Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HL100002	A. BUILDING: _____ B. WING _____	08/30/2018

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BETHESDA HOSPITAL EAST	2815 S SEACREST BLVD BOYNTON BEACH, FL 33435

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H 000	INITIAL COMMENTS An unannounced Licensure and Risk Management survey was conducted on . . . . . through at Bethesda Hospital East, License #4452. The facility had deficiencies at the time of the visit.	H 000		
H 120	59A-3.2085(5)(e)1-3, FAC NURSING SERVICE - Care Process (e) The nursing process of assessment, planning, intervention and evaluation shall be documented for each hospitalized patient from admission through discharge. 1. Each patient's nursing needs shall be assessed by a registered nurse at the time of admission or within the period established by each facility's policy. 2. Nursing goals shall be consistent with the , , prescribed by the responsible medical practitioner 3. Nursing intervention and patient response, and patient status on discharge from the hospital, must be noted on the medical record. This Statute or Rule is not met as evidenced by: Based on policy review, clinical record review and interview, it was determined, the facility failed to ensure quality of nursing care provided to each patient is in accordance with established standards of practice of nursing care, chapter 464.003(5). This failure affected 4 of 10 sampled patients (Patient #2, #4, #5, and #6) as evidenced by failure to reassess pain as specified in the facility policies and procedures; failure to follow prescription parameters for pain management and failure to administer as needed medications to manage elevated , and sugar.	H 120		

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H 120	Continued From page 1 The findings included: Facility policy titled "Pain Management" revised documents "The efficacy of pain management interventions should be continually evaluated and dosages adjusted based on the changing nature of the pain. Pain should be reassessed at least once per shift and when the condition warrants. For those patients having pain, documentation of intervention must occur at least once per shift on the problem list or plan of care. Pain reassessment must be done after each intervention. Pain reassessment will be completed as soon as possible but not to exceed 2 hours. Pain reassessment is documented." 1) Clinical record review conducted on revealed a Physician's Order for Patient #6 dated , the order documents mg every six hours as needed for pain level 3-8. Review of the Medication Administration Records and Assessment and Reassessments documentation indicates the nursing staff administered pain medication on at 1:41 AM for pain at level 5. The nursing staff failed to reassess the patient's pain level to monitor effectiveness of the drug administration. There is no evidence the pain reassessment was completed within two hours of the pain medication administration. 2) Clinical record review conducted on revealed Patient #4 was prescribed Hydrazaline 10 mg every 6 hours as needed for ,	H 120		

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H 120	Continued From page 2 pressure greater than 160 on . . . . (B/P) readings documented for Patient #4 included the following: On . . . . . at 12 AM the B/P was documented as 163 . . . . . at 4 AM B/P 181 at 8 AM B/P 163 . . . . . at 8 AM B/P 170 at 12 PM B/P 178 . . . . . at 4 PM B/P 178 at 4 PM B/P 164 . . . . . at 12 PM B/P 163 at 12 PM B/P 178 Review of the medication administration records and nursing notes failed to provide evidence the nursing staff followed the medication order and administered the Hydrazaline when the . . . . , readings were above 160. There is no documentation of medication refusal or other clinical judgement to omit the doses when the patient's . . . . , ... met the prescribed parameters. 3) Clinical record review conducted on revealed a Physician's Order for Patient #4 dated , the order documents Oxyr 5-15 mg every four hours as needed for pain. Review of the Medication Administration Records and Assessment and Reassessments documentation indicates the nursing staff administered pain medication on at 4:41 AM for pain. The nursing staff failed to reassess the patient's pain level to monitor effectiveness of the drug administration. There is no evidence the pain reassessment was completed within two	H 120		

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H 120	Continued From page 3 hours of the pain medication administration. 4) Clinical record review conducted on . . . . revealed Physician's Orders for Patient #2 dated . . . . . , the orders document . . . . . mg every four hours as needed for pain level 3-7 and . . . . . 1 milliliter every four hours as needed for pain 7-10. Review of the Medication Administration Records and Assessment and Reassessments documentation indicates the nursing staff administered . . . pain medication on . . . at 11 PM for pain level of 6. The nursing staff failed to follow the prescribed parameters for pain management. 5) Clinical record review conducted on . . . . . revealed Patient #5 was prescribed Regular . . . sliding scale on . . . . . at 4:21 AM, with instructions to give 1 unit of . . . for . sugar readings of 176-200; 2 units for . . . . sugar 201-250; 3 units for readings 251-300, 4 units for readings 301-350 and 5 units for readings 351-400. Glucose monitoring results indicates the patient . . . . sugar on . . . . . at 11:33 AM was 200. Review of the medication administration records and nursing notes failed to provide evidence the nursing staff followed the medication order and administered the . . . when the . . . sugar readings was above 176. There is no documentation of medication refusal or other clinical judgement to omit the doses when the patient's . . . sugar met the prescribed	H 120		

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H 120	Continued From page 4 parameters. Interview with The Quality Coordinator who was navigating the electronic record on . . . . . starting at 12:30 PM confirmed the findings indicated above.	H 120		
H 121	59A-3.2085(5)(f), FAC NURSING SERVICE - Sufficient Staffing (f) A sufficient number of qualified registered nurses shall be on duty at all times to give patients the nursing care that requires the judgment and specialized skills of a registered nurse, and shall be sufficient to insure immediate availability of a registered nurse for bedside care of any patient when needed, to assure prompt recognition of an untoward change in a patient's condition, and to facilitate appropriate intervention by nursing, medical or other hospital staff members. This Statute or Rule is not met as evidenced by: Based on staff interview and clinical and administrative record review, the facility nursing staff failed to provide the necessary care and services to ensure medications were administered as prescribed by the physician and according to accepted standards of practice for 2 of 4 patients reviewed for medication administration (Patients # 23 and # 24). The nursing staff also failed to provide evidence of following the established standards of practice for . . . . . regarding monitoring and administration for 1 of 1 patients reviewed for . . . . . (Patient # 19). The findings included:	H 121		

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H 121	Continued From page 5 The facility's policy regarding Medication Administration Times, Origin Date, , , 2018, documented "Medications are to be administered between 1 hour prior and 1 hour post the standard administration time. Standard Medication Administration times chart reflect every 6 hour schedule is 0400, 1000, 1600 (4:00 PM), 2200 (10:00 PM). 1) Review of the clinical record for Patient # 24 revealed the physician prescribed on for the patient to receive Piperacil/Tazabatam 3.375 G/NS 50 ML , ( ) every 6 hours. On , the Medication Administration Record (MAR) documented the nurse administered the Piperacil at 4:14 AM, 9:11 AM, 7:03 PM (1903) and 11:56 PM (2356). An notation received on by the Quality Manager, who acknowledged the nurse did not adhere to the prescribed schedule because she got busy. 2) Review of the clinical record for Patient # 23 revealed the physician prescribed on for the patient to receive , Sliding Scale every 4 hours as needed for Pain Management. Sliding Scale: 3 to 5 give 1 unit (mg); 6 to 10 give 2 Unit (mg). On at 10:31 AM, the nurse documented she administered 4 mg. An interview was conducted on at approximately 3:00 PM with the Quality Manager, who confirmed the nurse administered an amount not prescribed by the physician.	H 121		

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H 121	Continued From page 6 3) The facility's policy regarding Administering /Blood Component documented the following: "Identification of and products must be done at the patient's bedside by two licensed professionals. record."Once identification is complete, both nurses will sign." "Obtain patient's vital signs within 15 minutes of beginning of and record." "Once the is verified in the Services Department, deliver the product to the patient's bedside and initiate within 15 minutes. If unable to initiate within 15 minutes, return unit to Bank/ Services." Review of the clinical record, record for Patient # 19, revealed the staff noted they picked up two units of on at 11:03 AM. According to the record, the nurse documented one unit of was initiated at 11:10 AM. However, the second unit of was not documented as initiated until 11:55 (52 minutes after the was removed from the bank. The facility failed to produce evidence the 2nd unit was initiated within the established 15 minutes time limit from when the was removed from the bank. The record documented the 1st unit was initiated at 11:10 AM and was completed at 11:50 AM. The 2nd unit was initiated at 11:55 AM and was completed at 12:20 PM. Additionally, the 2nd unit of , initiated at 11:55 AM, the staff failed to document the full vital signs (temperature) 15 minutes after the initiation of the treatment at 12:10 PM. A record failed to	H 121		

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H 121	Continued From page 7 document two nurses' signature verifying the identification of the patient and the . An interview with the Nurse Manager on at 12:50 PM. The NM confirmed the . . . . . Sheet did not have the signature of two nurses verifying the . . . . and patient. The . . . . . Sheet initiated at 11:55 AM did not have a temperature documented at 12:10 PM	H 121		
H 199	59A-3.250(1)FAC SURVEIL/PREVEN/CONTROL OF . . . . - Program (1) Each hospital shall establish an . . . . control program involving members of the organized medical staff, the nursing staff, other professional staff as appropriate, and administration. The program shall comply with the requirements in Sections 381.0098 and 395.1011, F.S. and shall provide for: (a) The surveillance, prevention, and control of . . . . . among patients and personnel; (b) The establishment of a system for identifying, reporting, evaluating and maintaining records of . ; (c) Ongoing review and evaluation of all . . . . , isolation and sanitation techniques employed in the hospital; and (d) Development and coordination of training programs in . . . . control for all hospital personnel. This Statute or Rule is not met as evidenced by: Based on observation, staff interview and clinical and administrative record review, the facility staff failed to adhere to established standards of practice for . . . . control as evidence by the	H 199		

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H 199	Continued From page 8 staff failure to discard biohazard dressing appropriately; failed to follow established control practices regarding isolation and hand hygiene standards related to isolation for 1 of 1 patient observed for . . . care dressing change (Patient # 23). The findings included: An observation of the care dressing change for Patient # 23 was conducted on beginning at 10:50 AM with the Care Nurse and the Registered Nurse, Staff A. The nurses removed the wrap and the Kling wrap on the patient's legs. The remaining 4 x 4 dressings on the left leg was noted to be covered in red colored drainage ( ) on the upper dressing and yellow tinged drainage on the . . . . dressing on the back of the patient's leg. The dressings were noted to have adhered to the patient's leg wounds, the nurses poured normal solution over the dressing to loosen the . . . dressing adhesion. Upon removing the . . . dressing, the WCN discarded the . . . dressing with the . . . . covered 4 x 4 and yellow colored drainage into the regular trash. The staff did not use a red, biohazard bag to discard the dressing. It should also be noted that the patient is on contact isolation. During the care, the patient's physician entered the . . . . . an isolation gown and gloves and examined the patient. Upon completion of the examination, the physician exited the patient's , wearing the isolation gown and gloves and proceeded down the hospital hallway at 11:35 AM. The surveyor, then questioned the staff nurses in the , , "Where was the physician going?" No one expressed an	H 199		

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H 199	Continued From page 9 intervention with the physician for not removing his isolation gown, gloves and performing hand hygiene prior to leaving the patient's . . . Furthermore, the WCN was noted on two separate occasions during the care dressing change to exit the patient's . . . . removing her isolation gown and gloves and failed to perform hand hygiene prior to leaving the . The nurse also went down the hall to retrieve additional supplies, etc. without performing hand hygiene. An interview was conducted with the WCN following the . . . . care observation on . . . . . at 12:20 PM, who confirmed she exited the . . without performing hand hygiene. She confirmed there was not a hand sanitizer outside the . . . . use and she confirmed she exited the . to obtain supplies and did not perform hand hygiene. The WCN also stated the . . . dressing has to be saturated with to be discarded in biohazard. The surveyor then questioned her regarding the noted colored staining noted to cover the 4 x 4 dressing on the patient's left leg dressing. Then she stated, "I guess I should have put it in a biohazard bag". An interview was conducted on . . . . . at 2:10 PM with the Preventionist and the . . . . . Control/Safety Coordinator, who stated they consider saturated when you hold up the dressing and "it drips". It doesn't matter the amount. They then stated they follow the Department of Health Guidelines and presented the surveyor a copy of the guidelines. After reviewing the Department of Health guidelines presented, the facility staff failed to follow the established guidelines by failing to discard the dressing appropriately. After reviewing	H 199		

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H 199	Continued From page 10 the Department of Health guidelines presented, the facility staff failed to follow the established guidelines by failing to discard the dressing appropriately. The guidelines documents "64 E-16.002, Definitions. Biomedical Waste - Any solid or liquid waste which may present a threat of to humans, including nonliquid tissue, body parts, , blood products, and body fluids from humans and other primates; laboratory and veterinary wastes which contain human causing agents; and discarded sharps. The following are also included; (a) Used, absorbent materials saturated with , blood products, body fluids, or excretions or secretions contaminated with visible ; and absorbent material saturated with and products that have dried." The facility's policy regarding Biomedical Waste documented as above but also included the following: "Used, absorbent materials such as bandages, gauzes, or sponges, having the potential to drip or splash, with or body fluids from areas as the operating , delivery and emergency and/or other patient care areas." "SEGREGATION: Biomedical waste shall be identified and separated from other regular solid waste at the point of origin within the hospital." Furthermore, the clinical record denotes, the patient is on Contact Isolation secondary to the patient's history of ( ). Additionally, the facility's policy regarding Hand Hygiene, revised , 2017 documented,	H 199		

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H 199	Continued From page 11 "Hands are to be washed before and after glove use." Gloves are not to be worn as a substitution for hand hygiene and should not be worn outside of patient . . . (i. e. hallways). The facility's policy regarding Standard Precautions, Isolation/Precaution, revised , 2014 documented, "Gloves and Hand Washing: ..During the course of providing care for a patient, change gloves after having contact with . . . . material that may contain high concentrations of microorganisms (fecal material and . . . . drainage). Remove gloves before leaving the patient's environment and wash hands immediately." Gown: A gown must be worn prior to entering the . . . . Remove the gown before leaving the patient's environment."	H 199		
H 412	59A-10.0055(2)(c)-(e), FAC INCIDENT REPORTING SYSTEM - Reports (c) Whether or not a physician was called; and if so, a brief statement of said physician's recommendations as to medical treatment, if any; (d) A listing of all persons then known to be involved directly in the incident, including witnesses, along with locating information for each; (e) The name, signature and position of the person completing the reports, along with date and time that the report was completed This Statute or Rule is not met as evidenced by: Based on facility document review, staff interview and review of the Risk Management Program and Plan, it was determined the facility failed to ensure the forms utilized for Incident/Event Reporting document all witnesses and all persons	H 412		

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H 412	Continued From page 12 then known to be involved directly in the incidents. This failure is evident in 5 of 10 sampled records reviewed (Reports #11, #12, #13, #14 and #15). The findings included: Review of sampled Incident Reports #11, #12, #13, #14 and #15 conducted on . . . . . revealed the documents lack the required information related to listing of all persons then known to be involved directly in the incidents and witnesses. Interview with The Director of Risk Management conducted on at 3:02 PM revealed after review of the reports identified above, the staff failed to document the names of all witnesses and persons then known to be involved on the occurrence reports.	H 412		
H 506	395.301(3) FS Price Transparency - Observation vs IP Status (3) If a licensed facility places a patient on observation status rather than inpatient status, observation services shall be documented in the patient's discharge papers. The patient or the patient's survivor or legal guardian shall be notified of observation services through discharge papers, which may also include brochures, signage, or other forms of communication for this purpose. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure that one of two patients were informed that they were on Observation status.	H 506		

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H 506	Continued From page 13 (Patient #1) The findings included: 1) In an interview with the Director of Quality on at 11:30 AM, she was asked how patients are informed that they are on Observation status instead of Inpatient status. She stated that the Discharge Planner provides this information to the patient and then documents it in the patient's clinical record, The surveyor requested all documents pertaining to the billing of Patient # 1 including documentation of notification that the patient was on Observation Status. On at 4:35 PM, the Director of Quality confirmed that there was no evidence including documentation that Patient # 1 was informed by facility staff of her Observation status. The Director confirmed that the facility failed to ensure that the patient was informed of her Observation status.	H 506		