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Tag	Regulation	Basis for Citation	# Fed Cites	# State Cites	Eventid
Discharge Planning			0	0	
EMTALA			2	0	
Governing Body			1	0	
Swing Bed: Hospital and CAH			0	0	
Infection Control			4	6	
A 339	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.	1.failed to ensure staff follows hospital policy regarding Protective Personal Equipment (PPE) use to prevent exposure to bodily fluids during surgery and reprocessing			
	The infection control officer or officers must develop a system for identifying, reporting, investigating, and controlling infections and communicable diseases of patients and personnel.	2.failed to ensure policies are in place for laundering supplies used for cleaning to prevent cross contamination			
A340	. The governing body or medical staff shall establish an infection control committee to carry out surveillance and investigation of infections in the hospital and to implement measures designed to reduce these infections to the extent possible.	1.Med pass without handwashing; placement of I.V. without handwashing; supplies stored under sinks; linens stored without dustcover; airflow from dirty to clean utility rooms in Respiratory Therapy area; airflow from corridor to clean storage room of OR.			
		2. Floors are not maintained to provide a sanitary environment; Equipment is not on a routine cleaning schedule to protect staff and patients from exposure to blood borne pathogens; Therapy staff are not promoting standard universal precautions; Clean linens are not protected from dust and debris; Patient care items are not properly stored			

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R 294	The hospital shall provide a sanitary environment to avoid sources and transmission of infections and communicable diseases. There shall be an active program for the prevention, control and investigation of infections and communicable diseases.	1.facility did not provide a system for potential sources of controlling infection: ceiling tiles contained apparent black mold; open soiled and clean linen containers provided potential source of cross contamination; open floor drain providing an open pathway for vermin to enter the building; linen and food receiving area allowied for potential contamination; dirty linen carts contained clothing and linen allowied for potential contamination to staff; clean paper supplies carried through the Soiled/Biohazard room with dirty overhead lighting, pipes and ductwork allowing for potential contamination of supplies; Central Supply Room allowed for recontamination of the clean restraints and potential contamination of clean supplies; seclusion/restraint room not cleaned after its use in the event another patient needed to be placed in restraints or seclusion., etc.			
		2.Floors are not maintained to provide a sanitary environment; Equipment is not on a routine cleaning schedule to protect staff and patients from exposure to blood borne pathogens; Therapy staff are not promoting standard universal precautions; Clean linens are not protected from dust and debris; Patient care items are not properly stored			
Medical Record Services			8	6	
A 230	All entries must be legible and complete, and must be authenticated and dated promptly by the person (identified by name and discipline) who is responsible for ordering, providing, or evaluating the service furnished.	1.failed to document the time the Medical Doctor (MD)was notified of the patient's presence in the ER, when the MD examined/treated the patients, amd failed to document the patient's discharge time from the ER			

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		2.facility failed to ensure all orders were dated and/or timed, telephone and standing orders were authenticated by the Medical Doctor (MD) with a date and time, and failed to ensure progress notes were timed to provide a chronological record of events.			
		3.medical record entries did not contain times and dates per medical staff rules and regulations and hospital policy and procedure.			
R 496	All entries in medical records by medical staff or other hospital staff shall be legible, permanently recorded, dated and authenticated with the name and title of the person making the entry	1. consents do not include the time the consents for treatment were signed by the patient/representative and witness			
		2. facility failed to ensure all orders were dated and/or timed, telephone and standing orders were authenticated by the Medical Doctor (MD) with a date and time, and failed to ensure progress notes were timed to provide a chronological record of events.			
		3. facility failed to ensure the restraint orders included one or more of the following: date, time and length of time.			
Medical Staff			1	1	
Nursing Servcies			8	7	
A 204	A registered nurse must supervise and evaluate the nursing care for each patient.	1.failed to obtain a complete initial nursing history in ER; failed to review prior records to determine what medications the patient was taking; failed to provide central monitoring for patients receiving an IV analgesic medication with a known side effect of respiratory depression; patient died.			

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		2. registered nurse did not re-evaluate patient's transfer ability and did not supervise a two-person assist transfer to ensure patient safety; and failed to evaluate risk for falls out the wheelchair/ chair.			
		3. staff failed to follow facility policy to ensure that patients admitted with pain are assessed for pain			
R 417	A registered nurse shall plan, supervise and evaluate the care of all patients, including the care assigned to other nursing personnel.	1.nursing staff failed to follow written direction from the case manager on 6/27/06 to check the patient hourly			
		2. registered nurse did not re-evaluate patient's transfer ability and did not supervise a two-person assist transfer to ensure patient safety; and failed to evaluate patients risk for falls out the wheelchair/ chair			
		3. staff failed to follow facility policy to ensure patients admitted with pain receive pain assessment			
A 205	The hospital must ensure that the nursing staff develops, and keeps current, a nursing care plan for each patient.	1. failed to ensure care plans are established for patients in labor			
		2.nursing staff did not develop and keep current a safety care plan for falls			
		3.staff failed to develop a plan of care that addresses pain for patients admitted with pain			
R 430	There shall be a written nursing care plan for each patient which shall include the elements of assessment, planning, intervention and evaluation.	1. facility failed to ensure care plans are established for patients in labor			
		2. staff failed to develop a plan of care that addresses pain for patients admitted with pain			
Services: Anesthesia, Emrgcy, Food & Dietetic, Nucl Medicine, Respiratory, Outpt, Radiologic, Rehab & Surgical			6	7	
Pharmaceutical Services			6	5	

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A 208	Drugs and biologicals must be prepared and administered in accordance with Federal and State laws, the orders of the practitioner or practitioners responsible for the patient's care as specified under §482.12I, and accepted standards of practice.	1. Nursing staff failed to correctly transcribe a BP medication as written by the physician ordering the medication.			
		2. Patient received Epidural medication instead of ordered Penicillin medication which resulted in seizures and loss of vital signs			
Organ Tissue, Eye Procurement			2	1	
Patient Rights			9	11	
R 250	Every patient shall be informed in writing about the hospital's policies and procedures for initiation, review and resolution of patient complaints, including the address where complaints may be filed with the department	1. the hospital failed to ensure that patient/representative complaints are appropriately investigated, and that patients are notified of the results and resolution.			
		2. staff failed to follow facility policy to ensure that patients received a response to grievances they filed with the Clients Rights Facilitator			
A 57	The patient has the right to receive care in a safe setting.	1. facility does not meet accepted patient safety guidelines of providing an environment that is free of possible suicide hazards; 9 suicide attempts connected to these hazards			
		2. staff failed to protect a patient from another patient with a documented history of aggression toward peers			
R 241	Every patient, the patient's legally authorized representative or any person authorized in writing by the patient shall receive, from the appropriate person within the facility information about the patient's illness, course or treatment	1. The parents of newborn patient were not kept informed by the medical staff of the status, plan, and prognosis for recovery . Hospital staff did not follow the patient rights given to patients/representatives at the time of admission			

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	and prognosis for recovery in terms the patient can understand;	2. Patient was not given the right to be informed of health status when discharged from the emergency department			
Physical Environment			87	13	
A 317	The hospital must be constructed, arranged, and maintained to ensure the safety of the patient, and to provide facilities for diagnosis and treatment and for special hospital services appropriate to the needs of the community.	1.The cumulative effects of environment deficiencies in the areas of corridor door latching, door locking, fire and smoke dampers missing, hazardous area containment, sprinkler protection, corridor air plenums, smoke barrier walls, interior wall finish, and smoke detector installations resulted resulted in the Hospital's inability to ensure a safe environment for the patients			
		2. problems include not providing 2 hour wall separation between buildings, too many delayed egresses in the path of egress, corridors not maintaining corridors clear, and doors to corridors not latching. Refer to the following K tags for details: K-0011, K-0018, K-0037, K-0039, K-0043, K-0051, K-0067, and, K-0130			

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A 321	The hospital must ensure that specific life safety from fire requirements are met.	1. Based on observation, staff interviews and review of maintenance records between July 17, 2006 and July 19, 2006, the Facility failed to construct, install and maintain the building systems to ensure life safety to patients due to environmental deficiencies in the areas of corridor door latching, door locking, fire and smoke dampers missing, hazardous area containment, sprinkler protection, corridor air plenums, smoke barrier walls, interior wall finish, and smoke detector installations.Refer to K-17, K-18, K-25, K-29, K-39, K41, K-43, K-48, K-51, K-56, K-67, K-104, K-130, and K-147.			
		2. problems include not providing 2 hour wall separation between buildings, too many delayed egresses in the path of egress, corridors not maintaining corridors clear, and doors to corridors not latching. Refer to the following K tags for details: K-0011, K-0018, K-0037, K-0039, K-0043, K-0051, K-0067, and, K-0130.			
K 72	Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10	1. Exits obstructed			
		2. materials obstructing the egress path			
		3. materials were in the aisles of storage room that totally blocked the egress path.			

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K 17	Corridors are separated from use areas by walls constructed with at least ½ hour fire resistance rating. In sprinklered buildings, partitions are only required to resist the passage of smoke. In non-sprinklered buildings, walls properly extend above the ceiling. (Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Charting and clerical stations, waiting areas, dining rooms, and activity spaces may be open to the corridor under certain conditions specified in the Code. Gift shops may be separated from corridors by non-fire rated walls if the gift shop is fully sprinklered.) 19.3.6.1, 19.3.6.2.1, 19.3.6.5	1. Registration area and changing area of imaging department do not have full sprinkler/24 hr observation; circumcision area and changing area of imaging department are open to corridor;			
		2. facility failed to prevent the passage of smoke due to a transfer grille opening in the wall			
		3. corridor walls were not properly sealed			
		4. did not have corridor walls that were 1 hour fire rated			
K 18	Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities.	1. Corridor doors did not latch			
		2. doors to the corridor from the ER suite did not latch when closed			
		3. facility failed to maintain two corridor doors due to a wood wedge placed underneath one door propping it open, and a transfer grille on the second door			
		4. corridor door did not latch			
		5. did not have corridor doors that latch			

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K 25	Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4	1. smoke barrier walls were not properly taped nor fire caulked.			
		2. facility failed to maintain a ½ hr fire-resistance rating and smoke tightness of smoke barriers in three locations due to unsealed penetrations			
		3. the smoke barrier walls penetrations were not properly fire stopped.			
K 39	Width of aisles or corridors (clear and unobstructed) serving as exit access is at least 4 feet. 19.2.3.3	1. Observed were two, 3-foot wide doors across the corridor. The doors are required to be 41.5 inches in the clear. (44 inch door).			
		2. multiple objects in the corridor that are not attended and the objects are obstructing the corridor			
		3. exiting room doors swing 90 degrees and block the egress corridor			
K 43	Patient room doors are arranged so that the patient can open the door from inside without using a key. (Special door locking arrangements are permitted in mental health facilities.) 19.2.2.2.2	1. facility has special exiting (delayed egress) that did not meet all of the requirements for special locking.			
		2. In the path of egress to the main medical / surgical rooms one must travel through two delayed egress locks. Only one is allowed per NFPA 101, 19.2.2.4.			
		3. exit doors were locked and staff did not carry keys to operate the doors.			

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K 48	There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 19.7.1.1	1. according to the plan, entry into the MRI room including for emergency purposes, would be delayed until personnel responsible for the MRI stated that it was permissible to enter. Staff qualified to do this are not at the hospital at all times as required in NFPA 19 7.2.2			
		2. the proprietary supervising station system did not maintain the station in compliance with NFPA 72.			
K 51	A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building….	1. facility did not have a fire alarm system which met the requirements of NFPA 72			
		2. no a smoke detector for the smoke damper at the smoke barrier wall between the corridor and the exercise room in the basement of the rehab building			
K 56	If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building….	1. facility did not have full sprinkler coverage and that the sprinkler system is not installed according to NFPA 13			
		2. a light fixture obstructing the sprinkler discharge			
		3. the fire alarm panel was fed from the normal power circuit.			
		4. facility did not have full sprinkler coverage in the building and that the sprinkler system is not installed according to NFPA 13.			
		5. did not have full sprinkler coverage in the basement and that the sprinkler system is not installed according to NFPA 13.			
K 67	Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's	1. facility did not have Heating, Ventilation and Air Conditioning system in compliance with NFPA 90A.			

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	specifications.	2. air supplied to the corridor without proper returns			
		3. facility did not have fire dampers located in or properly installed in rated shafts and floors.			
K 104	Penetrations of smoke barriers by ducts are protected in accordance with 8.3.6.	1. facility did not have smoke dampers in the smoke barrier walls			
		2. facility failed to protect duct penetrations of smoke barriers with smoke dampers at two locations.			
K 130	OTHER LSC DEFICIENCY: NFPA 101, 19.2.5.8 states “Suites of rooms, other than patient sleeping rooms, shall be permitted to have one intervening room if the travel distance within the suite to the exit access door does not exceed 100 ft and shall be permitted to have two intervening rooms where the travel distance within the suite to the exit access door does not exceed 50 ft.: OTHER LSC DEFICIENCY NOT ON 2786	1. procedure room had a wood peg-board on the wall that did not have a Class A, B, or C rating; stairs had a closet opening into the stairs and storage in the stairs; medical records room was not enclosed with one hour walls and rated doors nor did the sprinkler system conform to NFPA 13; corridor in the basement by the restroom, does not have full sprinkler coverage. At a second outpt location, procedure room had a wood peg-board on the wall that did not have a Class A, B, or C rating; hazardous areas were not enclosed in 1 hour rated walls nor fully sprinklered			
		2. exit distance is greater than 50 feet			
		3. cites uncorrected at V.V.: facility did not have labeled fire doors, the doors did not latch nor did the doors have panic hardware; . facility did not have stairwell walls that are enclosed with one hour fire resistance rating; door to the elevator equipment room, which is a hazardous area, did not have a fire rating nor did it have a closer;			

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		4. did not have exterior windows that were breakable, openable or had a smoke evacuation system.			
K 21	Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure is held open only by devices arranged to automatically close all such doors by zone or throughout the facility…	1. Stairwell 'B' door was not self-closing to keep the door in a normally closed position per NFPA 101 Section 19.3.1.2. The door closer was observed hanging from the door not attached to the door frame			
		2. floor penetrations not properly fire stopped			
		3. doors were held open improperly			
K 29	One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas…	1. numerous wall construction deficiencies from penetrations in fire-rated walls (1-hour or 2-hour) and door deficiencies not meeting either a ¾-hour or 90 minute fire/smoke rating.			
		2. facility failed to protect door opening to one hazardous area with a self-closing door			
K 67	Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications.	1. numerous deficiencies with the installation and maintenance of the heating, ventilating, and air conditioning system as identified in NFPA 101 2000 Edition			
		2. facility did not have fire dampers located in or properly installed in rated shafts and floors.			
K 103	Interior walls and partitions in buildings of Type I or Type II construction are noncombustible or limited-combustible materials. OTHER LSC	1. numerous interior walls and partitions built of exposed wood studs and chicken wire in the basement open area			

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	DEFICIENCY	2. numerous 'animal droppings' in different corners of different rooms including AHU #3 room, incinerator room, soiled linen chute room, service tunnel areas, janitor closet, equipment storage room, and stairwells; laundry room roof drain is missing insulation around pipe to prevent freezing in winter and condensation droppings onto clean linens and patient or resident clothes; laundry room waste water floor grate was damaged; laundry room south wall and ceiling were dusty and dirty; facility staff bring dirty carts across the clean laundry area			
K 147	Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2	1. electrical panel with non-compliant lock-out clips. There was black tape over the breaker switches in the 'on or off' position depending on what was needed or what they were working on. The Laundry Room is a 'Wet Location' creating a dangerous situation for persons working on the electrical panel when the laundry room is in operation. A cart was observed in front of the electrical panel which is also not code, a 3'-0" distance is required in front of all electrical panels			
		2. did not meet the requirements of NFPA 70 for an electrical system that meets the National Electrical Code			
K 39	Width of aisles or corridors (clear and unobstructed) serving as exit access is at least 4 feet. 19.2.3.3	1. multiple objects in the corridor that are not attended and the objects are obstructing the corridor.			
		2. facility did maintain minimum corridor width			

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K 61	Required automatic sprinkler systems have valves supervised so that at least a local alarm will sound when the valves are closed. NFPA 72, 9.7.2.1	1. facility did not have tamper switches on the control valves for the sprinkler system			
		2. building did not have a tamper switch connected to the fire alarm system that indicates that the control valve has been moved			
R 865	The buildings of the hospital shall be constructed and maintained so that hey are functional for diagnosis and treatment and for the delivery of hospital services appropriate to the needs of the community and with due regard for protecting the health and safety of the patients.	1. hospital failed to insure properly functional fire alarm system.			
		2. Exit hallways were found to be blocked causing a hazard in case of a fire if patients and staff are attempting to evacuate in a smoke filled hallway.			
		3. facility does not meet accepted patient safety guidelines of providing an environment that is free of possible suicide hazards; 9 suicide attempts connected to these hazards			
QAPI			4	3	
Chief of Service			0	0	
Psychiatric Services			0	0	
Other			1	3	
	1 federal CAH specific; 1 state maternity; 2 state Caregiver				

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	Total Federal/State Cites		139	63	
	Total Cites		202		