STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	HL100127	**02/06/2019**
NAME OF PROVIDER OR SUPPLIER **MORTON PLANT HOSPITAL**	STREET ADDRESS, CITY, STATE, ZIP CODE **300 PINELLAS ST** **CLEARWATER, FL 33756**	

SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

0000 - INITIAL COMMENTS

An unannounced Risk Management survey was conducted from . . . through . . . ., in conjunction to a complaint survey revisit to CCR# 2018017967 (QYXG12), at Morton Plant Hospital, an acute care hospital, in Clearwater, FL.

Deficiencies were identified related to the Risk Management survey.

License # 4064.

0231 - MAINTENANCE - Preventive Plan - 59A-3.276(1)(a)-(g), FAC

Based on policy and procedure review, document review, staff interviews, and observations, it was determined the facility failed to monitor patient care equipment in conjunction with the facility policy and procedures.

Findings included:

During a tour of the facility's post anesthesia care unit (PACU), observations were made that the PACU had a blanket warmer with a temperature monitoring log sheet on the top of the warmer. Review of the log showed there was no date, to indicate the month it was last checked, and 21 out of 31 temperature date fields on the form were blank. It reflected the temperature of the blanket warmer was only recorded for 10 days in the unknown month the log was for.

In an interview with the Director of PACU and Manager of PACU on . . . . . at 10:45 a.m., they both confirmed the blanket warmer temperature should be checked and recorded on the log daily and include the month and date it was checked. After reviewing the blanket warmer temperature log, both the director and manager confirmed it was incomplete.

Review of facility policy titled "BLANKET/ FLUID/ IRRIGATION SOLUTION WARMER", number BC-CES-68, dated . . . , revealed blankets are to be warmed to temperatures not exceeding 130 degrees Fahrenheit. The policy stated to contact engineering if the temperature alarm was sounding and if the temperature exceeded 130 degrees Fahrenheit.

In an interview with the Director of PACU and Manager of PACU on . . . . . at 10:45 a.m., both confirmed that the blanket warmer was not connected to an electronic monitoring system that would notify engineering automatically if the temperature exceeded 130 degrees Fahrenheit, and the only way

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to know if the temperature was out of range, would be if an audible alarm sounded or to visually observe and monitor the temperature displayed on the outside of the warmer.

0417 - SEXUAL MISCONDUCT - 395.0197(9), F.S.

Based on policy and procedure review, document review, and staff interviews, it was determined the facility failed to report allegations of sexual misconduct to the Department of Health (DOH) and the facility Administrator, when the allegation included a licensed health care practitioner and a patient.

Findings included:

On 02 0/6/19 at 1:48 p.m., a review of the facility files on allegations of sexual misconduct revealed in the previous year (2018), there were five allegations of sexual misconduct made by five different individual patients.
The following files were reviewed:

Case 1- dated . . . . . - Patient #7, allegation against a male licensed physical therapist by a female patient. Allegation was regarding inappropriate sexual connotation and misconduct regarding the physical handling of the patient.
Case 2- dated . . . . - Patient #8, allegation against a female Patient Care Tech (PCT). Allegation was regarding inappropriate . . . . comments made to a male patient by the PCT, and witnessed by the patient's fiancée.
Case 3-dated . . . . . - Patient #9, allegation against a male licensed physician by a male patient involving inappropriate touching of the patient by the physician.
Case 4- dated . . . . - Patient #10- allegation against 2 male staff members, a licensed Registered Nurse and a PCT, inappropriately touching a female patient during a bed bath.
Case 5- dated . . . . . - Patient #11- allegation against a male staff member by a female patient. Allegation was regarding inappropriate handling of the patient by the PCT while receiving a bed bath.

There was no evidence that the facility notified the Department of Health on any of the allegations involving sexual misconduct involving a licensed practitioner. There was no evidence in the file that the facility's Administrator was notified of these incidents.

According to facility policy titled "SEXUAL MISCONDUCT", dated , any allegation of sexual misconduct involving patients and medical staff or allied health will be reported by the Risk Manager to the Department of Health (DOH), Vice President or Chief Medical Officer, and Administration.

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In an interview with the Risk Manager (RM) on [redacted] at 2:45 p.m., the RM confirmed the facility does not report allegations of sexual misconduct to the Department of Health unless, through their own investigation, they determine there was sexual misconduct.