

| Department of Health and Family Services | | | | |
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| Division of Quality Assurance | | | | |
| Hospital Citation Report for July 1, 2007 -September 30, 2007 | | | | |
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| Discharge Planning | | | 2 | 2 |
| A 357 | | | | |
| C 294 | | | | |
| R 233 | The discharge planning program shall:Provide that every patient receive relevant information concerning continuing health needs and is appropriately involved in his or her own discharge planning; | 1. the hospital did not ensure that nursing staff provide each patient/representative relevant information concerning continuing health care needs at the time of discharge. | | |
| | | 2. the hospital failed to provide the receiving facility information regarding the need to monitor for complications after removing a central line | | |
| EMTALA | | | 4 | 0 |
| A 2400 | | | | |
| A 2405 | | | | |
| A 2406 | | | | |
| A 2407 | | | | |
| Governing Body | | | 1 | 2 |
| A 84 | | | | |
| R 212 | | | | |
| R 323 | | | | |
| Swing Bed: Hospital and CAH | | | 4 | 0 |
| C 271 | | | | |
| C 272 | | | | |
| C 280 | These policies are reviewed at least annually by the group of professional personnel required under paragraph (a)(2) of this section, and reviewed as necessary by the Critical Access Hospital. | 1. the hospital does not ensure that all hospital policies and procedures are reviewed at least annually. Some have not been reviewed since 2001 when the hospital became a Critical Access Hospital. | | |

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| | | 2. policy and procedures for departments of Housekeeping, Rehabilitation, Dietary, Plant Operations, Human Resources and Finance have not had their annual review since their Critical Access Certification. Per Chief Quality Officer, there is not always a Medical Doctor involved in the approval of policies. | | |
| C 385 | | | | |
| | | | 7 | 6 |
| | Infection Control | | | |
| A 747 | The hospital must provide a sanitary environment to avoid sources and transmission of infections and communicable diseases. There must be an active program for the prevention, control, and investigation of infections and communicable diseases. | 1. hospital failed to implement a policy or plan of action to prevent infections and cross contamination while caring for patients during a water use advisory ; failed to properly inform patients and visitors that the hospital was under a water use restriction order issued by the Wisconsin Department of Natural Resources; failed to provide education to their staff and patient's on infection control, cross contamination and handwashing technique while the hospital was under a water use advisory, and had no running water. | | |
| | | 2. hospital failed to maintain a sanitary care environment in order to prevent and/or control the transmission of infections and communicable diseases; failed to have an effective environmental surveillance system with regard to departmental monitoring for housekeeping cleanliness, wall and ceiling surface maintenance, and on-going monitoring of construction projects; failed to have an active infection control program that was hospital-wide, inclusive of all hospital locations and departments, that covered all in-and out-patients care and services; staff failed to follow infection control guidelines to prevent biohazardous splash injuries and failed to demonstrate proper handwashing procedures. | | |
| A 748 | | | | |
| A 749 | | | | |
| A 750 | | | | |

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| C 278 | The policies include a system for identifying, reporting, investigating and controlling infections and communicable diseases of patients and personnel. | 1. the hospital does not ensure that, nursing staff observe universal precautions, that patient equipment is kept clean, that dirty and clean areas and equipment are kept separate, that the surgery department floors are kept clean, and that staff wear personal protective equipment. | | | |
| | | 2. facility failed to ensure there is an active surveillance program in place to control and prevent infections | | | |
| 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. the hospital does not ensure that, nursing staff observe universal precautions, that patient equipment is kept clean, that dirty and clean areas and equipment are kept separate, that the surgery department floors are kept clean, and that staff wear personal protective equipment. | | | |
| | | 2. facility failed to ensure there is an active surveillance program in place to control and prevent infections | | | |
| | | 3. hospital failed to provide a sanitary environment when the water pump malfunctioned during the scheduled water shut down. | | | |
| | | 4. hospital failed to maintain a sanitary care environment in order to prevent and/or control the transmission of infections and communicable diseases. | | | |
| R 492 | | | | | |
| R 310 | | | | | |
| Medical Record Services | | | 11 | 15 | |
| A 230 | | | | | |
| A 449 | | | | | |
| A 467 | | | | | |
| A 452 | | | | | |
| A 454 | | | | | |
| A 466 | | | | | |
| A 468 | | | | | |
| C 304 | | | | | |

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| C 306 | | | | | |
| C 307 | | | | | |
| C 308 | | | | | |
| R 238 | The patient's medical record, including all computerized medical information, shall be kept confidential; | 1. facility failed to ensure all medical records are protected from unauthorized individuals. | | | |
| | | 2. hospital staff failed to ensure the confidentiality of patient records. | | | |
| R 367 | | | | | |
| R 374 | | | | | |
| 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. | 1. facility failed to ensure all orders were timed when written and /or authenticated with a date and time. | | | |
| | | 2. hospital failed to ensure all entries in the medical record were dated and timed | | | |
| 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. | 1. facility failed to ensure pain interventions were assessed and documented for effectiveness per policy. | | | |
| | | 2. hospital failed to document the response to treatment given to patients filing hospital complaints, and response to treatment of patients receiving CT (Computerized Tomography) scans with contrast media | | | |

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| R 471 | | | | |
| R 473 | | | | |
| 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. the hospital failed to ensure that entries into the medical record are timed, dated, authenticated, and that consents are properly executed. | | |
| | | 2. records did not contained complete authenticated of the physicians; telephone and verbal orders. No documentation was found for the time the physician was notified or the time the physician saw patients in the ER. | | |
| | | 3. records had missing dates, times, signatures of medical and nursing staff. | | |
| R 810 | Adequate medical records to permit continuity of care after provision of emergency services shall be maintained on all patients. The emergency room patient record shall contain: a. Patient identification; b. History of disease or injury; c. Physical findings; d. Laboratory and x-ray reports, if any; e. Diagnosis; f. Record of treatment; g. Disposition of the case; h. Authentication as required by s. HFS 124.14(3)(b); and i. Appropriate time notations, including time of the patient's arrival, time of physician notification, time of treatments, including administration of medications, and time of patient discharge or transfer from the service. | 1. facility failed to ensure the Medical Doctor (MD) notification time and exam time is documented. | | |

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| | | 2. hospital failed to ensure the Medical Doctor (MD) notification time is documented. | | |
| Medical Staff | | | 2 | 1 |
| A 48 | | | | |
| A 757 | | | | |
| R 352 | | | | |
| Nursing Services | | | 6 | 6 |
| A 200 | | | | |
| A 205 | | | | |
| A 306 | | | | |
| A 395 | A registered nurse must supervise and evaluate the nursing care for each patient. | 1. hospital's registered nursing staff failed to evaluate patient's statements of Depression when admitted. | | |
| | | 2. registered nurses failed to supervise and evaluate restraints; failed to supervise and evaluate patients experiencing pain; and failed to supervise and evaluate infant breast feeding ability | | |
| C 298 | | | | |
| R 417 | | 1. hospital failed to keep current care plan; No care plan was initiated or updated to address risk of skin break down or potential for weight loss related to Patient immobility, and week long illness and dehydration from the nausea and vomiting; No care plan was initiated nutritional deficits related a week long illness including nausea, vomiting, and diarrhea; No care plan was initiated for gastrointestinal symptoms;No care plan was initiated after central line was placed to define monitoring or potential complications, or for what purposes the central line was to be used for example medication administration or laboratory blood draws, and special consideration that coincide with using the central line. | | |
| | | 2. hospital's registered nursing staff failed to evaluate patient's statements of Depression when admitted. | | |

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| | | 3. registered nurses failed to supervise and evaluate restraints ; failed to supervise and evaluate patients experiencing pain; and failed to supervise and evaluate infant breast feeding ability | | | |
| R 425 | | | | | |
| R 428 | | | | | |
| R 430 | | | | | |
| | Services: Anesthesia, Emrgcy, Food & Dietetic, Nucl Medicine, Respiratory, Outprt, Radiologic, Rehab & Surgical | | 8 | 11 | |
| A 93 | | | | | |
| A 622 | | | | | |
| A 629 | | | | | |
| A 1002 | | | | | |
| A 1004 | | | | | |
| A 1104 | | | | | |
| C 279 | | | | | |
| C 322 | | | | | |
| R 536 | | | | | |
| R 554 | Equipment and work areas shall be clean and orderly. Effective procedures for cleaning and sanitizing all equipment and work areas shall be consistently followed in order to safeguard the health of the patients. | 1. the facility did not have sufficient systems to assure adequate nutritional intake for patients. The facility did not have a system to assure that food and food equipment were handled in a sanitary manner consistent with recognized dietary practices. | | | |
| | | 2. hospital failed to have competent staff in the food service department to assure that equipment was properly cleaned prior to use in food preparation and to assure that cooling temperatures of potentially hazardous foods are monitored according to recognized standards of practice found in the Food and Drug Administration (FDA) Food Code. | | | |
| R 556 | | | | | |
| R 558 | | | | | |
| R 566 | | | | | |
| R 567 | | | | | |
| R 660 | | | | | |

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| R 673 | Every surgical patient shall have a preanesthetic evaluation by a person qualified to administer anesthesia, with findings recorded within 48 hours before surgery, a preanesthetic visit by the person administering the anesthesia, and an anesthetic record and post-anesthetic follow-up examination, with findings recorded within 48 hours after surgery by the individual who administers the anesthesia. | 1. facility failed to ensure the pre-anesthesia examination was documented per policy and the post-anesthesia examination note contained an evaluation of the patient following post-anesthesia recovery including Cardiopulmonary status, level of consciousness, observations and any complications. | | | |
| | | 2. hospital failed to ensure that pre-anesthesia evaluations were completed within the 48 hours timeframe and complied with hospital policy. | | | |
| R 789 | | | | | |
| Pharmaceutical Services | | | 6 | 7 | |
| A 404 | | | | | |
| A 505 | | | | | |
| C 276 | The policies include rules for the storage, handling, dispensation, and administration of drugs and biologicals. These rules must provide that there is a drug storage area that is administered in accordance with accepted professional principles, that current and accurate records are kept of the receipt and disposition of all scheduled drugs, and that outdated, mislabeled, or otherwise unusable drugs are not available for patient use. | 1. hospital failed to ensure that the hospital keeps current a drug formulary, that nursing staff are trained to prepare sterile parenteral or intravenous products, and that nursing and pharmacy staff do not accept "blanket orders" from medical staff per hospital policy and procedure. | | | |
| | | 2. facility failed to ensure all expired medications are not available to patients, all medication are labeled per policy, all medications are secured and monitored, sample medications are inventoried and reconciled per policy, medication refrigerator temperatures are recorded per policy and all medications are administered per policy. | | | |
| C 277 | | | | | |
| C 297 | | | | | |
| R 442 | | | | | |

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| R 511 | | | | |
| R 517 | Storage and equipment. Drugs shall be stored under proper conditions of sanitation, temperature, light, moisture, ventilation, segregation and security. In a pharmacy, current reference materials and equipment shall be provided for the compounding and dispensing of drugs. Hospitals utilizing automated dispensing systems must meet the requirements under Phar 7.09. | 1. facility failed to ensure all medications are unavailable to unauthorized staff and individuals, medication refrigerators are monitored per policy and crash carts are checked for security per policy. | | |
| | | 2. hospital failed to ensure medications were properly stored and/or labeled once prepared or opened per facility policy; and that outdated biologicals were not available for patient use. | | |
| R 519 | | | | |
| R 530 | | | | |
| R 533 | | | | |
| Organ Tissue, Eye Procurement | | | 6 | 1 |
| A 369 | | | | |
| A 370 | | | | |
| A 371 | | | | |
| A 372 | | | | |
| A 373 | | | | |
| A 376 | | | | |
| R 271 | | | | |
| Patient Rights | | | 25 | 9 |
| A 40 | | | | |
| A 41 | | | | |
| A 42 | | | | |
| A 57 | | | | |
| A 115 | | | | |
| A 117 | | | | |
| A 118 | | | | |
| A 120 | | | | |

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| A 123 | In its resolution of the grievance, the hospital must provide the patient with written notice of its decision that contains the name of the hospital contact person, the steps taken on behalf of the patient to investigate the grievance, the results of the grievance process, and the date of completion. | 1. hospital failed provide resolution and written notice for complaints filed. | | | |
| | | 2. hospital failed to provide complainants who were referred from the Clients Rights Facilitator, on to other departments, with written resolution to the grievance. | | | |
| | | 3. hospital failed to provide a written notice of the hospital's decision-making, inclusive of the hospital contact person, investigative details, grievance process results with completion date | | | |
| A 129 | | | | | |
| A 130 | | | | | |
| A 131 | | | | | |
| A 132 | | | | | |
| A 144 | | | | | |
| A 146 | | | | | |
| A 164 | | | | | |
| A 168 | | | | | |
| A 172 | | | | | |
| A 174 | | | | | |
| A 700 | | | | | |
| A 709 | | | | | |
| A 722 | | | | | |
| C 364 | | | | | |
| R 242 | Every patient shall have the opportunity to participate to the fullest extent possible in planning for his or her care and treatment; | 1. hospital failed to allow Patient to implement his pain management during a scheduled offsite | | | |
| | | 2. hospital failed to give patients the right to formulate an advanced directive | | | |

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| R 243 | Every patient or his or her designated representative shall be given at the time of admission, a copy of the hospital's policies on patient rights and responsibilities | 1. hospital does not ensure that patients/representatives are given a copy of all patient rights at the time of admission. | | | |
| | | 2. the facility failed to include all patient rights in the patient rights brochure; 9 rights were missing including the right to file complaint with DHFS. | | | |
| | | 3. the hospital failed to provide Patient Rights information in advance of furnishing services | | | |
| | | 4. failed to inform patients/ patient representatives of their patient's rights in advance of furnishing patient cares. | | | |
| R 245 | | | | | |
| R 250 | | | | | |
| R 265 | | | | | |
| Physical Environment (all K tags are counted as federal cites) | | | 74 | 2 | |
| A 700 | | | | | |
| A 701 | | | | | |
| A 709 | | | | | |
| R 865 | | | | | |
| R 899 | | | | | |
| C 220 | The CAH must ensure that specific physical plant and environment requirements are met. | 1. Refer to the the full description at the cited K-tags: corridor doors not properly latching (K-18), incorrect marking of exits (K-22), hazardous areas improperly enclosed (K-29), the proper travel exit distance through a suite (K-36), clear and unobstructed corridors (K-39), deficiencies in the sprinkler system (K-56), improper testing and inspection of sprinkler system (K-62), and deficiencies in the distance between the propane and oxygen tanks (K-130). | | | |

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| | | 2.the facility failed to construct, install and maintain the building systems to ensure life safety to patients due to unsealed penetrations in fire and smoke barriers, one fire door not installed as automatic closing, non-latching exit stairwell door and exit access corridor doors, one vertical fire shutter not automatic closing, lack of a continuous fire-rated exit passageway from one stairwell, lack of self-closing device or latching hardware on doors of hazardous areas, corridors not kept clear and unobstructed, obstructions to sprinkler discharge pattern, and lack of emergency power outlets in patient care areas. | | | |
| C 222 | | | | | |
| C 226 | | | | | |
| C 231 | Except as otherwise provided in this section, the CAH must meet the applicable provisions of the 2000 edition of the Life Safety Code of the National Fire Protection Association... | 1. Refer to the the full description at the cited K-tags: corridor doors not properly latching (K-18), incorrect marking of exits (K-22), hazardous areas improperly enclosed (K-29), the proper travel exit distance through a suite (K-36), clear and unobstructed corridors (K-39), deficiencies in the sprinkler system (K-56), improper testing and inspection of sprinkler system (K-62), and deficiencies in the distance between the propane and oxygen tanks (K-130). | | | |

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| | | 2. Failed to protect the life safety of patients from fire due to (1)unsealed pipe and cable penetrations in 2 hr occupancy separation, 2-hr fire and smoke barriers, and lack of fire-stopping along the top edge of fire barriers where the wall intersects with floor or roof deck above; (2)Mail Room that is kept open to corridor with its window opening protected with a fire shutter that cannot close due to obstructions in the window opening, and that does not automatically close upon activation of fire alarm or sprinkler system or local smoke detectors;(3) lack of positive latching hardware on several exit access corridor doors; (4) fire door in a 2-hr fire and smoke barrier not installed as automatic closing upon activation of building fire alarm or sprinkler system, and due to one set of double smoke doors having a more than necessary gap at the meeting edge; (5) failure to provide a 1-hr fire-rated continuous exit passageway from stairwell, and due to a non-latching stairwell door; (6)corridors not kept clear and unobstructed; etc. | | | |
| K 11 | | | | | |
| K 11 | | | | | |
| K 12 | | | | | |

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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. facility failed to provide smoke-tight corridor walls, or to meet the permitted exceptions via smoke detection or sprinkler protection for spaces open to a corridor. | | | |
| | | 2. facility failed to separate a patient use area from corridors | | | |
| | | 3. facility failed to protect opening in corridor wall with a properly installed shutter that closes upon activation of fire alarm system, or local smoke detectors. | | | |

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| 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. facility failed to provide a door to the corridor that latched in the x ray gownned waiting room. | | | |
| | | 2. exit access corridor doors did not have suitable means, such as a positive latching hardware, to keep the door closed. | | | |
| | | 3. the facility failed to provide corridor doors with a reliable latching device and ensure a smoke-tight seal. | | | |
| | | 4. facility failed to properly install a corridor door that prevents a passage of smoke into corridor due to a lack of astragal in one Dutch door | | | |
| K 20 | Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least one hour. An atrium may be used in accordance with 8.2.5.6. 19.3.1.1. | 1. facility failed to maintain one stairwell door functional due to failure to latch | | | |

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| | | 2. facility failed to provide rated enclosures of vertical openings, because of untapped drywall, unsealed penetrations, as required by NFPA 101-8.2.3.2.4.2. | | | |
| 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. 19.2226-72182 | 1. failure of a fire-rated door in 2-hr fire and smoke barrier to automatically close | | | |
| | | 2. facility failed to properly install smoke doors to automatically close upon activation of fire alarm system | | | |
| K 22 | Access to exits is marked by approved, readily visible signs in all cases where the exit or way to reach exit is not readily apparent to the occupants. 7.10.1.4 | 1. facility failed to provide exit signs pointing a path to an exit | | | |
| | | 2. facility failed to ensure the path of egress is clearly identified by exit signage in corridors. | | | |

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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. facility failed to provide a 2-hr fire/smoke barrier wall between the sprinkler protected 1990 building and a partially sprinklered building | | | |
| | | 2. facility failed to maintain a 1/2 hr fire-resistance rating and smoke tightness of smoke barriers due to unsealed penetrations and smoke doors that did not provide a smoke-tight seal. | | | |
| | | 3. failed to maintain a one-half fire resistance rating of one smoke barrier due to unsealed penetration and lack of fire stop sealant on top of the smoke barrier below the floor deck above | | | |

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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 | 1. 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. | | | |
| | | 2. hazardous areas were not properly enclosed | | | |
| K 27 | | | | | |
| K 28 | | | | | |
| K 29 | | | | | |
| K 33 | | | | | |
| K 34 | | | | | |
| K 36 | | | | | |
| K 38 | Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 | 1. facility failed to ensure that all corridors are readily accessible because a door signed as an exit was found locked. | | | |
| | | 2. facility failed to maintain exit access cross-corridor doors such that doors can be opened readily from the egress side | | | |
| | | 3. failure of exit access doors and stairwell exits to open readily from the egress side. | | | |
| K 39 | Width of aisles or corridors (clear and unobstructed) serving as exit access is at least 4 feet. 19.2.3.3 | 1. facility failed to provide clear and unobstructed corridors because of storage in the corridor. | | | |

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| | | 2. facility failed to maintain exit access corridors free of obstructions | | | |
| | | 3. facility failed to provide 8 foot wide corridors in inpatient areas because doors that swing out into the corridor obstructs the required egress width by more than 7 " when in the full open position. | | | |
| | | 4. objects stored in corridors in the following three locations provided obstruction to access to exits | | | |
| K 45 | | | | | |
| K 51 | | | | | |
| 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 | 1. facility failed to provide a sprinkler system that complies with NFPA 13; sprinkler water flow was blocked by inappropriate storage, heads were missing, or inappropriately installed | | | |
| | | 2. facility failed to install the sprinkler system in accordance with NFPA 13 due to obstructions to sprinkler discharge pattern | | | |

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| | | 3. the facility failed to provide a sprinkler system that complies with NFPA 13. | | | |
| K 61 | | | | | |
| K 62 | | | | | |
| K 63 | | | | | |
| 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. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2 | 1. facility failed to provide a ventilation system described in NFPA 90A.(12 examples | | | |
| | | 2. facility failed to provide a ventilation system described in NFPA 90A. | | | |
| K 72 | | | | | |
| K 74 | | | | | |
| K 75 | | | | | |
| K 76 | | | | | |
| K 77 | | | | | |
| K 104 | | | | | |
| K 106 | Hospitals, and nursing homes and hospices with life support equipment, have a Type I Essential Electrical System powered by a generator with a transfer switch and separate power supply. The EES is in accordance with NFPA 99, 3.4.2.2, 3.4.2.1.4. | 1. facility failed to provide an essential electrical system that had the required automatic transfer switches for the life safety, critical and equipment branches for transfer and retransfer, and two separate systems to supply essential loads upon loss of normal power. | | | |
| | | 2. the facility's essential electrical system did not have (i) automatic transfer switches for the life safety, critical and equipment branches for transfer and retransfer, and (ii) two separate systems to supply essential loads upon loss of normal power. | | | |

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| K 130 | OTHER LSC DEFICIENCY NOT ON 2786 | 1. facility failed to provide the proper distance between the bulk oxygen tank and the propane tank which is over 1000 gallons per NFPA 50; the propane tank and the oxygen tank were closer than 25 feet from each other and there was not a 2 hour wall between the two. | | | |
| | | 2. Clinic failed to ensure safety to patients due to objects stored in front of HVAC units, and electrical panels and switches in Mechanical Rooms. | | | |
| | | 3. facility failed to provide evidence that all doors in fire barriers provided the appropriate fire protective rating for the location they were installed, as required by NFPA 101 (2000 ed), 8.2.3.2.1; facility failed to maintain all panic exit devices in operating condition when the device was no longer required to satisfy code requirements, as described by NFPA 101 (2000 ed), 4.6.12.1; the facility failed to prohibit communicating openings between adjacent stairwells, as required by NFPA 101 (2000 ed), 7.1.3.2.1(f); facility failed to provide patient sleeping suites that were less than 5000 sq ft in size, as required by NFPA 101 (2000 ed), 19.2.5.6. The facility also failed to provide non-sleeping suites that had a maximum travel distance of 50 ' when passing through two intervening rooms, as required by NFPA 101 (2000 ed), 19.2.5.8; facility failed to provide a smoke purge system at all anesthetizing locations, as required by NFPA 99 (1999 ed), 5-4.1.3. | | | |

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| | | 4. facility failed to maintain cross-corridor doors in smoke partitions and fire barriers due to lack of automatic-closing smoke and fire doors to fully close, and latch in case of fire doors; facility failed to maintain corridors free of obstructions as required by NFPA 101 7.1.10.1; facility failed to provide reliable hazardous room enclosures. Enclosures had deficiencies with improperly functioning hardware and unsealed wall penetrations; facility failed to provide a safe exit discharge; failed to install fire extinguisher cabinets so that they are conspicuous; facility failed to properly maintain corridor doors in door openings to hazardous areas due to either an impediment to closing of doors or lack of self-closing device on doors; failed to maintain working clearances in front of electrical switches and panels; failed to provide a clearly delineated exit signage system; failed to maintain a 2-hr fire resistance rating of floor construction due to an unsealed penetration; failed to fire stop the top edge of vertical fire-barriers as required; failed to maintain sprink | | | |
| | | 4. EXIT RATING; EXIT ACCESSIBILITY; | | | |
| K 147 | | 1. facility failed to supply emergency electrical power to patient rooms, and one infant nursery room in accordance with NFPA 70 517-18 | | | |
| | | 2. facility failed to provide an electrical installation compliant with NFPA 70 the National Electrical Code. Access to electrical panels obstructed by storage in multiple locations. | | | |

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| | | 3. facility failed to (i) install branch circuit and receptacles supplied by normal power system in surgery rooms, and (ii) identify receptacles supplied by the critical branch of the emergency power as to the electrical panel and circuit number | | |
| | | 4. FIRE DOOR HOLD-OPEN; EXIT SIGNAGE; PROTECTION FROM HAZARDS; EXIT ACCESSIBILITY; SPRINKLER SYSTEM; OBSTRUCTIONS TO EGRESS WIDTH; ELECTRICAL CODE COMPLIANCE | | |
| | | 5. facility failed to identify critical branch receptacles in two rooms as to which branch circuit and electrical panel the receptacles are connected to in accordance with the NFPA 70 517-19(a) requirement | | |
| | | 6. SMOKE BARRIER RATING; EXIT ACCESSIBILITY; DOOR OPERATION; VENTILATION SYSTEM; MEDICAL GAS PIPING; ELECTRICAL SYSTEM | | |
| | | 7. facility failed to provide a clearly delineated exit signage system | | |
| K 154 | | | | |
| QAPI | | | 2 | 2 |
| A 152 | | | | |
| A 167 | | | | |
| R 324 | | | | |
| R 330 | | | | |
| Chief of Service | | | 0 | 0 |
| Psychiatric Services | | | 0 | 0 |
| Other | | | 0 | 4 |

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| Z 53 | | | | | |
| Z 54 | | | | | |
| Z 55 | Entity's duty to report to the department. Except as provided under par. (b), an entity shall report to the department any allegation of an act, omission or course of conduct described in this chapter as client abuse or neglect or misappropriation of client property committed by any person employed by or under contract with the entity if the person is under the control of the entity. HFS 13.05 (3) (a): REPORT FORM DSL-2447: The entity shall submit its report on a form provided by the department within 7 calendar days from the date the entity knew or should have known about the misconduct. The report shall contain whatever information the department requires. | 1. hospital failed to submit a report within the 7 days required under HFS 13.05 (3) (a) once the became aware of an alleged act of caregiver misconduct for patient whose family complained about alleged staff misconduct | | | |
| | | 2. hospital failed to report to the department an alleged misconduct within 7 days for patient who made an allegation. | | | |
| | | | | | |
| | Total Federal/State Cites | | 158 | 68 | |
| | Total Cites | | 226 | | |