DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	100179	A. BUILDING _____ B. WING _____	03/04/2010

RECEIVED
MAR 31 2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL HOSPITAL JACKSONVILLE	3625 UNIVERSITY BLVD. SOUTH JACKSONVILLE, FL 32216

AHCA - HQA-4

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 A full federal survey was conducted on March 1-4, 2010 as a result of non-compliance at the COP for Medical Staff noted during the investigation conducted on January 12-13, 2010.	A 000	On March 30, 2010, the Hospital's Chief Executive Officer apprised the Board of Trustees of the deficiencies and the corrective actions in the CMS Plan of Correction, which was received by Memorial Hospital on March 22, 2010. The Board voted and approved the plan of correction.	04/01/10
A 043	482.12 GOVERNING BODY The hospital must have an effective governing body legally responsible for the conduct of the hospital as an institution. 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 observation, patient record reviews, and staff interviews, the governing body failed to ensure that the facility's medical care met the specific needs of the patients, specifically for wound care. The findings include: A review of wound care policies and procedures on May 2, 2010, at 11:30 A.M. revealed that nursing care for patients with potential or actual skin breakdowns were not being assessed unless a wound care consult was requested. Follow up assessments were not completed on a scheduled basis but listed only as needed. On May 3, 2010, at 1:30 P.M., an interview with wound care nurses revealed that staffing for the wound care team was approximately 1.7 FTE's (full time employees), and identified as potential or actual wound care patients during the survey was 132. The wound care nurses revealed that the majority of wound care assessment and treatment was conducted by staff nurses assigned to the	A 043	The Wound Care Program policy was reviewed and revised by Nursing Administration on March 24, 2010, to reflect the following changes in process notification and initiation of wound care nurse evaluation of all patients admitted with skin breakdown. Staffing for the wound care program has been revised by the Chief Nursing Officer on March 26, 2010, and is as follows: Current wound care staffing levels include 1.0 FTE wound care program coordinator, 2.0 FTE wound care nurses and 0.75 FTE wound care nurse, for a total of 3.75 FTE's. Further expansion includes recruitment of an additional 1.0 FTE nurse to bring the total wound care program staffing to 4.75 FTE's. An electronic report will be generated from the electronic medical record based on admission skin assessment on all patients who were admitted with skin breakdown and a phone call will be placed to the wound care team to identify new patients to be seen. Every patient admitted with a pressure ulcer as indicated by the report and/or phone call, will be evaluated by a wound care nurse or wound care resource nurse, which is someone who has completed wound care training and deemed qualified through competencies, within 24 hours of admission.	03/24/10 04/01/10 04/01/10 04/01/10

LABORATORY DIRECTOR'S OR PROVIDER/ SUPPLIER REPRESENTATIVE'S SIGNATURE: Kelly Mullis — TITLE: Director Risk Management — (X6) DATE: 3/31/10

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 disclosabte 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 043	Continued From page 1 medical and surgical units. These nurses received one hour of training in wound care. The system of treatment for wound care places patients at risk for additional medical complications. (See A386, A392, and A397, for more specific information).	A 043	After initial assessment by the wound care team or wound care resource nurse and appropriate protocols are initiated, the staff nurse will follow the treatment plan. A wound care nurse will reassess patients with pressure ulcers at least once a week to ensure the treatment plan being followed is appropriate for the patient. If the patient has a hospital acquired pressure ulcer or the patient has now developed a stage III or IV Pressure ulcer the wound care team will be notified to re-evaluate the patient every 72 hours and initiate new protocols. All bedside nursing staff including the wound care team were educated on the policy changes and new protocols by reviewing the policy with the nurse managers by April 1, 2010. Education was facilitated by the Nurse Directors and charge nurses. Competency were done through online education courses "NDNQI Pressure Ulcer Training" and the "Pressure Ulcer Prevention Module" with post-test after each module and monitored annually for compliance by the nursing unit Director. New nurse staff orientation will include 2 hours of specific wound care instruction, presented by a certified wound care nurse. Post-orientation competency will be evaluated at the unit level by the nurse director. The revised policy was reviewed and approved by the Medical Executive Committee on March 29, 2010. The revised policy was approved by the Board of Trustees on March 30, 2010.	04/01/10 04/01/10 04/01/10 04/01/10 04/01/10 04/01/10 03/29/10 03/30/10

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			Responsible Person: Chief Nursing Officer, Assistant Chief Nursing Officer, Department Directors and managers.	04/01/10
			The Nursing Policy on Skin and Wound Care was reviewed and revised by nursing administration to reflect new wound staging and treatment protocols on March 25, 2010.	03/25/10
			Clinical nursing staff were educated on the policy changes reflecting new staging and treatment protocols by reviewing the policy with the nurse director. This was completed on April 1, 2010.	04/01/10
			Ongoing education will be provided on an annual basis through online education courses "NDNQI Pressure Ulcer Training" and the "Pressure Ulcer Prevention Module" with post-test after each module and monitored annually for compliance by the nursing unit Director.	04/01/10
			Re-designed 2010 Wound care competencies. To be completed annually and monitored for compliance by the unit Director.	04/01/10
			New nursing staff orientation will include 2 hours of specific wound care instruction presented by a certified wound care nurse. Post-orientation competency will be evaluated at the unit level by the nurse director.	04/01/10
			The Medical Executive Committee approved the changes to the policy on March 29, 2010.	03/29/10
			The Board of Trustees approved the changes to the policy on March 30, 2010.	03/30/10

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			Responsible Person: Chief Nursing Officer, Assistant Vice President of Nursing, Department Directors and Managers	03/30/10
			The Assessment and Re-assessment policy was reviewed by nursing administration on March 23, 2010 and no revision was indicated.	04/01/10
			Clinical nursing staff were re-educated by unit directors and managers on the process of admission assessments including; upon admission all patients will receive a skin assessment, Braden Score evaluation for skin breakdown risk factors and specialty bed placement or other prevention measures. This will be initiated by the staff nurse during the initial admission assessment and reassessment every shift.	03/23/10
			Upon assessment, the staff nurse will implement the appropriate protocols as indicated by the MHJ wound staging and Treatment Protocols.	04/01/10
			All staff nurses involved in care of inpatients, including skin, wound and ulcer assessments will complete education on National Data Base of Nursing Quality Indicators Pressure Ulcer training and Pressure Ulcer Prevention through online training courses.	04/01/10

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			Ongoing education will be provided on an annual basis through online education courses "NDNQI Pressure Ulcer Training" and the "Pressure Ulcer Prevention Module" with post-test after each module and monitored annually for compliance by the nursing unit Director.	04/01/10
			Compliance Monitoring to assure that all applicable patients are identified on admission with timely follow-up by wound care team will be audited by the Director of Support Services and reported to the Leadership Organizational Committee, Medical Executive Committee and the Board of Trustees quarterly.	04/01/10
			Responsible Person: Chief Nursing Officer, Assistant Chief Nursing Officer, Department Directors and Managers.	04/01/10

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A 122	482.13(a)(2)(ii) PATIENT RIGHTS: GRIEVANCE REVIEW TIME FRAMES At a minimum: The grievance process must specify time frames for review of the grievance and the provision of a response. This STANDARD is not met as evidenced by: Based on facility record review and staff interview, it was determined that the facility failed to implement specific time frames for review of grievances and providing written responses for five of five grievances reviewed. The findings include: 1. Review of the facility's Patient Grievance Resolution policy on 3/2/10 included that a written complaint is always considered a grievance. According to the policy, the hospital should inform the complainant if the grievance cannot be resolved or if the investigation will not be completed within 7 days, and the hospital will follow-up with a written response within 30 days. Review of the facility's grievance logs included the file for all complaints in January 2010. Of the January 2010 complaints, five (5) written grievances were reviewed. Five of five grievances were not reviewed and responded to timely by the facility. 2. A grievance for Patient #6 included a letter	A 122	The Patient Grievance Resolution policy was reviewed by the Director or Risk management on 03/22/10 and revised to include a 45 day time frame to follow-up with a written response to all grievances and to clarify that patient response cards are not considered grievances unless the patient writes a written complaint on the response card. If it is a complaint on the response card, it should be considered a grievance. The policy changes were approved by the Board of Trustees on March 30, 2010. All department directors responsible for responding to grievances were educated on the policy changes on March 25, 2010 at the Department Director meeting. Monitoring for compliance with time frames for responding in writing to any grievance will be done by weekly audits by the risk manager and reported to the Leadership Organization Committee, Medical Executive Committee and the Board of Trustees quarterly. Responsible Person: Director, Risk Management	03/30/10 03/30/10 03/25/10 04/01/10 04/01/10

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A 122	Continued From page 2 from the family dated 12/1/09. An internal patient concern/complaint form was dated 1/6/10 with notes from hospital staff dated 1/8/10 including telephone contact made with complainant to discuss concerns. However, there was no written response from the facility at the time of review. A written response from the hospital, dated 3/3/10, was provided after surveyor inquiry. 3. A grievance for Patient #7 included a written complaint on a Patient Response Card received 1/26/10. An internal patient concern/complaint form was dated 1/27/10 with notes from staff regarding review of case, but there was no contact with the complainant. A written response from the hospital, dated 3/2/10, was provided after surveyor inquiry. 4. A grievance for Patient #8 included a letter dated 1/2/10. An internal patient concern/complaint form indicated the letter was received on 1/5/10, and included notes, emails, and a call to the complainant on 1/8/10. However, there was no written response from the hospital until 3/3/10 after surveyor inquiry. 5. A grievance for Patient #9 included a letter dated 1/17/10. An internal patient concern/complaint form was dated 1/25/10 with notes that staff spoke with spouse on 1/26/10. However, there was no written response from the hospital until 3/3/10 after surveyor inquiry. However, there was no written response from the hospital until 3/3/10 after surveyor inquiry. 6. A grievance for Patient #10 included a letter dated 1/28/10. An internal patient concern/complaint form was dated 1/29/10 with a note dated 2/1/10 regarding staff review of the chart. However, there was no contact with the complainant and no written response from the	A 122		

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A 122	Continued From page 3 hospital until 3/3/10 after surveyor inquiry. 7. Interviews with the facility's Risk Manager on 3/2/10 at 3:15 PM, and on 3/3/10 at 9:00 AM and 10:30 AM, confirmed the time frames in the current policy, and that written responses to complainants were not provided timely.	A 122		
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 medical record review, multiple staff interviews, facility provided documentation and observation, the facility failed to ensure that patients who had skin breakdown or who were at risk for skin breakdown had nursing care and services specific to the prevention and treatment of pressure ulcers. The facility failed to ensure a safe and adequate number of "wound care nurses" leaving the daily assessments, care and services to staff nurses assigned on the floor. Five out of 30 medical records reviewed revealed the patients wound care management was the primary nurse's responsibility and not the wound care team (#1, #2, #3, #4, #5). The findings include: Review of the medical record for Patient #1, who was admitted on 2/25/10 and had multiple wounds including an infected stage 4 to the sacrum area. The patient had a wound vac, and had daily treatments ordered. This patient was seen by the wound care nurse on 2/26/10 and on discharge on 3/1/10. Patient #2 was admitted to the facility on 2/22/10 with extensive multiple wounds and had daily and twice daily dressing	A 385	The Wound Care Program policy was reviewed and revised by Nursing Administration on March 24, 2010, to reflect the following changes in process notification and initiation of wound care nurse evaluation of all patients admitted with skin breakdown. Staffing for the wound care program has been revised by the chief nursing officer on March 26, 2010, and is as follows: Current wound care staffing levels include 1.0 FTE wound care program coordinator, 2.0 FTE wound care nurses and 0.75 FTE wound care nurse, for a total of 3.75 FTE's. Further expansion includes recruitment of an additional 1.0 FTE nurse to bring the total wound care program staffing to 4.75 FTE's. An electronic report will be generated from the electronic medical record based on admission skin assessment on all patients who were admitted with skin breakdown and a phone call will be placed to the wound care team to identify new patients to be seen. Every patient admitted with a pressure ulcer as indicated by the report and/or phone call, will be evaluated by a wound care nurse or wound care resource nurse, which is someone who has completed wound care training and deemed qualified through competencies, within 24 hours of admission.	03/24/10 04/01/10 04/01/10 04/01/10

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A 385	Continued From page 4 changes ordered. The wound care nurse did not see Patient #2 until 2/24/10 when a partial assessment was done, the wound care nurse returned on 2/26/10 to complete the assessment. The wound care nurse did not see Patient #2 again until 3/3/10 when an appointment was made by the surveyors to watch a dressing change. Patient #3 was admitted on 2/22/10 with a stage 3 wound, and was seen by the wound care nurse on 2/23/10 and not again through3/2/10. Patient #4 was admitted on 2/19/10 with multiple stage wounds, and was not seen by the wound care nurse through 3/4/10, with documentation being inconsistent for the number and locations of wounds. Patient #5, was admitted on 2/24/10 with an "infected wound". Documentation revealed an unstageable right heel wound, a left lower leg wound that was draining and a stage 1 of the buttocks. A physician's order dated 2/25/10, was written for a wound care consultation. The wound care nurse did not see or assess Patient #5 who was discharged on 3/1/10. (See A386, A392 and A397 for more specific information).	A 385	After initial assessment by the wound care team or wound care resource nurse and appropriate protocols are initiated, the staff nurse will follow the treatment plan. A Wound Care nurse will reassess patients with pressure ulcers at least once a week to ensure the treatment plan being followed is appropriate for the patient. If the patient has a hospital acquired pressure ulcer or the patient has now developed a stage III or IV Pressure ulcer the wound care team will be notified to re-evaluate the patient every 72 hours and initiate new protocols. All bedside nursing staff including the wound care team were educated on the policy changes and new protocols by reviewing the policy with the nurse managers by April 1, 2010. Education was facilitated by the Nurse Directors and charge nurses. Competency were done through online education courses "NDNQI Pressure Ulcer Training" and the "Pressure Ulcer Prevention Module" with post-test after each module and monitored annually for compliance by the nursing unit Director. New nurse staff orientation will include two hours of specific wound care instruction, presented by a certified wound care nurse. Post-orientation competency will be evaluated at the unit level by the nurse director. The revised policy was reviewed and approved by the Medical Executive Committee on March 29, 2010. The revised policy was approved by the Board of Trustees on March 30, 2010. Responsible Person: Chief Nursing Officer, Assistant Chief Nursing Officer, Department Directors and managers.	04/01/10 04/01/10 04/01/10 04/01/10 04/01/10 04/01/10 03/29/10 03/30/10 04/01/10

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			The Nursing Policy on Skin and Wound Care was reviewed and revised by nursing administration to reflect new wound staging and treatment protocols on March 25, 2010.	03/25/10
			Clinical nursing staff were educated on the policy changes reflecting new staging and treatment protocols by reviewing the policy with the nurse director. This was completed on April 1, 2010.	04/01/10
			Ongoing education will be provided on an annual basis through online education courses "NDNQI Pressure Ulcer Training" and the "Pressure Ulcer Prevention Module" with post-test after each module and monitored annually for compliance by the nursing unit Director.	04/01/10
			Re-designed 2010 wound care competencies. To be completed annually and monitored for compliance by the unit Director.	04/01/10
			New nursing staff orientation will include 2 hours of specific wound care instruction presented by a certified wound care nurse. Post-orientation competency will be evaluated at the unit level by the nurse director.	04/01/10
			The Medical Executive Committee approved the changes to the policy on March 29, 2010.	03/29/10
			The Board of Trustees approved the changes to the policy on March 30, 2010.	03/30/10
			Responsible Person: Chief Nursing Officer, Vice President of Nursing, Department Directors and Managers	04/01/10
			The Assessment and Re-assessment policy was reviewed by nursing administration on March 23, 2010 and no revision was indicated.	03/23/10

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			Clinical nursing staff were re-educated by unit directors and managers on the process of admission assessments including; upon admission all patients will receive a skin assessment, Braden Score evaluation for skin breakdown risk factors and specialty bed placement or other prevention measures. This will be initiated by the staff nurse during the initial admission assessment and reassessment every shift.	04/01/10
			Upon assessment, the staff nurse will implement the appropriate protocols as indicated by the MHJ wound staging and Treatment Protocols.	04/01/10
			All staff nurses involved in care of inpatients, including skin, wound and ulcer assessments will complete education on National Data Base of Nursing Quality Indicators Pressure Ulcer training and Pressure Ulcer Prevention through online training courses.	04/01/10
			Ongoing education will be provided on an annual basis through online education courses "NDNQI Pressure Ulcer Training" and the "Pressure Ulcer Prevention Module" with post-test after each module and monitored annually for compliance by the nursing unit Director.	04/01/10
			Compliance Monitoring to assure that all applicable patients are identified on admission with timely follow-up by wound care team will be audited by the Director of Support Services and reported to the Leadership Organizational Committee, Medical Executive Committee and the Board of Trustees quarterly.	04/01/10
			Responsible Person: Chief Nursing Officer, Assistant Chief Nursing Officer, Department Directors and Managers.	04/01/10

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A 386	482.23(a) ORGANIZATION OF NURSING SERVICES The hospital must have a well-organized service with a plan of administrative authority and delineation of responsibilities for patient care. The director of the nursing service must be a licensed nurse. He or she is responsible for the operation of the service, including determining the types and numbers of nursing personnel and staff necessary to provide nursing care for all areas of the hospital. This STANDARD is not met as evidenced by: Based on medical record review of 30 medical	A 386	The Wound Care Program policy was reviewed and revised by Nursing Administration on March 22, 2010, to reflect the following changes in process notification and initiation of wound care nurse evaluation of all patients admitted with skin breakdown. Staffing for the wound care program has been revised by the Chief Nursing Officer on March 26, 2010, as follows: Current wound care staffing levels include 1.0 FTE wound care program coordinator, 2.0 FTE wound care nurses and 0.75 FTE wound care nurse, for a total of 3.75 FTE's. Further expansion includes recruitment of an additional 1.0 FTE nurse to bring the total wound care program staffing to 4.75 FTE's.	03/22/10 04/01/10

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A 386	Continued From page 5 records with findings on 5 of the 30 medical records, multiple staff interviews, facility provided documentation and observation the facility failed to ensure that appropriate and well organized nursing care was provided to patients with potential skin breakdown or patients who had actual skin breakdown. Wound care assessments on patients who were at risk for skin breakdown or had actual skin breakdown were only being completed if a consultation was ordered and then not in a timely manner. Patient wounds could only be cultured if a physician wrote an order for one to be completed. The majority of the wound care assessments and treatments were being provided by floor nurses who had completed a one hour training course during orientation. The facility, which has 425 beds, an average daily census of 300, and employs 642 full time registered nurses, has only one point seven (1.7) full time registered nurses who are assigned wound care. The findings include: 1. Review of the facility's Organization Chart, revealed the Chief Nursing Officer was responsible for all clinical practice of licensed nursing personnel and for quality functions. All nursing policies and procedures are reviewed and approved by the Chief Nursing Officer. Interview with the Chief Nursing Officer on 3/1/10, at 2pm revealed she has the ultimate responsibility for all nursing care to patients and all licensed nursing personnel. Review of policy and procedure on wound care and interview with the Chief Nursing Officer on 3/3/10 at 3pm, revealed there are no set protocols for patients with wound care concerns, as to whether a wound care physician is to be consulted or if all patients who are admitted with wounds are to be assessed by the wound care	A 386	An electronic report will be generated from the electronic medical record based on admission skin assessment on all patients who were admitted with skin breakdown and a phone call will be placed to the wound care team to identify new patients to be seen. Every patient admitted with a pressure ulcer as indicated by the report and/or phone call, will be evaluated by a wound care nurse or wound care resource nurse, which is someone who has completed wound care training and deemed qualified through competencies, within 24 hours of admission. After initial assessment by the wound care team or wound care resource nurse and appropriate protocols are initiated, the staff nurse will follow the treatment plan. A wound care nurse will reassess patients with pressure ulcers at least once a week to ensure the treatment plan being followed is appropriate for the patient. If the patient has a hospital acquired pressure ulcer or the patient has now developed a stage III or IV Pressure ulcer the wound care team will be notified to re-evaluate the patient every 72 hours and initiate new protocols. All bedside nursing staff including the wound care team were educated on the policy changes and new protocols by reviewing the policy with the nurse managers by April 1, 2010. Education was facilitated by the Nurse Directors and charge nurses. Competency were done through online education courses "NDNQI Pressure Ulcer Training" and the "Pressure Ulcer Prevention Module" with post-test after each module and monitored annually for compliance by the nursing unit Director.	04/01/10 04/01/10 04/01/10 04/01/10 04/01/10 04/01/10 04/01/10

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A 386	Continued From page 6 nurse. Interview with the Director of Supportive Services and the Wound Care Nurse on 3/2/10 at 1 pm, revealed there is only one full time wound care nurse; there are also 2 as needed wound care nurses who total work hours amounted to approximately to 20-30 hours per week. The wound care nurse can only assesses a patient after a consultation is received and then the wound care nurse has up to 2 business days to see the patient. It is the wound care nurse's judgment when her services are to be discontinued and who will provide wound care treatments to patients. Patients' wounds are only cultured after a physician assesses the patient and orders a culture. Continued interview with the Director of Supportive Services revealed all nurses have an hour of education during orientation on Wound Care. Review of the facility's General Nursing Orientation Handbook for Nurses 2010 - Wound Care & You, revealed photographs which are not clear, written text with the photographs is blurry and unable to be read, printing of directions such as, Initiate Appropriate Treatment & Orders, are so small it is unreadable. Facility provided documentation revealed 132 patients identified on the requested "Wound Care/Ulcer/High Risk Skin Breakdown Report". Interview with the Director of Supportive Services and the Wound Care Nurse on 3/2/10 at 11am, revealed not all patients listed on this report have current skin breakdown, but the facility was unable to provide (requested patients identified from 3/1/10 thru 3/4/10) documentation of those patients who actually did have skin breakdown . 2. Medical record review of five patients who were identified on the Wound Care Report revealed:	A 386	New nurse staff orientation will include 2 hours of specific wound care instruction, presented by a certified wound care nurse. Post-orientation competency will be evaluated at the unit level by the nurse director. The revised policy was reviewed and approved by the Medical Executive Committee on March 29, 2010. The revised policy was approved by the Board of Trustees on March 30, 2010. Responsible Person: Chief Nursing Officer, Assistant Chief Nursing Officer, Department Directors and Managers. The Nursing Policy on Skin and Wound Care was reviewed and revised by nursing administration to reflect new wound staging and treatment protocols. Clinical nursing staff were educated on the policy changes reflecting new staging and treatment protocols by reviewing the policy with the nurse director. This was completed on April 1, 2010. Ongoing education will be provided on an annual basis through online education courses "NDNQI Pressure Ulcer Training" and the "Pressure Ulcer Prevention Module" with post-test after each module and monitored annually for compliance by the nursing unit Director. Re-designed 2010 wound care competencies to be completed annually and monitored for compliance by the unit Director. New nursing staff orientation will include 2 hours of specific wound care instruction presented by a certified wound care nurse. Post-orientation competency will be evaluated at the unit level by the nurse director.	04/01/10 03/29/10 03/30/10 04/01/10 03/25/10 04/01/10 04/01/10 04/01/10 04/01/10

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A 386	Continued From page 7 Patient #1, was admitted on 2/25/10 with a stage IV sacrum/coccyx wound, and a KCI home vac machine attached to the dressing; a stage 1 wound of the right lateral ankle; a dark reddened non-blanching right second toe; and a extensive fungal rash of the sacrum, peri-rectum, thighs and groin area. Patient #1 was assessed by the wound care nurse on 2/26/10 as per physician's order and not again until discharge on 3/1/10. Documentation revealed ordered daily dressing changes and care of the wound vac were done by the floor nurse. Patient #2, was admitted 2/22/10 and the initial assessment done by the primary floor nurse revealed wounds of the right and left leg which were unstageable (stage 4), Braden scales for risk of skin breakdown varied from 18-21. After a physician's order on 2/22/10, the wound care nurse assessed Patient #2's wound on 2/23/10. The wound care nurse assessed Patient #2's wounds as a stage III on the right leg, a wound on the left leg which the wound care nurse did not stage, bilateral heels at being at risk, and a puncture wound of the abdomen. After the initial assessment the wound care nurse signed off the daily multiple treatments to be done by the floor nurse, and the wound care nurse did not see Patient #2 again. Patient # 3 who was currently in the critical care unit was readmitted on 2/22/10 after having a cardiac arrest at another hospital and transported to this facility. The primary nurse assessed Patient #3's skin concerns, documenting, multiple wounds on the buttocks, back, inner thighs, left big toe is purple; 4 wounds the nurse was unable to document on the left inner thigh, a 9x7 black and neurotic unstageable wound below that one,	A 386	The Medical Executive Committee approved the changes to the policy on March 29, 2010. The Board of Trustees approved the changes to the policy on March 30, 2010. Responsible Person: Chief Nursing Officer, Assistant Vice President of Nursing, Department Directors and Managers The Assessment and Re-assessment policy was reviewed by nursing administration on March 23, 2010 and no revision was indicated. Clinical nursing staff were re-educated by unit directors and managers on the process of admission assessments including; upon admission all patients will receive a skin assessment, Braden Score evaluation for skin breakdown risk factors and specialty bed placement or other prevention measures. This will be initiated by the staff nurse during the initial admission assessment and reassessment every shift. Upon assessment, the staff nurse will implement the appropriate protocols as indicated by the MHJ wound staging and Treatment Protocols. All staff nurses involved in care of inpatients, including skin, wound and ulcer assessments will complete education on National Data Base of Nursing Quality Indicators Pressure Ulcer training and Pressure Ulcer Prevention through online training courses. Ongoing education will be provided on an annual basis through online education courses "NDNQI Pressure Ulcer Training" and the "Pressure Ulcer Prevention Module" with post-test after each module and monitored annually for compliance by the nursing unit Director.	03/29/30 03/30/10 04/01/10 03/23/10 04/01/10 04/01/10 04/01/10 04/01/10

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A 386	Continued From page 8 and an unstageable wound that is 6x2.5 on the right upper thigh. The patient had a large unstageable hole that is 8x3x2 that is black on the inside; the left upper thigh had 2 other small areas that are 75% neurotic unstable wounds that are small round areas that are 1x1 and 2x2. A consult for a wound care nurse was completed and the wound care nurse assessed Patient #3 on 2/24/10 but was unable to do a full assessment due to the patient receiving dialysis at the time of the assessment. The wound care nurse did not return to finish the assessment until 2/26/10. The only other time the wound care nurse had seen Patient #3 was on 3/3/10 after a physician's order on 3/3/10 at 12noon was written, stating that the wound care nurse is to do the wound dressing changes at 1500 (3pm) (which was the time the surveyor at previously made an appointment with the floor nurse to observe the dressing change). Patient #3 very intensive wound ulcers treatments were being done from 2/22/10 thru 3/2/10 by floor nurses. Patient #4 was admitted on 2/19/10 with diagnosis that would make the patient at risk for skin breakdown including end stage renal disease, poorly controlled diabetes and cerebral vascular accident. The patient was initially assessed by the primary floor nurse as having 4 stage one wounds located in the sacral area, the spine and bilateral heels. Assessments done by the floor nurses were completed every shift but were inconsistent as to the Baden scale which ranged from 13-16, and the number of wounds from 1-4. Patient #4 was identified on the Wound Care/Ulcer/High Risk Skin Breakdown Report but was not evaluated by the wound care nurse during the patient's stay from 2/19/10 thru 3/3/10.	A 386	Compliance Monitoring to assure that all applicable patients are identified on admission with timely follow-up by wound care team will be audited by the Director of Support Services and reported to the Leadership Organizational Committee, Medical Executive Committee and the Board of Trustees quarterly. Responsible Person: Chief Nursing Officer, Assistant Vice President of Nursing, Department Directors and Managers.	04/01/10 04/01/10

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A 386	Continued From page 9 Patient #5 was admitted on 2/24/10 with diagnoses including an infected wound, and failure to thrive. Patient #5 was identified on the Wound Care Report and a physician's order for a wound care consultation was done on 2/25/10. The initial assessment completed by the floor nurse revealed a stage 1 on the right buttock, a tissue injury on the right heel and left calf. Documentation was completed by the floor nurses who revealed a Baden scales range of14-18, and the right buttock wound remaining a stage 1, an open left calf wound with drainage, and the right heel wound being unstageable on 2/25/10. Patient #5 was not assessed by the wound care nurse through discharge on 3/1/10.	A 386		
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 medical record review, multiple staff interviews, facility provided documentation and observation the facility failed to ensure that there was an adequate number of qualified registered nurses to provide wound care management/ treatment to those patients who were at risk for skin breakdown, were admitted with skin breakdown or developed a pressure ulcer while hospitalized. Although Registered Nurses were doing treatments on the units, the wound care nurses did not consistently return to check on the patients wounds as to the status, or	A 392	The Wound Care Program policy was reviewed and revised by Nursing Administration on March 22, 2010, to reflect the following changes in process notification and initiation of wound care nurse evaluation of all patients admitted with skin breakdown. Staffing for the wound care program has been revised by the Chief Nursing Officer on March 26, 2010, as follows: Current wound care staffing levels include 1.0 FTE wound care program coordinator, 2.0 FTE wound care nurses and 0.75 FTE wound care nurse, for a total of 3.75 FTE's. Further expansion includes recruitment of an additional 1.0 FTE nurse to bring the total wound care program staffing to 4.75 FTE's. An electronic report will be generated from the electronic medical record based on admission skin assessment on all patients who were admitted with skin breakdown and a phone call will be placed to the wound care team to identify new patients to be seen.	03/22/10 04/01/10 04/01/10

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A 392	Continued from Page 10 if a treatment needed to be changed. This could lead to the wounds getting worse and having a detrimental affect on the patients health status. The findings include: 1. Facility provided documentation revealed the facility has 425 patient beds with a daily average census of 300. Facility provided documentation revealed 132 patients were identified on the requested "Wound Care/Ulcer/High Risk Skin Breakdown Report". Interview with the Director of Supportive Services and the Wound Care Nurse on 3/2/10 at11am, revealed not all patients listed on this report have current skin breakdown, but the facility was unable to provide (requested 3/1/10 thru 3/4/10) documentation of those patients who actually did have skin breakdown . Facility provided documentation revealed a wound care nurse has 2 business days to assess a patient after a consult is received. Interview with the Director of Supportive Services and the wound care nurse revealed currently the hospital employs one full time wound care nurse and 2 as needed wound care nurses, with one as 1 needed nurse working very little, and the other working part time approximately half time. 2. Medical record review revealed: Patient #1 who was admitted on 2/25/10 with a stage IV sacrum/coccyx wound, a KCI home vac machine attached to the dressing; a stage 1 wound of the right lateral ankle; a dark reddened non-blanching right second toe; and a extensive fungal rash of the sacrum, peri-rectum, thighs and groin area. Patient #1 was assessed by the wound care nurse on 2/26/10 as per physician's order and not again until discharge on 3/1/10. Documentation revealed ordered daily dressing changes and care of the wound vac were done by	A 392	Every patient admitted with a pressure ulcer as indicated by the report and/or phone call, will be evaluated by a wound care nurse or wound care resource nurse, which is someone who has completed wound care training and deemed qualified through competencies, within 24 hours of admission. After initial assessment by the wound care team or wound care resource nurse and appropriate protocols are initiated, the staff nurse will follow the treatment plan. A wound care nurse will assess patients with pressure ulcers at least once a week to ensure the treatment plan being followed is appropriate for the patient. If the patient has a hospital acquired pressure ulcer or the patient has now developed a stage III or IV Pressure ulcer the wound care team will be notified to re-evaluate the patient every 72 hours and initiate new protocols. All bedside nursing staff including the wound care team were educated on the policy changes and new protocols by reviewing the policy with the nurse managers by April 1, 2010. Education was facilitated by the Nurse Directors and charge nurses. Competency were done through online education courses "NDNQI Pressure Ulcer Training" and the "Pressure Ulcer Prevention Module" with post-test after each module and monitored annually for compliance by the nursing unit Director. New nurse staff orientation will include 2 hours of specific wound care instruction, presented by a certified wound care nurse. Post-orientation competency will be evaluated at the unit level by the nurse director. The revised policy was reviewed and approved by the Medical Executive Committee on March 29, 2010.	04/01/10 04/01/10 04/01/10 04/01/10 04/01/10 04/01/10 03/29/10

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A 392	Continued from Page 11 the floor nurse. Patient #2 who was currently in the critical care unit was readmitted on 2/22/10 after having a cardiac arrest at another hospital and transported to this facility. The primary nurse assessed Patient #3's skin concerns documenting, multiple wounds on the buttocks, back, inner thighs, left big toe is purple. There were 4 wounds the nurse was unable to document on the left inner thigh, 9x7 black and necrotic unstageable wound below that one she has one that is unstageable. There is a 6x2.5 on the right upper thigh, there is a large unstageable hole that is 8x3x2 that is black on the inside; the left upper thigh has 2 other small areas that are 75% neurotic unstable wounds that are small round areas that are 1x1 and 2x2. A consult for a wound care nurse was completed and the wound care nurse assessed Patient #2 on2/24/10 but was unable to do a full assessment due to the patient receiving dialysis at the time of the assessment. The wound care nurse did not return to finish the assessment until 2/26/10. The only other time the wound care nurse had seen Patient #3 was on 3/3/10 after a physician's order on 3/3/10 at 12noon stating the wound care nurse was to do the wound dressing changes at 1500(3pm) (which was the time the surveyor had previously made an appointment with the floor nurse to observe the dressing change). Patient#2's very intensive wound ulcer treatments were being done from 2/22/10 thru 3/2/10 by floor nurses. Patient #3 was admitted on 2/22/10 and the initial assessment done by the primary floor nurse revealed wounds of the right and left leg which were unstageable (stage 4), Braden scales for risk of skin breakdown varied from 18-21. After a physician's order on 2/22/10 the wound care	A 392	The revised policy was approved by the Board of Trustees on March 30, 2010. Responsible Person: Chief Nursing Officer, Assistant Chief Nursing Officer, Department Directors and Managers. The Nursing Policy on Skin and Wound Care was reviewed and revised by nursing administration to reflect new wound staging and treatment protocols. Clinical nursing staff were educated on the policy changes reflecting new staging and treatment protocols by reviewing the policy with the nurse director. This was completed on April 1, 2010. Ongoing education will be provided on an annual basis through online education courses "NDNQI Pressure Ulcer Training" and the "Pressure Ulcer Prevention Module" with post-test after each module and monitored annually for compliance by the nursing unit Director. Re-designed 2010 wound care competencies. To be completed annually and monitored for compliance by the unit Director. New nursing staff orientation will include 2 hours of specific wound care instruction presented by a certified wound care nurse. Post-orientation competency will be evaluated at the unit level by the nurse director. The Medical Executive Committee approved the changes to the policy on March 29, 2010.	03/30/10 04/01/10 03/25/10 04/01/10 04/01/10 04/01/10 04/01/10 03/29/10

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A 392	Contnued from Page 12 nurse assessed Patient #3's wounds on 2/23/10. The wound care nurse assessed Patient #3's wounds as a stage III on the right leg, the wound on the left leg was not staged, bilateral heels at being at risk, and a puncture wound of the abdomen. After the initial assessment the wound care nurse signed off the daily multiple treatments to be done by the floor nurse, and the wound care nurse did not see Patient #3 again during the patient's hospitalization. Patient #4 was admitted on 2/19/10 with diagnoses that would increase the risk for skin breakdown including end stage renal disease, poorly controlled diabetes and cerebral vascular accident. The patient was initially assessed by the primary floor nurse as having 4 stage one wounds located in the sacral area, the spine and bilateral heels. Assessments done by the floor nurses were completed every shift but were inconsistent as to the Baden scale which ranged from 13-16, and the number of wounds from 1-4. Patient #4 was identified on the Wound Care/Ulcer/High Risk Skin Breakdown Report but was not evaluated by the wound care nurse from2/19/10 thru 3/3/10, the time of the patient's hospitalization. Patient #5 was admitted on 2/24/10 with diagnoses including an infected wound, and failure to thrive. Patient #5 was identified on the Wound Care report and a physician's order for a wound care consultation was written on 2/25/10. The initial assessment done by the floor nurse revealed a stage 1 on the right buttock, a tissue injury on the right heel and left calf. Documentation was completed by the floor nurses who revealed a Braden scale range of 14-18, and the right buttock wound remaining a	A 392	The Board of Trustees approved the changes to the policy on March 30, 2010. Responsible Person: Chief Nursing Officer, Assistant Vice President of Nursing, Department Directors and Managers The Assessment and Re-assessment policy was reviewed by nursing administration on March 23, 2010 and no revision was indicated. Clinical nursing staff were re-educated by unit directors and managers on the process of admission assessments including; upon admission all patients will receive a skin assessment, Braden Score evaluation for skin breakdown risk factors and specialty bed placement or other prevention measures. This will be initiated by the staff nurse during the initial admission assessment and reassessment every shift. Upon assessment, the staff nurse will implement the appropriate protocols as indicated by the MHJ wound staging and Treatment Protocols. All staff nurses involved in care of inpatients, including skin, wound and ulcer assessments will complete education on National Data Base of Nursing Quality Indicators Pressure Ulcer training and Pressure Ulcer Prevention through online training courses. Ongoing education will be provided on an annual basis through online education courses "NDNQI Pressure Ulcer Training" and the "Pressure Ulcer Prevention Module" with post-test after each module and monitored annually for compliance by the nursing unit Director.	03/30/10 04/01/10 03/23/10 04/01/10 04/01/10 04/01/10 04/01/10

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A 392	Continued from Page 13 stage 1, an open left calf wound with drainage, and the right heel wound being unstageable on 2/25/10. Patient #5 was not assessed by the wound care nurse through discharge on 3/1/10. The facility has 425 patient beds with a daily average census of approximately 300 patients; there were 132 patients identified on the Wound Care Report. The facility employs one full time wound care nurse and 2 as needed nurses with a total of approximately 60-70 hours a week. Evidence presented through medical record review, facility provided documentation and staff interviews revealed the facility is understaffed in they wound care management unit leaving the bulk of assessments and treatments to the primary nurses. Although primary nurses can do treatments on patient wounds, the wound care nurses did not do follow up to see how the wounds were progressing or if there was a needed change in treatment for the wound(s).	A 392	Compliance Monitoring to assure that all applicable patients are identified on admission with timely follow-up by wound care team will be audited by the Director of Support Services and reported to the Leadership Organizational Committee, Medical Executive Committee and the Board of Trustees quarterly. Responsible Person: Chief Nursing Officer, Assistant Chief Nursing Officer, Department Directors and Managers.	04/01/10 04/01/10
A 397	482.23(b)(5) PATIENT CARE ASSIGMENTS 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 medical record review, multiple staff interviews, facility provided documentation and observation the facility failed to ensure that patients who had skin breakdown were assigned nursing staff who had specialized training in the treatment of wounds. The facility has 425 patient beds, average daily census of 300 patients, and 642 full time registered nurses. The Wound Care /Ulcer/ High Risk Skin Breakdown Report	A 397	The Wound Care Program policy was reviewed and revised by Nursing Administration on March 22, 2010, to reflect the following changes in process notification and initiation of wound care nurse evaluation of all patients admitted with skin breakdown. Staffing for the wound care program has been revised by the Chief Nursing Officer on March 26, 2010, as follows: Current wound care staffing levels include 1.0 FTE wound care program coordinator, 2.0 FTE wound care nurses and 0.75 FTE wound care nurse, for a total of 3.75 FTE's. Further expansion includes recruitment of an additional 1.0 FTE nurse to bring the total wound care program staffing to 4.75 FTE's.	03/22/10 04/01/10

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A 397	Continued from Page 14	A 397		
	revealed 132 patient names. Patients were logged into this report who had actual wounds or were at risk for wounds during the four days of the survey. Facility staff were unable to produce a list of those patients with actual wounds. The facility employs one full time nurse and 2 as needed nurses for wound care with the total working hours per week approximately 60-70 hours. Due to the very limited employees on the"Wound Care Management Team" and the large number of patients on the Wound Care Report, the majority and in some cases all the care and treatments were the responsibility of the floor nurse.		An electronic report will be generated from the electronic medical record based on admission skin assessment on all patients who were admitted with skin breakdown and a phone call will be placed to the wound care team to identify new patients to be seen. Every patient admitted with a pressure ulcer as indicated by the report and/or phone call, will be evaluated by a wound care nurse or wound care resource nurse, which is someone who has completed wound care training and deemed qualified through competencies, within 24 hours of admission.	04/01/10 04/01/10

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	The findings include: 1. Interview with administrative personnel on 3/2/10 including the Chief Nursing Officer, Director of supportive Services and the Wound Care Nurse, revealed "all nurses get one hour orientation on wound care; also they get an additional hour (which was unclear when they get this additional time and what it consists of)" there was no documentation presented at that time. The staff did produce at a later time, an orientation booklet for nurses, "General Nursing Orientation Handbook for Nurses 2010 (which was represented as the additional education). The section in this booklet on Wound Care(Wound Care & You) consisted of 10 pages with the majority of the pages being photographs. The black and white copied photographs in "Wound Care & You" were very poor in quality and many were blurry. The printing on the pages as in Initiate Appropriate Treatment of Wounds" was extremely small and unclear making it impossible to read. Facility provided documentation and interview		After initial assessment by the wound care team or wound care resource nurse and appropriate protocols are initiated, the staff nurse will follow the treatment plan. A wound care nurse will reassess patients with pressure ulcers at least once a week to ensure the treatment plan being followed is appropriate for the patient. If the patient has a hospital acquired pressure ulcer or the patient has now developed a stage III or IV Pressure ulcer the wound care team will be notified to re-evaluate the patient every 72 hours and initiate new protocols. All bedside nursing staff including the wound care team were educated on the policy changes and new protocols by reviewing the policy with the nurse managers by April 1, 2010. Education was facilitated by the Nurse Directors and charge nurses. Competency were done through online education courses "NDNQI Pressure Ulcer Training" and the "Pressure Ulcer Prevention Module" with post-test after each module and monitored annually for compliance by the nursing unit Director.	04/01/10 04/01/10 04/01/10 04/01/10 04/01/10

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	with the Director of Supportive Services and the Wound Care Nurse on 3/2/10 at 11am, revealed the "Wound Care team" only assesses a patient after a consultation request is made to their department. The wound care nurse after the consultation is received has a time frame of two business days to see the patient. If a consult is not ordered, then the wound care nurse does not see the patient, although the patient may have wounds. 2. Patient #1, was admitted on 2/25/10 with a stage IV sacrum/coccyx wound, and a KCI home vac machine attached to the dressing; a stage 1 wound of the right lateral ankle; a dark reddened non-blanching right second toe; and a extensive fungal rash of the sacrum, peri- rectum, thighs and groin area. Patient #1 was assessed by the wound care nurse on 2/26/10 as per physician's order and not again until discharge on 3/1/10. Documentation revealed ordered daily dressing changes and care of the wound vac were done by the floor nurse. Patient #3 was admitted on 2/22/10 and the initial assessment done by the primary floor nurse revealed wounds of the right and left leg which were unstageable (stage 4), Baden scales for risk of skin breakdown varied from 18-21. After a physician's order on 2/22/10 the wound care nurse assessed Patient #3's wound on 2/23/10. The wound care nurse assessed Patient #3's wounds as a stage III on the right leg, the wound on the left leg which was not staged by the wound care nurse, bilateral heels as being at risk, and a puncture wound of the abdomen. After the initial assessment the wound care nurse signed off the daily multiple treatments to be done by the floor nurse, and the wound care nurse did not see Patient #3 again.		New nurse staff orientation will include 2 hours of specific wound care instruction, presented by a certified wound care nurse. Post-orientation competency will be evaluated at the unit level by the nurse director. The revised policy was reviewed and approved by the Medical Executive Committee on March 29, 2010. The revised policy was approved by the Board of Trustees on March 30, 2010. Responsible Person: Chief Nursing Officer, Assistant Chief Nursing Officer, Department Directors and managers. The Nursing Policy on Skin and Wound Care was reviewed and revised by nursing administration to reflect new wound staging and treatment protocols. Clinical nursing staff were educated on the policy changes reflecting new staging and treatment protocols by reviewing the policy with the nurse director. This was completed on April 1, 2010. Ongoing education will be provided on an annual basis through online education courses "NDNQI Pressure Ulcer Training" and the "Pressure Ulcer Prevention Module" with post-test after each module and monitored annually for compliance by the nursing unit Director. Re-designed 2010 wound care competencies. To be completed annually monitored for compliance by the unit Director. New nursing staff orientation will include 2 hours of specific wound care instruction presented by a certified wound care nurse. Post-orientation competency will be evaluated at the unit level by the nurse director.	04/01/10 03/29/10 03/30/10 04/01/10 03/25/10 04/01/10 04/01/10 04/01/10 04/01/10

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A 397	Continued from page 16 Patient #4 was admitted on 2/19/10 with diagnose which would make the patient at risk for skin breakdown including end stage renal disease, poorly controlled diabetes and cerebral vascular accident. The patient was initially assessed by the primary floor nurse as having 4 stage one wounds located in the sacral area, the spine and bilateral heels. Assessments done by the floor nurses were completed every shift but were inconsistent as to the Baden scale which ranged from 13-16, and the number of wounds from 1-4. Patient #4 was identified on the Wound Care/ Ulcer/High Risk Skin Breakdown Report but was not evaluated by the wound care nurse from 2/19/10 thru discharge on 3/3/10. Patient #5 was admitted on 2/24/10 with diagnoses including an infected wound, and failure to thrive. Patient #5 was identified on the Wound Care report and a physician's order for a wound care consultation was written on 2/25/10. The initial assessment done by the floor nurse revealed stage 1 on the right buttock, a tissue injury on the right heel and left Documentation was completed by the floor nurses who revealed a Baden scales range of calf. 14-18, the right buttock wound remaining a stage1, an open left calf wound with drainage, and the right heel wound unstageable on 2/25/10. Patient #5 was not assessed by the wound care nurse through discharge on 3/1/10. Patient # 2 who was currently in the critical care unit was readmitted on 2/22/10 after having a cardiac arrest at another hospital and transported to this facility. The primary nurse assessed Patient #2's skin concerns documenting, multiple wounds on the buttocks, back, inner thighs, left big toe was purple. There were 4 wounds she was unable to document on the left inner thigh 9x7 black and necrotic unstageable wound below	A 397	The Medical Executive Committee approved the changes to the policy on March 29, 2010. The Board of Trustees approved the changes to the policy on March 30, 2010. Responsible Person: Chief Nursing Officer, Assistant Vice President of Nursing, Department Directors and Managers The Assessment and Re-assessment policy was reviewed by nursing administration on March 23, 2010 and no revision was indicated. Clinical nursing staff were re-educated by unit directors and managers on the process of admission assessments including; upon admission all patients will receive a skin assessment, Braden Score evaluation for skin breakdown risk factors and specialty bed placement or other prevention measures. This will be initiated by the staff nurse during the initial admission assessment and reassessment every shift. Upon assessment, the staff nurse will implement the appropriate protocols as indicated by the MHJ wound staging and Treatment Protocols. All staff nurses involved in care of inpatients, including skin, wound and ulcer assessments will complete education on National Data Base of Nursing Quality Indicators Pressure Ulcer training and Pressure Ulcer Prevention through online training courses. Ongoing education will be provided on an annual basis through online education courses "NDNQI Pressure Ulcer Training" and the "Pressure Ulcer Prevention Module" with post-test after each module and monitored annually for compliance by the nursing unit Director.	03/29/10 03/30/10 04/01/10 03/23/10 04/01/10 04/01/10 04/01/10 04/01/10

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A 397	Continued From Page 17 that one she has another one that was unstageable that is 6x2.5 on the right upper thigh; the patient had a large unstageable hole that was 8x3x2 that was black on the inside; the left upper thigh had 2 other small areas that were 75% necrotic unstable wounds that were small round areas that were 1x1 and 2x2. A consult for a wound care nurse was completed and the wound care nurse assessed Patient #2 on 2/24/10 but was unable to do a full assessment due to the patient receiving dialysis at the time of the assessment. The wound care nurse did not return to finish the assessment until 2/26/10. The only other time the wound care nurse had seen Patient#3 was on 3/3/10 after a physician's order on 3/3/10 at 12noon that stated the wound care nurse was to do the wound dressing changes at 1500 (3pm) (which was the time the surveyor had previously made an appointment with the floor nurse to observe the dressing change). The dressing change observation on 3/3/10 at 3pm revealed Patient #2 had very extensive, multiple pressure ulcers on the right buttock, thigh, coccyx, with a small skin/tape tear on the right lower leg. The primary wound care nurse cleansed the entire area which consisted of a large blackened eschar area measuring approximately 20 inches by 10 inches, there were several other wounds located in this area with one 6x6 inch wound with yellow slough which was loose and hanging (this was not removed) at the inner corner of this wound was a large round hole (stage 3) that had tunneling present to the adjoining tissue, and cleaned using very little saline gotten from a few 5cc pink plastic containers. The assisting wound care nurse squeezed a large amount of Safegel on a 4X4 and smeared it over the entire blacked eschar area. When the primary nurse asked for some	A 397	Compliance Monitoring to assure that all applicable patients are identified on admission with timely follow-up by wound care team will be audited by the Director of Support Services and reported to the Leadership Organizational Committee, Medical Executive Committee and the Board of Trustees quarterly. Responsible Person: Chief Nursing Officer, Assistant Vice President of Nursing, Department Directors and Managers	04/01/10 04/01/10

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A 397	Continued from Page 18 Safegel the assisting nurse used the same 4x4 she had smeared the wounds with and squeezed more gel onto the used 4x4 and handed to the primary nurse who applied it to the rest of the wounds. Patient #2 had very intensive daily dressing changes and some of the dressing changes were to be done twice. The daily wound ulcers treatments were being done from 2/22/10 thru 3/2/10 by unit floor nurses.	A 397		
A 491	482.25(a) PHARMACY ADMINISTRATION The pharmacy or drug storage area must be administered in accordance with accepted professional principles. This STANDARD is not met as evidenced by: Based on observation, review of the Pharmacy Policy and Procedures and interview with the Director of Pharmacy, the facility failed to ensure one of the refrigerated units, which contained patient pharmaceuticals, had been maintained within the manufacturers accepted recommendations for temperature control to ensure that the medications would maintain their efficacy. The findings include: 1. Observation of the refrigerated units in the Pharmacy Department on 3/1/10 at 10:30 am revealed the outside digital thermometer on one of the units read 1.8 degrees Celsius. The refrigerated unit stored single dose patient pharmaceuticals. Review of the Manufacturer's recommendations revealed the unit should be maintained between 2 - 8 degrees Celsius. Interview with the Director of Pharmacy at 10:40	A 491	Manual Daily Monitoring log initiated by the Director of Pharmacy on March 4, 2010. Temperature will be checked by the IV pharmacy technician and manually recorded on this log daily. This will serve as a back-up to the continuous 24 hour temp monitoring wheel. External alarms installed by facilities on March 4, 2010, which will alarm if temperature goes out of range of 2 – 8 C (35 – 46 F). Alarms are tested for proper functioning quarterly by facilities. If external alarms sound the pharmacy personnel verifies the refrigerator temperature by checking internal thermometer, ensures all doors are closed. If temperature out of range a work order is placed to facilities to evaluate and repair. Medications will be relocated per manufacturer temperature guidelines. Quarterly battery checks and alarm test implemented. Once per quarter a facilities representative will check batteries and perform a test to ensure alarm is in good working order. Check will be documented on log maintained in the pharmacy. Additionally, twice a year at daylight savings time changes, the batteries will be automatically replaced by a facilities representative.	03/04/10 04/01/10 04/01/10 04/01/10

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A 491	Continued From page 19 pm on 3/1/10, confirmed the refrigerated units should be maintained between 2-8 degrees Celsius. She stated the units were equipped with an alarm that would sound if the temperature fell outside acceptable ranges. When interviewed about why the refrigerated unit alarm had not sounded, given the unit was holding at 1.8 degrees Celsius, the Director of Pharmacy was unsure. Interview with the Director of Pharmacy at 3:10 pm on 3/1/10, revealed maintenance had been contacted relative to the unacceptable temperature range on the refrigerated unit. Maintenance adjusted the temperature and had to replace the battery. The Director of Pharmacy stated the battery on the refrigerated unit was dead which is why the alarm was not audible. The battery was changed immediately. Review of the Policy and Procedure titled "Pharmacy Refrigerator Log" confirmed the "refrigerators would be maintained between 2-8 degrees Celsius for medication storage. Deviation outside the appropriate temperature ranges (as noted by audible alarm) should be recorded on the temperature log, cause of variance investigated and stability of items contained in refrigerator reviewed. Temperature monitoring devices/logs will be inspected daily and changed monthly by the Pharmacy Purchasing agent". Interview with the Director of Pharmacy on 3/3/10 at 9:30 am, confirmed the Pharmacy Department did not maintain a temperature log for the refrigerated unit and no documentation could be located they had inspected or changed the battery monthly, per their Policy and Procedure.	A 491	Education conducted by the Director of Pharmacy via certified email communication to all pharmacy staff regarding process to follow when refrigerator alarms activate. This was completed on March 26, 2010. Compliance will be monitored by the Director of Pharmacy and reported to the Safety Committee on a quarterly basis. Responsible Person: Director, Pharmacy	04/01/10 04/01/10 04/01/10

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A 701	482.41(a) MAINTENANCE OF PHYSICAL PLANT The condition of the physical plant and the overall hospital environment must be developed and maintained in such a manner that the safety and well-being of patients are assured. This STANDARD is not met as evidenced by: Based on observation, review of the Food and Nutrition Policy and Procedures and interview with the Food Service Director, the facility failed to ensure they maintained enough non perishable food on the premises in the case of an "unplanned" emergency. They also failed to develop a policy and procedure for food services and the necessary supply of non perishable foods if an unplanned emergency/disaster was realized. The findings include: 1. Observation of the kitchen and the dry storage area on 3/1/10 at 11:20 am, revealed two stand-up metal racks which contained #10 cans of food. The racks contained few #10 cans of vegetables, fruits, beans, soups etc. Interview with staff assigned to dry storage on 3/1/10 at 11:20 am, revealed there was only one case of evaporated milk available in the dry food storage area. Interview with the Food Service Director on 3/1/10 at 11:25 am, revealed the hospital census was approximately 300 and the facility did not maintain enough "non perishable" dry food supply to ensure all the patients would have their nutritional needs met for at least 7 days in the case of an emergency. She stated per the Food and Nutrition Policy and Procedures, the facility	A 701	The Food and Nutrition Services policy "Disaster Plan" has been reviewed and revised by the Director of Food and Nutrition Services on March 23, 2010, to include that in the event of an unplanned disaster, non-perishable food supplies will be available to serve the hospital's patients for one week. Emergency food supplies were inventoried by The Director and Production Manager on March 23, 2010, and par levels of non-perishable food supplies have been increased to be sufficient to serve the hospital's patients for one week. Non-perishable food supplies were ordered and have been received. The food and nutrition management staff were educated by the Director of Food and Nutrition Services on March 26, 2010, on the policy changes by reviewing the policy and acknowledging receipt. Compliance will be monitored through monthly Inventory of non-perishable food supplies by the production or patient service manager and reviewed by the Director of Food and Nutrition Services. Inventory logs of non-perishable food will be reported to the Safety Committee, Medical Executive Committee and the Board of Trustees on a quarterly basis. Responsible Person: Director, Food & Nutrition Services	03/23/10 03/23/10 03/26/10 04/01/10 04/01/10 04/01/10

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A 701	Continued from Page 21 needed only to prepare for a "planned" emergency. The policy stated what would be expected from the Food Service Department if given a 72 hour notice before the emergency/ disaster was realized. When interviewed about how the facility would handle an "unplanned emergency" the Food Service Director was unsure. Review of the Food and Nutrition Policy and Procedures dated 2/23/10 revealed an emergency disaster plan which included a 7 day menu using all the "perishable" foods in the freezer and refrigerator first. No policy or procedure could be located relative to what the disaster plan would be in the case of an unplanned emergency/ disaster. However, review of the "Comprehensive Emergency Management Plan" dated 04/09 revealed the Food Service Department would maintain adequate supplies and manpower to provide meals to an estimated 1300 people for seven days. Interview with the Food Service Director on 3/1/10 at 11:25am, revealed the dry storage area did not contain enough food for 1300 people for seven days. Interview with the Food Service Director on 3/1/10 at 11:25 a.m., revealed the dry storage area did not contain enough food for 1300 people for seven days.	A 701		
A 724	482.41(c)(2) FACILITIES, SUPPLIES, EQUIPMENT MAINTENANCE Facilities, supplies, and equipment must be maintained to ensure an acceptable level of safety and quality. This STANDARD is not met as evidenced by: Based on observation, interviews with the kitchen staff and review of the Food and Nutrition Policy and Procedures, the facility failed to ensure food safety and an acceptable level of quality when	A 724	The Food and Nutrition policy on Pot and Pan Washing was reviewed and revised by the Food and Nutrition Services Director on March 10, 2010, to ensure final sanitation occurs through the dish machine. Food and Nutrition staff who wash pots & pans were educated on the new pot and pan washing process to include final sanitation occurs through the dish machine, by the Patient Services Manager on March 11 & 23, 2010.	03/10/10 03/23/10

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A 724	Continued From page 22 they did not maintain the dish room, food service equipment, and transport carts in a safe and sanitary fashion. The findings include: 1. Observation of the facility's kitchen and dish room on 3/1/10 at 11:20 am, revealed the dish room contained a three compartment sink for cleaning and sanitizing pots and pans. The dish room also contained; five garbage bins filled with garbage, many rolling carts which contained left over foods and dirty pots and pans. It also contained the "ready to use" cleaned and sanitized pots and pans which were located against the wall on an upright metal shelf. Observation of the third compartment sanitizing sink, at that time, revealed the sides of the sink was soiled, the water was covered with debris and the water surface appeared greasy. Interview with the dish room staff revealed he had not checked the third compartment sanitizing sink for the correct Parts Per Million (PPM) of sanitizing solution, however he stated he had already washed and rinsed the pots and pans. When asked check the PPM at 11:20am on to 3/1/10 staff was unable to complete the task because the sanitizing test strips were not available. Review of the container which housed the sanitizing test strips revealed it was empty. Consequently, staff could not ensure there was an effective amount of sanitizing solution in the third compartment sink to ensure food safety. The dish room staff went on to say that after the pots and pans were submersed into the sanitizing sink, they were then placed on the metal shelving	A 724	Compliance will be monitored through daily observation by the production or patent service manager and will be logged on the Managers daily log and reviewed by the Director of Food and Nutrition Services weekly. The audit results will be reported to the Safety Committee, Medical Executive Committee and Board of Trustees on a quarterly basis for the next 6 months. Responsible Person: Director of Food & Nutrition Services The Food and Nutrition staff were educated by the Director of Food and Nutrition Services on March 26, 2010, on proper garbage disposal, separation of clean and dirty pots and pans to prevent cross-contamination, and sanitizing sinks with the correct solution as well as checking the PPM. Sanitizing test strips were purchased March 26, 2010, and are kept in stock for daily use Responsible Person: Director of Food and Nutrition Services.	04/01/10 04/01/10 04/01/10 03/26/10 03/26/10 04/01/10

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	100179	A. BUILDING _____ B. WING _____	03/04/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL HOSPITAL JACKSONVILLE	**3625 UNIVERSITY BLVD. SOUTH JACKSONVILLE, FL 32216**

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A 724	Continued from Page 23 unit against the wall to air dry. Then they were ready to be reused. Observation of the dish room at 3:00 pm on 3/1/10 revealed an over filled garbage bin had come in contact with the metal shelving unit which housed the clean pots and pans. Also, dirty pots and pans and left over food containers were in very close proximity to the clean pots and pans which could have allowed for cross contamination. Interview with the Food Service Director at 3:00 pm on 3/1/10 revealed staff was instructed to send all the pots and pans through the dish machine for final sanitation before they were removed from the metal shelving unit and reused. However, staff failed to complete that task and he stated "they had stopped sending the pots and pans to the dish machine for final sanitation some time ago". Review of the Food and Nutrition Policy and Procedures dated 2/23/10 for washing and sanitizing pots and pans revealed there was no mandate to send the pots and pans through the dish machine for a final sanitizing before reuse. It read the pots and pans needed to be submersed in the third compartment sink then placed on the metal rack to air dry. Interview with the Food Service Director on 3/2/10 at 9:30 am revealed she was unaware the policy and procedure did not state how to complete the final sanitation process for the pots and pans and she would correct it immediately. 2. Observation of the kitchen equipment on 3/1/10 at 11:30 am revealed the metal blades on	A 724		

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A 724	Continued From page 24 the Buffalo Chopper and the Robot Coupe were chipped and cracked. Once the metal blades become chipped and cracked there is a potential for metal shavings to enter into the patient's food. 3. Observation of the kitchen on 3/3/10 at 9:50 am revealed the facility had prepared to transport approximately 60 lunch meals to an offsite facility. There were three insulated food carts that were placed in the kitchen and one of the carts had already been filled with 20 lunch meal trays. Observation of the inside of the transportation carts revealed the doors were covered with food debris and each door felt sticky when touched. Interview with the Food Service Director, at that time, revealed staff were trained to rinse, clean and sanitize the transportation carts inside and outside prior to placing ready to eat meals in the cart. She stated they had just failed to complete that task at this time. The food trays were removed immediately and the carts were cleaned and sanitized before reused.	A 724	The Buffalo Chopper and Robot Coupe blades were sharpened by the facility's maintenance department on March 1, 2010, to remove any broken edges. Advantage Mobile Sharpening Knife and Blade Company has been contracted to inspect and sharpen all knives and blades on a monthly basis. Monitoring for compliance with sharpened blades will be performed on a monthly basis by the production or patient service manager and recorded on the knife and blade log and reviewed by the Director of Food and Nutrition Services monthly. Monitoring logs will be presented to the Safety Committee, Medical Executive Committee and Board of Trustees on a quarterly basis for the next six months. Transportation Carts are washed 3 times a day and monitored by the Driver Host and logged on an audit form. The audit results are reviewed by the Director on a monthly basis and reported to the Safety Committee, Medical Executive Committee and Board of Trustees quarterly Responsible Person: Director Food & Nutrition Services	03/01/10 04/01/10 04/01/10 04/01/10 04/01/10 04/01/10

CHARLIE CRIST
GOVERNOR

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

Better Health Care for all Floridians

THOMAS W. ARNOLD
SECRETARY

March 16, 2010

Administrator
Memorial Hospital Jacksonville
3625 University Blvd South
Jacksonville, FL 32216

Dear Administrator:

To participate in the Medicare Program, a hospital must meet all of the statutory provisions of Section 1861(e) of the Social Security Act and comply with all of the Conditions of Participation issued as regulations by the Secretary of health and Human Services.

Section 1865 of the Social Security Act and implementing regulations provide that a hospital accredited by The Joint Commission or the American Osteopathic Association will be "deemed" to meet all Medicare health and safety requirements. Section 1864 of the Act requires the Secretary of Health and Human Services to authorize a survey of an accredited hospital participating in Medicare if there is a substantial allegation of a serious deficiency or deficiencies which would, if found to be present, adversely affect the health and safety of patients. If the hospital is found to have significant deficiencies and therefore fails to comply with the Medicare Conditions of Participation, the Centers for Medicare and Medicaid Services is required to keep the hospital under State Agency monitoring until there is full compliance with all of the Medicare Conditions of Participation.

During a complaint investigation conducted on January 12-13, 2010 by the Agency for Health Care Administration, your hospital was found to be in non-compliance with the following Medicare Condition of Participation:

42 CFR 482.22 Medical Staff

As a result a full survey of all Conditions of Participation was conducted on March 1-4, 2010. During this subsequent Medicare survey, the following Medicare Conditions of Participation were found not met:

42 CFR 482.12 Governing Body
42 CFR 482.23 Nursing Services

Enclosed is the Statement of Deficiencies and Plan of Correction (CMS-2567) which lists the deficiencies cited at the time of the survey. You may take steps to meet Medicare Program requirements and thereby establish your hospital's continued eligibility to participate as a provider of hospital services. If you believe that compliance has been achieved, you should notify us in writing within 10 days, describing in detail the specific corrective measures taken to resolve these problems. If your "credible allegation" of compliance is

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2727 Mahan Drive
Tallahassee, FL 32308
http://ahca.myflorida.com

Jacksonville Field Office
921 N. Davis St., Bldg. A, Suite 115
Jacksonville, FL 32209
Phone (904) 359-6046; Fax (904) 359-6054

accepted, the Agency will conduct a resurvey. **Please be advised, however, that failure to achieve compliance will result in your hospital's termination under Medicare, effective June 4, 2010.**

Please complete a Plan of Correction (POC) for the deficiencies shown on the Statement of Deficiencies and Plan of Correction, including the date corrective action was accomplished or is anticipated to be accomplished. Also, please sign and date all forms on the bottom and **return them to this office within ten (10) calendar days of receipt of this letter.** Failure to submit a reply within this time frame may jeopardize your certification status.

Plan of Correction (POC)

A POC for the deficiencies must be submitted on the enclosed forms. Your POC must contain the following information:

- The plan of correcting the specific deficiency cited. The plan should address the processes that lead to the deficiency cited;
- The procedure for implementing the acceptable plan of correction for the specific deficiency cited;
- The monitoring procedure to ensure that the plan of correction is effective and that the specific deficiency cited remains corrected and/or in compliance with the regulatory requirements;
- The title of the person responsible for implementing the acceptable plan of correction.

The requirement that your hospital correct these deficiencies does not affect your accreditation, Medicare payments, or your current status as a participating provider of hospital services in the Medicare Program. When an acceptable POC has been implemented and all the Conditions of Participation are met, your hospital will not be subject to further State Agency monitoring. However, if deficiencies are not corrected, we will recommend to the Centers for Medicare and Medicaid Services that termination action continues.

The Quality Assurance Questionnaire has long been employed to obtain your feedback following survey activity. This form has been placed on the Agency's website at http://ahca.myflorida.com/Publications/Forms.shtml as a first step in providing a web-based interactive consumer satisfaction survey system. You may access the questionnaire through the link under Health Facilities and Providers on this page. Your feedback is encouraged and valued, as our goal is to ensure the professional and consistent application of the survey process.

Thank you for the assistance provided to the surveyors. Should you have any questions please call this office at 359-6046.

Sincerely,

Helen Edstrom, RN

Robert E. Dickson
Field Office Manager
Div. of Health Quality Assurance

JL/cw
Enclosures