

**Central Regional Hospital (CRH)
Full, Follow-up and Complaint Survey
(November 17-21, 2008)
Plan of Correction**

Corrective Actions	Complete Date
A000 Initial Comments	
The findings resulted in an Immediate Jeopardy (IJ) identification in regards to facility staff's failure to provide care in a safe environment, failure to prevent patient abuse, and failure to prevent patient neglect November 20, 2008 and November 21, 2008 respectively.	
<p>Central Regional Hospital Leadership took immediate steps to address the IJ identifications in the environment as well as the patient abuse and neglect issues surrounding the restraint of a patient on the Acute Admissions Unit (AAU).</p> <p>Functioning Egress Lightings (see also A702, Life Safety POC -K046): Emergency lighting (McBryde East and Edgerton)</p> <p><u>Corrective Action:</u></p> <ul style="list-style-type: none"> a. Exit discharge lighting near employee lounge was repaired and returned to working order. b. Egress lighting in stairway vestibule near Room 625 was repaired and returned to working order. c. Egress lighting in stair #2 on the 5th and 6th floors of McBryde East was repaired and returned to working order. d. Egress lighting in stairway vestibule 4018 on the 4th floor of McBryde East was repaired and returned to working order. e. Egress lighting in stairway vestibule 4025 on the 4th floor of McBryde East was repaired and returned to working order. f. Egress lighting in stairway vestibule 3005 on the 3rd floor of McBryde East was repaired and returned to working order. g. Egress lighting in stairway vestibule 3019 on the 3rd floor of McBryde East was repaired and returned to working order. h. Egress lighting in stairway vestibule 1025 on the 1st floor of McBryde East was repaired and returned to working order. i. Egress lighting on the stairway landing at exit #1 of the Edgerton Building was repaired and returned to working order. j. Egress lighting at exit #5 of the Edgerton Building was repaired and returned to working order. <p><u>Monitoring:</u> The Building & Mechanical Trades Managers, EOC Coordinator, and Safety Officers will monitor and inspect egress lighting while performing scheduled monthly Environmental Rounds. The Environmental Rounds will be adjusted to specifically highlight this item in future rounds. Conditions will be recorded in the Environmental Rounds reports. The results of the Environmental Rounds will receive oversight from the Environment of Care Committee which meets on a monthly basis.</p> <p>Additional lighting inspections will be performed by staff in their respective areas under the coordination of the Safety Officers. The existing PM program will be re-emphasized to appropriate maintenance staff to inspect and repair egress lighting per the PM schedule by retraining of staff.</p> <p>The Unit Administrative Directors will perform weekly general safety inspections of all the units to ensure a safe environment (i.e. doors working</p>	<p>11-21-2008</p> <p>11-21-2008</p> <p>11-21-2008</p> <p>11-21-2008</p> <p>11-21-2008</p> <p>11-21-2008</p> <p>11-21-2008</p> <p>11-21-2008</p> <p>11-21-2008</p> <p>11-21-2008</p> <p>11-21-2008</p> <p>11-21-2008</p> <p>12-9-08</p> <p>Monthly</p> <p>12-12-2008</p>

<p>appropriately, lights on, no wedges) They will perform follow up of any deficiencies and will be responsible for submitting work orders to Central Regional maintenance as appropriate. These checklists will be sent to the Safety Officers on a weekly basis.</p>	
<p>Unobstructed Egress (primary exit door unlocked/unblocked) (See also A701; Life Safety POC K032):</p>	
<p>Egress doors</p>	
<p><u>Corrective actions:</u></p>	
<p>The hardware on the exit discharge door in Stair A2 was changed to include a cylinder on the interior side. This change was made immediately upon notification to the Facility Maintenance Director during the survey. It should also be noted that this level (Lower Level) of the facility had not yet been occupied by staff or patients. Final preparatory actions for occupancy had not yet been completed. The exit at Stair A2 was not a primary or secondary exit for the occupied spaces on the levels above this area.</p>	<p>11/18/08</p>
<p><u>Monitoring:</u></p>	
<p>All exit discharge doors will be inspected by the Building Trades Manager, EOC Coordinator, and Safety Officers during scheduled Environmental Rounds. Conditions will be recorded in the Environmental Rounds reports.</p>	<p>12/8/08</p>
<p>The results of the Environmental Rounds will receive oversight from the Environment of Care Committee which meets monthly.</p>	<p>Monthly</p>
<p>The Locksmith will check all egress hardware quarterly while performing scheduled PM actions.</p>	<p>Quarterly</p>
<p>The Unit Administrative Directors will perform weekly general safety inspections of all the units to ensure a safe environment (i.e. doors working appropriately). They will perform follow up of any deficiencies and will be responsible for submitting work orders to Central Regional Maintenance as appropriate. These checklists will be sent to the Safety officers on a weekly basis.</p>	<p>12/12/08</p>
<p>Functioning Fire Alarm Panel/Fire Watch Procedures for the McBryde East/Hargrove and Williams Buildings (See also A714; Life Safety POC K051):</p>	
<ul style="list-style-type: none"> ▪ As an immediate interim measure to ensure safety, on the evening of 11/19/08 the CRH Environment of Care (EOC) Coordinator met with the CRH – Raleigh campus telecommunicators on duty and advised them of the procedures as outlined in the CRH Fire Watch Policy to follow in the event of a fire or trouble alarm from the fire alarm panel. 	<p>11/19/08</p>
<ul style="list-style-type: none"> ▪ On 11/19/08, the EOC Coordinator hung posters on the CRH Raleigh campus fire alarm panels with instructions on how to respond to a fire alarm or trouble alarm. 	<p>11/19/08</p>
<ul style="list-style-type: none"> ▪ On 11/20/08, the EOC Coordinator developed a formal training program on the emergency procedures for establishing a fire watch. On 11/20/08, all five CRH Raleigh campus telecommunicators were trained on the following procedures to follow in the McBryde-East/ Hargrove and the Williams Buildings. 	<p>11/20/08</p>
<ul style="list-style-type: none"> 1) In the event of a fire alarm the telecommunicators are to immediately dial 911 to report the fire; notify the CRH Safety Officer who will determine whether a fire watch needs to be implemented; notify Central Regional Maintenance who will assess the fire alarm panel and system and make any 	

<p>needed repairs to correct the impairment. The Safety Officer will immediately notify the Hospital Director or the Administrator on call.</p> <p>2) In the event of a trouble alarm for the McBryde-East/Hargrove and Williams Buildings, the telecommunicators will check the power light on the McBryde East & Hargrove fire alarm panel and inform the Safety Officer of its status; contact the Safety Officer, make a public announcement in these buildings that “The Building is operating with a fire alarm impairment and a fire watch is being implemented.” The telecommunicators will also call Central Regional Maintenance (CRM) who will assess the fire alarm panel and system and make any needed repairs to correct the impairment.</p>	
<p><u>Monitoring</u></p> <ul style="list-style-type: none"> ▪ The Safety Officer will perform a monthly check, on all three shifts, to ensure the telecommunicators are following the procedures outlined in the Fire Alarm Control Panel Operation training, as stated above. 	12/4/08
<ul style="list-style-type: none"> ▪ On 12/3/08, the Safety Office conducted live drills to test the performance of the telecommunicators in respect to the fire watch procedures. 	12/3/08
<p>Proper restraining procedures/Monitoring Patients in Restraint; (See also A145, A385, A392)</p> <p>CRH administration immediately began an investigation of the inappropriate restraint episode. The nursing staff involved in the event was put on investigatory leave status pending the outcome of the investigation.</p>	11/19/08
<p><u>Forced Blood Draw: (precipitant to the restraint)</u></p> <ul style="list-style-type: none"> ▪ The CRH medical staff were re-educated on the revised CRH Policy: Non-consenting Patients: Administration of Treatments and Procedures. The revised policy requires the physician to contact the CRH Clinical Director or Director of Medical Services to discuss the need for any forced medical treatment before an order can be written for such. 	12/8/08
<p><u>Monitoring:</u></p> <p>Training rosters verifying that Medical Staff completed review of the revised policy were submitted to the CRH Clinical Director.</p>	12/8/08
<p><u>Appropriate placement of patients in restraint:</u></p> <ul style="list-style-type: none"> • CRH medical staff received re-education that patients should never be restrained face down while in mechanical restraints. 	12/8/08
<p><u>Monitoring:</u></p> <p>Training rosters verifying that Medical Staff received education on the proper placement of patients in mechanical restraint were submitted to the CRH Clinical Director.</p>	12/8/08
<p><u>Appropriate carry and restraint procedures; Nursing Assessment of Restrained patients; Continuous Monitoring of Patients in Restraint</u></p> <ul style="list-style-type: none"> ▪ The CRH Restrictive Interventions policy was revised to specifically state face down restraints are prohibited. The revised policy was approved by the CRH Executive Team. 	12/4/08
<ul style="list-style-type: none"> ▪ Nursing Educators retrained all CRH Adult Admissions Unit nursing staff on the approved NCI techniques for carrying patients and for placing patients in mechanical restraint. 	12/8/08
<ul style="list-style-type: none"> ▪ All CRH nursing staff reviewed a self study training packet stating the requirements for behavioral restrictive interventions including the requirements for assessments, care and monitoring of patients in 	12/8/08

<p>restraint, the use of approved NCI techniques with patients, and release criteria.</p> <p><u>Monitoring:</u> The nursing staff then completed a post-test to affirm their understanding of the requirements for assessing and monitoring patients while in restraint. The completed post tests were submitted to the DON (Raleigh Campus) and the ADON (Butner campus) to confirm the re-education of nursing staff on assessment and reassessment requirements for patients place in restraints.</p> <p>The Risk Manager and/or Senior Nursing Leadership will review at least one episode of mechanical restraint each week on the CRH Butner campus were video monitoring of the seclusion and restraint rooms are available to evaluate whether the staff used approved NCI techniques and provided continuous monitoring of the patient.</p> <p>The ward RNs on the Adult Admissions Unit will call the Nurse Shift Supervisor/Nurse Manager or House Coordinator during off hours after each episode of mechanical restraint. The Nurse Shift Supervisor/Nurse Manager or House Coordinator will review the restraint episode with the ward RN to evaluate compliance by asking a list of structured questions regarding reason for the restraint, how the patient is restrained and the assessment and monitoring provided to the patient once he/she was placed in mechanical restraint. These questionnaires will be submitted to the DON or ADON for review and follow-up as needed.</p>	<p>12/8/08</p> <p>12/5/08</p> <p>12/8/08</p>
A043 482.12 GOVERNING BODY	
<p>The Governing Body failed to ensure:</p> <ol style="list-style-type: none"> 1. maintain an environment for the safety of patients as referenced in the Life Safety survey 2. promote and protect patient rights 3. nursing staff failed to provide safe patient care, assessment of patients and reassessment of patients 4. leadership staff failed to maintain and ensure safe radiological services were provided to the patients 5. leadership failed to maintain an effective, hospital-wide, data-driven quality assessment and performance improvement program 6. Governing body failed to have a system or process in place to ensure rehabilitation services were adequately staffed to provide hearing, vision and speech screenings to children and adolescents. Staff failed to ensure a physician’s order for hearing, vision and speech screenings were completed prior to a patient’s discharge from the facility. 7. Governing Body failed to ensure the facility was adequately and appropriately staffed with trained individuals for the delivery of respiratory services in a safe manner. 	
<ol style="list-style-type: none"> 1. maintain an environment for the safety of patients as referenced in the Life Safety survey (A700, Please refer to the Life Safety Plan of Correction, K Tags) 2. promote and protect patient rights (Please refer to plan of correction A168, A144, A143, A171 for A115) 	

<p>3. nursing staff failed to provide safe patient care, assessment of patients and reassessment of patients (Please refer to plan of correction for A385)</p> <p>4. leadership staff failed to maintain and ensure safe radiological services were provided to the patients (Please refer to plan of correction for A528)</p> <p>5. leadership failed to maintain an effective, hospital-wide, data-driven quality assessment and performance improvement program (Please refer to plan of correction A263)</p> <p>6. Governing body failed to have a system or process in place to ensure rehabilitation services were adequately staffed to provide hearing, vision and speech screenings to children and adolescents. Staff failed to ensure a physician’s order for hearing, vision and speech screenings were completed prior to a patient’s discharge from the facility. (Please refer to plan of correction for A1124)</p> <p>7. Governing Body failed to ensure the facility was adequately and appropriately staffed with trained individuals for the delivery of respiratory services in a safe manner. (Please refer to plan of correction for A1152)</p>	
A 083 482.12 (e) CONTRACTED SERVICES	
Hospital staff failed to ensure a physician’s order for hearing for hearing, vision and speech screenings were completed prior to a patient’s discharge from the facility.	
<ul style="list-style-type: none"> ▪ CRH leadership approved extra duty hours (20 hrs per week) for CRH SLPs staff to ensure speech-language screenings on the Child and Adolescent Unit at both campuses are completed as ordered by the physician (and prior to the patient’s discharge). The SLP staff will be available on both campuses as directed by the SLP Director. CRH has posted and is actively recruiting for one additional full-time SLP. ▪ The Speech and Hearing Dept policy – scope of service statement was revised to state “Routine speech-language-hearing screenings for children and adolescents will be completed within 2 weeks of admission. Screenings ordered by the MD will be conducted before patients are discharged.” <p><u>Monitoring:</u> A log will be maintained on the Child and Adolescent Unit to track the completion of speech and language screenings. The RNs will enter the patient’s name and date of the physician’s order (referral) for the screening on the log and the SLPs will enter the date the screening was completed. The Director of SLP services will monitor the log weekly to ensure screenings are being completed within the required timeframe.</p> <p>The Speech- Language Services Director established the following Quality Improvement indicator: “All child and adolescent speech and hearing screenings</p>	<p>12/1/08</p> <p>12/5/08</p> <p>12/8/08</p> <p>12/8/08</p>

<p>will be completed within 2 weeks or prior to discharge.” The SLP Director began collecting data on 12/2/08 and will aggregate data from the log on a monthly basis and submit a quarterly report to the CRH Quality Management Committee for review and follow-up actions as indicated.</p>	
A 084 482.12 (e)(1) CONTRACTED SERVICES-	
<p>The Governing Body failed to have a system or process in place to ensure radiology , laboratory and respiratory services provided under contract were performed in a safe and effective manner.</p>	
<p>1. Outpatient Child and Adolescent Clinic</p> <ul style="list-style-type: none"> ▪ The Outpatient Clinic will be supervised by Dr. Mayo, Clinical Director-Raleigh campus. Dr. Mayo will meet with the Director of the Outpatient Child and Adolescent Clinic on at least a monthly basis to provide ongoing oversight of the clinic. ▪ The Child Outpatient Clinic Training Director established two QI indicators: 1) For every newly admitted patient, the child therapist will query the patient regarding the history of physical abuse and document response or reason for not asking (.i.e., significant cognitive or language delays) in the Admissions Assessment Part A within 24 hours, and 2) For every newly admitted patient aged 13 or older, the Admission Assessment Part A will document within 24 hours appropriate information about patient’s drug and alcohol abuse. <p><u>Monitoring:</u> The Child Outpatient Clinic Training Director will begin data collection on 12/3/08 and submit quarterly QI indicator reports to the CAU Unit Management Team and to the CRH Quality Management Committee for review and follow-up actions as indicated.</p> <p>2. Pharmacy Services</p> <ul style="list-style-type: none"> ▪ The Pharmacy Director developed a performance plan for the contract pharmacist and completed an evaluation of the contract pharmacist’s performance. ▪ The performance evaluation and a current job description was filed in the contract pharmacist’s personnel record. ▪ An addendum was added to the supplemental pharmacy services contract which specified that the contract pharmacists’ services would be evaluated using the CRH performance management program. <p><u>Monitoring:</u> The Pharmacy Director will use the Performance Management Program (PMP) process to evaluate the contract pharmacist’s performance. The PMP evaluation will occur at mid-cycle (at 6 month point 12/3/08) and a final evaluation will be completed at year end (annually). Performance issues will be addressed by the Pharmacy Director with the contract employee and also reported to the contract agency as indicated.</p> <p>3. Radiology Services</p> <ul style="list-style-type: none"> ▪ The Radiology Services Director created a log sheet to collect clinical data on which includes the dates of exams and the turn around time of the diagnostic report availability by the contracted radiology service. 	<p>12/8/08</p> <p>12/3/08</p> <p>12/3/08</p> <p>12/3/08</p> <p>12/3/08</p> <p>12/8/08</p> <p>12/3/08 & year end (6/09).</p> <p>12/1/08</p>

<p>The CRH contract for radiology services includes acceptable turnaround times for diagnostic reports.</p>	
<p><u>Monitoring:</u> The CRH Radiology Director will begin collecting data on 12/1/08 and aggregate the data on a monthly basis and submit a quarterly report to the CRH Quality Management Committee for review and follow-up actions as needed.</p>	12/1/08
<ul style="list-style-type: none"> ▪ The contracted radiology service will perform 30 over reads per month between the two campuses to assess the quality of the diagnostic interpretations and submit them to the CRH Director of Medical Services. 	12/1/08
<p><u>Monitoring:</u> The Director of Medical Services will aggregate the over read data monthly and submit a quarterly report to the CRH Quality Management Committee for review and follow-up action as needed.</p>	12/1/08
<p>4.Laboratory Services</p>	
<p>--- <u>Contract #CRH4309 (Contract agreement with Hospital B)</u></p>	
<ul style="list-style-type: none"> ▪ The performance of the contracted lab services will be tracked by the CRH Lab Supervisors via a QI indicator. The QI indicator is: “The Lab Supervisors will ensure that lab testing performed by the contract reference lab is completed in a timely manner by monitoring the turn around times of stat labs.” 	12/8/08
<p><u>Monitoring:</u> The House Coordinator will document the time the specimen is sent to the reference lab and send this information to the Lab Supervisors who will track the time the specimen arrived at the reference lab and when the results were available. The Lab Supervisors will aggregate the data on a monthly basis and submit a quarterly QI report to the CRH Quality Management Committee for review and follow-up actions as indicated.</p>	12/8/08
<p>--- <u>No contract with Hospital A for after hour stat lab services:</u></p>	
<ul style="list-style-type: none"> ▪ The CRH Business Manager has developed a contract with Hospital A to provide after hour stat lab services. 	12/23/08
<p><u>Monitoring:</u> The performance of the contracted lab services will be tracked by the CRH Lab Supervisors via a QI indicator. The QI indicator is: “The Lab Supervisors will ensure that lab testing performed by the contract reference lab is completed in a timely manner by monitoring the turn around times of stat labs.” The Lab Supervisors will aggregate the data on a monthly basis and submit a quarterly QI report to the CRH Quality Management Committee for review and follow-up actions as indicated.</p>	12/8/08
<p>5. Respiratory Contracted Services</p>	
<ul style="list-style-type: none"> ▪ As advised by the respiratory therapist, the CRH Purchasing Officer amended the respiratory services contracts to add three requirements: 1) training and documentation of training for staff/patient (using a training roll sheet provided by the House Coordinator) will be required at the 	1/4/09

A143 Patient Rights: Personal Privacy (Cross reference to 482.13(c)(1) Patient Rights: Personal Privacy The patient has right to personal privacy.	
The hospital failed to ensure internal patient advocates did not disclose confidential patient information to unauthorized family members prior to patient consent.	
<ul style="list-style-type: none"> ▪ The Director of CRH Advocacy Services re-educated all the CRH internal advocates on two CRH Policies: 1) Authorization to Release – Disclose Health Information policy and the 2) Confidentiality policy. ▪ The internal advocates also took the on line self study CRH annual HIPAA training program. 	12/5/08 12/5/08
<u>Monitoring:</u>	
<ul style="list-style-type: none"> ▪ The advocates signed a policy review verification form attesting that they have read and understand the requirements of obtaining and documenting the patient’s consent prior to disclosure of confidential information to others. The advocates also completed a post test to evaluate competency on the annual HIPAA training module. 	12/5/08
A144 Patient Rights: Care in a safe setting (Cross reference to 482.13 (c)(2) Patient Rights: Care in a Safe Setting Tag A0143). The patient has the right to receive care in a safe setting.	
The hospital failed to ensure a safe environment in a courtyard to prevent patient elopement for 2 of 2 sampled patients that eloped.	
<ul style="list-style-type: none"> ▪ The Central Regional Maintenance (CRM) staff installed steel framing above the gate in the courtyard to close the opening between the gate and the retaining wall; checked and tightened the anchor bolts; and checked the locking bar to ensure it was in working order. 	12/1/08
<u>Monitoring:</u>	
Nursing staff will continue to be posted at the fence whenever patients are in the courtyard to prevent patient elopement from this area.	11/21/08 & ongoing
A 145 Patient Rights: Free from Abuse/Harassment (Cross reference to 482.13 (e)(5) Patient Rights: Restraint or Seclusion Tag A0145) The patient has the right to be free from all forms of abuse or harassment.	
The hospital failed to prevent staff to patient abuse for 1 of 10 sampled patients.	
CRH administration immediately began an internal investigation of the inappropriate restraint episode. The nursing staff involved in the event was put on investigatory leave status pending the outcome of the investigation.	11/19/08
<u>Forced Blood Draw:</u> (precipitant to the restraint)	
<ul style="list-style-type: none"> ▪ The CRH medical staff were re-educated on the revised CRH Policy: Non-consenting Patients: Administration of Treatments and Procedures. The revised policy requires the physician to contact the CRH Clinical Director or Director of Medical Services to discuss the need for any forced medical treatment before an order can be written for such. 	12/8/08
<u>Monitoring:</u>	
Training rosters verifying that Medical Staff completed review of the revised policy were submitted to the CRH Clinical Director.	12/8/08
<u>Appropriate placement of patients in restraint:</u>	
<ul style="list-style-type: none"> ▪ CRH medical staff received re-education that patients should never be restrained face down while in mechanical restraints. 	12/8/08

<p><u>Monitoring:</u> Training rosters verifying that Medical Staff received education on the proper placement of patients in mechanical restraint were submitted to the CRH Clinical Director.</p>	12/8/08
<p><u>Appropriate carry and restraint procedures; Nursing Assessment of Restrained patients; Continuous Monitoring of Patients in Restraint</u></p>	12/4/08
<p>The CRH Restrictive Interventions policy was revised to specifically state face down restraints are prohibited. The revised policy was approved by the CRH Executive Team.</p>	12/8/08
<ul style="list-style-type: none"> ▪ Nursing Educators retrained all CRH Adult Admissions Unit nursing staff on the approved NCI techniques for carrying patients and for placing patients in mechanical restraint. 	12/8/08
<ul style="list-style-type: none"> ▪ All CRH nursing staff reviewed a self study training packet stating the requirements for behavioral restrictive interventions including the requirements for assessments, care and monitoring of patients in restraint, the use of approved NCI techniques with patients, and release criteria. 	12/8/08
<p><u>Monitoring:</u></p>	12/8/08
<p>The nursing staff then completed a post-test to affirm their understanding of the requirements for assessing and monitoring patients while in restraint. The completed post tests were submitted to the DON (Raleigh Campus) and the ADON (Butner campus) to confirm the re-education of nursing staff on assessment and reassessment requirements for patients place in restraints.</p>	12/8/08
<p>The Risk Manager and/or Senior Nursing Leadership will review at least one episode of mechanical restraint each week on the CRH Butner campus where video monitoring of the seclusion and restraint rooms are available to evaluate whether the staff used approved NCI techniques and provided continuous monitoring of the patient.</p>	12/5/08
<p>The ward RNs on the Adult Admissions Unit will call the Nurse Shift Supervisor/Nurse Manager or House Coordinator during off hours after each episode of mechanical restraint. The Nurse Shift Supervisor/Nurse Manager or House Coordinator will review the restraint episode with the ward RN to evaluate compliance by asking a list of structured questions regarding reason for the restraint, how the patient is restrained and the assessment and monitoring provided to the patient once he/she was placed in mechanical restraint. These questionnaires will be submitted to the DON or ADON for review and follow-up as needed.</p>	12/8/08
<p>A0168 482.13(e)(5) Patient Rights: Restraint or Seclusion: The use of a restraint must be in accordance with the order of a physician or other licensed LIP who is responsible for the care of the patient.</p>	
<p>The hospital failed to document a physician order for a restraint per hospital policy for 1 of 10 sampled patients with restraints.</p>	
<ul style="list-style-type: none"> ▪ The CRH licensed nursing staff reviewed a self study training packet stating the requirements that the nurse is required to contact the assigned physician to obtain a written or verbal order for the restrictive intervention prior to or at the time of initiation if possible. 	12/8/08

<p><u>Monitoring:</u> The Quality Management staff will conduct a monthly audit of at least 10% of manual restraint episodes to ensure that there was a documented physician order for the restraint. The QM staff will submit the monthly audit results to the Director of Nursing (DON) and/or ADONs and a quarterly QI indicator report to the CRH QM committee for review and follow-up as indicated.</p>	12/8/08
<p>A0171 482.13(e)(8) Patient Rights: Restraint or Seclusion: Each order for restraint or seclusion used for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, a staff member, or others may be renewed in accordance within time limits.</p>	
<p>The hospital staff failed to ensure a time limited restraint order was obtained for 1 of 10 patients restrained and failed to ensure an age appropriate time limited restraint and/or seclusion order for 1 of 10 patients restrained or secluded.</p>	
<ul style="list-style-type: none"> ▪ CRH medical staff were re-educated on the requirement that a restraint order must be time limited: 4 hours for adults; 2 hours for children ages 9-17 and 1 hour for children under the age of 9. 	12/8/08
<p><u>Monitoring:</u> The Quality Management staff will conduct monthly audits of seclusion and restraint documentation requirements, including the requirement for time limited physician orders. The QM staff will submit the monthly audit results to the CRH Clinical Director and submit quarterly QI reports to the CRH QM committee for review and follow-up.</p>	12/8 /08
<p>A263 482.21 QAPI The hospital must develop, implement, and maintain an effective, ongoing, hospital-wide, data-driven quality assessment and performance improvement program.</p>	
<p>The facility’s leadership staff failed to maintain an effective, ongoing, hospital-wide, data-driven quality assessment and performance improvement program.</p>	
<p>1. Radiology, Laboratory, Respiratory services (See also A0267) Radiology:</p> <ul style="list-style-type: none"> ▪ The Radiology Services Director created a log sheet to collect clinical data on which includes the dates of exams and the turn around time of the diagnostic report availability by the contracted radiology service. The CRH contract for radiology services includes acceptable turnaround times for diagnostic reports. <p><u>Monitoring:</u> The CRH Radiology Director will begin collecting data on 12/1/08 and aggregate the data on a monthly basis and submit a quarterly report to the CRH Quality Management Committee for review and follow-up actions as needed.</p> <ul style="list-style-type: none"> ▪ The contracted radiology service will perform 30 over reads per month between the two campuses to assess the quality of the diagnostic interpretations and submit them to the CRH Director of Medical Services. <p><u>Monitoring:</u> The Director of Medical Services will aggregate the over read data monthly and submit a quarterly report to the CRH Quality Management Committee for review and follow-up action as needed.</p>	<p>12/1/08</p> <p>12/1/08</p> <p>12/1/08</p> <p>12/1/08</p>

<p>Laboratory:</p> <ul style="list-style-type: none"> The performance of contracted lab services will be tracked by the CRH Lab Supervisors via a QI indicator. The QI indicator is: “The Lab Supervisors will ensure that lab testing performed by the contract reference lab is completed in a timely manner by monitoring the turn around times of stat labs.” The Lab Supervisors will aggregate the data on a monthly basis and submit a quarterly QI report to the CRH Quality Management Committee for review and follow-up actions as indicated. 	12/8/08
<p>Respiratory Therapy:</p> <ul style="list-style-type: none"> The respiratory therapist will audit each use of a contract vendor of CPAP machines for the presence of the 3 new requirements added to the contract: 1) training and documentation of training for staff/patient (using a training roll sheet provided by the House Coordinator) will be required at the time the equipment is delivered; 2) an operator’s manual will be required to be left with Nursing at the time the equipment is delivered, 3) the service/equipment must be delivered within 24 hours of request. The audits will be on-going and data aggregated quarterly with a report submitted to the CRH Quality Management Committee for review and follow-up actions as indicated. 	1/4/09
<p>2. Physical Environment (See also A700)</p> <ul style="list-style-type: none"> The CRH Environment of Care (EOC) Coordinator developed a weekly EOC checklist to monitor the campuses for physical plant for safety issues. 	12/3/08
<p><u>Monitoring:</u> The Unit Administrators will complete the weekly EOC checklist and submit them to the CRH Safety Officers as well as report any work orders that need to be completed.</p>	12/12/08
<ul style="list-style-type: none"> Enviro-rounds will be conducted at least 2 x a year by a team which includes the EOC Coordinator, Safety Officers, ICRNs, Central Regional Maintenance, Environmental Services and Risk Management. 	12/12/08
<p><u>Monitoring:</u> A list of deficiencies found in the enviro-rounds will be submitted to the Unit Administrative Directors and the CRH EOC (Safety) committee for review and follow-up actions as needed.</p>	1/09
<p>A267 482.21(a)(2) QAPI Quality Indicators: The hospital must measure, analyze, and track quality indicators, including adverse patient events, and other aspects of performance that assess the processes of care, hospital services, and operations.</p>	
<p>The Governing Body failed to have a system or process in place to ensure radiology, laboratory, and respiratory therapy services provided under contract were evaluated and performed in a safe and effective manner.</p>	
<p>Radiology:</p> <ul style="list-style-type: none"> The Radiology Services Director created a log sheet to collect clinical data on which includes the dates of exams and the turn around time of the diagnostic report availability by the contracted radiology service. The CRH contract for radiology services includes acceptable turnaround times for diagnostic reports. 	12/1/08

<p><u>Monitoring:</u> The CRH Radiology Director will begin collecting data on 12/1/08 and aggregate the data on a monthly basis and submit a quarterly report to the CRH Quality Management Committee for review and follow-up actions as needed.</p>	12/1/08
<ul style="list-style-type: none"> ▪ The contracted radiology service will perform 30 over reads per month between the two campuses to assess the quality of the diagnostic interpretations and submit them to the CRH Director of Medical Services. 	12/1/08
<p><u>Monitoring:</u> The Director of Medical Services will aggregate the over read data monthly and submit a quarterly report to the CRH Quality Management Committee for review and follow-up action as needed.</p>	12/1/08
<p>Laboratory:</p> <ul style="list-style-type: none"> ▪ The performance of the contracted lab services will be tracked by the CRH Lab Supervisors via a QI indicator. The QI indicator is: “The Lab Supervisors will ensure that lab testing performed by the contract reference lab is completed in a timely manner by monitoring the turn around times of stat labs.” The Lab Supervisors will aggregate the data on a monthly basis and submit a quarterly QI report to the CRH Quality Management Committee for review and follow-up actions as indicated. 	12/8/08
<p>Respiratory Therapy:</p> <ul style="list-style-type: none"> ▪ The respiratory therapist will audit each use of a contract vendor of CPAP machines for the presence of the 3 new requirements added to the contract: 1) training and documentation of training for staff/patient (using a training roll sheet provided by the House Coordinator) will be required at the time the equipment is delivered; 2) an operator’s manual will be required to be left with Nursing at the time the equipment is delivered, 3) the service/equipment must be delivered within 24 hours of request. The audits will be on-going and data aggregated quarterly with a report submitted to the CRH Quality Management Committee for review and follow-up actions as indicated. 	1/4/09
<p>A275 482.21(b)(2)(i) QAPI Quality of Care: The hospital must use the data collected to monitor the effectiveness and safety of the service and quality of care.</p>	
<p>The hospital failed to monitor and maintain an environment for the safety of the patients.</p>	
<ul style="list-style-type: none"> ▪ The CRH Environment of Care (EOC) Coordinator developed a weekly EOC checklist to monitor the campuses for physical plant for safety issues. 	12/3/08
<p><u>Monitoring:</u> The Unit Administrators will complete the weekly EOC checklist and submit them to the CRH Safety Officers as well as report any work orders that need to be completed.</p>	12/12/08
<ul style="list-style-type: none"> ▪ Enviro-rounds will be conducted at least 2 x a year by a team which includes the EOC Coordinator, Safety Officers, ICRNs, Central Regional Maintenance, Environmental Services and Risk Management. 	12/12/08

<p><u>Monitoring:</u> A list of deficiencies found in the enviro-rounds will be submitted to the Unit Administrative Directors and the CRH EOC (Safety) committee for review and follow-up actions as needed.</p>	Jan 2009
<p>A385 482.23 Nursing Services: The hospital must have an organized nursing service that provides 24 hour nursing services. The services must be furnished or supervised by a registered nurse.</p>	
<p>The nursing staff failed to provide safe patient care, assessment of patients and reassessments of patients.</p>	
<p>1. Monitor and Supervise patients in restraint</p> <ul style="list-style-type: none"> ▪ All CRH nursing staff reviewed a self study training packet stating the requirements for behavioral restrictive interventions including the requirements for assessments, care and monitoring of patients in restraint, the use of approved NCI techniques with patients, and release criteria. <p><u>Monitoring:</u> The nursing staff completed a post-test to affirm their understanding of the requirements for assessing and monitoring patients while in restraint. The completed post tests were submitted to the DON (Raleigh Campus) and the ADON (Butner campus) to confirm the re-education of nursing staff on assessment and reassessment requirements for patients place in restraints.</p> <p>2. Monitoring Patients on CPAPs</p> <ul style="list-style-type: none"> ▪ The Respiratory Director and Medical Services Unit CNS developed a flow sheet for use by nursing to document the daily monitoring of CPAP and the required interventions such as weekly washing of masks, etc. and a nursing intervention plan to document patient education for CPAP machine usage. ▪ The Respiratory Therapist developed a “train the trainer” program for the nurse educators and a competency assessment checklist. The respiratory therapist will train the nurse educators/managers who will then be qualified to conduct training and competency sessions for nursing staff. A nursing intervention plan will also be developed to document the patient education for CPAP machine usage. ▪ The CPAP operator’s manual will be available to nursing for the duration of the use of the CPAP machine. For hospital-owned equipment, the operator’s manual will be attached to the CPAP equipment by the respiratory therapist. For contract vendor provided CPAP equipment, a vendor provided operator’s manual will be given to the nursing staff at the time of delivery of the CPAP machine. <p><u>Monitoring:</u> The Nurse Educators/Manager will train CRH RNs on the use of the flow sheet and nursing intervention plan and each RN will complete a CPAP competency assessment to ensure they are knowledgeable on the monitoring of patients on CPAPs.</p> <p>The Respiratory Services Director will review the flow sheets weekly to ensure that are completed as required and report the results to the Environment of Care Committee on a quarterly basis.</p>	<p>12/8/08</p> <p>12/8/08</p> <p>1/4/09</p> <p>12/21/08</p> <p>1/4/09</p> <p>1/4/09</p> <p>1/4/09</p>

<p>2) Monitoring Vital Signs</p> <ul style="list-style-type: none"> ▪ The Director of Medical Services established new parameters for vital signs for children and the new parameters were posted on the Child and Adolescent Unit (CAU). ▪ The Unit Nurse Directors (UNDS) re-educated the CAU nursing staff on the expectations that daily vital signs are the responsibility of first shift nursing staff and the RN on each ward is responsible for reviewing the vital signs flow sheet to ensure all vital signs are taken as ordered. HCT were re-educated on the requirement to report out of range vitals to the RN immediately. <p><u>Monitoring:</u> The Shift supervisors will check the flow sheet every twenty-four hours to ensure all vital signs were taken as ordered and that the ward RN signed the sheet indicating he/she had reviewed these for out of range vitals. The UND will receive copies of these flow sheets daily and give them to the CNS who will audit all out of range vital signs using the Vital Signs Audit tool to ensure they were reported to the nurse and that the MD was notified. The ADONs will review the VS audit results on a weekly basis to identify follow-up actions as needed.</p>	<p>11/25/08</p> <p>12/8/08</p> <p>1/4/09</p>
<p>A392 482.23(b) Staffing and delivery of care: The nursing service must have an adequate numbers of licensed RNs, LPNs, and other personnel to provide nursing care to all patients as needed.</p>	
<p>The hospital’s nursing staff failed to provide care to ensure that patient needs were met by failing to monitor and supervise a patient placed in restraints to prevent patient abuse and neglect in 1 of 10 patients restrained.</p>	
<ul style="list-style-type: none"> ▪ All CRH nursing staff reviewed a self study training packet stating the requirements for behavioral restrictive interventions including the requirements for assessments, care and monitoring of patients in restraint, the use of approved NCI techniques with patients, and release criteria. <p><u>Monitoring:</u> The nursing staff then completed a post-test to affirm their understanding of the requirements for assessing and monitoring patients while in restraint. The completed post tests were submitted to the DON (Raleigh Campus) and the ADON (Butner campus) to confirm the re-education of nursing staff on assessment and reassessment requirements for patients place in restraints.</p>	<p>12/8/08</p> <p>12/8/08</p>
<p>A395 482.23(b)(3) RN Supervision of Nursing: A registered nurse must supervise and evaluate the nursing care for each patient.</p>	
<p>Nursing staff failed to ensure monitoring of a patient on CPAP and monitoring of a patient’s vital signs as ordered by a physician for 4 of 7 child and adolescent patient records reviewed.</p>	
<p>Monitoring patients on CPAPs</p> <ul style="list-style-type: none"> ▪ The Respiratory Director and Medical Services Unit CNS developed a flow sheet for use by nursing to document the daily monitoring of CPAP and the required interventions such as weekly washing of masks, etc. and a nursing intervention plan to document patient education for CPAP machine usage. ▪ The Respiratory Therapist developed a “train the trainer” program for the nurse educators and a competency assessment checklist. The 	<p>1/4/09</p> <p>12/21/08</p>

<p>respiratory therapist will train the nurse educators/managers who will then be qualified to conduct training and competency sessions for nursing staff. A nursing intervention plan will also be developed to document the patient education for CPAP machine usage.</p> <ul style="list-style-type: none"> ▪ The CPAP operator’s manual will be available to nursing for the duration of the use of the CPAP machine. For hospital-owned equipment, the operator’s manual will be attached to the CPAP equipment by the respiratory therapist. For contract vendor provided CPAP equipment, a vendor provided operator’s manual will be given to the nursing staff at the time of delivery of the CPAP machine. 	<p>1/4/09</p>
<p><u>Monitoring:</u> The Nurse Educators/Manager will train CRH RNs on the use of the flow sheet and nursing intervention plan and each RN completed a CPAP competency assessment to ensure they are knowledgeable on the monitoring of patients on CPAPs.</p>	<p>1/4/09</p>
<p>The Respiratory Services Director will review the flow sheets weekly to ensure that are completed as required and report the results to the Environment of Care Committee on a quarterly basis.</p>	<p>1/4/09</p>
<p>Monitoring patients’ vital signs</p> <ul style="list-style-type: none"> ▪ The Director of Medical Services established new parameters for vital signs for children and the new parameters were posted on the Child and Adolescent Unit (CAU). ▪ The Unit Nurse Directors (UNDs) re-educated the CAU nursing staff on the expectations that daily vital signs are the responsibility of first shift nursing staff and the RN on each ward is responsible for reviewing the vital signs flow sheet to ensure all vital signs are taken as ordered. HCT were re-educated on the requirement to report out of range vitals to the RN immediately. 	<p>11/25/08 12/8/08</p>
<p><u>Monitoring:</u> The Nursing Shift Supervisors will check the flow sheet every twenty-four hours to ensure all vital signs were taken as ordered and that the ward RN signed the sheet indicating he/she had reviewed these for out of range vitals. The UND will receive copies of these flow sheets daily and give them to the CNS who will audit all out of range vital signs using the Vital Signs Audit tool to ensure they were reported to the nurse and that the MD was notified. The ADONs will review the VS audit results on a weekly basis to identify follow-up actions as needed.</p>	<p>1/4/09</p>
<p>A528 482.26 Radiologic Services: The hospital must maintain or have available diagnostic radiological services.</p>	
<p>The leadership staff failed to maintain and ensure safe radiological services were provided to patients.</p>	
<p>1. Credentialing of Teleradiology</p> <ul style="list-style-type: none"> ▪ The Deputy Medical Director will revise the CRH Medical Staff Bylaws to include a category for Radiology for teleradiology privileges and the revised MS Bylaws will be approved by the CRH Medical Staff. ▪ The Deputy Medical Director will revise the delineation form to include teleradiology privileges. 	<p>12/18/08 12/18/08</p>

<ul style="list-style-type: none"> All radiologists performing radiology diagnostic interpretations will be credentialed for teleradiology privileges through the CRH medical staff. The credentialing process will include verification of licensure and board certification in addition to a referral by Wake Radiology. 	1/4/09
<p><u>Monitoring:</u> Contracted radiology service will provide quality assurance information for each radiologist performing diagnostic radiology services to the Deputy Medical Director by 1/4/09 and annually. The Deputy Medical Director will provide QA data to be used in the re-credentialing process.</p>	1/4/09
<p>2. Annual PM for dental equipment</p>	
<ul style="list-style-type: none"> Preventative maintenance was performed by Sullivan-schein Dental Supply on the dental radiology equipment. 	12/1/08
<p><u>Monitoring:</u> The CRH Radiology Director will monitor and oversee the preventative maintenance of the dental xray equipment and equipment repair schedule. Preventative maintenance will be completed on a least an annual basis as well as a yearly physicist visit.</p>	12/1/08
<p>3. Evaluation of contract radiology services</p>	
<ul style="list-style-type: none"> The Radiology Services Director created a log sheet to collect clinical data on which includes the dates of exams and the turn around time of the diagnostic report availability by the contracted radiology service. The CRH contract for radiology services includes acceptable turnaround times for diagnostic reports. 	12/1/08
<p><u>Monitoring:</u> The CRH Radiology Director will begin collecting data on 12/1/08 and aggregate the data on a monthly basis and submit a quarterly report to the CRH Quality Management Committee for review and follow-up actions as needed.</p>	12/1/08
<ul style="list-style-type: none"> The contracted radiology service will perform 30 over reads per month between the two campuses to assess the quality of the diagnostic interpretations and submit them to the CRH Director of Medical Services. 	12/1/08
<p><u>Monitoring:</u> The Director of Medical Services will aggregate the over read data monthly and submit a quarterly report to the CRH Quality Management Committee for review and follow-up action as needed.</p>	12/1/08
<p>A529 482.26(a) Scope of Services: The hospital must maintain, or have available radiologic services according to the needs of the patients.</p>	
<p>The leadership staff failed to have system or process in place to ensure radiology services provided under contract were evaluated and performed in a safe and effective manner.</p>	
<ul style="list-style-type: none"> The Radiology Services Director created a log sheet to collect clinical data on which includes the dates of exams and the turn around time of the diagnostic report availability by the contracted radiology service. The CRH contract for radiology services includes acceptable turnaround times for diagnostic reports. 	12/1/08

<p><u>Monitoring:</u> The CRH Radiology Director will begin collecting data on 12/1/08 and aggregate the data on a monthly basis and submit a quarterly report to the CRH Quality Management Committee for review and follow-up actions as needed.</p> <ul style="list-style-type: none"> ▪ The contracted radiology service will perform 30 over reads per month between the two campuses to assess the quality of the diagnostic interpretations and submit them to the CRH Director of Medical Services. <p><u>Monitoring:</u> The Director of Medical Services will aggregate the over read data monthly and submit a quarterly report to the CRH Quality Management Committee for review and follow-up action as needed.</p>	<p>12/1/08</p> <p>12/1/08</p> <p>12/1/08</p>
<p>A537 482.26(b)(2) Periodic Equipment Maintenance</p>	
<p>The leadership staff failed to ensure the dental xray equipment had the required preventative maintenance performed annually.</p>	
<ul style="list-style-type: none"> ▪ Preventative maintenance was performed by Sullivan-schein Dental Supply on the dental radiology equipment. <p><u>Monitoring:</u> The CRH Radiology Director will monitor and oversee the preventative maintenance of the dental xray equipment and equipment repair schedule. Preventative maintenance will be completed on a least an annual basis as well as a yearly physicist visit.</p>	<p>12/1/08</p> <p>12/1/08</p>
<p>A546 482.26.(c)(1) Radiologist responsibilities:</p>	
<p>The leadership failed to ensure teleradiologists were credentialed and privileged to interpret radiological diagnostic tests. lack of isolation precautions with positive culture patients</p>	
<ul style="list-style-type: none"> ▪ The Deputy Medical Director will revise the CRH Medical Staff Bylaws to include a category for Radiology for teleradiology privileges and the revised MS Bylaws will be approved by the CRH Medical Staff. ▪ The Deputy Medical Director will revise the delineation form to include teleradiology privileges. ▪ All radiologists performing radiology diagnostic interpretations will be credentialed for teleradiology privileges through the CRH medical staff. The credentialing process will include verification of licensure and board certification in addition to a referral by Wake Radiology. <p><u>Monitoring:</u> Contracted radiology service will provide quality assurance information for each radiologist performing diagnostic radiology services to the Deputy Medical Director by 1/4/09 and annually. The Deputy Medical Director will provide QA data to be used in the re-credentialing process.</p>	<p>12/18/08</p> <p>12/18/08</p> <p>1/4/09</p> <p>1/4/09 and annually thereafter.</p>
<p>A582 Adequacy of Laboratory Services: The hospital must have laboratory services available, either directly or through a contractual agreement with a certified laboratory that meets the requirements of part 493 of this chapter.</p>	
<p>The hospital failed to have a contractual agreement with the laboratory that provided after hours lab services.</p>	
<ul style="list-style-type: none"> ▪ The CRH Business Manager has developed a contract with Hospital A to provide after hour stat lab services. 	<p>12/23/08</p>

<p><u>Monitoring:</u> The performance of the contracted lab services will be tracked by the CRH Lab Supervisors via a QI indicator. The QI indicator is: “The Lab Supervisors will ensure that lab testing performed by the contract reference lab is completed in a timely manner by monitoring the turn around times of stat labs.” The Lab Supervisors will aggregate the data on a monthly basis and submit a quarterly QI report to the CRH Quality Management Committee for review and follow-up actions as indicated.</p>	12/8/08
<p>A700 482.41 Physical Environment: 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>	
<p>The hospital failed to maintain an environment for the safety of patients.</p>	
<p>1. 482.41(a) - A701 Please refer to the Life Safety Plan of Correction K032, K011, K029, K017, K025, K027, K029, K038, K045, K045, K071, K145</p> <p>2. 482.41(a)(1) - A702 Please refer to the Life Safety Plan of Correction K046</p> <p>3. 482.41(b)(5) - A712 Please refer to the Life Safety Plan of Correction K018</p> <p>4. 482.41(b)(7) - A714 Please refer to the Life Safety Plan of Correction K051</p> <p>5. 482.41(b)(8) - A715 Please refer to the Life Safety Plan of Correction K050</p> <p>6. 482.41(c)(2)- A724 Please refer to the Life Safety Plan of Correction K076, K144, K147, K033, K062, K067, K072, K104</p>	
<p>A701 482.41(a) Maintenance of the Physical Plant; The condition of the physical plant and the overall hospital environment must be developed and maintained in such a manner that the safety and well-being patients are assured.</p>	
<p>The hospital failed to develop and maintain a safe physical plant and overall safe environment assuring the safety and well being of patients.</p>	
<p>1. Please refer to the Life Safety Plan of Correction K032 (public walkway - page 6, egress door A2 - page 18)</p> <p>2. Please refer to the Life Safety Plan of Correction K011, page 1</p> <p>3. Please refer to the Life Safety Plan of Correction K029, pages 5 and 18</p> <p>4. Please refer to the Life Safety Plan of Correction K017, page 1</p> <p>5. Please refer to the Life Safety Plan of Correction K025, page 4</p> <p>6. Please refer to the Life Safety Plan of Correction K027, page 4</p>	

7. Please refer to the Life Safety Plan of Correction K029, page 5	
8. Please refer to the Life Safety Plan of Correction K038, page 7	
9. Please refer to the Life Safety Plan of Correction K045, page 8	
10. Please refer to the Life Safety Plan of Correction K045, page 8	
11. Please refer to the Life Safety Plan of Correction K071, page 14	
12. Please refer to the Life Safety Plan of Correction K145, page 16	
A702 482.41(a)(1) Emergency Power and Lighting: There must be emergency power and lighting in at least the operating, recovery, intensive care, and ERs and stairwells.	
The hospital failed to have emergency lighting in stairwells.	
Please refer to the Life Safety Plan of Correction K046, page 8	
A712 482.419b)(5) Roller latches prohibited:	
The hospital failed to discontinue usage of roller latches.	
Please refer to the Life Safety Plan of Correction K018, pages 1-4	
A714 482.41(b)(7) Fire Control Panels: The hospital must have written fire control plans that contain provisions for prompt reporting of fires; extinguishing fires; protection of patients; personnel and guests; evacuation; and cooperation with fire fighting authorities.	
The hospital failed to have emergency procedures in place for posting a fire watch during a power outage event, audible fire alarms and a smoke detector in an elevator room.	
Please refer to the Life Safety Plan of Correction K051, pages 10-11 & 19	
A715 482.41(b)(8) Regular Fire and Safety Inspections: The hospital must maintain written evidence of regular inspection and approval by State or local fire control agencies.	
The staff failed to perform the required number of fire drills.	
Please refer to the Life Safety Plan of Correction K050, page 10	
A724 482.41 (c)(2) Facilities, Supplies, Equipment Maintenance: Facilities, supplies and equipment must be maintained to ensure an acceptable level of safety and quality.	
The hospital failed to ensure supplies, equipment and the physical plant were maintained in a safe level.	
1. The EOC Coordinator installed the proper signage for RM F2043 on 11/18/08. Please also refer to the Life Safety Plan of Correction K076, page 14-15	11/18/08

<p>2. Please refer to the Life Safety Plan of Correction K144, page 15</p> <p>3. Please refer to the Life Safety Plan of Correction K147, page 17 &20</p> <p>4. Please refer to the Life Safety Plan of Correction K033, pages 6-7</p> <p>5. Please refer to the Life Safety Plan of Correction K062, pages 11-12</p> <p>6. Please refer to the Life Safety Plan of Correction K067, pages 12-13</p> <p>7. Please refer to the Life Safety Plan of Correction K072, page 14</p> <p>8. Please refer to the Life Safety Plan of Correction K104, page 15</p>	
<p>A749 482.42(a)(1) Infection Control officer Responsibilities: 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>Infection Control staff failed to ensure patients with positive multi-drug resistant organisms (MDRO) cultures were placed on facility-defined isolation precaution for 3 of 3 records reviewed of patients with positive MDRO cultures.</p>	
<ul style="list-style-type: none"> ▪ A new Multi-drug Resistant Organisms/ Clostridium Difficile Policy with attachments (CRH additional precautions used for MDRO, Modified Standard Precautions guideline sheet & Contact Precautions & Contact Precautions Special-Enteric signage from the Statewide Infection Control and Epidemiology Program) was approved by the Infection Control Committee on 12/05/08. The new MDRO policy will include: line listings for MDRO organisms identified by a positive culture report and an additional precaution to be used for specific cases of MDRO infection or colonization that meet the criteria for the use of the additional precaution, (CRH Modified Standard Precautions). ▪ The ICRNs prepared a study guide (an educational review in a Power Point format) on the new MDRO/C. policy. ▪ The study guide will be used by applicable depts. (which includes nursing and medical staff) to educate staff on the new MDRO / C. diff policy. <p><u>Monitoring:</u> Staff training rosters to verify that nursing staff completed the study guide will be submitted to the ADONs. The staff training rosters for medical staff will be submitted to the Clinical Director's Office.</p> <p>The CRH ICRNs will review the positive lab cultures on at least a weekly basis and evaluate to ensure appropriate precautions have been ordered and followed.</p>	<p>12/5/08</p> <p>12/11/08</p> <p>1/4/09</p> <p>1/4/09</p> <p>1/4/09</p>
<p>A750 482.42 (a)(2) Infection Control Log: The infection control officer or officers must maintain a log of incidents related to infections and communicable diseases.</p>	
<p>Infection Control staff failed to record a complete log of incidences of identified multi-drug resistant organisms (MDRO) for 1 of 3 records reviewed of patients with positive MDRO cultures.</p>	
<ul style="list-style-type: none"> ▪ The ICRNs on both CRH campuses will record on the IC log all identified cases of MRDO. ▪ The Multi-drug Resistant Organisms/ Clostridium Difficile Policy was 	<p>12/8/08</p>

<p>approved by the IC Committee which included the statement that “all multi-drug resistant organisms will be tracked and listed by the Infection Control Practitioners.</p>	1/4/09
<p><u>Monitoring</u> The IC Surveillance Officer will review the IC log on a weekly basis and compare it to positive lab cultures to ensure all cases are listed and tracked by the Infection Control Practitioners.</p>	12/8/08
<p>A827 482.43(c)(6)(iii) Discharge Planning Document: The hospital must document in the patient’s medical record that the list was presented to the patient or to the individual acting on the patient’s behalf.</p>	
<p>Discharge planning staff failed to have a process and system in place to document in the medical record a list of available facilities (Home Health Agencies and/or Skilled Nursing Facilities) given to the patient for 2 of 2 discharged patients reviewed.</p>	
<ul style="list-style-type: none"> ▪ The CRH Director of Social Work developed a Freedom of Choice Resource List of available home health agencies (HHA), skilled nursing facilities (SNF) and hospices that the social work staff will present to the patient or the individual acting on the patient’s behalf as part of the discharge planning process. 	12/2/08
<ul style="list-style-type: none"> ▪ The Unit Social Work Supervisors educated the CRH social work staff on the discharge planning requirement to present the Freedom of Choice Resource List of HHA, SNFs to the patient or the individual acting on the patient’s behalf. Staff training rosters will be completed and submitted to the Director of Social Work. 	12/12/08
<ul style="list-style-type: none"> ▪ The Director of Social work revised the CRH discharge planning policy to reflect the requirement that a list of available home health agencies, skilled nursing facilities and hospices that the social work staff must be presented to the patient or the individual acting on the patient’s behalf as part of the discharge planning process. The policy was approved by the CRH Executive Team on will become effective on 12/29/08. 	12/29/08
<p><u>Monitoring:</u> The Unit Social Worker Supervisors will conduct a monthly audit of at least 50% of the cases whose discharge planning for patients included possible placement in a HHA, SNF or hospice program and submit the audits to the Director of Social Work who will review the audit results and take follow-up actions as needed.</p>	12/29/08
<p>A1124 482.56(a) Organization of Rehabilitation Services: The organization of the service must be appropriate to the scope of the services offered.</p>	
<p>Staff failed to ensure a physician’s order for hearing, vision and speech screenings were completed prior to a patient’s discharge from the facility for 2 of 4 child and adolescent records reviewed.</p>	
<ul style="list-style-type: none"> ▪ CRH leadership approved extra duty hours (20 hrs per week) for CRH SLPs staff to ensure speech-language screenings on the Child and Adolescent Unit at both campuses are completed as ordered by the physician (and prior to the patient’s discharge). The SLP staff will be available on both campuses as directed by the SLP Director. CRH has posted and is actively recruiting for one additional full-time SLP. 	12/1/08
<ul style="list-style-type: none"> ▪ The Speech and Hearing Dept policy – scope of service statement was revised to state “Routine speech-language-hearing screenings for children and adolescents will be completed within 2 weeks of admission. 	12/5/08

<p>Screenings ordered by the MD will be conducted before patients are discharged.”</p>	
<p><u>Monitoring:</u> A log will be maintained on the Child and Adolescent Unit to track the completion of speech and language screenings. The RNs will enter the patient’s name and date of the physician’s order (referral) for the screening on the log and the SLPs will enter the date the screening was completed. The Director of SLP services will monitor the log weekly to ensure screenings are being completed within the required timeframe.</p>	<p>12/8/08</p>
<p>The Speech- Language Services Director established the following Quality Improvement indicator: “All child and adolescent speech and hearing screenings will be completed within 2 weeks or prior to discharge.” The SLP Director began collecting data on 12/2/08 and will aggregate data from the log on a monthly basis and submit a quarterly report to the CRH Quality Management Committee for review and follow-up actions as indicated.</p>	<p>12/8/08</p>
<p>A1152 482.57(a) Organization of Respiratory Care Services: The organization of the respiratory care services must be appropriate to the scope and complexity of the services offered.</p>	
<p>The facility failed to ensure evidence of documentation of training for 4 of 4 nurses that cared for a patient on a Constant Positive Airway pressure Mask (CPAP).</p>	
<ul style="list-style-type: none"> ▪ The Respiratory Director and Medical Services Unit CNS developed a flow sheet for use by nursing to document the daily monitoring of CPAP and the required interventions such as weekly washing of masks, etc. and a nursing intervention plan to document patient education for CPAP machine usage. ▪ The Respiratory Therapist developed a “train the trainer” program for the nurse educators and a competency assessment checklist. The respiratory therapist will train the nurse educators/managers who will then be qualified to conduct training and competency sessions for nursing staff. A nursing intervention plan will also be developed to document the patient education for CPAP machine usage. ▪ The CPAP operator’s manual will be available to nursing for the duration of the use of the CPAP machine. For hospital-owned equipment, the operator’s manual will be attached to the CPAP equipment by the respiratory therapist. For contract vendor provided CPAP equipment, a vendor provided operator’s manual will be given to the nursing staff at the time of delivery of the CPAP machine. 	<p>1/4/09</p> <p>12/21/08</p> <p>1/4/09</p>
<p><u>Monitoring:</u> The Nurse Educators/Manager will train CRH RNs on the use of the flow sheet and nursing intervention plan and each RN will complete a CPAP competency assessment to ensure they are knowledgeable on the monitoring of patients on CPAPs.</p>	<p>1/4/09</p>
<p>The Respiratory Services Director will review the flow sheets weekly to ensure that are completed as required and report the results to the Environment of Care Committee on a quarterly basis.</p>	<p>1/4/09</p>

A1161 482.57(b)(1) Respiratory Care Personnel Policies: Personnel qualified to perform specific procedures and the amount of supervision required to carry out specific procedures must be designated in writing.	
The hospital failed to ensure personnel qualified to perform specific respiratory therapy procedures was designated in writing.	
<ul style="list-style-type: none"> ▪ The Respiratory Therapist will develop a CRH Clinical Policy – Respiratory Therapy Services, which provides an overview of the personnel qualified to perform respiratory therapy procedures and the amount of supervision required to carry out specific procedures as well the competencies required qualifying the licensed nursing staff to manage and monitor respiratory treatment. 	1/4/09
<p><u>Monitoring:</u> The new Clinical Practice Manual - Respiratory Therapy Services policy will be reviewed and approved by the CRH Executive Team.</p>	1/4/09
B106 482.61(a)(2) Development of Assessment/Diagnostic Data: A provisional or admitting diagnosis must be made on every patient at the time of admission, and must include the diagnosis of intercurrent diseases as well as the psychiatric diagnosis.	
Medical staff failed to ensure the medical history and physical was completed within 24 hours of patient admission for 4 of 7 adolescent admissions reviewed.	
<p>Developmental Assessment / Physical Exams within 24 hours</p> <ul style="list-style-type: none"> ▪ The Director of Medical Services will revise the CRH Physical Exam policy as follows: “If the physical exam suggests a physical developmental problem then a Tanner staging is done within 24 hours. If the initial physical exam does not indicate a physical developmental problem, then the Tanner staging is completed within 1 week of admission. The revised policy was approved by the CRH Executive Team on 12/9/08. ▪ The Director of Medical Services will issue a memo to all physicians highlighting the above referenced revisions to the CRH Physical Exam policy with guidelines about when the Tanner staging is completed. ▪ The Director of Medical Services will re-educate the medical providers that physical exams not completed at the time of admission must be attempted daily (and documented as attempted) until completed. ▪ For patients who leave the Screening and Admissions Unit (SAU) without a completed physical, the SAU staff will call the assigned medical provider to give him/her the name of the patient who requires follow-up to complete the physical exam. 	12/9/08
	12/10/08
	12/8/08
<p><u>Monitoring:</u> The SAU staff will fax a list of the uncompleted physical exams (including Tanner staging not done) to the Quality Management Department and Medical Administration each day. The list will be communicated to the medical providers on a daily basis at morning check-in rounds. The QM staff will audit medical records to monitor the compliance with physician staff completing the physical exams in all populations and developmental exams in child/adolescent admissions.</p>	12/8/08

