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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 154050 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 04/01/2014 |
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| A000000 | The visit was for a recertification survey. Facility Number: 003734 Survey Date: 3-31-14 to 4-01-14 Surveyors: Brian Montgomery, RN Public Health Nurse Surveyor Linda Plummer, RN Public Health Nurse Surveyor | A000000 | No reponse required. | |
| A000052 | QA: cloughlin 04/10/14 482.12((a)(8), (a)(9) MEDICAL STAFF [The governing body must:] (8) Ensure that, when telemedicine services are furnished to the hospital's patients through an agreement with a distant-site hospital, the agreement is written and that it specifies that it is the responsibility of the governing body of the distant-site hospital to meet the requirements in paragraphs (a)(1) through (a)(7) of this section with regard to the distant -site hospital's physicians and practitioners providing telemedicine services. The governing body of the hospital whose patients are receiving the telemedicine services may, in accordance with §482.22(a)(3) of this part, grant privileges based on its medical staff recommendations that rely on information provided by the distant-site hospital. (9) Ensure that when telemedicine services | | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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

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| | <p>are furnished to the hospital's patients through an agreement with a distant-site telemedicine entity, the written agreement specifies that the distant-site telemedicine entity is a contractor of services to the hospital and as such, in accordance with §482.12(e), furnishes the contracted services in a manner that permits the hospital to comply with all applicable conditions of participation for the contracted services, including, but not limited to, the requirements in paragraphs (a)(1) through (a)(7) of this section with regard to the distant-site telemedicine entity ' s physicians and practitioners providing telemedicine services. The governing body of the hospital whose patients are receiving the telemedicine services may, in accordance with §482.22(a)(4) of this part, grant privileges to physicians and practitioners employed by the distant-site telemedicine entity based on such hospital's medical staff recommendations; such staff recommendations may rely on information provided by the distant-site telemedicine entity.</p> <p>Based on document review and interview, the survey hospital's written agreement for distant-site radiology services furnished to its inpatients failed to indicate the responsibility of the distant-site hospital's governing board to assure that all medical staff providing radiology services maintained their medical staff membership and privileging requirements in accordance with all Federal conditions of participation pertaining to the governing body requirements for medical providers furnishing the service. The survey hospital failed to document privileging of the radiologists associated with the distant-site</p> | A000052 | <p>No telemedicine radiology services are provided by DeKalb health or any other external provider for Northeastern Inpatient</p> <p>Northeastern's policy CL 8570 covers the use of internal telemedicine services at Northeastern.</p> <p>According to Northeastern's agreement with DeKalb Health, radiology services are available at DeKalb Health for</p> | 05/23/2014 |

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| A000085 | <p>facility providing radiology services including evidence of a medical staff recommendation based upon the decisions of the distant-site hospital or based upon a credential file review for each distant-site radiologist by the survey hospital.</p> <p>Findings:</p> <ol style="list-style-type: none"> Review of the written agreement for radiology services between the survey hospital and the distant-site hospital failed to indicate the responsibility of the distant-site hospital ' s governing board to assure that all medical staff providing radiology services maintained their medical staff membership and privileging requirements in accordance with all Federal conditions of participation pertaining to the governing body requirements for medical providers furnishing the service. During an interview on 4-01-14 at 1100 hours, administrator A1 confirmed that the agreement lacked the indicated provision. On 3-30-14 at 1115 hours, staff A1 and A2 were requested to provide evidence of hospital privileging for the radiology service practitioners including a medical staff recommendation based upon a hospital-based credential review for each practitioner or based upon the decisions of the distant-site hospital. During an interview on 4-01-14 at 1550 hours, staff A1 confirmed that the facility lacked evidence of hospital privileging for the distant-site radiology service practitioners. <p>482.12(e)(2) CONTRACTED SERVICES The hospital must maintain a list of all</p> | | <p>any Northeastern inpatient. No telemedicine radiology services are provided by DeKalb Health for Northeastern Inpatient.</p> <p>By 5/23/14, Northeastern will enter into a new contract with DeKalb Health that clarifies the credentialing of their radiologists and the services they provide. Person responsible: Jim Kelly, Hospital Administrator</p> | | | | |

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| A000168 | <p>contracted services, including the scope and nature of the services provided.</p> <p>Based on document review and interview, the facility failed to maintain a list of all contracted services, including the scope and nature of services provided for 5 of 25 contracted services.</p> <p>Findings:</p> <ol style="list-style-type: none"> The list of contracted services failed to indicate a provider for biohazardous waste disposal, biomedical engineering, fire extinguisher service, fire alarm monitoring and maintenance, and emergency generator maintenance services. Review of facility maintenance documentation indicated the following: biohazardous waste disposal by CS1, fire extinguisher service by CS2, fire panel monitoring and certification by CS3, and generator service by CS4. During an interview on 3-31-14 at 1630 hours, staff A2 confirmed that the facility lacked a biomedical service provider. During an interview on 4-01-14 at 1530 hours, administrator A1 confirmed that the list of contracted services lacked a provider for the indicated services. <p>482.13(e)(5) PATIENT RIGHTS: RESTRAINT OR SECLUSION The use of restraint or seclusion must be in accordance with the order of a physician or other licensed independent practitioner who is responsible for the care of the patient as specified under §482.12(c) and authorized to</p> | A000085 | <p>Northeastern will revise its contract list to include its contracts for biohazardous waste disposal; fire extinguisher service; fire alarm monitoring and maintenance; and emergency generator maintenance services. This will be completed by 5/23/14.</p> <p>Northeastern will contract with DeKalb Health for biomedical services. This will be completed by 5/23/14 and all preventative maintenance will be done on Northeastern clinical equipment by 5/23/14 and annually thereafter. All contracted services will be reviewed annually at the Psychiatric Committee meeting. Person Responsible: Jim Kelly, Administrator</p> | 05/23/2014 |

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| | <p>order restraint or seclusion by hospital policy in accordance with State law.</p> <p>Based on policy and procedure review, medical record review, and interview, the facility failed to ensure that the type of restraint was ordered when a restraint order was given, and failed to ensure the authentication of restraint and seclusion orders, as per facility policy, for 2 of 2 patients who had restraint orders (pts. #7 and #8).</p> <p>Findings: 1. review of the policy and procedure "Physician Orders - Inpatient", policy number MD1110, last reviewed July 1, 2013, indicated: a. under "Procedure", it reads in section 2.0: "Authentication of physician or APN (advanced practice nurse) verbal orders 2.1 Ideally, each physician or APN should sign his/her own verbal orders within 48 hours of the time the order was given;..."</p> <p>2. review of the policy and procedure "Original Order to Restrain or Seclude and One Hour Face-to-Face Evaluation", policy number FA0407, with a last review date of January 1, 2014, indicated: a. the policy does not address that the type of restraint/restraints the provider may order must be stated in the order b. the policy does not address a time frame for authentication of telephone or verbal orders for restraint or seclusion for patients c. the forms attached to policy number FA0407 with the numbers FA0407 and FA0486 and FA0488 and a revised date of 01/01/14, lacks the type of physical restraint the provider is ordering</p> | A000168 | <p>Policy FA0407 will be modified by 5/1/14 to clarify the type of restraint to be used. The time frame for authentication of telephone or verbal orders (48 hours) will also be added to the policy. Staff, physicians, and nurse practitioners will be educated on these policy additions by 5/15/14. This will be audited and reported to the Quality Council. Person responsible: Jim Kelly, Administrator</p> | 05/15/2014 | |

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| | <p>3. review of the policy and procedure "Restraint/Seclusion Initiation", policy number \\, with a last review date of January 1, 2014, indicated:</p> <p>a. under "Statement of Information:", it reads in section 3.: "Upon receiving orders for a restraint or seclusion, the date, time and type of restraint or seclusion is to be noted..."</p> <p>4. review of patient medical records indicated:</p> <p>a. pt. #7 had:</p> <p>A. a telephone order written at 4:15 AM on 1/19/14 that read: "Seclude/Restraint for violent agitated behavior..."</p> <p>B. a form FA0488, that had "Restraining: Seclusion: and Chemical restraint" checked, but lacked specificity of the type of restraint ordered</p> <p>b. pt. #8 had:</p> <p>A. a telephone order at 1418 hours on 8/18/13 for "...4 [hour] Seclusion et (and) restraint"</p> <p>B. a telephone order on 8/2/13 at 1614 hours to "Restraining et Seclude...for up to 4 hrs..."</p> <p>C. had forms FA0488 that had "Restraining: Seclusion: and Chemical restraint" checked, but lacked specificity of the type of restraint ordered</p> <p>5. interview with staff member #51, the director of nursing, at 3:10 PM on 3/31/14 and at 2:07 PM on 4/4/14, per phone, indicated:</p> <p>a. the facility utilizes two types of restraint: a "come along" velcro restraint used on the upper body, and "velcro 4 point" restraints</p> <p>b. the orders given, and the forms listed in 3 above, do not specify which type of restraint the practitioner is ordering</p> | | | |

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| A000347 | <p>c. physicians were unaware that there was a policy specifying authentication of verbal and telephone orders within 48 hours 482.22(b) MEDICAL STAFF ORGANIZATION & ACCOUNTABILITY The medical staff must be well organized and accountable to the governing body for the quality of the medical care provided to the patients.</p> <p>(1) The medical staff must be organized in a manner approved by the governing body.</p> <p>(2) If the medical staff has an executive committee, a majority of the members of the committee must be doctors of medicine or osteopathy.</p> <p>(3) The responsibility for organization and conduct of the medical staff must be assigned only to one of the following: (i) An individual doctor of medicine or osteopathy. (ii) A doctor of dental surgery or dental medicine, when permitted by State law of the State in which the hospital is located. (iii) A doctor of podiatric medicine, when permitted by State law of the State in which the hospital is located.</p> <p>Based on document review and interview, the professional staff bylaws failed to assure that the individual responsible for the organization and conduct of the credentialed professional staff was a doctor of medicine or osteopathy, dental medicine or dental surgery, or a doctor of podiatric medicine.</p> <p>Findings:</p> | A000347 | Northeastern's Professional Staff Organization (PSO) represents all clinical staff members including the medical staff. The Medical Director (Currently Dr. Lynnea Carder) shall chair the PSO executive committee and shall review and approve PSO bylaws annually. Responsible Person: Steve Howell, Chief Clinical Officer | 05/23/2014 | |

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| A000359 | <p>1. The Professional Staff Bylaws (approved 2-14) indicated that the Chairperson of the PSO [A10] signed the Bylaws as the representative of the PSO and indicated that "...The chairperson shall be responsible to the Chief Clinical Officer ..." rather than the Chief Medical Officer [CMO].</p> <p>2. During an interview on 4-01-14 at 1535 hours, compliance officer A8 confirmed that the bylaws failed to assure that the PSO chairperson was accountable to the CMO. 482.22(c)(5) MEDICAL STAFF RESPONSIBILITIES [The bylaws must:]</p> <p>[Include a requirement that --]</p> <p>(ii) An updated examination of the patient, including any changes in the patient's condition, be completed and documented within 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services, when the medical history and physical examination are completed within 30 days before admission or registration. The updated examination of the patient, including any changes in the patient's condition, must be completed and documented by a physician (as defined in section 1861(r) of the Act), an oromaxillofacial surgeon, or other qualified licensed individual in accordance with State law and hospital policy.</p> <p>Based on document review and interview, the facility failed to assure that professional staff completed documentation of an update (including any changes in patient condition)</p> | A000359 | Northeastern has a contract, as of 9/18/13, with a qualified nurse practitioner that does all the H & Ps on our inpatients. The contract requires the completion of H & Ps in 24 hours. This is | 04/28/2014 |

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| A000395 | <p>within 24 hours of admission for all History and Physical (H&P) examinations completed within the authorized period prior to admission by the qualified licensed professional.</p> <p>Findings:</p> <ol style="list-style-type: none"> The Professional Staff Bylaws (approved 2-14) indicated the following: "Medical Records Requirements [page 24] All PSO members will abide by the policies and procedures of the Center in regard to the documentation of treatment." The policy/procedure History and Physical Examinations - Inpatient (approved 1-14) failed to indicate a requirement for documenting an H&P update by the qualified professional staff within 24 hours of the patient ' s arrival to the facility. During an interview on 4-01-14 at 1335 hours, staff A8 confirmed that the professional staff policy/procedure lacked the indicated provision. 482.23(b)(3) RN SUPERVISION OF NURSING CARE A registered nurse must supervise and evaluate the nursing care for each patient. <p>Based on policy and procedure review, medical record review, and interview, the nursing staff failed to implement orders for CIWA (clinical institute withdrawal assessment) scale protocol at the time of admission orders for one patient (pt. #5).</p> <p>Findings:</p> <ol style="list-style-type: none"> review of the policy and procedure "CIWA Evaluation Form", policy number FA0414, | A000395 | <p>audited daily by the night shift, reported to Quality Council and Continuous Quality Improvement. Responsible person: Jim Kelly, Administrator</p> <p>Policy FA0414 will be modified to show that every patient admitted with an order for a CIWA evaluation will have it done immediately upon admission. Policy additions and staff education will be completed 5/1/14. This will be audited for compliance and reported to the Quality Council and Continuous Quality Improvement Committee. Responsible person:</p> | 05/01/2014 | |

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| | <p>with a last review date of July 1, 2013, indicated:</p> <p>a. under "Procedure", it reads in section 4.0, "If the physician deems detoxification is needed, CIWA protocol will be ordered. The nursing staff will complete CIWA orders and protocol."</p> <p>2. review of medical records indicated:</p> <p>a. pt. #5 had :</p> <p>A. orders on admission 2/2/14 at 6:20 PM for CIWA every 4 hours "while awake"</p> <p>B. nursing noted that the patient arrived to the unit "...in wheelchair..." at 7:00 PM; that the patient was "...on phone with friend..." at 7:35 PM; and that the nursing admission assessment was completed at 8:00 PM</p> <p>C. documentation on the "Psychiatric Close Observation Record" form indicating the patient was in their room with staff from 7:45 PM to 8:45 PM; in the "Dining/Activity Room" with peers from 9:00 PM to 9:45 PM and then in their room "Quiet" from 9:45 PM to 10:45 PM; and noted as "sleeping" beginning at 10:45 PM</p> <p>D. the first CIWA assessment done on 2/3/14 at 6:25 AM when the patient scored at 15</p> <p>3. interview with staff member #51, the director of nursing, at 4:50 PM on 3/31/14 and 8:30 AM and 11:30 AM on 4/1/14, indicated:</p> <p>a. "it takes a long time to do an admission assessment" so that nursing may not have had time to do the CIWA the evening of admission for pt. #5</p> <p>b. nursing doesn't have to do a CIWA assessment "while a patient is in bed, or sleeping, nursing can determine when they want to complete an assessment"</p> <p>c. with the physician order at 6:20 PM for</p> | | Jim Kelly, Administrator | | |

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| A000450 | <p>CIWA protocol, it appears that nursing had time to begin the CIWA assessment at some time between 7 PM, when the patient arrived on the unit, and 10:45 PM when the patient was first noted as sleeping--waiting until 6:25 AM, when the patient scored high--15, was not following/implementing physician orders for a detoxing patient who was at risk 482.24(c)(1)</p> <p>MEDICAL RECORD SERVICES All patient medical record entries must be legible, complete, dated, timed, and authenticated in written or electronic form by the person responsible for providing or evaluating the service provided, consistent with hospital policies and procedures.</p> <p>Based on policy and procedure review, document review, medical record review, and interview, the facility failed to ensure the timing and/or completion of medical records by staff for 6 of 8 patients (pts. #1 through #5 and #8).</p> <p>Findings: 1. review of the policy and procedure "Chart Document - Inpatient", policy number CR1115, with a last date reviewed of July 1, 2013, indicated: a. under "Policy Statement", it reads: "A complete, concise and accurate medical record for Inpatient will be maintained on each patient for services provided by patient care personnel." b. under "Procedure", it reads in section 4.0: "...4.3 All entries should be neat, legible, accurate, concise and written in black ink..."</p> <p>2. review of the policy and procedure "Inpatient Nursing Assessment", policy</p> | A000450 | In-services on the timely completion and appropriate documentation on the "nursing assessment" form have been completed with all nursing staff. This will be audited for compliance and reported to the Quality Council and Continuous Quality Improvement Committee. Responsible person: Jim Kelly, Administrator | 05/23/2014 | |

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| | <p>number \, with a last review date of July 1, 2012, indicated:</p> <p>a. under "Guidelines for use of Nursing Assessment Record", it reads in section 8.0: "After the nursing assessment is taken at admission, vitals will be taken every shift for three days or more often as indicated and weekly thereafter..."</p> <p>3. review of the policy and procedure "Graphic Record Form - IP", policy number FA0423, with a last review date of July 1, 2012, indicated:</p> <p>a. under "Policy Statement", it reads: "This form is utilized each shift to record temperature, pulse, blood pressure, height, and weight. Vitals are taken one (1) time per shift for the first 3 days after admission."</p> <p>4. review of the document titled "Nursing Assessment Form", an attachment to the policy FA0418, with a last revised date of 07/01/04, indicated:</p> <p>a. at the top of the page, the "Instructions" read: "Place your initials and time in the appropriate box...A nursing assessment shall be completed one time each 8 hour shift by the RN (registered nurse) or designated LPN (licensed practical nurse)."</p> <p>5. review of medical records indicated:</p> <p>a. pt. #1 was admitted on 2/28/14 and lacked:</p> <p>A. a third set of vital signs on the evening/night shift the day of admission, 2/28/14 (had 11 AM and 5 PM vital signs, but lacked later shift vitals)</p> <p>B. on the Nursing Assessment Form: the time of assessment for the 2300 to 0700 assessment on 3/22/14; the 1500 to 2300 shift on 3/23/14; and the 2300 to 0700 and 0700 to 1500 shifts on 3/30/14</p> | | | |

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| | <p>b. pt. #2 was admitted on 3/22/14 and lacked:</p> <p>A. a date of authentication of physician orders written 3/26/14 at 9:30 AM</p> <p>B. on the Nursing Assessment Form: the time of assessment for the 0700 to 1500 shift and the 1500 to 2300 shift on 3/24/14; the 0700 to 1500 shift on 3/26/14 and 3/27/14; the 2300 to 0700 shift on 3/28/14; and the 0700 to 1500 shift on 3/29/14</p> <p>c. pt. #3 was admitted on 3/28/14 and lacked:</p> <p>A. on the Nursing Assessment Form: the time of assessment for the 2300 to 0700 and 1500 to 2300 shifts on 3/30/14</p> <p>d. pt. #4 was admitted on 3/27/14 and lacked:</p> <p>A. on the Nursing Assessment Form: the time of assessment for the 2300 to 0700 and the 0700 to 1500 shifts on 3/29/14 and the 2300 to 0700 shift on 3/30/14</p> <p>e. pt. #5 was admitted on 2/2/14 and lacked:</p> <p>A. a third set of vital signs on 2/3/14 (vitals at Midnight and 9 PM only)</p> <p>B. on the Nursing Assessment Form: the time of assessment for all three shifts on 2/7/14; 2/8/14; 2/9/14; and 2/10/14</p> <p>f. pt. #8 was admitted on 8/17/13 and lacked:</p> <p>A. on the Nursing Assessment Form: the time of assessment for all three shifts on 8/18/13; 8/19/13; and 8/20/13</p> <p>6. interview with staff member #51, the director of nursing, at 3:10 PM on 3/31/14, indicated:</p> <p>a. nursing staff were unaware that the "time" needed to be documented with each shift assessment and thought it was OK to just put it in the correct shift area, such as 0700 to 1500</p> | | | | | | |

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| A000724 | <p>b. without putting the specific time of assessment on the Nursing Assessment Form, it is not clear exactly when the assessment was performed and does not follow the instructions at the top of the form 482.41(c)(2)</p> <p>FACILITIES, SUPPLIES, EQUIPMENT MAINTENANCE Facilities, supplies, and equipment must be maintained to ensure an acceptable level of safety and quality.</p> <p>Based on document review, observation and interview, the facility failed to maintain its equipment and supplies for 1 medical device and 1 floor maintenance equipment observed on a tour of the facility.</p> <p>Findings:</p> <p>1. During a tour of the facility on 3-31-14 at 1510 hours, the following condition was observed: a Welch Allyn AED 10 (automatic external defibrillator) without evidence of preventive maintenance. Staff A4 was requested to provide evidence of periodic maintenance and testing and none was provided prior to exit.</p> <p>2. Documentation provided on request indicated that AED product manufacturing by Welch Allyn was discontinued in 2009 and indicated that effective 3-31-14 that the device would no longer be supported by the manufacturer.</p> <p>3. During an interview on 3-31-14 at 1630 hours, staff A4 confirmed that the facility lacked a biomedical service provider and confirmed that no documentation of preventive maintenance for the AED was</p> | A000724 | Northeastern will contract with DeKalb Health for biomedical services. This will be completed by 5/23/14 and all preventative maintenance will be done on Northeastern clinical equipment by 5/23/14. This contract, along with all other contracts, will be reviewed annually by the inpatient Quality Council and Psychiatric Committee. The broken ground pin on floor scrubber was fixed 4/21/14. Responsible person: Jim Kelly, Administrator | 05/23/2014 | | | |

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| A000748 | <p>available.</p> <p>4. During a tour of the facility on 3-31-14 at 1537 hours, the following condition was observed in an environmental services storage room: a broken ground pin on the male power cord connector for a 170 rpm Viper 20" floor scrubber.</p> <p>5. During an interview on 3-31-14 at 1540 hours, staff A1 confirmed that the equipment had not been maintained to an acceptable level of safety.</p> <p>482.42(a) INFECTION CONTROL OFFICER(S) A person or persons must be designated as infection control officer or officers to develop and implement policies governing control of infections and communicable diseases.</p> <p>Based on policy and procedure review, personnel file review, and interview, the infection control committee failed to ensure the continuing education of the infection preventionist related to infection control practices, and based on observation and interview, the infection control committee failed to ensure the cleanliness of the staff pantry area and refrigerators in the central supply room #304.</p> <p>Findings: 1. Review of the policy and procedure RMO 140, " Infection Control Monitoring and Education " , with a last review date of July 1, 2013, indicated: a. Under " Procedure " , in section 4.0 " The Responsibilities of the Risk Management and Environment Safety Subcommittee for Infection Control Activities " , it reads: " 4.1 Specific member responsibilities for Infection Control: .1 Bring clinical, administrative, or</p> | A000748 | The Director of Nurses will complete 2 educational sessions annually promoted by the CDC and/or the WHO. This will be evaluated during this position's annual evaluation. By 5/1/14 a cleaning schedule will be placed with the temperature log of each refrigerator and responsibility assigned. Each month these logs will be audited and reported to the P & T/Infection Control Committee, and the Quality Council at Inpatient. Responsible Person: Jim Kelly | 05/01/2014 |

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| | <p>epidemiological expertise to the committee; ... "</p> <p>2. Review of the education documentation for the infection preventionist (staff member #51), indicated the only education, related to infection control, for 2013 was one hour for hand hygiene as presented by the WHO (world health organization)-no documentation was found for 2012</p> <p>3. Interview with staff member #51 confirmed that:</p> <p>a. there was no other continuing education received, related to infection prevention practices, for this infection preventionist in 2012 or 2013</p> <p>b. it cannot be determined what epidemiological expertise staff member #51 possesses to act as the infection control preventionist for the facility</p> <p>4. While on tour of the facility in the company of staff member #51, the infection preventionist and director of nursing, it was observed:</p> <p>a. at 1:00 PM on 4/1/14, in the staff break room, it was observed that were:</p> <p>A. crumbs at the back of the freezer shelf and under the left vegetable drawer of the refrigerator and the bottom shelf of the refrigerator was sticky as was the lip of glass on top of the vegetable drawer</p> <p>B. the two drawers under the coffee maker had spilled coffee stains and coffee grounds spilled and loose in the drawer</p> <p>C. the drawer under the microwave had crumbs present in the back left corner area</p> <p>D. the microwave was dirty with spattered food throughout</p> <p>b. at 3:05 PM on 4/1/14, it was observed in the small pantry refrigerator on the patient unit that there was spilled/dried liquid on the shelf and door</p> <p>c. at 3:10 PM on 4/1/14, it was observed in</p> | | | | | | |

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| A000749 | <p>the storage room/Central Supply Room #304 on the North wing:</p> <p>A. the left refrigerator had debris on the lower shelf of the door and the right refrigerator had dribbles of dried liquids on the lower door shelf</p> <p>5. interview with staff member #51 at 1:00 PM and 3:30 PM on 4/1/14 indicated:</p> <p>a. the areas listed in 4 above were unclean as described</p> <p>b. housekeeping staff used to clean the refrigerators, but only wash the exteriors now--it is unclear why this practice was discontinued</p> <p>c. nursing staff are to clean the interiors of the refrigerators but staffing has been short lately</p> <p>d. there is no policy related to how often to clean the refrigerators and exactly who has this responsibility</p> <p>e. a form titled "Unit Routines:" was provided and staff member #51 indicatd that MHTs (mental health technicians), as part of routine duties, are to: "...45. Clean & organize break room - including fridge..."--it is unclear how often this is to occur</p> <p>482.42(a)(1) INFECTION CONTROL PROGRAM The infection control officer or officers must develop a system for identifying, reporting, investigating, and controlling infections and communicable diseases of patients and personnel.</p> <p>Based on policy and procedure review, personnel file review, and interview, the infection control committee failed to implement its policy and procedure related to the immunization status of 4 of 6 nursing and technician staff members (staff N2, N3, N4</p> | A000749 | Infection Control will be reorganized to ensure proper oversight and reporting of infection control issues per the following: · The current Pharmacy and Therapeutics committee will be expanded to include Hospital infection control | 05/23/2014 | |

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| | <p>and N6). Findings: 1. Review of the policy \, " Immunization Record -IP (inpatient) ", with a last review date of July 1, 2013, indicated: a. Under " Summary " , on page one, it reads: " To meet necessary state and federal mandates, all inpatient staff that provide direct care must provide documentation of immunizations for, or antibodies to, MMR (measles, mumps, rubella) and Varicella (Chicken Pox), by having the attached form completed on their behalf, or by submitting a copy of an official State Immunization Form which indicates immunization. " b. Under " Statement of Information " , it reads: " ...2.0 NEC (Northeastern Center) Inpatient Services employees shall secure evidence from their general practitioner that they have either had the required immunizations, a titer test indicating immunization, have had the inquired about disease, or have secured the official State Immunization form as evidence of immunization ... " 2. Review of personnel files indicated: a. Staff member N2 was a RN (registered nurse) hired 1/10/12 who lacked any information or documentation in the file regarding immunization status related to Rubella, Rubeola, and Varicella b. Staff member N3 was a RN hired 1/10/12 who had documentation of an equivocal Rubeola result (0.9 with 0.9 to 1.0 being " equivocal " per the lab document)-no follow up was noted c. Staff member N4 was a MHT (mental health tech) who was hired 10/9/12 and lacked any documentation of Varicella immunity d. Staff member N6 was a MHT hired</p> | | <p>information and issues. This will be reported to the Psychiatric committee, Risk Management Committee, Continuous Quality Improvement Committee, and the Board. A member of facilities will be represented on the P & T/Infection Control Committee. This will ensure that all cleaning supplies and procedures are reviewed and approved by infection control. This will be accomplished no later than 5/23/14. The DON/Infection control nurse will work with Human Resources to ensure that all employees hired have proper immunization records. This will be audited periodically and reported to the P & T/Infection Control Committee. Responsible person: Jim Kelly, Administrator</p> | | | | |

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| A000756 | <p>6/11/13 who lacked any documentation in the file related to the immunity of Rubella, Rubeola, or Varicella</p> <p>e. Staff member N1 was hired 10/11/11 and had a last TB (tuberculosis) test done 1/18/13</p> <p>f. N3 was hired 1/10/12 and had no TB test documentation in the file</p> <p>g. N4 was hired 10/9/12 with a last TB of 10/12</p> <p>3. Interview with staff members #51, the infection control practitioner, and # 56, the human resources director, at 11:00 AM on 4/1/14, indicated:</p> <p>a. The personnel files are lacking immunization documentation as listed in 2. Above</p> <p>b. There was no follow up to the equivocal Rubeola result for staff member N3, making it unknown whether this staff member has immunity to the disease, or not</p> <p>c. All three employees (N1, N3, and N4) have lapsed TB tests or no documentation in their files as stated above</p> <p>(Note: a policy related to TB testing was requested on 4/4/14 at 2:07 PM by phone call and on 4/7/14 at 11:19 AM by e-mail, with no receipt of the policy at this time</p> <p>482.42(b)</p> <p>INFECTION CONTROL LEADERSHIP RESPONSIBILITIES</p> <p>Standard: Responsibilities of Chief Executive Officer, Medical Staff, and Director of Nursing Services</p> <p>The chief executive officer, the medical staff, and the director of nursing must--</p> <p>(1) Ensure that the hospital-wide quality assessment and performance improvement (QAPI) program and training programs address problems identified by the infection control officer or officers; and</p> | | | |

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| | <p>(2) Be responsible for the implementation of successful corrective action plans in affected problem areas.</p> <p>Based on policy and procedure review, document review, and interview, the infection control committee failed to ensure medical staff involvement in the infection control committee, which is part of the risk management committee at this facility.</p> <p>Findings:</p> <p>1. review of the policy and procedure "Continuous Quality Improvement Program-Inpatient Services", policy number QI1125, with a last review date of July 1, 2009, indicated:</p> <p>a. on page 2 under "Procedures", in item 6.0., it reads: "Staff composition on Risk Management/Infection Control Committee shall include the Risk Management Nurse as chair, Chief Operating Officer, Hospital Administrator, Hospital Nurse, Hospital Mental Health Technician, Hospital Janitor, Hospital Maintenance, and Quality Improvement Coordinator..."</p> <p>2. review of Risk Management committee meetings for: 10/2012, 11/2012, 5/1/13, 6/27/13, 10/4/13, 11/22/13, and 2/6/14 indicated that:</p> <p>a. a physician was only listed as "present" at the 5/1/13 meeting</p> <p>b. the meeting minutes of 6/27/13 indicated the physician was "absent"</p> <p>3. interview with staff members # 51, the infection preventionist, and #56, the human resources director, at 12:35 PM on 4/1/14 indicated:</p> <p>a. the committee composition lacks the</p> | A000756 | <p>Infection Control will be reorganized to ensure proper oversight and reporting of infection control issues. Below is how:</p> <ul style="list-style-type: none"> · The current Pharmacy and Therapeutics committee will be expanded to include Hospital infection control information and issues. This will be reported to Psychiatric committee and to the Risk Management Committee, Continuous Quality Improvement and the Board. · A member of facilities will be represented on the P & T/Infection Control Committee. This will ensure that all cleaning supplies and procedures are reviewed and approved by infection control. · This will be accomplished no later than 5/23/14. <p>Responsible person: Jim Kelly, Administrator</p> | 05/23/2014 |

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| | <p>inclusion of a medical staff member</p> <p>b. it cannot be determined that there is physician involvement in the infection control program and committee processes without medical staff member attendance at the committee meetings</p> <p>c. it was stated that the physician attends QI (quality improvement) meetings pertinent to infection control issues and practices, but review of the QI committee meeting minutes of 8/23/13; 10/18/13; 11/15/13; 1/24/14 and 2/28/14 also lacked indication that a physician was present at these meetings</p> | | | |