 from ED RN #1 around 11:00 P.M. ED RN #2 said that ED RN #1 indicated Patient #2 arrived in the ED under a Section 12a, in police custody with an ankle injury and possible drug overdose.

ED RN #2 said that shortly after getting report from ED RN #1, she observed Patient #2 standing at the end of his/her stretcher in the Behavioral Health Treatment Area (BHTA), looking like he/she might be getting ready to leave. ED RN #2 reported asking the security officer covering the BHTA (Security Officer #1) if he was watching Patient #2. ED RN #2 said that Security Officer #1 indicated that Patient #2 was not on a Security Watch. ED RN #2 reported informing Security Officer #1 that Patient #2 needed to be on a Security Watch and filling out a Confidential Patient Observation/Restraint Form.

A Confidential Patient Observation/Restraint Form dated 6/22/12 indicated that Patient #2 was placed on Observation at 12:45 A.M. by ED RN #2 because Patient #2 was a significant flight risk. Documentation on the Form indicated that the observation was to be provided by Security staff and the security officer was to remain outside the room. Patient #2 could use the bathroom and was not to be restrained if he/she attempted to leave. The documentation also indicated that the room was cleared of all possible hazards, Patient #2 was searched and placed in a hospital gown, and Patient #2's belongings were removed and secured.

ED RN #2 said that Patient #2 was wearing his/her clothes when she filled out the Confidential Patient Observation/Restraint Form. ED RN #2 said that Security Officer #1 told Patient #2 that he/she needed to change into hospital scrubs. ED RN #2 said that Patient #2 indicated that he/she did not want to change into the scrubs and wanted to talk with his/her spouse. ED RN #2 said the Spouse was in the ED Waiting Room and she summoned him/her for Patient #2.

ED RN #2 said that she completed the 6/22/12 Confidential Patient Observation/Restraint Form without verifying that

Patient #2's belongings were removed and secured. ED RN #2 said that she did this because she thought Patient #2 had arrived on a Section 12a and ED RN #1 had secured the belongings and forgot to document. ED RN #2 also said that she knew Patient #2 was thought to be suicidal and she should have indicated this on the Confidential Patient Observation/Restraint Form.

ED RN #2 said that Patient #2 spoke with his/her spouse twice and then went into the BHTA bathroom to put on scrubs.

Documentation completed by ED RN #2 on 6/22/12 indicated that at 2:15 A.M., a security officer reported that Patient #2 went into the bathroom with a personal bag and shortly after emerging, had slurred speech.

Documentation completed by ED Physician #3 on 6/22/12 indicated that Patient #2's slurred speech was evaluated and determined to be secondary to the ingestion of multiple tablets of Xanax (a benzodiazepine medication) in the bathroom. Emergency treatment interventions were provided. Patient #2 required intubation (the insertion of a tube into the airway to facilitate breathing) and mechanical ventilation (a breathing machine) for respiratory depression. Patient #2 was transferred to the Intensive Care Unit (ICU).

ICU documentation dated 6/23/12 indicated that Patient #2 was extubated (the breathing tube and mechanical ventilation were discontinued) on 6/22/12 and transferred to a General Medical Unit in stable condition on 6/23/12. A Psychiatric Unit transfer was planned.

The Hospital's Risk Manager said a Hospital Internal Investigation was conducted regarding Patient #2's 6/21/12-6/22/12 ED care/overdose.

A review of the Hospital Internal Investigation revealed that it determined that items posing potential danger to a suicidal patient were not removed from Patient #2 and that there were several hand-off communication issues related to Patient #2's care. A Corrective Action Plan was not developed/implemented.

The Hospital Internal Investigation did not determine that Patient #2 was not supervised in accordance with the Hospital's policy/procedure titled "Homicidal/Suicide Precautions in a Non-Psychiatric Setting" and/or that ED Physician #3 did not order a specific type or level of observation for Patient #2.

PATIENTS #5, #6, #7 and #8:

A Tour of the ED conducted on 7/16/12 at 8:15 A.M. revealed a large Department with 25+ treatment areas including a 4-room BHTA along a hallway off the Main ED. BHTA rooms #2 and #4 and the BHTA bathroom were on the left side of the hallway and BHTA rooms #1 and #3 were on the right side. All of the BHTA rooms had doors and were "safe rooms" (rooms without equipment that could be hazardous to impaired or suicidal patients). BHTA rooms #2 and #4 had observation windows. Security Officer #2 was posted in the BHTA. Security Officer #2 was sitting between BHTA rooms #2 and #4, near the BHTA bathroom, facing the Main ED.

Continued tour of the ED revealed there were 5 patients in the BHTA (Patients #3, #4, #5 and #6) and 1 behavioral health patient in the Main ED (Patient #8). One of the patients in the BHTA was on a stretcher in the hallway and the other 4 patients were in BHTA rooms #1-#4.

During the tour of the BHTA, the ED Nurse Manager asked Security Officer #2 if someone was in the bathroom and Security Officer #2 indicated that he did not know.

PATIENT #5:

A Section 12a Form completed on 7/14/12 (not timed) indicated that Patient #5 was at substantial risk of physical harm secondary to suicidal ideation.

A Psychiatric assessment dated [DATE] at 2:30 P.M. indicated that Patient #5 was at high risk for suicide.

During the 7/16/12 ED tour, Patient #5 was observed to be in BHTA room #1. The door to the room was open approximately 2 inches and the room was dark. Patient #5 was not on constant visual observation within arm's length of a staff member. Security Officer #2 could not see Patient #5 from where he was sitting.

PATIENT #6:

A Section 12a Form completed on 7/15/12 at 1:00 P.M. indicated that Patient #6 was at substantial risk of physical harm secondary to suicidal ideation.

A Psychiatric assessment dated [DATE] at 7:21 P.M. indicated that Patient #6 was at high risk for suicide.

During the 7/16/12 ED tour, Patient #6 was observed to be in BHTA room #4. Patient #5 was not on constant visual observation within arm's length of a staff member.

PATIENT #7:

A Section 12a Form completed on 7/15/12 at 4:15 P.M. indicated that Patient #7 was at substantial risk of physical harm secondary to suicidal ideation.

A Psychiatric assessment dated [DATE] at 5:23 P.M. indicated that Patient #7 was at moderate risk for suicide.

During the 7/16/12 ED tour, Patient #7 was observed to be in BHTA room #3. The door to the room was partially closed. Patient #7 was not on constant visual observation within arm's length of a staff member. Security Officer #2 could not see Patient #7 from where he was sitting.

PATIENT #8:

A Section 12a Form completed on 7/16/12 at 1:25 A.M. indicated that Patient #8 was at substantial risk of physical harm secondary to suicidal ideation.

ED physician documentation dated 7/16/12 indicated that a Psychiatric Assessment was ordered for Patient #8.

During the 7/16/12 ED tour, Patient #8 was observed to be in Main ED treatment room #3. The large glass door to the room was closed and the room was darkened. A mental health counselor was sitting in a chair outside of the room and across the hallway. Patient #8 was not on constant visual observation within arm's length of a staff member.

Following the 7/16/12 ED tour, the Surveyors informed the Hospital System's Regional Director of Quality & Patient Safety and the Hospital's Director of Quality of concerns regarding the Hospital Internal Investigations related to Patients #1 and #2 and the monitoring of suicidal patients in the ED. Within a short period of time, all patients deemed suicidal in all non-psychiatric Hospital settings were placed on one-to-one observation within arm's length of the staff member.

VIOLATION: *PATIENT RIGHTS: RESTRAINT OR SECLUSION* **Tag No:** A0168

Based on documentation review, it was determined that the Hospital failed to ensure that a physician or other licensed independent practitioner's order was obtained for the application of 1 of 3 Emergency Department (ED) behavioral health emergency physical restraint applications (related to Patient #1).

Findings include:

Please see Tag A-0144 for information regarding Patient #1.

An Application for and Authorization of Temporary Involuntary hospitalization (commonly known as a Section 12a; a form that when properly completed mandates an involuntary hospitalization until a formal psychiatric evaluation is completed) completed by ED Physician #1 on 6/23/12 at 3:30 A.M. indicated that Patient #1 was at substantial risk of physical harm secondary to suicidal ideation and impaired judgement.

ED Nursing documentation dated 6/23/12 indicated that at 10:30 A.M., Patient #1 asked for his/her underwear and a security officer provided his/her belongings bag. Patient #1 put on underwear and a pair of shorts and proceeded to leave the ED. Patient #1 was ordered to stop, but took flight. Patient #1 was apprehended by a security officer and put in 4-point leather restraints.

A review of Patient #1's ED Physician Orders did not evidence an order for the 4-point leather restraints.

ED Nursing documentation dated 6/23/12 indicated that Patient #1 was evaluated by ED Physician #2 almost immediately after being placed in the 4-point leather restraints.

A review of the Hospital Internal Investigation related to Patient #1's 6/23/12 ED care/elopement revealed that it identified that there was no written physician or other licensed independent practitioner's order for the emergency behavioral health restraints applied to Patient #1 shortly after 10:30 A.M. on 6/23/12. A Corrective Action Plan was not developed/implemented.

VIOLATION: *UNSPECIFIED CATEGORY* **Tag No:**

Based on documentation review, it was determined that the Hospital failed to ensure that a patient in simultaneous restraint and seclusion (Patient #1) was continually monitored face-to-face or by both video and audio equipment.

Findings include:

Please see Tags A-0144 and A-0168 for information regarding Patient #1.

An Application for and Authorization of Temporary Involuntary hospitalization (commonly known as a Section 12a; a form that when properly completed mandates an involuntary hospitalization until a formal psychiatric evaluation is completed) completed by ED Physician #1 on 6/23/12 at 3:30 A.M. indicated that Patient #1 was at substantial risk of physical harm secondary to suicidal ideation and impaired judgement.

Emergency Department (ED) Nursing and Physician Notes, ED Physician Orders, a Restraint Documentation Flow Sheet and a Confidential Patient Observation/Restraint Form dated 6/23/12 indicated that Patient #1 was simultaneously restrained and secluded for 3 periods of time on 6/23/12. The restraint episodes commenced at 3:30 A.M., shortly after 10:30 A.M. and at 8:50 P.M.

ED documentation did not indicate that Patient #1 was on face-to-face (one-to-one) monitoring at any time on 6/23/12.

The information below comes from the statement of deficiencies compiled by health inspectors and provided to AHCJ by the Centers for Medicare and Medicaid Services. It does not include the steps the hospital plans to take to fix the problem, known as a plan of correction. For that information, you should contact the hospital, your state health department or CMS. Accessing the document may require you to file a Freedom of Information Request. Information on doing so is available here.

NORWOOD HOSPITAL **800 WASHINGTON STREET NORWOOD, MA 2062** **Feb. 14, 2012**

VIOLATION: *PATIENT RIGHTS: NOTICE OF RIGHTS* **Tag No:** A0117

Based on review of the Emergency Department Record and staff interview, the Hospital failed to provide an American Sign Language Interpreter on 09/13/10 for Patient #1's Spouse who was deaf.

Findings include:

Background information:

Review of the medical record indicated that Patient #1 was transported to the ED with advanced life support following a motorcycle accident. Cardiopulmonary resuscitation (CPR) was initiated at the scene and continued in the ED without success. Patient #1 expired. Nursing Supervisor #1 was interviewed in person on 02/13/12 from 11:30 A.M. to 11:50 A.M. Nursing Supervisor #1 did not provide an interpreter for Patient #1's Spouse when requested.

Review of the Emergency Medical Service (EMS) Report and the Emergency Department (ED) Record for Patient #1 dated 09/13/10 indicated Patient #1 was found, face down and unresponsive. Patient #1 was without spontaneous respirations and a pulse. Advanced life support was initiated and continued during transport to the ED. Cardiopulmonary Resuscitation efforts continued in the ED without success. Patient #1 died .

1) Nursing Supervisor #1 was interviewed in person on 02/13/12 from 11:30 A.M. to 11:50 A.M. Nursing Supervisor #1 said that she went to the ED to support the family. Nursing Supervisor #1 said Patient #1's Spouse requested to have an interpreter. Nursing Supervisor #1 said Patient #1's Spouse did not want to use the telephone for the deaf. Nursing Supervisor #1 said that she called the interpreter service, but was informed no one was available. Nursing Supervisor #1 did not request the interpreter services on line, according to the Hospital Policy for Interpreter Services, nor did she access the American Sign Language live video interpreter for the Spouse. Nursing Supervisor #1 said that she thought it would be more compassionate to speak to the Spouse herself because the Spouse could read lips. The Nursing Supervisor did not effectively communicate with Patient #1's Spouse. The Nursing Supervisor denied Patient #1's Spouse a request to have an interpreter during a critical need. The Nursing Supervisor denied Patient #1's Spouse the right and opportunity to understand the severity of Patient #1's injuries and death.

VIOLATION: *PATIENT RIGHTS: NOTICE OF GRIEVANCE DECISION* **Tag No:** A0123

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY

Based on review of documentation, interviews and review of the Complaint file, the Hospital failed to provide the Complainant with a written notice of the results of the investigation which addressed the essence of the complaint.

Findings include:

The Patient Advocate was interviewed in person on 02/13/12 from 11:52 P.M. to 12:15 P.M. The Patient Advocate said that a complaint was filed with the hospital on [DATE] about the interpreter services not being provided to Patient #1. However, review of the ED record indicated that Patient #1 was unresponsive and continuous resuscitation was being provided. Review of the Complaint file indicated that the complaint letter was filed through a telephone service for the deaf in an email format. The message was unclear in that the Spouse/Complainant was "looking for a report/document on a deaf patient." Clarification was sought and the response was: "for the interpreter that was used on 9/13/10." Further emails addressed a plan to meet with the Spouse/Complainant with a Sign Language Interpreter present, but the meeting was declined. The Spouse responded in an email indicating that she did not want to have a meeting, "all I'm asking is did the ER requested an American Sign interpreter the date of September 13, 2010."

Review of the complaint file indicated that the Patient Advocate was persistent in attempting to contact the Spouse. The Patient Advocate sent seven e-mails from 11/16/11 to 11/22/11 to the Spouse. Despite many efforts made to have contact with the Spouse, meetings were declined. The essence of the complaint was never clarified, an assumption was made that the complaint was about Patient #1 not being provided with an interpreter. Based on Patient #1's unresponsive condition and ultimate death, Patient #1 was not able to communicate.

Review of the Hospital's Complaint Response Letter dated 12/09/11 indicated an interpreter was not provided to Patient #1 because of Patient #1's medical condition and inability to communicate. The letter never answered the Spouses question about the request for an American Sign Language Interpreter. Despite ongoing challenges in communicating with the Spouse, the essence of the complaint, the Spouse never being provided with an interpreter as requested, was never addressed. The investigation also did not include the fact that Nursing Supervisor #1 did not follow hospital procedure in providing the Spouse with an American Sign Language Interpreter when requested. According to interview with the Surveyor, Nursing Supervisor #1 assumed that the Spouse could read her lips and understand the circumstances that lead to Patient #1's death.

The information below comes from the statement of deficiencies compiled by health inspectors and provided to AHCJ by the Centers for Medicare and Medicaid Services. It does not include the steps the hospital plans to take to fix the problem, known as a plan of correction. For that information, you should contact the hospital, your state health department or CMS. Accessing the document may require you to file a Freedom of Information Request. Information on doing so is available here.

NORWOOD HOSPITAL **800 WASHINGTON STREET NORWOOD, MA 2062** **March 30, 2011**

VIOLATION: *RN SUPERVISION OF NURSING CARE* **Tag No:** A0395

Based on interview and documentation review, it was determined that Labor and delivery nursing staff failed to consistently assess a woman's labor pain according to Hospital Policy and procedure in 7 (#1, #2, #5, #6, #7, #8, #9) of 10 records reviewed.

Findings include:

1) Review of the Labor Delivery (LD)-Flow sheet of Patient #1 with the Nurse Manager indicated that on 3/9/11 at 5:22 AM Patient #1 requested pain medication. However, there was no assessment or documentation to indicate the intensity of the labor pain, medication administered, or the response to the pain medication.

Review of policies and procedures related to the obstetrical patient indicated a labor pain and coping assessment shall be performed initially on admission using the Labor Pain Coping Scale (LPCS) and subsequent assessments to be documented every hour as patient condition warrants; and document interventions and response to interventions.

The Nurse Manager of the Maternity Center was interviewed in person on 3/28/11 at 8:40 AM. The Nurse Manager said the Maternity Nursing staff were expected to assess the labor patient's pain, response to medications and document the assessment in the medical record.

2) Patient #2 had her labor pain assessed using the Labor Pain Coping Scale on 3/16/11 at 6:22 AM. Review of Patient #2's record indicated no further LPCS assessments were documented.

3) Patient #5 had no LPCS documented on 3/7/11. Nursing documentation at 11:41 Am indicated anesthesia was called for epidural placement.

4) Patient #6 had no LPCS documented on 3/4/11. Nursing documentation at 1:55 AM indicated an epidural catheter was placed.

5) Patient #7 had no LPCS documented on 2/28/11. Nursing documentation at 2:10 PM indicated an epidural catheter was placed.

6) Patient #8 had no LPCS documented on 2/28/11. Nursing documentation at 7:00 PM indicated an epidural catheter was placed.

7) Patient #9 had no LPCS documented on 2/22/11. Nursing documentation at 8:52 AM indicated an epidural catheter was placed.

VIOLATION: *UNSPECIFIED CATEGORY* **Tag No:**

Based on interview and documentation review it was determined the Hospital failed to ensure the data collected for the monitoring of the effectiveness and quality of care provided as relates to anesthesia administration.

Findings included:

1) Data and analysis documentation collected for November 2010-February 2011 was reviewed. The only data reviewed and analyzed was related to the provider of anesthesia and the number of cases. There was no documentation in Department of Anesthesia Quality Improvement Meeting Minutes that demonstrated adequate comprehensive analysis is performed to ensure that appropriate quality anesthesia services is reviewed.

2) The Chief of Anesthesia was interviewed in person on 3/28/11 at 12:00. PM. The Chief said that monthly department meetings are held to review cases.

Review of Department Meetings from November 3, 2010 to February 9, 2011 indicated that the meeting minutes did not consistently indicate that quality assessment was performed on cases where anesthesia was provided in the Hospital to evaluate the appropriateness of anesthesia care and service.

VIOLATION: *OUTPATIENT POST-ANESTHESIA EVALUATION* **Tag No:** A1005

Based on medical record review, interviews, and review of policies and procedures, the facility failed to ensure a post anesthesia evaluation was completed and documented by an individual qualified to administer anesthesia, for nine (#1, #3, #4, #5, #6, #7, #8, #9, #10) of 10 patients' records reviewed.

Findings include:

1) Review of 10 patient records indicated all but Patient #2 had epidural anesthesia for a C-section. Patient #2 had spinal anesthesia.

2) Review of patient records #1, #4, #9 and #10 indicated no post anesthesia was performed and the forms were blank.

3) Review of patient records #3, #5, #6 and #8 indicated a post-operative assessment was performed, however, only a checked box with an x was marked to indicate no post-operative complications.

4) The anesthesia department staff member signatures on #3 and #6 were illegible.

5) Review of a copy of the Department of Anesthesia's policy for post-anesthesia evaluation, indicated the standards were based on policies and procedures that were lasted amended on October 24, 2004. The Guidelines for Regional Anesthesia in Obstetrics was last reviewed and amended on October 18, 2000.

6) The policies and procedures indicated that post-operative visits will be performed on all in-house patients receiving anesthesia. The post operative written note is to be placed on the back of the pre-operative evaluation. However, the policies and procedure did not include the elements of an adequate post-anesthesia evaluation such as an assessment of: respiratory function, including respiratory rate, airway patency and oxygen saturation; cardiovascular function, including pulse rate and blood pressure; mental status; temperature; pain; nausea and vomiting; and postoperative hydration as recommended by the American Society of Anesthesiologists for routine post-anesthesia assessment.

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NORWOOD HOSPITAL **800 WASHINGTON STREET NORWOOD, MA 2062** **March 30, 2011**

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Findings include:

1) Review of the Labor Delivery (LD)-Flow sheet of Patient #1 with the Nurse Manager indicated that on 3/9/11 at 5:22 AM Patient #1 requested pain medication. However, there was no assessment or documentation to indicate the intensity of the labor pain, medication administered, or the response to the pain medication.

Review of policies and procedures related to the obstetrical patient indicated a labor pain and coping assessment shall be performed initially on admission using the Labor Pain Coping Scale (LPCS) and subsequent assessments to be documented every hour as patient condition warrants; and document interventions and response to interventions.

The Nurse Manager of the Maternity Center was interviewed in person on 3/28/11 at 8:40 AM. The Nurse Manager said the Maternity Nursing staff were expected to assess the labor patient's pain, response to medications and document the assessment in the medical record.

2) Patient #2 had her labor pain assessed using the Labor Pain Coping Scale on 3/16/11 at 6:22 AM. Review of Patient #2's record indicated no further LPCS assessments were documented.

3) Patient #5 had no LPCS documented on 3/7/11. Nursing documentation at 11:41 Am indicated anesthesia was called for epidural placement.

4) Patient #6 had no LPCS documented on 3/4/11. Nursing documentation at 1:55 AM indicated an epidural catheter was placed.

5) Patient #7 had no LPCS documented on 2/28/11. Nursing documentation at 2:10 PM indicated an epidural catheter was placed.

6) Patient #8 had no LPCS documented on 2/28/11. Nursing documentation at 7:00 PM indicated an epidural catheter was placed.

7) Patient #9 had no LPCS documented on 2/22/11. Nursing documentation at 8:52 AM indicated an epidural catheter was placed.

VIOLATION: *UNSPECIFIED CATEGORY* **Tag No:**

Based on interview and documentation review it was determined the Hospital failed to ensure the data collected for the monitoring of the effectiveness and quality of care provided as relates to anesthesia administration.

Findings included:

1) Data and analysis documentation collected for November 2010-February 2011 was reviewed. The only data reviewed and analyzed was related to the provider of anesthesia and the number of cases. There was no documentation in Department of Anesthesia Quality Improvement Meeting Minutes that demonstrated adequate comprehensive analysis is performed to ensure that appropriate quality anesthesia services is reviewed.

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Review of Department Meetings from November 3, 2010 to February 9, 2011 indicated that the meeting minutes did not consistently indicate that quality assessment was performed on cases where anesthesia was provided in the Hospital to evaluate the appropriateness of anesthesia care and service.

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Based on medical record review, interviews, and review of policies and procedures, the facility failed to ensure a post anesthesia evaluation was completed and documented by an individual qualified to administer anesthesia, for nine (#1, #3, #4, #5, #6, #7, #8, #9, #10) of 10 patients' records reviewed.

Findings include:

1) Review of 10 patient records indicated all but Patient #2 had epidural anesthesia for a C-section. Patient #2 had spinal anesthesia.

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4) The anesthesia department staff member signatures on #3 and #6 were illegible.

5) Review of a copy of the Department of Anesthesia's policy for post-anesthesia evaluation, indicated the standards were based on policies and procedures that were lasted amended on October 24, 2004. The Guidelines for Regional Anesthesia in Obstetrics was last reviewed and amended on October 18, 2000.

6) The policies and procedures indicated that post-operative visits will be performed on all in-house patients receiving anesthesia. The post operative written note is to be placed on the back of the pre-operative evaluation. However, the policies and procedure did not include the elements of an adequate post-anesthesia evaluation such as an assessment of: respiratory function, including respiratory rate, airway patency and oxygen saturation; cardiovascular function, including pulse rate and blood pressure; mental status; temperature; pain; nausea and vomiting; and postoperative hydration as recommended by the American Society of Anesthesiologists for routine post-anesthesia assessment.

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NORWOOD HOSPITAL **800 WASHINGTON STREET NORWOOD, MA 2062** **March 8, 2011**

VIOLATION: *COMPLIANCE WITH LAWS* **Tag No:** A0021

Based on interview and documentation review it was determined the Hospital failed to ensure all disposal of protected health information (PHI) was performed in a manner to ensure compliance with Federal laws.
Findings included:
The Director of Environmental Services said the landfill staff ripped open the clear plastic trash bags and had sent pictures of the bag's contents to the Hospital.

Review of the pictures provided to the Hospital by the landfill indicated two 100 milliliter IV bags were found by the Landfill staff. Labels were affixed to the bags and printed on the labels was protected health information (the Patient's name, medical record number, dates and medication infused in the IV solution).

The Infection Control Manager (Manager) was interviewed in person on 2/22/11. The Manager said the IV bags had been appropriately discarded in the regular trash.

The Hospital Policy titled Safeguard and Management of Protected Health Information for Disposal of Protected Health Information (PHI) was reviewed. The Policy stated all hospital medical staff, employees, volunteers and students safeguard protected health information by ensuring appropriate disposal of all hard copy documentation containing protected health information. Documents containing PHI will be either shredded or placed in a locked confidential containers. All Hospital medical staff, employees, volunteers and students will be responsible for the disposal of any documentation that contains PHI.

The Hospital Policy titled Protecting Patient Privacy was reviewed. The Policy stated PHI is any information which identifies an individual and the provision of health care to the individual. The Policy listed information that identifies an individual. This information included but was not limited to: Name, service dates, and medical record number. The section that addressed disposing of PHI stated Personnel must dispose of paper PHI by shredding or placing in locked recycle bin. The Policy did not address how labels affixed to IV bags or other items, that were labeled with PHI, during the course of an individuals stay as a patient at the Hospital, would be disposed of.

VIOLATION: *PATIENT RIGHTS: PERSONAL PRIVACY* **Tag No:** A0143

Based on interview and documentation review it was determined the Hospital failed to ensure the method utilized for the final disposal of used supplies that included patients' individually identifiable health information was effective and in compliance with Standards for Privacy related to protected health information.

Findings included:

Refer to Tag # A-021

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QUINCY MEDICAL CENTER **114 WHITWELL STREET QUINCY, MA 2169** **Dec. 21, 2011**

VIOLATION: *INFECTION CONTROL OFFICER(S)* **Tag No:** A0748

Based on observations and staff interviews, the Hospital Infection Control Officer failed to consistently enforce hospital policies that governed the control and prevention of infection. Specifically, implementation of policies for cleaning and storage of patient equipment.

Findings included:

Observations of the Operating Room (OR) Suite, and interviews with the Director of Perioperative Services at 9:20 A.M. and 10:30 A.M. on 12/19/2011, revealed two areas [the OR corridor and Post -Anesthesia Care Unit (PACU)] in which supplies and equipment were stored in a manner that created a risk for cross-contamination and patient safety, as follows:

A. Observation of the OR corridor revealed approximately nine pieces of large equipment (e.g., video towers - equipment used during endoscopic procedures, stored in the high traffic corridor. The stored equipment reduced the accessible width of the corridor from approximately nine feet to five feet, making it difficult for staff to safely navigate the corridor with patients on stretchers, and increased the risk of cross-contamination of the equipment from staff, patients and visitors utilizing the corridor. Interview with the Director of Perioperative Services revealed that the corridor was not the best place to store the equipment.

B. Observations in the PACU at approximately 10:30 A.M. revealed the following:

1). The negative pressure isolation room was cluttered with: three metal file cabinets that measured approximately three feet high, one foot wide and 2.5 feet deep; three patient walkers; one wheelchair, two recliner chairs; one over-riding table; one precautions cart; three boxes of printer paper; two linen hampers, and one poster that measured approximately three and one half feet by two feet. The precautions cart contained a machine used to monitor patients' blood pressure and pulse, and a device that monitored patients' blood oxygen levels. Both pieces of equipment were dirty with built-up layers of dust. The top of the cart was also dirty with built-up layers of dust and small particles of white paper. Additionally, the ceiling vent was dirty with built-up layers of dust. The floor was dirty with dust and debris.

2). Observation of the Phase 2 Recovery Area (where patients awaiting discharge were located), revealed the vinyl fabric on the backs of eight recliner chairs was ripped and had been repaired with duct tape. The arms of the chairs had holes that exposed the chair stuffing. Tape residue was also observed where the holes had been covered with tape and then the tape removed. The chairs could not be effectively disinfected due to the poor condition of the chairs, increasing the risk of cross-contamination.

VIOLATION: *INFECTION CONTROL OFFICER RESPONSIBILITIES* **Tag No:** A0749

Based on observations, staff interviews, and review of hospital policies, procedures, cleaning schedules, patient medical records and employee health records, the Infection Control Coordinator (ICO) developed a system for identifying, reporting, investigating, and controlling infections. However, the Hospital failed to ensure that staff consistently implemented hospital infection control protocols for 7 of 14 sampled patients (#3, #4, #5, #6, #8, #9, #13). Specifically, non-compliance with protocols and standards for sterilization and disinfection, medication administration, use of personal protective equipment, aseptic technique (a method used to prevent contamination), hand hygiene, waste management, ventilator associated pneumonia and device related prevention activities, and infection prevention in the environment of care. Findings included:

A. Observations in the Operating Room (OR) Suite between 9:20 A.M. and 12:45 P.M. on 12/19/11, revealed the following:

In the Pre-Operative Holding Area at 11:20 A.M. on 12/19/11, RN #5 punctured the patient's finger to obtain a blood specimen for testing on Patient #3. The RN failed to perform hand hygiene prior to donning a pair of clean gloves and obtaining the blood specimen, although required by Hospital policy.

B. Observations in the reprocessing area of the OR at 10:00 A.M. on 12/19/11, revealed a tray for disinfecting flexible endoscopes (i.e. ureteroscopes) stored directly on the floor. Interview with Certified Surgical Technician (CST) #2, during the observation, revealed that the tray should have been stored on the shelf and not on the floor. The CST removed the tray from the floor and placed it on a shelf. However, the CST did not disinfect the tray after it had been on the floor, increasing the risk of cross-contamination.

Additionally, observations also revealed an open container of sterilizer testing strips used to ensure the disinfection process. The container lacked the date it was opened and an expiration date. CST #2 said that the strips expired six months after they were opened. The CST also said that Hospital policy required the container to be labeled with the date it was opened and the date it expired, and since the container was not labeled, there was no way to determine if the strips were safe to use.

C. Observations in the sub-sterile room that serviced OR #8, at 10:30 A.M. on 12/19/2011, revealed two containers of sterilizer testing strips (#1, #2). Container #1 lacked the date the container was opened and an expiration date. Container #2, was labeled with the date the container was opened (7/19/11), and an expiration date (1/9/12). The container of strips that was dated (Container #2), in accordance with Hospital policy, was full. The container of strips that was not dated (Container #1), was almost empty. Interview with the Nurse Manager of Perioperative Services during the observation, revealed that staff had been using the strips from Container #1, the container that had not been labeled. Since the container was not dated, there was no way to determine if the unlabeled container of strips was outdated and would accurately reflect test results.

D. Observations in OR #2, between 11:30 A.M. and 12:10 P.M. on 12/19/11, during the surgical procedure for Patient #3, revealed the following:

1. At 11:45 A.M., Anesthesia Technician #1, entered the OR with a surgical mask that was not adequately secured. The Anesthesia Technician failed to tie the mask around his neck. During the observation, the Nurse Manager of Perioperative Services said that OR policy required masks to be securely tied around the necks and heads of OR staff, when in OR procedure rooms. The Anesthesia Tech failed to adhere to the OR policy.

2. At 11:50 A.M., RN #3 left OR #2 to obtain additional supplies. The RN did not perform hand hygiene prior to leaving or prior to re-entering the room. Interview with the Nurse Manager of Perioperative Services at approximately 12:30 P.M. on 12/19/11, revealed that Hospital policy required staff to perform hand hygiene when leaving and entering an OR.

3. At approximately 12:00 P.M., RN #3 handled blood soaked sponges with gloved hands, to perform a sponge count. After glove removal, the RN failed to perform hand hygiene. With contaminated hands, the RN delivered sterile gauze packing and dressing sponges to the sterile, surgical field, and touched the computer keyboard to document in the patient's electronic medical record, increasing the risk of cross-contamination.

E. Observations in the Post-Anesthesia Care Unit (PACU) at 12:10 P.M. on 12/19/11, revealed that a thermometer (used to take patients' temperatures) fell on the floor. Anesthesiologist #1 picked it up from the floor and placed it on patient #3's bed, without first disinfecting the thermometer. RN #4 used the thermometer that had fallen on the floor and was now contaminated, to take Patient #3's temperature. The RN failed to disinfect the thermometer prior to use and prior to returning the thermometer to the thermometer holder.

F. Observations of a spinal injection procedure for Patient #8, in the Pain Clinic from 2:00 P.M. to 2:30 P.M. on

12/19/11 revealed the following:

1. Upon entering the procedure room, multidose vials of the medications Lidocaine (a topical anesthetic) and Kenalog (an antibiotic) were observed on the bedside table. Observation revealed that Anesthesiologist #2 drew each medication into separate syringes at the bedside of Patient #8. Anesthesiologist #2 said that he had used medication from the vials for the previous patient and he would use medication from the same vial for other patients because they were multidose vials and he used a new needle and syringe with each patient. According to CDC (Center for Disease Control) Standards of Infection Control, injectable medications, in multidose vials, brought to a patient's bedside, must be used for only that patient.

Additionally, Anesthesiologist #2 failed to perform hand hygiene prior to donning the sterile gloves used to perform the spinal injection.

2. After cleansing the patient's back, RN #12 removed her gloves. However, the RN failed to perform hand hygiene after glove removal. The RN also failed to perform hand hygiene after helping Patient #8 put on both shoes and prior to handling the patient's chart.

3. Interview with Corporate Quality Consultant #1, at approximately 2:30 P.M. on 12/19/11, revealed that both Anesthesiologist #2 and RN #12 failed to adhere to the Hospital's infection control policies for hand hygiene and use of multidose medication vials, increasing the risk of cross-contamination.

G. Observations in the Central Processing Department (CPD) at 3:30 P.M. on 12/19/2011, revealed that the inside of the ultrasonic machine (used to remove debris from surgical instruments by sonic waves) was dirty with a gritty substance and the cover of the ultrasonic machine was stored directly on the floor next to the machine. During the observation, the CPD Supervisor said that the ultrasonic machine looked like it had not been cleaned the previous night and that the machine cover should have been stored on the machine, not the floor. The CPD Supervisor removed the cover from the floor and placed it on top of the ultrasonic machine, without first disinfecting the cover.

H. Observations of a colonoscopy (a procedure to examine portions of the intestines using a flexible tube passed through the anus) in the Endoscopy Suite for Patient #9, from 8:50 A.M. to 10:00 A.M. on 12/20/11, revealed the following:

1. Observations at 8:50 A.M., revealed that while disinfecting the video cart (used to set-up the colonoscopy equipment), Endoscopy Technician (ET) #1 removed the contaminated specimen holder, containing six containers of specimens from the previous patient, and placed it on top of a box of clean gloves. ET #1 failed to remove the box of gloves contaminated by the specimen holder from the disinfected video cart, until Surveyor intervention.

2. Observations at 9:05 A.M. revealed that Physician #1 failed to perform hand hygiene prior to donning clean gloves, to perform the patient's colonoscopy. After completing the procedure, Physician #1 removed the contaminated gloves and picked up the contaminated specimen holder from the video cart without first performing hand hygiene and donning a pair of gloves. The Physician then placed the contaminated specimen holder on the procedure room desk. Physician #1, then handled and labeled each specimen container, without wearing gloves. After labeling the specimens, the physician failed to perform hand hygiene.

I. Observations of the insertion of a central venous catheter (CVC) and an indwelling urinary catheter, for Patient #13 [a patient diagnosed with Methicillin Resistant Staphylococcus Aureus (MRSA)], in OR #7, between 8:45 A.M. and 10:30 A.M. on 12/21/11, revealed the following:

1. At 8:45 A.M., RN #15 donned sterile gloves in order to verify the safe function of the urinary catheter balloon. The RN failed to perform hand hygiene prior to donning sterile gloves, although required by the Hospital's Infection Control Policy.

2. The RN dropped the patient safety strap on the floor and failed to disinfect the strap prior to placing it back on the OR table. Interview with the Director of Perioperative Services during the observation, revealed Hospital policy required the strap to be disinfected if contaminated, e.g., in contact with the floor.

3. RN #15 left and re-entered OR #7, on two occasions. Both times the RN failed to perform hand hygiene upon exiting and re-entering the OR. Prior to inserting the patient's indwelling urinary catheter, the RN donned sterile gloves without first performing hand hygiene. Additionally, the RN failed to perform hand hygiene after glove removal. Interview with the Director of Perioperative Services during the observation, revealed Hospital policy required hand hygiene to be performed prior to donning and after removal of gloves.

4. Observation of the insertion of a CVC at 9:55 A.M., revealed that Anesthesiologist #1 failed to use a sterile drape that covered the full body and head of the patient, as required by CDC, Guidelines for the Prevention of Intravascular Catheter-Related Infections, 2011. The Anesthesiologist only applied the sterile drape from Patient #13's waist to, and covering, the patient's head.

J. After several requests for the schedules of routine preventative maintenance of the CPD sterilizers, and the Endoscopy high level disinfection machines, on 12/19, 12/20, and 12/21/11, the Hospital was unable to provide documentation of the maintenance.

K. The hospital failed to structure their respiratory protection program to comply with the Occupational Safety and Health Administration (OSHA) general industry standard for respiratory protection for healthcare workers.
Findings include:

Review of the written hospital policy entitled "TB Exposure Plan," revealed that the requirements for the Respiratory Protection Team did not meet the OSHA standard, i.e., annual fit testing (a procedure to ensure correct fit of an employee's respirator/mask). Instead of an annual fit test for all members of the respiratory protection team as required by OSHA, the hospital performed an annual respirator evaluation questionnaire. According to interview with the Employee Health Nurse, new employees were fit tested upon hire and annually would answer questions related to any facial changes (i.e. weight gain or facial surgery). Review of employee health records on 12/19/11 indicated 6 of 6 nursing personnel had not received annual fit testing as required by OSHA.

L. The Hospital failed to ensure that a high level disinfection (HLD) process (a cleaning process that should destroy all microorganisms, except for bacterial spores) was used to reprocess semi-critical items (items that contact mucous membranes or non-intact skin) in the Ultrasound Department.
Findings include:

Interview with the Director of Ultrasound on 12/21/11 at 3:20 P.M. and review of the hospital policy entitled "Transvaginal Sonographic Probe Cleaning and Disinfection" indicated the vaginal probe was cleaned with bleach. Bleach solution is not a Federal Drug Administration (FDA) approved high level disinfectant. According to the Director of Ultrasound, he was aware that the probe required HLD, however, he had not identified a space in the department to accommodate HLD processing.

M. The hospital failed to consistently comply with Infection Prevention standards for the prevention of Ventilator Associated Pneumonia (VAP).
Findings include:

To prevent aspiration of secretions or tube feedings, a patient undergoing mechanical ventilation is to be positioned in the semi-recumbent position (head of bed [HOB] at 30-45 degree elevation). The degree of elevation is to be measured, documented and validated regularly. Observations and interviews with Registered Nurse (RN #8) in the Intensive Care Unit (ICU) on 12/20/11 between 9:20 A.M. and 11:00 A.M., revealed the Patient #6 was positioned at less than a 30 degree elevation.

According to RN #8 Patient #6 was in an older bed that lacked an HOB measurement device and therefore the HOB measurement was estimated. However, the ICU Nurse Manager was able to identify the measurement device on the bed, and it indicated a position below 30 degrees.

N. The hospital failed to minimize the risk of cross contamination during fingerstick blood sugar (FSBS) testing procedures.
Findings include:

1. Observation on the A 3 medical/surgical unit on 12/19/11 between 11:30 A.M. and 12 Noon, revealed four glucometer cases each containing two liquid "controls" (performance tests that are conducted on the glucometer [device to monitor blood sugar] to ensure that it is functioning properly.) According to the manufacturer's directions for use, the controls expire three months after opening. However, 6 of the 8 opened controls were not dated, therefore, the effectiveness of the control solution could not be assured.

2. Observation of Nurse Technician (NT #1) on the A 3 unit at 11:35 A.M., revealed NT #1 brought the glucometer case into the patient's room (containing the meter, test strips, finger lancets, alcohol swabs, gauze, and band-aids.)

The case was placed on the patient's overbed table. After direct contact with the patient, NT #1 reached back into glucometer case to retrieve additional clean supplies to complete the procedure, increasing the risk of cross-contamination between patients. The case was returned to the storage area for future use.

O. The hospital failed to monitor the airborne infection isolation room (AIIR) according to an acceptable standard of safety.
Findings include:

Observation in the Intensive Care Unit (ICU) on 12/20/11 between 9:20 A.M. and 11:00 A.M., revealed an AIIR room. Observation in the AIIR room, the ante-room and interview with the ICU Nurse Manager revealed a visual air pressure monitor was not in place to indicate the negative pressure status of the room. According to the Nurse Manager, prior to the admission of a patient requiring an AIIR, the room was checked by the facilities department personnel, using a smoke tube, to ensure the room was in negative pressure. However, ongoing monitoring was not provided to ensure negative pressure was maintained while the room was occupied by a patient requiring airborne isolation.

P. The hospital failed to consistently comply with Infection Prevention standards for the prevention of device-related infections (i.e. central lines, indwelling urinary catheters) by documenting the indications for use, and an ongoing review for the necessity of these devices.
Findings include:

1. Review of Patient #6's record, on 12/20/11, indicated the patient had a central line in place. A central line is a tube that is placed into a large vein of a patient, usually in the neck, chest, arm or groin. A central line provides direct access to administer fluids, medication, withdraw blood, and monitor the patient's condition. However, according to the CDC, Guidelines for the Prevention of Intravascular Catheter-Related Infections, 2011, of an estimated 248,000 bloodstream infections that occur in U.S. hospitals each year, a large proportion of these are associated with the presence of a central line. Therefore, prompt removal of the central line is an important approach to the prevention of central line associated bloodstream infection (CLABSI). According to review of the record of Patient #6, there was no indication of ongoing review to determine the continued necessity of the central line.

2. Review of the medical records of Patient #4 and #5 on 12/20/11 indicated both patients had an indwelling urinary catheter device in place. According to the CDC Guideline for the Prevention of Catheter-Associated Urinary Tract infections 2009, to identify and remove catheters that are no longer needed (e.g., daily review of their continued need) has demonstrated effectiveness in reducing infections. According to review of the patients' records there was no indication of ongoing review for the continued necessity of the indwelling urinary catheters.

Q. According to 105 CMR 480.100 (B) and 480.100 (C)(1), all areas for on-site storage of containers of medical or biological waste, shall be in a room or area used exclusively for waste storage and be designed to prevent unauthorized access.
Findings include:

Based on observation and staff interview, the Hospital failed to ensure the Biohazard Waste Storage Room was used exclusively for waste storage.

Observation in the Biohazard Waste Storage Room and interview with the Director of Facilities, revealed biohazard waste was stored in an area that was not used exclusively for waste storage. The room was used as a soiled laundry storage area.

R. The hospital failed to provide education to the Health Care Worker (HCW) in accordance with the Occupational Safety and Health Administration (OSHA) Bloodborne Pathogen standard.
Findings include:

According to provision 1910.1030(g)(2)(ii)(A) and 1910.1030(g)(2)(ii)(B), HCW's receive training "at the time of initial assignment to tasks where occupational exposure may take place; and at least annually thereafter". Review of employee files on 12/20/2011 indicated nine of nine employee files lacked evidence that they had completed Bloodborne Pathogen training in 2011.

S. The hospital failed to consistently meet the standard of care for transport of soiled equipment.

1) Observations in the Operating Room (OR) on 12/20/2011 at 7:40 AM included a Transesophageal Echocardiography (TEE) procedure in OR Room 6. (The TEE probe is a long flexible instrument with an ultrasound

sensor located at the tip. The probe is passed through the patient's mouth, down the back of the throat, and into the esophagus and stomach. This allows viewing of the patient's heart and valves through ultrasound images.) According to the Echocardiogram Technician (ET #1), the TEE probe is stored in a clean storage closet in the Ambulatory Care area. On observation, it was noted that the TEE probe was placed in a container lined with a clear plastic bag. At the completion of the procedure, the soiled TEE probe was returned to the container and covered with the same clear plastic bag. The probe was then returned to the decontamination room in the Ambulatory Care area. According to ET #1, the process described was the routine procedure for transporting soiled scopes.

2) According to the Occupational Safety and Health Administration (OSHA) regulations,1910.1030(g)(1)(A), warning labels shall be affixed to containers used to store, transport or ship blood or other potentially infectious materials. The soiled TEE probe was not transported in a manner that would comply with OSHA requirements, nor was a visual warning label affixed to the container (i.e., biohazard label or red bag), to reduce the risk of exposure to employees or patients to equipment that has not been disinfected.

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QUINCY MEDICAL CENTER **114 WHITWELL STREET QUINCY, MA 2169** **June 9, 2011**

VIOLATION: *PATIENT RIGHTS: CARE IN SAFE SETTING* **Tag No:** A0144

Based on interview and documentation review it was determined the Hospital failed to ensure a safe care setting was provided/maintained in the ED for all patient placed on a safety watch.

Findings included:

Review of Patient #1's clinical record indicated Patient #1 presented on the right wrist and admitted to wanting to commit suicide/do self harm. A safety watch was initiated per Hospital policy.

The ED Guidelines that addressed performing safety watches in the ED was review. The Guidelines stated patients who are placed on safety watch for suicidal ideation shall have constant surveillance while in the psychiatric area.

Review of hospital documentation indicated the registered nurse assigned to the area left to obtain medications and left the security officer to watch both rooms, a total of 6 patients. When Security Officer #2 relieved Security Officer #1, a walk through of room 10 was performed to check patients. Security Officer #2 upon entering room 10 heard gurgling sounds coming from one of the beds and witnessed Patient #1 struggling to breathe. Upon closer inspection it was discovered Patient #1 had wrapped pieces of blanket around his/her neck and tied the length of blanket to the back of the bed. The pieced of blanket was removed from Patient #1's neck and an examination by a physician found no ill effects from the attempted suicide.

Documentation indicated an internal investigation was performed. Changes that was put into place as a result of this review included a policy change to ensure that an additional nurse be dispatched to cover the nurse obtaining medications.

The Nurse Manager of the ED was interviewed in person on 6/6/11 at 1:10 PM and throughout the Survey. She said patients with psychiatric issues were placed in either room nine or room ten in the ED. Both rooms can have as many as 4 patient in each. Prior to this incident on 4/5/11, the area was staffed with one security officer, one registered nurse and one nursing technician. Since this incident, the area, when there is more than 6 patients, is now staffed with two registered nurses, two security officers and two nursing technicians.

Review of policies that addressed safety watches in the ED did not indicate a change had been made to the policy as identified in the May 2011 verbal report given to DPH.

The Nurse Manager of the ED said the policy had not been revised to reflect the staffing changes.

VIOLATION: *UNSPECIFIED CATEGORY* **Tag No:**

Based on interview and documentation review it was determined the Hospital failed to ensure the prompt

implementation of preventive actions related to maintaining a safety watch in the ED.

Findings included:

Refer to Tag # A-0144

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SAINT ANNE'S HOSPITAL **795 MIDDLE STREET FALL RIVER, MA 2721** **April 28, 2011**

VIOLATION: *UNSPECIFIED CATEGORY* **Tag No:**

Based on interviews and documentation review the Hospital investigation failed to identify that the Hospital's Policy and practice did not identify the process for ensuring the site marking was visible after draping (if applicable).

Findings included:

Observation of a procedure performed in the Pain Management Center during the survey determined that the site for the intended procedure was properly marked and was visible after draping. The time-out was performed with all members present and actively participating, including the patient (Patient #10) however, the time-out did not include members observing the site marking to ensure it was visible after draping.

Signage posted in the suite regarding the time-out process indicated that it was not the practice to include observation of the site marking to ensure it was visible after draping.

Nurse #1 was interviewed on 4/28/11 at 12:05 P.M. Nurse #1 said observation of the procedure site after draping to ensure the site marking was visible did not occur during the time-out process.

Review of the Hospital's Policy/Procedure titled Universal Protocol indicated that the site marking had to be visible after draping (if applicable) but did not indicate who was responsible or what step(s) were taken to ensure that occurred.

The Hospital conducted an investigation following a wrong side procedure. The Investigation did not identify that the Hospital's Policy and practice did not identify how it was ensured that site marking was visible after draping (if applicable).

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SAINT ANNE'S HOSPITAL **795 MIDDLE STREET FALL RIVER, MA 2721** **Feb. 23, 2011**

VIOLATION: *RECEIVING AN INAPPROPRIATE TRANSFER* **Tag No:** A2401

Based on interview and documentation review it was determined Hospital #1 failed to promptly report it may have received Patient #1 from Hospital #2 who had been transferred in an unstable emergency medical condition.

Findings included:

Documentation review indicated Patient #1 presented to Hospital #1 ED on 2/9/11 and was admitted to the ICU for care and treatment of a seizure disorder. Patient #1, on 2/11/11 eloped after a psychiatric evaluation determined a need of an inpatient psychiatric admission and a section 12a was completed as Patient #1 was identified at risk of self harm. The Police were called and notified of the elopement.

Review of internal Hospital #1 documentation indicated Hospital #1 had become aware on 2/12/11 at 3:46 PM of a potential EMTALA violation involving Patient #1 having been brought by police to Hospital #2 ' s ED were they were told by staff members to bring Patient #1 to Hospital #1. The police took Patient #1 to Hospital #1 as directed.

Further review of internal Hospital #1 documentation indicated on 2/17/11 at 2:11 PM Hospital #1 staff noted an EMTALA violation had occurred because no medical screening was done and the transfer elements were not met.

Review of a letter addressed to the CMS regional office indicated the letter was dated 2/22/11 and reported Hospital #2 ' s EMTALA violation that occurred 2/11/11.

VIOLATION: *APPROPRIATE TRANSFER* **Tag No:** A2409

Based on documentation review it was determined out of a sample of 20 ED Patient's records reviewed, 14 ED patients had been transferred from Hospital #1's ED to another facility during the time period of 8/22/10-2/22/11. Out of the 14 Patients transferred only Patient # 10 was transferred without a completed Authorization for Transfer Form that provided required information related to the appropriateness of the transfer

Findings included:

Documentation review indicated Patient #10 presented to Hospital ED and reported the reason for the visit was for necessary medical clearance prior to admission to a psychiatric facility. Patient #10 reported a history of a bipolar disorder, anxiety post traumatic stress disorder and the desire to be admitted to a dual diagnosis bed for treatment of drug use. When evaluated by the ED Physician Patient #10 indicated although there was no current active suicidal thoughts he/she had thought about it lately and when a mental health evaluation was conducted reported recent audio hallucination by a male voice telling Patient #10 to harm him/herself and others. Patient #10 was made a Section 12a (involuntary hospitalization) because of impulsivity, poor insight/judgment and recent audio

hallucinations for self harm. Patient #10 was cleared medically for psychiatric referral. Patient #10's Authorization To Transfer Form did not indicate if Patient #10 Emergency Medical Condition was stabilized, the reason for transfer, a summary of the risks and benefits of transfer upon which the decision to transfer were based, that the receiving facility had available space/qualified personnel for treatment of Patient #10, the receiving facility would be provided with appropriate medical records of the examination/treatment provided and that transfer would be provided by qualified personnel utilizing appropriate transportation equipment.

The ED Policy /Procedure that addressed transfer of patients with unstable emergency medical conditions was reviewed. The Policy/Procedure stated the emergency department physician will complete and sign the Authorization for Transfer. The Transferring physician will complete and sign the Authorization for Transfer.

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ST ELIZABETH'S MEDICAL CENTER	**736 CAMBRIDGE STREET BRIGHTON, MA 2135**	**March 8, 2012**

VIOLATION: *PATIENT RIGHTS*

Tag No: A0115

Based on review of documentation, interviews, observations, record reviews and review of the facility's complaint log, the facility failed to protect and promote each patient's right's.

Findings include:

A.) The facility failed to ensure proper disposal of patient health information (PHI) that contained information related to payment for service on 10/15/09 for the provision of health care provided by the Hospital.

1.) The Director of Compliance/Privacy Officer was interviewed on 3/7/12 at 10:55 A.M. and 1:30 P.M. and on 3/8/12 at 8:05 A.M. The Director of Compliance/Privacy Officer said that the papers found in Charleston mostly likely came from Central Billing Office, on second floor in Building #1, accounts payable. She said that building #1 was one of three buildings that were going to be demolished. The Privacy Officer said that in July 2011, the billing office was going to move to another location in another town. However, for various reasons, no employee was moved and the door to that office was locked. The papers remained in an empty, locked billing office, unaccounted for, on hospital grounds from July 2011 to approximately January 31, 2012. The Director of Compliance/Privacy Officer said the safekeeping and ultimate disposal of the documents in that room were the responsibility of the VP for Revenue, who was no longer employed by the Hospital.

2.) The Director of Support Services was interviewed in person on 3/8/12 at 1:50 P.M. The Director of Support

Services said that during the walk through of the six floors of the building, blue & white stickers were placed on items that needed shredding. He said there was no list to quantify the items and he did not know how the items would be removed for the shredding process.

3.) The VP for Finance was interviewed in person on 3/7/12 at 7:30 AM. The VP for finance said that an individual called the Hospital 2/3/12 to report that he had found a package of papers and reported seeing other similar packages of papers blowing in the wind. The individual reported that the papers had contained the name of the Hospital and patient names. The VP for Finance said that the person was asked to fax the papers to the Hospital, The VP for Finance said that he and the Director of Security immediately went to the site where the papers were found. Their search to find the other packages of papers was unsuccessful, no other papers were found. The VP for Finance said that the papers were forms for collection of payment for services provided at the Hospital. The Hospital was in the process of emptying buildings for demolition where the files were stored.

PHI was found on the ground, outside in Charlestown, several miles from the Hospital's campus, unkown to the Hospital.

B.) The facility failed to inform patients of their right to receive written notice of its decision and actions taken in its resolution of a complaint/grievance.

Review of the Welcome Guide Booklet provided to inform patients of their rights indicated that: a patient advocate is available to meet with any patient who has a conflict, complaint or concern regarding any aspect of the care process. In the event that a problem occurs which interferes with either their right as a patient, or with the quality of care, the patient is encouraged to notify the presidents and the patient advocates office. The Welcome Guide Booklet did not inform patients of their right to expect that the facility would investigate the complaint/grievance, send a written notice which included the steps taken on behalf of the patient to investigate the grievance and the results of the grievance process.

Review of the Hospital's Policy Titled Patient Rights indicated that a patient representative is available to meet with any patient who has a conflict, complaint or concern regarding any aspect of the care process. The policy did not indicate that as part of patient rights, a patient would receive a written response as a result of the Hospital's investigation.

The Director of Quality and Safety and the Quality and Safety Coordinator were interviewed in person on 3/7/12 and 3/8/12. Based on review of the Hospital complaint file and interviews, patients were not notified/informed that the Hospital will perform an investigation and provide written notice of the Hospital's investigation results.

Review of the facility's complaint/grievance log from September 2011-March 8, 2012 indicated that 3 of 11 complaints reviewed (Pt #8, Pt #12 and Pt #16), from a total sample of 16 patients reviewed, indicated they had requested a written response from the Hospital regarding the results of the investigation. The patients were not aware that they had the right to receive a written response to their complaint.

i.) Review of a complaint received on 11/4/12 indicated that Pt #8 requested to speak to someone regarding care received during her hospitalization in which she had a cesarean delivery instead of an intended vaginal delivery. The complaint log indicated Pt #8 was advised to discuss her experience with her physician. There was no documentation of an investigation or that the patient's concerns regarding the cesarean section were sufficiently addressed.

ii) Review of a complaint received on 12/1/11 indicated that Pt #16 complained that after having a spinal injection procedure, the patient developed wobbly legs. Review of the Hospital's investigation regarding the complaint indicated that a physician from the pain clinic had a conversation with Pt #16. However, the complaint file did not contain a written response to Pt #16 regarding the complaint.

iii) Review of a complaint received on 2/6/12 indicated that Pt #12 complained about a possible Health Information Portability Act (HIPAA) violation. The complaint indicated that Pt #12 wanted a written response from the Hospital. Pt #12's complaint indicated that on 2/5/12, a resident physician discussed the patient's medication treatment plan for acquired immune deficiency syndrome (AIDS) in front of PT #12's family and friends. Pt #12 had not informed the family, except a sister, of the diagnosis and did not want the diagnosis disclosed to anyone.

C.) The facility failed to protect a patient's right's for personal privacy.

i) The Resident violated Pt #12's rights to personal privacy. Refer to point (iii) above.

D.) The facility failed to ensure that all patients have the right to be free from restraints, both physical and chemical.

i) Review of a complaint received on 11/2/11 indicated that Pt #7 was prescribed Haldol (an antipsychotic medication) which was used as a chemical restraint to control behavior. The Haldol was not his/her usual prescribed medications and was used to an unwanted control behavior.

Review of the physician orders for Pt #7 indicated that on 10/30/12 at 6:06 P.M. Haldol 0.5 mg three times a day was ordered.

Review of the medication administration records (MAR) for Pt #7 indicated that on 10/30/11 at 8:50 P.M. Pt #7 received Haldol. Review of the MAR dated 10/31/11 indicated that at 5:49 A.M. and at 2:23 P.M., Pt #7 was administered Haldol.

ii) Review of a complaint received on 12/5/11 indicated that Pt #10's Family Member requested that the patient not

be placed in physical restraints and if there was any change in Pt #10's plan, the family wanted to be notified.

The Hospital's review of Pt #10's care indicated that Pt #10 was placed in physical restraints and his/her family was not notified. Pt #10 was provided 1:1 care in an attempt to keep the Patient safe, however, Patient #10 continued to remain in physical restraints.

E. The facility failed to inform each patient, or his or her representative, about patient's visitation rights.

i.) Review of the Welcome Guide Booklet, page 12, under Visiting, indicated the facility requested that visitors check with the nurse regarding visiting hours on his or her unit. The facility failed to: 1.) inform patients that visitation rights included the right, subject to his or her consent, to receive visitors whom he or she designates, including, but not limited to, a spouse, a domestic partner, another family member, or a friend and his or her right to withdraw or deny such consent at any time and 2.) not restrict, limit, or otherwise deny visitation privileges on the basis of race, color, national origin, religion, sex, gender identity, sexual orientation, or disability.

VIOLATION: *CONFIDENTIALITY OF MEDICAL RECORDS* **Tag No:** A0441

Based on review of documentation and interviews, the Hospital failed to ensure there were processes in place to ensure the confidentially of patient health information [PHI] regarding payment for care provided at the Hospital. The Hospital was never able to definitively determine how the PHI documents ended up in Charlestown, blowing in the wind, several miles from the hospital, because accountability for the proper disposal of the documents were never established.

Findings include:

Please refer to Tag A 115.

There was no accountability process to ensure confidential patient information on the second floor of building #1 was properly disposed of.

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ST ELIZABETH'S MEDICAL CENTER	736 CAMBRIDGE STREET BRIGHTON, MA 2135	Jan. 31, 2012

VIOLATION: *ADMINISTRATION OF DRUGS* **Tag No:** A0405

Based on review of one (Pt #10) of 10 medical records, the Hospital's policy/procedure regarding allergies required the application of a red allergy band, however, the policy/procedure did not require documentation to indicate that in fact the band was placed on the patient.

Findings include:

Review of Pt #10's ED record indicated the patient came to the ED on 9/12/11 at 3:10 P.M. Pt #10's ED record indicated he/she had an allergy to Levaquin. The ED record indicated that Levaquin was ordered by a physician and was then administered by a nurse at 6:45 P.M.

Review of the Hospital's policy and procedure related to patient allergies indicated that patients with allergies will wear a red identification band with Allergies written in ink, in addition to the standard identification band. A registered nurse (RN) is responsible for placing the red identification band on the patient. The policy and procedure did not include that the RN responsible for the application of the red identification band was accountable for the application of the allergy band because the policy/procedure did not require documentation or a check off to ensure that in fact the red identification band was placed on the patient.

VIOLATION: *PATIENT RIGHTS: NOTICE OF GRIEVANCE DECISION* **Tag No:** A0123

Based on interviews with the Complainant and the Risk Manager, review of the Hospital's response letter to Patient #2 and the Hospital's policy and procedure related to grievance/complaint, it was determined that the Hospital failed to indicate the steps taken on behalf of the patient to investigate the grievance/complaint and the result of the grievance process in its written response letter dated 1/6/12.

Findings include:

The Complainant was interviewed on 1/26/12 at 12:50 P.M. The Complainant provided a copy of the Hospital's response letter dated 1/6/12. The Complainant said the letter was vague, nonspecific and did not directly address the issues presented in the complaint. The Complainant said the response did not meet his/her informational needs.

The Risk Manager was interviewed on 1/30/12 and 1/31/12 at 10: 30 A.M. The Risk Manager said a complaint was filed regarding care provided by ED Technician #1 on 1/1/12 during Patient #2's ED visit. The Risk Manager said she sometimes reviews the response letters written by the Hospital's Patient Relations Coordinator before the letter is mailed. The Risk Manager said she did not review the Hospital's letter sent to Patient #2 before it was mailed.

Review of the Hospital's written response to Patient #2 indicated that an investigation was performed regarding the patient's concerns and appropriate action was taken with the individual involved in the patient's care. The letter also apologized for any inconvenience that was caused to the patient during his/her stay.

Review of the Hospital's policy and procedure titled Patient Complaints and Grievances indicated that the Hospital's response letter will include the steps taken on behalf of the patient to investigate the grievance/complaint and the result of the grievance process.

VIOLATION: *UNSPECIFIED CATEGORY* **Tag No:**

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY

Based on review of 2 (Pt #1 and Pt #2) of 10 medical records, the Hospital's Internal Investigations regarding Pt #1 and Pt #2 and interviews with Hospital staff, it was determined that the Hospital failed to identify all opportunities for improvement.

Findings include:

A) Documentation by a member of the Department of Anesthesia regarding a disclosure discussion of the

medication error which occurred on 1/4/12 in the OR was not written in Patient #1's medical record as required by Hospital policy/procedure.

1.The Attending Anesthesiologist was interviewed on 1/31/12 at 8:30 A.M. The Attending Anesthesiologist said that he attended a family conference on Friday 1/6/12 where they discussed the medication error with Patient #1's family. The Attending Anesthesiologist said that the Hospital's President and CEO, Chair for the Department of Anesthesia,Risk Manager and he were present at the meeting.

2. Review of Patient #1's operative report, dated 1/4/12 indicated that a medication error occurred in the operating room when the Attending Anesthesiologist gave norepinephrine in error, instead of the intended normal saline to measure cardiac output.

3. Review of the Hospital's policy and procedure titled Communication of Unanticipated Outcomes indicated that the disclosure should be documented in the patient's medical record. Documentation should include a brief summary of the discussion, as well as when the discussion occurred and who was present at the time.

B) Review of Patient #2's ED medical record, dated 1/1/12, indicated that Patient #2's pain was not properly assessed and managed in the Emergency Department (ED).

1. Review of Patient #2's ED record indicated that Patient #2 (MDS) dated [DATE] at 1:09 P.M. with complaints of constant rectal pain. During the Triage assessment phase, Patient #2 rated his pain as 6 out of 10 (utilizing a 0-10 pain scale, 0 indicates no pain with 10 indicating the worst pain). Patient #2's ED record indicated that Patient #2 did not receive pain relief measures for three and a half hours after reporting pain at a level of 6. At 4:45 P.M, Patient #2 was reassessed for pain and reported the pain as level 5. Review of Patient #2's ED record indicated the ED Attending ordered Dilaudid at 4:40 P.M. and Nurse #2 administered Dilaudid at 4:45 P.M. No further pain assessment was documented and Patient #2 was discharged home at 5:45 P.M.

2. The ED Attending Physician was interviewed on 2/2/12 at 12:30 P.M. The ED Attending said that Patient #2 complained of rectal pain. The ED Attending said that at the time he examined the patient, a narcotic was not needed, but this was his assumption and he maybe could have offered the patient something for pain.

3. Review of the Hospital policy and procedure titled "Patient Assessment and Management Policy" indicated that every patient has the right to a consistent approach to the management of pain. Patients will be informed regarding options available for pain management and can expect information about pain and pain relief measures from staff. The policy also indicated that assessment/reassessment of pain will occur during and after a known pain producing event/procedure and pain management interventions will be provided.

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ST ELIZABETH'S MEDICAL CENTER	736 CAMBRIDGE STREET BRIGHTON, MA 2135	Oct. 20, 2011

VIOLATION: *UNSPECIFIED CATEGORY* **Tag No:**

Based on review of documentation and interviews, it was determined that the Hospital failed to ensure there was a written plan for tracking the performance of endoscope cleaning to ensure that adherence to cleaning/disinfection procedures were sustained after the completion of six random monitoring checks.

Findings include:

1) Review of documentation indicated that all Central Processing Department (CPD) Staff had received education related to scope cleaning procedures as a result of the incident involving Patient #1 when a hysteroscope that had retained tissue from another patient in one of the channels was utilized.

2) Review of documentation indicated in response to the incident six monitoring check of processed/cleaned scopes had been scheduled for performance between September 26, 2011 and December 5, 2011.

3) The Director of CPD (Director) was interviewed in person on 10/19/11 at 10:45 am. The Director said she was performing the random monitoring of scopes and procedure kits once they had been processed to ensure, among other things, they were cleaned appropriately. She said she has already completed three of the six monitoring check and had not identified any issues. She said once the six planned monitoring checks were completed there was no formal plan or schedule in place for ongoing scope monitoring.

VIOLATION: *FACILITIES, SUPPLIES, EQUIPMENT MAINTENANCE* **Tag No:** A0724

Based on observations made in the Central Processing Department, it was determined that the Hospital failed to ensure equipment was stored in an area that would minimize the risk of contamination.

Findings included;

During a tour of the Central Processing Department conducted on 10/19/11 at 9:30 A.M, it was observed that there were several areas of water stains visible on ceiling tiles. In addition, the door to the Director's office located adjacent to the clean/sterile instrument packs was kept open with a door stop.

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ST ELIZABETH'S MEDICAL CENTER	736 CAMBRIDGE STREET BRIGHTON, MA 2135	Sept. 15, 2011

VIOLATION: *DISCHARGE PLANNING NEEDS ASSESSMENT* **Tag No:** A0806

Based on review of documentation and interviews, the Hospital failed to ensure that psychosocial assessments were completed and/or completed in a timely manner for 6 of 8 patients (Patients #1, #3, #4, #5, #7 and #8).

Findings included:

The Hospital's Policy/Procedure titled Discharge Planning, effective June, 2009, indicated discharge planning for patients admitted to the psychiatric inpatient unit was initiated at the time of admission. Initial plans or potential obstacles related to discharge were documented in the initial treatment plan, psychosocial assessment and in the progress notes.

The Case Manager was interviewed several times on 9/15/11. The Case Manager said the Psychosocial Assessment was an electronic document completed at the time of admission and included a section addressing discharge planning.

A) Review of medical record documentation indicated Patient #1 was admitted to the Inpatient Psychiatric Unit (IPU) on 3/3/11.

Review of Patient #1's discharge record indicated the Psychosocial Assessment was not completed until 5/12/11.

B) Review of medical records for Patients #2, #3, #4, #5, #6, #7 and #8 indicated Psychosocial Assessments were not completed for Patients #3, #4, #5, #7 and #8.