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PARK ROYAL HOSPITAL	9241 PARK ROYAL DR FORT MYERS, FL 33908

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 000	INITIAL COMMENTS An unannounced Federal validation survey was conducted at Park Royal Hospital, a , , hospital located in Fort Myers, Florida starting on 3/6 through . This survey was also associated with a state licensure validation survey, a risk management survey, and 8 complaint investigations.	A 000		
A 043	482.12 GOVERNING BODY There must be an effective governing body that is legally responsible for the conduct of the hospital. If a hospital does not have an organized governing body, the persons legally responsible for the conduct of the hospital must carry out the functions specified in this part that pertain to the governing body ... This CONDITION is not met as evidenced by: Based on a review of clinical records, interviews with both administrative and clinical staff, the govererning failed to ensure care and supervision was provided to patients, and medications were administered as ordered. Refer to details under the Condition of Participation of nursing services A385. The governing body failed to assure there was an active grievance program which resulted in investigations, changes as necessary, and resolution information being given to patients (refer to A120 and 123). The governing body failed to have an active, hospital wide quality assurance program to ensure there was quality care to patients (refer to Condition of Participation at A263). The hospital failed to ensure there was an active utilization review department performing chart reviews. (refer to condition of Participation at A658)	A 043		
A 119	482.13(a)(2) PATIENT RIGHTS: REVIEW OF	A 119		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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

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A 119	Continued From page 1 GRIEVANCES [The hospital must establish a process for prompt resolution of patient grievances and must inform each patient whom to contact to file a grievance.] The hospital's governing body must approve and be responsible for the effective operation of the grievance process, and must review and resolve grievances, unless it delegates the responsibility in writing to a grievance committee. This STANDARD is not met as evidenced by: Based on facility interviews and record review, the facility failed to provide interventions regarding grievances, verbal, and written complaints. The findings included: The grievance information request was included in the entrance conference conducted on . . . by the survey team. On , the Risk Manager (. .) presented an expandable file with grievance information and commented the grievance folder was "found" on a shelf in her office. On at 3:00 p.m., a record review of the grievance interventions and grievance logs was conducted after the grievance logs were located. The grievance facility form entitled " ... Complaint Grievance Log" review revealed the forms lacked entries for the "Status", "Letter", and "Resolved" sections of the form. A facility form contained a hospital Logo and a numeric key to indicate the type of "Complaint" and included a "Status Legend". The "Status Legend" contains an "S" for Substantiated, "U" for unsubstantiated and a "P"	A 119		

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A 119	Continued From page 2 for partially substantiated. The 2016 facility grievances and complaint form review included: On , , and Patient #67 had multiple complaints and grievances with no documentation of the status, interventions, or follow-up. The complaint/grievance log for , 2016 contains 18 entries documented as "complaints". The documentation of the complaint "status" sections for each of the complaints contains "unknown" as an entry. The current not comment on the follow-up for these entries. On Patient #66 had no documentation of status, interventions or follow-up. On Patient #65 had no documentation of status, interventions or follow-up. On Patient #68 had no documentation of status, interventions, or follow-up. On at 3:05 p.m., an interview and record review conducted with the the following findings. A handwritten "Patient Concern/Grievance Notification" form dated contains the signature of Patient #68's. The incident contained concerns regarding medication doses and staff conduct and communication. The disposition section was blank. On the same date of , Patient# 68 completed an additional grievance regarding privacy and confidentiality concerns regarding her chart information, commenting students entered her she observed the students in her chart. Another "Patient Concern/Grievance Notification" was without patient identifiers or disposition and contained a hand written entry of "HIPPA VIOLATION".	A 119		

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A 119	Continued From page 3	A 119		

Review of the grievances and complaints for , , and 2016 contained incomplete documentation of the follow up and status. The , the information was difficult to locate and this is all that was available.
The , she was a new hire at the facility in 2016 and could not speak to incident occurring before her hire date. When asked about Patient #68, the , the facility was a "hot mess" when she arrived. She continued to explain the facility risk management and quality programs require evaluations and interventions.
The , the facility had experienced multiple surveys. The , due multiple surveys, investigations or interventions regarding the risk management and quality programs, the grievance and complaints lacked follow-up. The "the processes" for indicators and interventions for trending or audits were not "in place" at the time of survey. The she completed staff education performed for immediate intervention, but the follow up to ensure effectiveness of the education intervention did not take place.

On at 4:45 p.m., an interview conducted with the corporate director of Clinical Services (CDCS) included a review of the grievance findings. The CDCS explained the expectation was the grievance information would be complete with explanation of interventions, plans for resolutions, including correspondence and final status.
The CDCS explained the facility was without a risk manager and quality manager for a few months. She explained the facility assigned the

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A 119	Continued From page 4 . . . . control nurse the additional responsibilities of risk management and quality. She explained the company did not intervene with assistance with the risk, quality, or control programs during the time the facility had not filled the position a for risk and quality manager. The CDCS did comment she was aware the company had sent assistance to other facilities during periods of employee searches to insure program success, but this did not occur with this facility.	A 119		
A 123	482.13(a)(2)(iii) PATIENT RIGHTS: NOTICE OF GRIEVANCE DECISION At a minimum: 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. This STANDARD is not met as evidenced by: Based on staff interviews, and record review, the facility failed to provide interventions regarding grievances, verbal, and written complaints and failed to show a resolution in writing for the grievance. The findings included: The grievance information was requested during the entrance conference conducted on by the survey team. On . . . . , the Risk Manager ( ) presented an expandable file with grievance information and commented the grievance folder	A 123		

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A 123	Continued From page 5 was "found" on a shelf in her office. On [redacted] at 3:00 p.m., a record review of the grievance interventions and grievance logs was conducted. The complaint /grievance log review revealed the forms lacked entries for the "Status", "Letter" and "Resolved" sections of the form. A facility form which contained a hospital Logo included a numeric key to indicate the type of "Complaint" and included a "Status Legend". The "Status Legend" contains an "S" for substantiated, "U" for unsubstantiated and a "P" for partially substantiated. The 2016 facility grievances/complaint forms review included: Patient #67 had multiple complaint and grievances with no documentation of any status,interventions, or follow-up. The complaints were dated [redacted]. The complaint/grievance log for [redacted], 2016 contains 18 entries documented as "complaints". The documentation of the complaint "status" sections for each of the complaints contain "unknown" as an entry. Patient #66 had no documentation of status, interventions or follow-up for a complaint on [redacted]. Patient #65 had no documentation of status, interventions or follow-up for a complaint on [redacted]. Patient #68 had no documentation of status, interventions or follow-up for a complaint on [redacted].	A 123		

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A 123	Continued From page 6	A 123		

During an interview and record review with the on at 3:05 p.m., of the grievance logs and the facility form entitled "Patient Concern/Grievance Notification", a handwritten "Patient Concern/Grievance Notification" form dated contained a signature with Patient #68's name. This incident contained concerns regarding medication doses and staff conduct and communication. The disposition section was blank. On the same date of , the same Patient# 68 completed an additional grievance regarding privacy and confidentiality concerns regarding her chart information, commenting students entered her she observed the students looking in her chart. Another "Patient Concern/Grievance Notification" was without patient identifier or disposition and contained a hand written entry "HIPPA VIOLATION".

The record review of grievances and complaints for , , and 2016 contained incomplete documentation of follow up and status of complaints. The , the information was difficult to locate and this is all that was available.

The , she was a new hire at the facility in 2016 and could not speak to incident occurring before her hire date. When asked about Patient #68, the , the facility was a "hot mess" when she arrived. She continued to explain the facility risk management and quality programs require evaluations and interventions to improve the programs.

The , due multiple surveys, investigations or interventions regarding the risk management and quality programs, the grievance

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A 123	Continued From page 7 and complaints lacked follow-up. The "the processes" for indicators and interventions for trending or audits were not "in place" at the time of survey. The she completed staff education performed for immediate intervention, but the follow up to insure effectiveness of the education intervention did not take place. On at 4:45 p.m., an interview conducted with the Corporate Director of Clinical Services (CDCS) included a review of the grievance findings. The CDCS explained the expectation is the grievance information would be complete with explanation of interventions, plans for resolutions, including correspondence and final status. The CDCS explained the facility was without a risk manager and quality manager for a few months. She explained the facility assigned the control nurse the additional responsibilities of risk management and quality. The CDCS explained the company did not intervene with assistance for the risk, quality, or control programs during the time the facility had not filled the position for risk and quality manager. The CDCS did comment she was aware the company had sent assistance to other facilities during periods of employee searches to insure program success, but this did not occur with this facility.	A 123		
A 142	482.13(c) PATIENT RIGHTS: PRIVACY AND SAFETY Patient Rights: Privacy and Safety This STANDARD is not met as evidenced by: Based on observation and staff interviews on	A 142		

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A 142	Continued From page 8 , the facility failed to maintain electrical equipment and wiring in accordance with NFPA 70, The National Electric Code (N.E.C.), and NFPA 99 Health Care Facilities Code to provide a facility free from electrical hazards. Failure to maintain electrical devices, equipment, and wiring in accordance with the applicable standards can result in the hazards of electric , electrocution, energized equipment and fire resulting from electric sources. The findings include: During the tour of the facility's unit on at 1:25 p.m. with the facility maintenance staff, the unit's population utilizes electrically operated hospital beds. Visual observations of these beds (patient care equipment), reveal the power had been modified by shortening them. This resulted in a two-foot power cord to provide the electrical connection in wall outlet for the beds in the Unit. On at 1:25 p.m., the facility maintenance staff on at 1:25 p.m. revealed he "had modified the power beds just enough to plug in and bed raised up or down". This supported the visual observation of that the to all the hospital beds in this unit had been shortened.	A 142		
A 263	482.21 QAPI The hospital must develop, implement and maintain an effective, ongoing, hospital-wide, data-driven quality assessment and performance improvement program.	A 263		

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A 263	Continued From page 9 The hospital's governing body must ensure that the program reflects the , , of the hospital's organization and services; involves all hospital departments and services (including those services furnished under contract or arrangement); and focuses on indicators related to improved health outcomes and the prevention and reduction of medical errors. The hospital must maintain and demonstrate evidence of its QAPI program for review by CMS. This CONDITION is not met as evidenced by: Based on a review of quality assurance minutes, governing body minutes, and interviews with both clinical staff, and administrative staff, the quality assurance committee is not being utilized to improve services by identification of opportunities for improvement, and the follow through to show consistent improvements. (see tag A283 for details) The programs failed to use incident reports to identify issues and interventions to improve activities. (see tag A286 for details) There were no established quality assurance projects established by the hospital for areas of improvement. (see A297 for details) The quality assurance program did not involved all departments of the hospital. (see A309 for details) The governing body did not provide sufficient resources to ensure the quality assurance program was viable, ongoing, and was involved in patient safety and prevention of errors throughout the hospital. (see A315) On the Risk Manager, who also acts as the QAPI manager confirmed the facility experienced a period of time during which the facility lacked the direction of a Risk Manager or a	A 263		

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A 263	Continued From page 10 Quality Manager. On . . . . . at 4:45 p.m., the CDCS explained the facility was without a risk manager and quality manager for a few months. The CDCS explained the facility assigned the control nurse the additional responsibilities of risk management and quality management. The CDCS explained the company did not intervene with assistance with the risk or quality programs during the time the facility had not filled the positions. The CDCS said she was aware the company had sent assistance to other facilities during periods of employee searches to insure program success, but this did not occur with this facility. A review of the grievance findings was conducted with the CDCS. She explained the expectation is the grievance information would be complete with explanation of interventions, plans for resolutions, including correspondence and final status	A 263		
A 273	482.21(a), (b)(1),(b)(2)(i), (b)(3) DATA COLLECTION & ANALYSIS (a) Program Scope (1) The program must include, but not be limited to, an ongoing program that shows measurable improvement in indicators for which there is evidence that it will improve health outcomes ... (2) The hospital must measure, analyze, and track quality indicators ... and other aspects of performance that assess processes of care, hospital service and operations. (b)Program Data (1) The program must incorporate quality indicator data including patient care data, and	A 273		

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other relevant data, for example, information submitted to, or received from, the hospital's Quality Improvement Organization.
(2) The hospital must use the data collected to--
(i) Monitor the effectiveness and safety of services and quality of care; and ....
(3) The frequency and detail of data collection must be specified by the hospital's governing body.

This STANDARD is not met as evidenced by:
Based on facility interviews, and record review, the facility failed to provide interventions regarding grievances, verbal, and written complaints.

The findings included:

The grievance information request is included in the entrance conference conducted on by the survey team. On , the Risk Manager ( ) presented an expandable file with grievance information and commented the grievance folder was "found" on a shelf in her office.
A review conducted on at 3:00 p.m. of the grievance interventions and grievance logs occurred once these were located.

The grievance facility form entitled " ... Complaint Grievance Log" review revealed the forms lacked entries for the "Status", "Letter" and "Resolved" form sections.
Another facility form contained a hospital Logo and a key to indicate the type of "Complaint" are indicated by numeric entry and included a "Status

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Legend".
The "Status Legend" contains an "S" for Substantiated, "U" for unsubstantiated and a "P" for partially substantiated.

The 2016 facility grievances and complaint forms review included:
, , : Patient #67- multiple complaint and grievances- no documentation of status /interventions/follow-up
The complaint/grievance log for , 2016 contains 18 entries documented as "complaints". The documentation of the complaint "status" sections for each of the complaints contain "unknown" as an entry. The current not comment on the follow-up for these entries.
: Patient #66--no documentation of status /interventions/follow-up
: Patient #65- - no documentation of status /interventions/follow-up
: Patient #68 - no documentation of status /interventions/follow-up

An interview with the conducted on at 3:05 p.m. regarding the grievance findings. The interview included a review of the grievance logs and the facility form entitled "Patient Concern/Grievance Notification". The handwritten "Patient Concern/Grievance Notification" form dated contains a signature of Patient #68's name. This incident contained concerns regarding medication doses and staff conduct and communication. The disposition section was blank without entry. On the same date of , the same Patient# 68 completed an additional grievance regarding privacy and confidentiality concerns regarding her chart information, commenting students entered her she observed the students in her

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chart. Another "Patient Concern/Grievance Notification" was without patient identifiers or disposition and contained a hand written entry "HIPPA VIOLATION".

The review of the grievances and complaints for [redacted], [redacted], and [redacted] 2016 contained incomplete documentation of follow up and status. The [redacted] the information was difficult to locate and this is all that was available.

The [redacted], she was a new hire at the facility in [redacted] 2016 and could not speak to incident occurring before her hire date. When asked about Patient #68, the [redacted] the facility was a "hot mess" when she arrived. She continued to explain the facility risk management and quality programs require evaluations and interventions.

The [redacted], the facility had experienced multiple surveys. The [redacted] due multiple surveys investigations or interventions regarding the risk management and quality programs including the grievance and complaints lacked follow-up. The [redacted] "the processes" for indicators and interventions for trending or audits were not "in place" at the time of survey.

The [redacted] she completed staff education performed for immediate intervention, but the follow up to insure effectiveness of the education intervention did not take place.

An interview conducted with the corporate director of Clinical Services on [redacted] at 4:45 p.m. included a review of the grievance findings. The corporate director of Clinical Services explained the expectation would be the grievance information would be complete with explanation of interventions, plans for resolutions, including

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A 273	Continued From page 14 correspondence and final status. The corporate director of Clinical Services explained the facility was without a risk manager and quality manager for a few months. She explained the facility assigned the control nurse the additional responsibilities of risk management and quality. The corporate director of Clinical Services explained the company did not intervene with assistance with the risk, quality, or control programs during the time the facility had not filled the position for risk and quality manager. The corporate director of Clinical services did comment she was aware the company had sent assistance to other facilities during periods of employee searches to insure program success, but this did not occur with this facility.	A 273		
A 283	482.21(b)(2)(ii), (c)(1), (c)(3) QUALITY IMPROVEMENT ACTIVITIES (b) Program Data (2) [The hospital must use the data collected to -.....] (ii) Identify opportunities for improvement and changes that will lead to improvement. (c) Program Activities (1) The hospital must set priorities for its performance improvement activities that-- (i) Focus on high-risk, high-volume, or problem-prone areas; (ii) Consider the incidence, prevalence, and severity of problems in those areas; and (iii) Affect health outcomes, patient safety, and quality of care. (3) The hospital must take actions aimed at performance improvement and, after	A 283		

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A 283	Continued From page 15	A 283		

implementing those actions, the hospital must measure its success, and track performance to ensure that improvements are sustained.

This STANDARD is not met as evidenced by:
Based on interview and review of quality assurance minutes, the hospital failed to ensure the identifications of opportunities for improvement included changes as needed, and included tracking of measures to ensure the improvement was sustained.

The findings included:

1. A review of the quality improvement meetings conducted with the new risk/quality assurance manager revealed the first meeting was on . The next was . No meeting was held in .
The most recent meeting was held in .
This review revealed an issue was identified with . On at 10:31 a.m., the risk/quality manager said they did training. She said they have not done any evaluation to ensure the training was effective, and was having a positive effect on . She said in , there was an incident report related to a medication error. It was identified as an error in transcription. Inservices were held with all nursing staff. She does not know if there was any improvement in the medication errors related to the inservices.

2. A meeting was held to address a patient focus review done by the risk/quality assurance manager. She said others attended the meeting but there was no documentation of who attended or the date of the meeting. They identified no

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A 283	Continued From page 16	A 283		

issues with the hospital as the incident occurred after discharge. The patient the day after discharge. The meeting identified several areas of improvement for the hospital which included patients are not to be discharged on Fridays and to encourage the use of the outpatient program for patients. On at 1:30 p.m., the risk/quality assurance manager said nothing has been done to follow through with these areas for improvement.

3. A review of the incident report logs for , and of 2016 revealed trending in the areas of , medication errors, contraband, and a very high level of patients transferred to higher levels of care. The review revealed the medication areas involved included administration, transcription, 24 hour audits, pharmacy fill errors, and omitted medications. These involve the entire medication administration practices of the facility. On at 4:49 p.m. the CNO (chief nursing officer) and the risk/quality manager indicated they had identified there were issues with medications. They admitted they had not assessed the medication system as a whole to determined the effectiveness of the system.

4. On at 4:49 p.m. the risk/quality manager said she had just started in of 2016. There had not been anyone in the position for many months. She said the Joint Commission for Accreditation of Hospitals, had just come in. She had been working on completing the plan of correction for them and having them come back to resurvey. They had just finished their survey. She has another plan of correction to write for the Joint Commission to be completed by the end of . She also said the Federal Validation and

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A 283	Continued From page 17 the Federal [illegible] surveys had made her unable to do all of her other work.	A 283		
A 286	482.21(a), (c)(2), (e)(3) PATIENT SAFETY (a) Standard: Program Scope (1) The program must include, but not be limited to, an ongoing program that shows measurable improvement in indicators for which there is evidence that it will ... identify and reduce medical errors. (2) The hospital must measure, analyze, and track ...adverse patient events ... (c) Program Activities ..... (2) Performance improvement activities must track medical errors and adverse patient events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the hospital. (e) Executive Responsibilities, The hospital's governing body (or organized group or individual who assumes full legal authority and responsibility for operations of the hospital), medical staff, and administrative officials are responsible and accountable for ensuring the following: ... (3) That clear expectations for safety are established. This STANDARD is not met as evidenced by: Based on a review of incident reports, quality assurance meetings, and governing body meeting minutes, and interview with the risk/quality assurance manager, the hospital failed to ensure the incident reporting system was	A 286		

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A 286	Continued From page 18 utilized to analyze the causes of complaints, and implement preventative actions. The findings included: 1. A review of the quality improvement meetings conducted with the new risk/quality assurance manager revealed the first meeting was done on . The next meeting was . No meeting was held in . The most recent meeting was held in . A review revealed an issue was identified with . On at 10:31 a.m., the risk/quality manager said they did training. She agreed they have not done any evaluation to ensure the training was effective and it had a positive effect on . She said in , there was an incident report related to a medication error. It was identified as an error in transcription and inservices were held with all nursing staff. She does not know if there was any improvement in the medication errors related to this inservice. 2. A patient focus review was done by the risk/quality assurance manager who said others attended the meeting but there was no documentation of who attended or the date of the meeting. They identified no issues with the hospital as the incident occurred after discharge. The patient the day after discharge. The meeting identified several areas of improvement for the hospital which included patients not to be discharged on Fridays and to encourage the use of the outpatient program for patients. On at 1:30 p.m., the risk/quality assurance manager said nothing has been done to follow through with these areas for improvement.	A 286		

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A 286	Continued From page 19 3. A review of the incident report logs for , and of 2016 revealed trending in the areas of , medication errors, contraband, and a very high level of patients transferred to higher levels of care. The review revealed the medications areas involved included, administration, transcription, 24 hour audits, pharmacy fill errors, and omitted medications, which involve the entire medication administration practices of the facility. On at 4:49 p.m. the CNO (chief nursing officer) and the risk/quality manager indicated they had identified there were issues with medications. They said they had not assessed the medication system as a whole to determined the effectiveness of the system. 4. On at 4:49 p.m., the risk/quality manager said she was hired in of 2016. There had not been anyone in the position for many months. She said the Joint Commission for Accreditation of Hospitals had just come in. She had been working on completing the plan of correction for them, and having them come back to resurvey. They had just finished their survey. She has another plan of correction to write for the Joint Commission to be completed by the end of . She also said the Federal Validation and the Federal surveys had made her unable to do all of her other work.	A 286		
A 297	482.21(d) QAPI PERFORMANCE IMPROVEMENT PROJECTS As part of its quality assessment and performance improvement program, the hospital must conduct performance improvement projects. (1) The number and scope of distinct	A 297		

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A 297	Continued From page 20 improvement projects conducted annually must be proportional to the scope and , , of the hospital's services and operations. (2) A hospital may, as one of its projects, develop and implement an information system explicitly designed to improve patient safety and quality of care. This project, in its initial stage of development, does not need to demonstrate measurable improvement in indicators related to health outcomes. (3) The hospital must document what quality improvement projects are being conducted, the reasons for conducting these projects, and the measurable progress achieved on these projects. (4) A hospital is not required to participate in a QIO , project, but its own projects are required to be of comparable effort. This STANDARD is not met as evidenced by: Based on a review of quality assurance minutes, and interview with the risk/quality assurance manager the hospital failed to ensure there were improvement projects identified and in progress. The findings included: 1. Review of the quality assurance minutes on showed meetings on , 22, 2016, a meeting in , none in , and one in . There was no mention in the minutes of any quality assurance projects being undertaken by the hospital. On at 10:31 p.m. the risk/quality assurance manager said they had not started any projects identified by the hospital for improvement.	A 297		
A 309	482.21(e)(1), (e)(2), (e)(5) QAPI EXECUTIVE	A 309		

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A 309	Continued From page 21 RESPONSIBILITIES The hospital's governing body (or organized group or individual who assumes full legal authority and responsibility for operations of the hospital), medical staff, and administrative officials are responsible and accountable for ensuring the following: 1) That an ongoing program for quality improvement and patient safety, including the reduction of medical errors, is defined, implemented, and maintained . (2) That the hospital-wide quality assessment and performance improvement efforts address priorities for improved quality of care and patient safety and that all improvement actions are evaluated. (5) That the determination of the number of distinct improvement projects is conducted annually. This STANDARD is not met as evidenced by: Based on a review of quality assurance minutes, interview with both administrative and clinical staff, the hospital administration failed to ensure there was an effective, active, ongoing quality assurance program in place, involving all departments and did not ensure there was any distinct quality assurance improvement projects conducted annually for the hospital. The findings included: 1. A review of the quality improvement meetings conducted with the new risk/quality assurance manager revealed the first meeting was done on	A 309		

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A 309	Continued From page 22	A 309		

. The next meeting was . No meeting was held in . The most recent meeting was held in . The meeting revealed an issue was identified with . On at 10:31 a.m., the risk/quality manager said they did training. She agreed they have not done any evaluation to ensure the training was effective and was having a positive effect on . She said in , there was an incident report related to a medication error. It was identified as an error in transcription and an inservices was held with all nursing staff. She does not know if there was any improvement in the medication errors related to this issue.

2. A patient focus review meeting held to review work done by the risk/quality assurance manager who said others attended the meeting, but there was no documentation of who attended or the date of the meeting. They did not identify any issues with the hospital, as the incident occurred after discharge. The patient the day after discharge. In the meeting, several areas of improvement were identified for the hospital which included patients to not be discharged on Fridays and to encourage the use of the outpatient program for patients. On at 1:30 p.m., the risk/quality manager indicated nothing has been done to follow through with these area for improvement.

3. A review of the incident report logs for , and of 2016 revealed trending in the areas of , medication errors, contraband, and a very high level of patients transferred to higher levels of care. Further reviewed revealed the medications areas involved included, administration, transcription, 24 hour audits, pharmacy fill errors, and omitted

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A 309	Continued From page 23 medications, which involve the entire medication administration practices of the facility. On at 4:49 p.m. the CNO (chief nursing officer) and the risk/quality manager indicated they had identified there were issues with medications. They said they had not assessed the medication system as a whole to determined the effectiveness of the system. 4. On at 4:49 p.m. the risk/quality manager indicated she had just started in of 2016. There had not been anyone in the position for many months. She said the Joint Commission for Accreditation of Hospitals had just come. She had been working on completing the plan of correction for them, and preparing for resurvey. She has another plan of correction to write for the Joint Commission to be completed by the end of . She also said the Federal Validation and the Federal , , surveys had made her unable to do all of her other work. 5. Review of the quality assurance minutes on showed meetings on , , a meeting in , none in , and one in , . There was no mention in the minutes of any quality assurance projects being undertaken by the hospital. On at 10:31 p.m. the risk/quality assurance manager said they had not started any projects identified by the hospital for improvement. Further review revealed there was no documentation which showed all hospital departments were involved in quality assurance.	A 309		
A 315	482.21(e)(4) PROVIDING ADEQUATE RESOURCES [The hospital's governing body (or organized	A 315		

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A 315	Continued From page 24 group or individual who assumes full legal authority and responsibility for operations of the hospital), medical staff, and administrative officials are responsible and accountable for ensuring the following:] (4) That adequate resources are allocated for measuring, assessing, improving, and sustaining the hospital's performance and reducing risk to patients. This STANDARD is not met as evidenced by: Based on observation, interview with managerial staff, and review of quality assurance minutes, the hospital failed to provide sufficient resources to ensure quality assurance was an active and ongoing program to measure, assess, improve and sustain the hospitals performance and reducing risk for all patients. The findings included: 1. On at 10:31 a.m. the risk/quality manager admitted she had walked into a "hot mess". There had been no one in the position for several months, and she indicated the former person had walked out leaving any information locked and inaccessible. She said since she started she had a survey with the Joint Commission for Hospitals. She had to create a plan of correction for them. They have returned to the hospital and cleared some issues, but they have more issues and she has to write a plan of correction by the end of for them. Additionally she has had the Federal and State Validations surveys, and a Federal survey and will have to write reports for these also. She has been responsible for the entire risk	A 315		

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A 315	Continued From page 25 management activities and any quality assurance activities for the hospital has by herself since she started. 2. The quality program had not been using incident reports to assist in identification of issues. There was no analysis of the systems involved, no interventions with the programs, and no assessments of effectiveness of interventions. There was no quality assurance program in place. On . . . at 4:49 p.m., the Chief Nursing Officer admitted the rest of the hospital departments were not doing any quality assurance programs within their departments. 3. An interview with the Corporate Director of Clinical Services conducted on at 4:45 p.m. verified the facility lacked a Risk Manger and a Quality Manager. The Corporate Director explained the facility assigned the . . . . control nurse the additional responsibilities of risk management and quality management. The corporate director of Clinical Services explained the facility was without a risk manager and quality manager for a few months. The corporate director of Clinical Services explained the company did not intervene with assistance with the risk or quality during the time the facility had not filled the position for risk and quality manager. The corporate director commented she was aware the company had sent assistance to other facilities during periods of employee searches to insure program success, but this did not occur with this facility. A review of the grievance findings conducted with the Corporate Director. The corporate director	A 315		

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A 315	Continued From page 26 explained the expectation would be the grievance information would be complete with explanation of interventions, plans for resolutions, including correspondence and final status.	A 315		
A 385	482.23 NURSING SERVICES The hospital must have an organized nursing service that provides 24-hour nursing services. The nursing services must be furnished or supervised by a registered nurse. This CONDITION is not met as evidenced by: Based on observation, staff and patient interviews, and record and policy reviews, the facility failed to provide nursing services to meet the needs of the patients for oversight of staff with 15-minute patient checks, medication education, and patient care with medication education and administering medication. The findings included: 1. On a review of Patients #20, #21, #43, #57, #59 and #60 fifteen-minute check sheets revealed Mental Health Technician (MHT) Staff AAA, and MHT Staff D were behind in documenting their observations. A review of Patients # 43, #61 and #62 revealed Social Worker Staff BBB and CCC had documented their observations before the time of the observations. An observation of Patient #63 and review of 15 minute check sheets revealed Staff PP documented an observation of the patient on the 15-minute check sheet when Patient #63 was not visible. Staff PP confirmed he could not see patient. On , RN Supervisor Staff WW,Social	A 385		

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A 385	Continued From page 27 Worker Staff BBB, and MHT Staff DDD observed Patient #46 walking around the unit with a long blue scarf wrapped around his waist. Patient #46's said his wife gave him the scarf on . The staff failed to check in the scarf and record on his belongings sheet, as per policy. 2. On and a review of Patients #30, #42, #45, #46, #47, #48, #49, #50, #51, #52, #53, #55, and #56 medical charts revealed they had not received medication education. LPN Staff TT said she uses the 2015 Nursing Drug handbook to educate patients. On , Patient #46 said she started on new medications and did not receive medication education. 3. On , a review of Patients # 30, #42, #47, #50 and #53 Medication Administration Record revealed Licensed Practical Nurse (LPN) Staff SS administered their medications after 1 hour of their scheduled time. Staff RN Supervisor Staff WW confirmed LPN Staff SS did not follow the policy for medication administration. 4. On , a review of Patient #44's Medication Administration Record (MAR) and Record revealed Patient #44 had ordered as a scheduled medication. LPN Staff SS reviewed the MAR and acknowledged unknown nurses gave Patient #44 according to a sliding scale. Patient #44 does not have an order for . 5. On a review of Patient #35's MAR revealed LPN Staff TT had documented Patient #35 was given 9:00 a.m., dose of and	A 385		

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A 385	Continued From page 28 [illegible] prior to administering the medication and without documenting Patient #35 had refused oral medication. Staff TT was observed after 9:00 a.m., with Patient #35 telling her if she refused her medications by mouth, the medications would have to be given [illegible]. Patient #35 said she wanted the medication orally. 6. On [illegible] Patient #41 had an Emergency Treatment Order (ETO) and received 2 ETOs. On [illegible], RN Supervisor Staff UU confirmed on [illegible], he had administered the ETO for Patient #35. A review of the MAR for Patient #41 revealed Staff UU failed to document the ETO medication and as having administered.	A 385		
A 392	482.23(b) STAFFING AND DELIVERY OF CARE The nursing service must have adequate numbers of licensed registered nurses, licensed practical (vocational) nurses, and other personnel to provide nursing care to all patients as needed. There must be supervisory and staff personnel for each department or nursing unit to ensure, when needed, the immediate availability of a registered nurse for bedside care of any patient. This STANDARD is not met as evidenced by: Based on observation and staff interviews, the facility failed to provide adequate staff to deliver nursing care to all patients as needed. The facility nurse failed to provide oversight for 9 (Patients #20, #21, #43, #46, #57, #59, #60, #61, #62, and #63) out of 64 sampled patients. The findings included: 1. A review of the 15 minute checks sheets on	A 392		

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and revealed the following:

On at 11:32 a.m., observed MHT (mental health technician) Staff AAA, sitting in Patient #43's . Staff AAA stated "[patients name]who is Patient #43, is on 1:1 and is checked every 15 minutes. I have to stay with him. Review of the 15-minute check sheet revealed 10:45 a.m., was the last 15 minute check documented. Staff AAA said he was just going to update the documentation.

On at 3:35 p.m., a review of Patient #43's 15 minute check sheet revealed MHT Staff C had already initialed and documented the behavior for Patient #43's activity at 3:45 p.m. Staff C said he documented it for 3:45 p.m., "because I knew I was gonna be here."

2. On at 12:03 p.m., observed MHT Staff D assisting patients in dining . MHT Staff E said Staff D had given her the 15-minute check sheets for #20, #21, #57, #59, and #60. Review of the 15-minute check sheets for #20, #21, #57, #59, and #60 revealed the last 15 minute check was documented at 11:10 a.m.

3. On at 11:55 a.m., Patient #63 was observed talking on the telephone. At 12:15 p.m., a review of the 15-minute check sheet revealed MHT Staff PP had initialed it and documented her behavior and activity for 12:00 p.m. He said Patient #63 already ate lunch in the dining , and went back to the unit. At 12:16 p.m., he acknowledged Patient #63 had not been in the dining , she was on the unit. He confirmed he was not able to see her from the dining . On the unit, RN Staff EEE said the patient went into the common area and would be eating lunch

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on the unit. She said she is watching her for the 15-minute checks but she did not have her 15-minute check sheet .

4. On . . . . at 12:10 p.m., review of the 15-minute check sheets for Patients # 61 and #62 revealed MHT Staff CCC documented their behavior and activity before the time of the check.

5. On at 9:45 a.m., observed Patient # 46 on the unit walking around in a mid-calf blue hospital gown with a piece of blue cloth wrapped around his waist hanging to mid-calf. At 10:30 a.m., observed Patient #46 dressed the same, during a group session held by social worker Staff BBB. At 11:35 a.m., observed RN Supervisor Staff WW ask Patient #46 for the blue cloth wrapped around his waist. The patient unwrapped the long blue cloth and gave it to her. At 11:37 a.m., MHT Staff DDD stated "Patient #46 had this scarf wrapped him and Staff WW took it from him because he can't have it." She said Staff WW told her his wife gave it to him at visitation last night. Staff DDD explained she would need to log Patient #46's scarf into his belongings list. She said, he would not get something like this back. The patient was told the hospital would hold it for him because it could be dangerous.

6. On at 1:00 p.m., RN supervisor Staff WW said there is not enough staff so she can spend time with the patients. She said she really has not had the time to see them today. She said she really needs another nurse. She said today she has had four patient discharges. She said yesterday, a physician ordered a draw, and it was not drawn. Today she had to stop what she was doing, and had to draw the today as a stat (urgent) . . . . draw. She said she had to

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A 392	Continued From page 31 complete the incident report and call the Chief Nursing Officer to tell her. She said while doing all of this, she is taking off MD orders and is supposed to help the medication nurse. She said she is overwhelmed at times. She said she has spoken up to administration to let them know she really needs more help. Review of the facility policy for Patient Observation dated , documents the "documentation of the observation is to be completed once the patient has been observed. It is not permissible to complete in advance and/or to back fill timeframes that were not completed in a timely manner." "During rounds staff are to make direct visual contact." Review of the facility's policy for Visitation and Telephone use dated . . . documents visitors must go to the nurses' station prior to seeing patients on the unit, present identification and sign in. Items brought for the patient will be checked by staff, and the policy for contraband will be strictly followed."	A 392		
A 397	482.23(b)(5) PATIENT CARE ASSIGNMENTS A registered nurse must assign the nursing care of each patient to other nursing personnel in accordance with the patient's needs and the specialized qualifications and competence of the nursing staff available. This STANDARD is not met as evidenced by: Based on observation, staff and patient interviews ,and review of facility policy, the facility failed to provide medication education for 13 (Patient #30, #42, #45, #46, #47, #48, #49, #50, #51, #52, #53, #55, and #56) of 13 patients	A 397		

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sampled for medication education out of 64 sampled patients and failed to ensure care was provided as ordered 2 patients #69 and #36.

The findings included:

Review of the facility policy for Informed Consent, Medications documented the procedure as "the nurse on the unit will discuss prescribed medications with the patient at the time of admission or at the time the new [illegible] medication is ordered. The discussion will be based on written medication information sheets generated and approved by US Pharmacopeias Drug Information approved sources. Written medication sheets will be given to the patients. the nurse, physician or pharmacist will follow the process when medications are changed or added ..."

On [illegible] at 10:00 a.m., Licensed Practical Nurse Staff SS, said medication administration starts between 8:00- 8:30 a.m. and it takes about 1- 1 ½ hours to complete it. She said if the patient has started on a new medication, she gives the patients a medication education sheet for the medications. She said she offers the medication education sheet to them, sometimes they take it while other times they read it and hand it back to her. She said she does not give the patients a medication education sheet that have been on the medications a long time or if they were taking it before their admission, because "they already know the side effects for them."

[illegible] at 11:02 a.m., Patient #46 said she had started four new medications she had never taken before. She said last night she asked the

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night nurse for the education sheets and he gave her two medication sheets out of the four medications she takes. She said the night nurse handed her the medication education sheets but no one spoke to her about them.

On , a review of Patient's #30, #42, #45, #46, #47, #48, #49, #50, #51, #52, #53, #55, and #56 failed to reveal documentation of medication education.

On observation during morning medication administration with Staff SS, she failed to educate the patients for possible side effects.

On at 10:03 a.m., LPN Staff TT said if a patient asks her about their medication and she does not know the side effects of it or what it is for, she will look it up in the Nursing Drug Handbook. A Nursing Drug Handbook dated 2015 was observed on a shelf above the counter in medication . She said it is not something she offers to the patient, but will do it if they ask about their medication.

On at 10:58 a.m., RN supervisor Staff WW said, the medication nurse does the medication education. She said she does not do it. She confirmed there is no documentation in the patients medical chart for medication education stating "we don't put anything in there for that."

Patient #36 had physician's orders dated for a dentist and a podiatrist. A review of the record revealed the order was signed by the physician at 6:40 p.m. It was signed off by the nurse on at an unknown time. There was also a note indicating there was a copy sent to the social worker. There was no

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A 397	Continued From page 34 evidence in the record about either referral being made to the appropriate provider, nor was there evidence either referral was ever implemented. On at 1:30 p.m., the Director of Clinical Services Staff K agreed there was no documentation on the record about these orders and the reason they were not implemented. A review of the clinical record for Patient #69 was conducted on . The record included a facility Treatment Orders sheet. An order was dated at 2:15 p.m. The handwritten order included "AM labs: Vit D (D), , level". A review of the treatment orders dated include " , level STAT (immediately)" and "hold ,". The Chief Nursing Officer verified the , level ordered for was omitted / not drawn by the facility clinical/nursing staff.	A 397		
A 398	482.23(b)(6) SUPERVISION OF CONTRACT STAFF Non-employee licensed nurses who are working in the hospital must adhere to the policies and procedures of the hospital. The director of nursing service must provide for the adequate supervision and evaluation of the clinical activities of non-employee nursing personnel which occur within the responsibility of the nursing services. This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to supervise a contract staff so they followed the hospital's policy for medication	A 398		

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A 398	Continued From page 35 administration for 1 (Patient #64) out 1 sampled patient during medication administration. The findings included: On at 11:20 a.m., review of Patient #64's Medication Administration Record (MAR) revealed Contract LPN (agency) Staff VV initialed as administering Patient #64's 11:00 a.m. dose of Pom- . He said when he sets up the medication in the medication cup; he will put a dot next to the medication. Staff VV said he initials it when Patient #64 takes it. He said he has not given Patient #64 the 11:00 a.m. medication yet, she should be up here in a few minutes. He acknowledged his initials are on the MAR for Patient #64 for the 11:00 a.m. medication, and there is no dot next to it. A review of the policy for Medication Administration dated documented, "Administration: Medications must be administered within 1 hour of the designated scheduled time. Report drug administration errors and adverse or untoward drug reactions immediately to the attending physician, pharmacist, and patient and/or family. Prepare and submit reports as required by the facility. Check patient's MAR to ensure that the order is accurate: verify patient, medication, dosage, route, frequency, stop date. Read the drug label. Document on the MAR the following information in the appropriate column: dose, time, route (if not by mouth) site and initials. Sign the bottom of the MAR where indicated."	A 398		
A 405	482.23(c)(1), (c)(1)(i) & (c)(2) ADMINISTRATION OF DRUGS	A 405		

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A 405	Continued From page 36 (1) Drugs and biologicals must be prepared and administered in accordance with Federal and State laws, the orders of the practitioner or practitioners responsible for the patient's care as specified under §482.12(c), and accepted standards of practice. (i) Drugs and biologicals may be prepared and administered on the orders of other practitioners not specified under §482.12(c) only if such practitioners are acting in accordance with State law, including scope of practice laws, hospital policies, and medical staff bylaws, rules, and regulations. (2) All drugs and biologicals must be administered by, or under supervision of, nursing or other personnel in accordance with Federal and State laws and regulations, including applicable licensing requirements, and in accordance with the approved medical staff policies and procedures. This STANDARD is not met as evidenced by: Based on observation, staff interviews and policy review, the facility failed to administer medications within the timeframe for 6 (Patients #30, #32, #35, #42, #47, #50, and #53) out of 13 patients sampled for medication administration. The facility nurse failed to administer medication as ordered for 1(Patient # 44) out of 2 sampled patients for . The facility failed to appropriately document for 1 (Patient #41) out 1 patient sampled for Emergency Treatment Orders. The findings included:	A 405		

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1. On . . . from 9:45 a.m. to 11:05 a.m., observation during medication administration revealed Licensed Practical Nurse (LPN) Staff SS administered Patient's #30, #42, #47, #50, and #53. The scheduled medication for 9:00 a.m., was administered after 10:00 a.m.

On . at 10:50 a.m., RN Supervisor Staff WW acknowledged there are four Styrofoam cups with medications in them. They were Patients #38, #41, #42 and #46 medication scheduled for for 9:00 a.m. LPN Staff SS stated, "I don't know what I am going to do with them, I am working on it."

On at 10:58 a.m., Staff WW said the timeframe for medication administration is 1 hour before to 1 hour after the time on the MAR. She stated, "It can be 11:00 a.m. before they get it." She confirmed if the patient has not taken their medication by 10:00 a.m., the medication nurse should notify the physician and get an order to give it.

2. On . . . at 11:00 a.m., Patient #44 approached the medication and said she was there for her . . . . . LPN Staff SS informed her the next is at 4:00 p.m. RN Supervisor Staff WW reviewed the form for Patient # 44 and said the nurses have documented for a sliding scale with given on and . She acknowledged on . . at 4:00 p.m., an unknown nurse performed an on Patient # 44. The nurse administered four units of

On . at 6:00 a.m., an unknown nurse performed an . . . . . on Patient # 44. The

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nurse administered four units of [illegible], with a second nurse initialing the Medication Administration Record (MAR) as confirming the [illegible]. LPN Staff SS is unable to determine who the nurses are by their initials. Patient #44 does not have a physician order for [illegible] or a sliding scale. Staff SS stated, "They keep doing this, putting it on the wrong form. She does not get sliding scale, her [illegible] is scheduled and she gets an [illegible] done twice a day. It belongs on this other form." Staff SS acknowledged the sliding scale form indicates Patient # 44 received [illegible] based on sliding scale. On [illegible] only one nurse initialed, (there should to be two nurses' initials). She confirmed there was no documentation on the patient's MAR for [illegible] to account for the four units of [illegible] given on two occasions.

A review of physician orders revealed an order dated [illegible] which documented Patient #44 is prescribed Lantus 25 units every evening and [illegible] 5 units before meals. There is a physician order for [illegible] twice a day.

On [illegible] at 10:15 a.m., RN Supervisior Staff WW said she is unable to locate the sliding scale order for Patient #44. She said according to the physician order dated [illegible], she is not on sliding scale. She is to have [illegible] twice a day, and 25 Units [illegible] at night and 5 units before each meal. She acknowledged the form in her chart for sliding scale coverage and stated, "This is the nurse who is a Nurse Practitioner that is doing this; many medication errors happen. She said staff SS did not tell her about this yesterday. She said a incident report needs to be completed when there is a medication error. She acknowledged LPN Staff SS did not follow the

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medication administration and reporting medication errors policy.

3. On at 10:00 a.m., observed LPN Staff TT exiting Patient #35's . She said she was her last patient for medication. She said Patient # 35 had been refusing her medication this morning. Staff TT stated, "I told her if she did not take it by mouth, I would have to give by , but now she said she would take it." Review of Patient #35's MAR revealed an order for by mouth, if refuses give and by mouth, if refuses give . The 9:00 a.m. doses for the and are circled, and , with staff initials is written under it. Staff TT said when you circle a time it means they refused it. Staff TT stated, "It's like that because she thought she would have to give it to her ."

4. On at 12:45 p.m., Patient # 41 said two nights ago she the nurse got an Emergency Treatment Order (ETO) and gave her two shots. One shot was for and the other for . A review of Patients #41 MAR did not reveal she received the ETO.

On at 9:00 a.m., RN Staff RR and RN Supervisor Staff UU confirmed Patient #41 received an ETO of and on . Staff UU said he was the nurse that gave it.

A review of the policy for Medication Administration dated documented "Orders: Only Practitioner who are lawfully authorized to prescribe and credentialed by the hospital may write orders for medication." Administration: "two nurses must check the dosage and prepare amount for . Medications must be administered within 1 hour

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of the designated scheduled time. Report drug administration errors and adverse or untoward drug reactions immediately to the attending physician, pharmacist, and patient and /or family. Prepare and submit reports as required by the facility. Check patient's MAR to ensure that the order is accurate: verify patient, medication, dosage, route, frequency, stop date. Read the drug label. Document on the MAR the following information in the appropriate column: dose, time, route (if not by mouth) site and initials. Sign the bottom of the MAR where indicated."

A review of the policy for Administration dated "...all doses must be checked by the administration nurse and a witness" "all is measured in units. No matter what is administered, always monitor and record on MAR the number of units administered. Record on the MAR the time of the injection, the amount of , and the injection site. All doses (type and amount) and syringe must be verified and documented by the administration nurse and a witness prior to patient administration. To promote consistency in sliding scale coverage and coverage, the order sheet for , should be used."

5. On , a review of the Patient #32's clinical record occurred.

The facility form entitled "Practitioner Order" (used as a physician order sheet) contained a handwritten entry on at "12 AM" including an order to "d/c (discontinue) ".

A review of the Medication Administration Record (MAR) for a four day period dated , included to . The 100 milligram (mg) 1 tablet PO (by mouth) daily dose

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A 405	Continued From page 41 was documented as administered on ... and at 9:00 a.m. On the MAR, a handwritten entry noted: "DC'd (discontinued) " with a nurse initial placed below the note. A review of the Medication Administration Record (MAR) for a three day period dated Saturday ..., 2016 included the dates ... to . The MAR documentation of the ... 100 mg 1 tablet PO (by mouth), daily dose is administered at 9:00 a.m. on ... and .... An interview with the Risk Manager conducted on ... at 3: 45 p.m. with an affirmative verification of the finding.	A 405		
A 508	482.25(b)(6) PHARMACY: REPORTING ADVERSE EVENTS Drug administration errors, adverse drug reactions, and incompatibilities must be immediately reported to the attending physician and, if appropriate, to the hospital' s quality assessment and performance improvement program. This STANDARD is not met as evidenced by: Based on administrative and pharmacy interviews, record reviews, and facility policy and procedure, the facility failed to ensure to have a system to notify the physicians of medications with potentially harmful interactions for 1 (patient #39) of 40 patient records reviewed. The findings included: 1. Patient #39 was admitted to the hospital on	A 508		

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A 508	Continued From page 42 as an involuntary admission and was discharged on . The evaluation indicated the patient was alert and oriented at the time of admission. The physician sent her home on , , , , , and . A review of the drug interactions noted in WebMD showed the and have a serious interaction which can cause a severe rhythm issue and sudden . This interaction was deemed serious and alternative drugs should be used. The and the will interact together by increasing sedation, caution should be used with these 2 drugs, and the patient should be monitored. 2. A review of the policy and procedure related to "new order handling" dated , indicated the pharmacist was to check for the appropriateness of the order. The computer would check for drug interactions when the medication order was entered into the computer. After the order was to be processed, the pharmacist would do a final check and then call the nurse or the physician for order clarification with the appropriate intervention. The policy had no mechanism to ensure the process was followed and interventions were made as necessary. 3. On at 1:30 p.m., the Pharmacist said the computer checks for interactions and colors them purple. She said she called on what she has, but to be honest and she did not do as much documentation as she should. If she was not present the alternate pharmacist would leave a note for her to handle any issues upon her return. She said she called the doctors to communicate, but she did not document this. She agreed she	A 508		

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A 508	Continued From page 43 had no documentation the issues with Patient #39's medications were evaluated for interactions, or the physician notified of the serious potential for interactions between medications.	A 508		
A 630	482.28(b)(2) DIETS All patient diets, including therapeutic diets, must be ordered by a practitioner responsible for the care of the patient, or by a qualified dietitian or qualified nutrition professional as authorized by the medical staff and in accordance with State law governing dietitians and nutrition professionals. This STANDARD is not met as evidenced by: Based on patient diets reviewed, facility staff interview, facility menu review and observations, the facility failed to provide the prescribed diets at the lunch meal for 2 (Patients #20 and #21) of 3 patients sampled. The findings included: A review of Patients #20 and #21's diet orders showed Patient #20 was on a 2 gram diet dated and Patient #21's was on a consistent diet dated . A review of the facility lunch menu for showed the 2 gram diet received buttered pasta and cole slaw and patients on the consistent diet received 1/2 for their sloppy Joe sandwich. Observation on at 11:45 a.m. showed Patient #20 did not receive butter pasta and cole slaw with her lunch, and Patient #21 received a whole with her sloppy Joe sandwich.	A 630		

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A 630	Continued From page 44 On at 1:45 p.m., the facility's Director of Food Service said he was not aware these two patients did not get their prescribed diet.	A 630		
A 652	482.30 UTILIZATION REVIEW The hospital must have in effect a utilization review (UR) plan that provides for review of services furnished by the institution and by members of the medical staff to patients entitled to benefits under the Medicare and Medicaid programs. This CONDITION is not met as evidenced by: Based on staff interviews on at 2:00 p.m. the facility had not developed their Utilization Review Committee and had no policy and procedures to meet the UR plan (refer to A 653 and A654): No Utilization Review Committee (URC) had developed a plan to provide review for Medicare and Medicaid patients (refer to A655); the URC did not determine the if the admission or continued stay at the facility is medically necessary (refer to A656); since the hospital is not paid under the prospective payment system, the facility did not review patients with extended stays (refer to A657); and the facility did not review the professional services provided to ensure the patients are receiving the most effective use of services and health care facilities (refer to A658).	A 652		
A 653	482.30(a) APPLICABILITY Standard: Applicability. The provisions of this section apply except in either of the following circumstances: (1) A Utilization and Quality Control Quality Improvement Organization (QIO) has assumed	A 653		

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A 653	Continued From page 45 binding review for the hospital. (2) CMS has determined that the UR procedures established by the State under title XIX of the Act are . , to the procedures required in this section, and has required hospitals in that State to meet the UR plan requirements under §§456.50 through 456.245 of this chapter. This STANDARD is not met as evidenced by: Based on facility staff interview, the facility had not developed a Utilization Committee and had no policies and procedures. The findings included: On at 2:00 p.m., the Director of Utilization Review (DUR) and the Chief Financial Officer (CFO) said at this time, the hospital did not have a Utilization Review Committee (URC). The DUR was in the process of developing this committee. The URC had not assumed binding review for the hospital and there were no UR procedures written specifically for this hospital.	A 653		
A 654	482.30(b) UTILIZATION REVIEW COMMITTEE A UR committee consisting of two or more practitioners must carry out the UR function. At least two of the members of the committee must be doctors of medicine or osteopathy. The other members may be any of the other types of practitioners specified in §482.12(c)(1). (1) Except as specified in paragraphs (b)(2) and (3) of this section, the UR committee must be one of the following: (i) A staff committee of the institution; (ii) A group outside the institution--	A 654		

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A 654	Continued From page 46 (A) Established by the local medical society and some or all of the hospitals in the locality; or (B) Established in a manner approved by CMS. (2) If, because of the small size of the institution, it is impracticable to have a properly functioning staff committee, the UR committee must be established as specified in paragraph (b)(1)(ii) of this section. (3) The committee or group's reviews may not be conducted by any individual who-- (i) Has a direct financial interest (for example, an ownership interest) in that hospital; or (ii) Was professionally involved in the care of the patient whose case is being reviewed. This STANDARD is not met as evidenced by: Based on facility staff interview, the facility has not developed a Utilization Review Committee (URC) and assign staff to this committee. The findings included: An interview was conducted with the Director of Utilization Review and the Chief Financial Officer (CFO) on at 2:00 p.m. They stated their plan is to have two physicians, the Director of Social Services, 1 nurse from a unit and another nurse from intake, CFO and anyone else that is appropriate. At this time they have not had any meetings.	A 654		
A 655	482.30(c) SCOPE AND FREQUENCY OF REVIEW (1) The UR plan must provide for review for Medicare and Medicaid patients with respect to	A 655		

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A 655	Continued From page 47 the medical necessity of-- (i) Admissions to the institution; (ii) The duration of stays; and (iii) Professional services furnished including drugs and biologicals. (2) Review of admissions may be performed before, at, or after hospital admission. (3) Except as specified in paragraph (e) of this section, reviews may be conducted on a sample basis. (4) Hospitals that are paid for inpatient hospital services under the prospective payment system set forth in Part 412 of this chapter must conduct review of duration of stays and review of professional services as follows: (i) For duration of stays, these hospitals need review only cases that they reasonably assume to be outlier cases based on extended length of stay, as described in §412.80(a)(1)(i) of this chapter; and (ii) For professional services, these hospitals need review only cases that they reasonably assume to be outlier cases based on extraordinarily high costs, as described in §412.80(a)(1)(ii) of this chapter. This STANDARD is not met as evidenced by: Based on facility staff interview, and facility record review, the facility had not developed a Utilization Review Committee and had no Utilization Review Plan developed to review patients with Medicare and Medicaid to ensure medical necessity of services.	A 655		

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A 655	Continued From page 48 The findings included: On . . . at 2:00 p.m., the Director of Utilization Review (DUR) said she did not have this committee organized as of yet. However, she had a form monitoring patients' admission to ensure it is necessary. She said she had not used this form for any patients at this time. A review of "Traditional Medicare UR (utilization Review) Inpatient Admission Oversight" form showed the form was for the review of patients with Medicare coverage. The DUR said they did not review patients with Medicaid only. They will admit patients with Medicaid under . . . . Then the business office staff will meet with the patient and qualify them as charity.	A 655		
A 656	482.30(d) DETERMINATIONS OF MEDICAL NECESSITY (1) The determination that an admission or continued stay is not medically necessary- (i) , be made by one member of the UR committee if the practitioner or practitioners responsible for the care of the patient, as specified in §482.12(c), concur with the determination or fail to present their views when afforded the opportunity; and (ii) Must be made by at least two members of the UR committee in all other cases. (2) Before making a determination that an admission or continued stay is not medically necessary, the UR committee must consult the practitioner or practitioners responsible for the care of the patient, as specified in §482.12(c), and afford the practitioner or practitioners the opportunity to present their views.	A 656		

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A 656	Continued From page 49 (3) If the committee decides that admission to or continued stay in the hospital is not medically necessary, written notification must be given, no later than 2 days after the determination, to the hospital, the patient, and the practitioner or practitioners responsible for the care of the patient, as specified in §482.12(c). This STANDARD is not met as evidenced by: Based on facility staff interview, and record review, the facility did not have a Utilization Review Committee to determine if patients that are admitted or had a continued stay were not medically necessary. The findings included: On . . . at 2:00 p.m., the Director of Utilization Review (DUR) said she did not have this committee organized as of yet. However, she had a form monitoring patients' admission to ensure it is necessary. She said she had not used this form for any patients at this time. A review of "Traditional Medicare UR (Utilization Review) Inpatient Admission Oversight" form showed a review for admission medical necessity.	A 656		
A 657	482.30(e) EXTENDED STAY REVIEW (1) In hospitals that are not paid under the prospective payment system, the UR committee must make a periodic review, as specified in the UR plan, or each current inpatient receiving hospital services during a continuous period of extended duration.	A 657		

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A 657	Continued From page 50 The scheduling of the periodic reviews may -- (i) Be the same for all cases; or (ii) Differ for different classes of cases. (2) In hospitals paid under the prospective payment system, the UR committee must review all cases reasonably assumed by the hospital to be outlier cases because the extended length of stay exceeds the threshold criteria for the diagnosis, as described in §412.80(a)(1)(i). The hospital is not required to review an extended stay that does not exceed the outlier threshold for the diagnosis. (3) The UR committee must make the periodic review no later than 7 days after the day required in the UR plan. This STANDARD is not met as evidenced by: Based on facility staff interview, the facility had not developed a Utilization Review Committee or Utilization Review plan to review each inpatients extended stay. The findings included: On ____ at 2:00 p.m., the Director of Utilization Review (DUR) said the facility had not developed a Utilization Review Committee or Utilization Review plan. They had not reviewed any patients extended stays.	A 657		
A 658	482.30(f) REVIEW OF PROFESSIONAL SERVICES The committee must review professional services provided, to determine medical necessity and to promote the most efficient use of available health facilities and services.	A 658		

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A 658	Continued From page 51 This STANDARD is not met as evidenced by: Based on facility staff interview, the facility had not developed a Utilization Review Committee to review professional services and other health facilities to best suit their patients. The findings included: On . . . at 2:00 p.m., the Director of Utilization Review (DUR) said the facility had not developed a Utilization Review Committee. They had not begun the review of professional services to determine the most efficient use of the health facilities and services that are available for each of their patients.	A 658		
A2402	489.20(q) POSTING OF SIGNS [The provider agrees,] in the case of a hospital as defined in §489.24(b), to post conspicuously in any emergency department or in a place or places likely to be noticed by all individuals entering the emergency department, as well as those individuals waiting for examination and treatment in areas other than traditional emergency departments (that is, entrance, admitting area, waiting , treatment area) a sign (in a form specified by the Secretary) specifying the rights of individuals under section 1867 of the Act with respect to examination and treatment for emergency medical conditions and women in labor; and to post conspicuously (in a form specified by the Secretary) information indicating whether or not the hospital or rural primary care hospital (e.g., critical access hospital) participates in the Medicaid program under a State plan approved under Title XIX. This STANDARD is not met as evidenced by:	A2402		

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A2402	Continued From page 52 Based on observation and staff interviews, the facility failed to post signage informing and indicating the hospital was a [redacted] hospital. The findings included: On [redacted] at 11:35 a.m., the Chief Nursing Officer said the sign outdoors said [redacted] urgent care. She said there was nothing posted for signage inside. People would just know when they came through the door. She said they had dealt with that many times. If someone came in, the staff clarify the patient needs. If there was an emergency, they call a code. She said there was nursing services available and the nurse would stabilize the patient and transfer them to a hospital to meet their medical needs. She said the receptionist would tell people walking in, this is a [redacted] hospital and not a medical hospital. On [redacted] at 12:15 p.m., the Director of Outpatient Services acknowledged during the tour of the receiving area for [redacted], there was no signage indicting what type of hospital this is. She acknowledged the front of the hospital, and the waiting area inside the entrance to the hospital there was no signage to indicate this was a [redacted] only treating facility. The Director of Outpatient Services confirmed the only signage was in the case next to the receptionist desk. She acknowledged you are unable to see the signage when entering the hospital. On [redacted] at 12:33 p.m., the Receptionist, Staff KK said if a person came here with a medical emergency by accident thinking this was a medical hospital, she would "assess them for the medical problem." If they were [redacted], she	A2402		

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A2402	Continued From page 53 "would assess the issue to see if they were [illegible] profusely." She said she would contact the [illegible] Control Nurse or the intake nurse. She said they are not a medical facility and stated, "We don't do medical treatment here." (The receptionist, Staff KK had no Medical or Mental Health background). On [illegible] at 5:15 p.m., the Director of Corporate Services said there is a sign outside that says [illegible] hospital. The receptionist should never assess, just call intake nurse or DON. ** photo evidence on file **	A2402		