

Department of Health and Family Services					
Division of Quality Assurance					
Hospital Citation Report for October 1, 2007 - December 31, 2007					
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Tag	Regulation	Basis for Citation	# Fed Cites	# State Cites	
		registered nurse failed to properly assess and document the actual skin condition of patients in the ICU.	0	0	
	Discharge Planning				
	EMTALA		8	0	
A 2400	[The provider agrees,] in the case of a hospital as defined in §489.24(b), to comply with §489.24.	1. not in compliance with CFR 489.24 Emergency Medical Treatment and Labor Act in regards to providing a medical screening examination			
		2. hospital failed to be in compliance with CFR 482.24 (2406, 2407, 2408, and 2409 all out of compliance)			
A 2402					
A 2406	In the case of a hospital that has an emergency department, if an individual (whether or not eligible for Medicare benefits and regardless of ability to pay) "comes to the emergency department", as defined in paragraph (b) of this section, the hospital must provide an appropriate medical screening examination within the capability of the hospital's emergency department, including ancillary services routinely available to the emergency department, to determine whether or not an emergency medical condition exists. The examination must be conducted by an individual(s) who is determined qualified by hospital bylaws or rules and regulations and who meets the requirements of §482.55 of this chapter concerning emergency services personnel and direction. etc.	1. nurse failed to triage and the physician failed to provide medical screenings to patients that left the Emergency Department without being seen			
		2. hospital failed to provide nursing assessments, continued monitoring and emergency medical screening to determine if an emergency medical condition existed			
A 2407					
A 2408					
A 2409					
	Governing Body		1	1	
A 84					

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R 323		registered nurse failed to properly assess and document the actual skin condition of patients in the ICU.			
Swing Bed: Hospital and CAH			1	0	
C 280					
Infection Control			2	4	
A 749					
C 278					
R 294					
R 295					
R 296					
R 312					
Medical Record Services			8	6	
A 43					
A 340	All patient medical record entries must be dated and timed.	1. facility failed to ensure all entries in the medical record are timed including History and Physicals, Advance Directive acknowledgements, progress notes, Nutritional assessments, Speech, Physical and Occupational therapy assessments and discharge summaries, and Discharge Aftercare Plan; failed to ensure all dictated documents are authenticated with a date and time; and failed to ensure daily nursing assessments are timed when completed.			
A 449					
A 455	All verbal orders must be dated, timed, and authenticated promptly by the ordering practitioner, except as noted in paragraph (c)(1)(ii) of this section.	1. hospital failed to authenticate verbal/telephone orders for patients in restraints.			
A 406					
A 452					
C 306					
C 307					

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R 378	Medical staff by-laws and rules shall include: A statement specifying categories of personnel duly authorized to accept and implement medical staff orders. All orders shall be recorded and authenticated. All verbal and telephone orders shall be authenticated by the prescribing member of the medical staff in writing within 24 hours of receipt.	<p>registered nurse failed to properly assess and document the actual skin condition of patients in the ICU.</p> <p>1. facility failed to ensure all orders had the time it is written and/or telephone orders are authenticated by the MD (medical doctor) with a date and time.</p>			
		2. facility failed to ensure all orders were written with a date and/or time and all verbal, telephone and standing orders were authenticated by the MD with a date and/or time.			
R 463					
R 471					
R 496					
R 810					
<b>Medical Staff</b>			<b>0</b>	<b>0</b>	
R 329					
<b>Nursing Services</b>			<b>3</b>	<b>10</b>	
A 395	A registered nurse must supervise and evaluate the nursing care for each patient.	1. registered nurses (RN) failed to supervise and evaluate when RN's delegated patient assessments to 16 licensed practical nurses (LPN) without oversight			
		2. registered nurse failed to properly assess and document the actual skin condition of patients in the ICU.			
		3. hospital nursing staff failed to ensure that patients are protected from harm from patients who are known to be dangerous to others. In addition, nursing staff failed to notify the physician after a patient with a colostomy, ileostomy, spinal fusion or her broken foot with a cast was pushed to the ground by another patient.			

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R 417	A registered nurse shall plan, supervise and evaluate the care of all patients, including the care assigned to other nursing personnel.	<p>registered nurse failed to properly assess and document the actual skin condition of patients in the ICU.</p> <p>1. the registered nurse failed to properly assess and document the actual skin condition of 1 of 5 patients in the ICU.</p> <p>2. hospital failed to provide necessary safety plan according to their ED policy, and failed to provide the necessary supervision in an attempt to prevent injury</p> <p>3. hospital nursing staff failed to ensure that patients are protected from harm from patients who are known to be dangerous to others.</p> <p>4. failed to ensure that the registered nurse evaluated care given to patients assigned to other nursing personnel.</p>			
R 428					
R 431	Documentation of nursing care shall be pertinent and concise and shall describe patient needs, problems, capabilities and limitations Nursing interventions and patient responses shall be noted.	<p>1. hospital failed to document fall risk factors and failed to document responses to treatment in the ER</p> <p>2. in obstetric medical records, the facility failed to ensure nursing documentation contained patient concerns, nursing actions and patient response.</p> <p>3. hospital failed to document nursing interventions for the treatment of pressure ulcers</p> <p>4. facility failed to ensure documentation of response to narcotic treatments for pain.</p>			
R 442					
Services: Anesthesia, Emrgcy, Food & Dietetic, Nucl Medicine, Respiratory, Outpt, Radiologic, Rehab & Surgical			5	7	
A 93					
A 621					
A 622					
A 630					
C 332					
R 429					
R 536					
R 554					
R 567					

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R 765		registered nurse failed to properly assess and document the actual skin condition of patients in the ICU.			
R 673					
R 810					
Pharmaceutical Services			3	2	
A 405					
A 505					
A 508					
R 519					
R 530					
Organ Tissue, Eye Procurement			0	0	
Patient Rights			7	6	
A 122					
A 131					
A 143					
A 144					
A 179					
A 184					
A 185					
R 237					
R 242					
R 243					
R 244					
R 250					
R 252					
Physical Environment (all K tags are counted as federal cites)			36	1	

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A 700	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.	<p>registered nurse failed to properly assess and document the actual skin condition of patients in the ICU.</p> <p>1. Unsealed penetrations through floors ( K 11), Door closer disconnected (K 21), Egress paths not clearly identified (K22), Hazardous areas not enclosed (K 29), Exit passages not fire resistive (K33), Lack of egress lighting (K 45), Smoke barriers do not meet UL design (K 104), Doors with delay egress lacked signage (K130)</p>			
		2. patient exam room door was not properly fitted with a door closer (K27), a sprinkler was blocked in a patient exam room (K56).			
A 709	The hospital must ensure that specific life safety from fire requirements are met.				
		2. patient exam room door was not properly fitted with a door closer (K27), a sprinkler was blocked in a patient exam room (K56).			
A 724					
C 220	Physical Plant and Environment	1. At a verification visit, it was found that (i) essential electrical power critical branch outlets (red outlets) were not yet installed in all 25 patient bed locations, and in one infant nursery room on the 1st floor; (ii) ducted ventilation supply air into each patient room in the Med-Surge Unit on the 1st Floor was not yet installed.			

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		registered nurse failed to properly assess and document the actual skin condition of patients in the ICU. 2.Facility failed to construct, install and maintain the building systems to ensure life safety to patients. The facility was found to contain the following deficiencies. Refer to the the full description at the cited K-tags: incorrect construction type caused by unsealed floor penetration and fire proofing missing on steel beams, (K12); areas open to the corridor not properly supervised (K17); corridor doors that did not latch, (K-18); fire or smoke barrier doors than had hold opens that did not have local smoke detectors (K21); smoke barriers walls not constructed properly (K25); no vision panel in across corridor smoke barrier doors, (K27); hazardous areas improperly enclosed (K29); improper exit discharge from a stair exit (K34), deficiencies in the sprinkler system (K56); air handler room as part of a shaft enclosure that did contain gas fired hot water boilers, (K67); paper covering the walls (K72); soiled linen hoppers exceeding the amount of storage per square foot (K75); improper location and labeling of medical gas valves (K77); the emergency generator sys			
C 231					
K 11					
K 12					
K 17					
K 18					

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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 upon activation of: a) the required manual fire alarm system; b) local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and c) the automatic sprinkler system, if installed. 19.2.2.2.6, 7.2.1.8.2	registered nurse failed to properly assess and document the actual skin condition of patients in the ICU. 1. facility failed to ensure the doors within rated walls are only held open with appropriate release devices and associated smoke detection.			
		2. facility failed to provide local smoke detectors at fire rated doors being held open by magnet hold-open devices and are tied to the fire alarm system			
K 22	a) the required manual fire alarm system;				
K 25					
K 27	Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7	1. doors were not properly installed with closers			
		2. across-corridor smoke doors that did not have a vision panel in the door as required in 18.3.7.7.			

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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. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1	<p>registered nurse failed to properly assess and document the actual skin condition of patients in the ICU.</p> <p>1. the facility failed to enclose hazardous areas with 1-hour rated construction and ¾ hour rated doors.</p>			
		2. facility failed to provide reliable hazardous room enclosures. Enclosures were circumvented by improper membrane penetrations, lack of a membrane enclosure or non-fire rated doors, thus, subjecting the compartment to potential toxic smoke and/or gases in the event of a fire.			
K 33					
K 34					
K 45					

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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. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5	registered nurse failed to properly assess and document the actual skin condition of patients in the ICU. 1. sprinkler discharges were blocked			
		2. sprinkler water flow was blocked by inappropriate storage, heads were missing, or inappropriately installed			
K 67					
K 72					
K 75					
K 77					
K 104					
K 106					

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K 130	OTHER LSC DEFICIENCY NOT ON 2786	registered nurse failed to properly assess and document the actual skin condition of patients in the ICU. 1. facility failed to provide exit doors that were kept unlocked at all times, as required by NFPA 101, 7.2.1.5.1. "doors shall be arranged to be pended readily from the egress side whenever the building is occupied". Delayed-egress locks are permitted, under NFPA 101, 7.2.1.6.1, only when the building is fully sprinkled and with signage on the door that reads "push until alarm sounds...door can be opened in 15 seconds".			
		2. facility failed to provide unoccupied rooms from opening onto stairs or exit passageways and failed to provide a barrier to prevent people from going beyond the level of exit discharge.			
K 147	Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2	1. On a verification visit, it was found that electrical outlets supplied by the critical branch of emergency power were not yet installed			
		2. lack of 3 feet of clearance in front of electrical panels and use of extension cords			
R 941					
QAPI			0	0	
Chief of Service			0	0	
Psychiatric Services			2	2	
A 999					
C 9999					
R 836					
R 843					
Other			0	2	
Z 005					
Z 0012					

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	Total Federal/State Cites	registered nurse failed to properly assess and document the actual skin condition of patients in the ICU.	76	41		
	Total Cites		117			