Centers for Medicare and Medicaid Services Conditions of Participation (CoP)
Provider Plan of Correction

Provider Name	CHI St Luke's Health Baylor College of Medicine Medical Center	**Provider Identification #**	450193	**Dates of Survey**	3/25/2019 -4/4/2019
Address	6720 Bertner Avenue Houston, TX 77030	**Survey Type**	Full CMS Visit	**Tags**	A

Tag A 000 - Through a collaborative effort of Baylor St. Luke's Medical Center's (BSLMC or "Hospital") Senior Leadership, administration, nursing staff, the medical staff and the Board of Trustees, BSLMC has taken prompt and significant corrective actions to ensure compliance with the CoPs (Conditions of Participation) under Tags A043, A084, A115, A131, A144, A145, A161, A263, A283, A386, A392, A395, A396, A405, A438, A491, A618, A619, A700, A701, A724, A747, and A749. BSLMC has corrected all cited deficiencies and has taken steps for sustained compliance with the CoPs over time to ensure safe, quality care for patients. Accordingly, BSLMC respectfully requests that CMS (Centers for Medicare and Medicaid) accept this Plan of Correction (PoC) as credible evidence of current and long-term sustained compliance with the CoPs.

BSLMC has an effective Board of Trustees that is legal responsible for the conduct of the hospital. BSLMC is currently in compliance with the CMS Condition of Participation Tag A043 as evidence by the following specific corrective actions, education and monitoring for compliance.

For all items within Tag A043, the Board of Trustees has been actively engaged in the oversight and implementation of the plan of correction. The Quality Committee of the Board of Trustees (reports quarterly to the Board of Trustees) has been actively involved in the development and advisement of this plan of correction through regular communications in order to provide increased oversight of the activities designed to comply with the Conditions of Participation. An Executive Quality Council (EQC), chaired by the President or Senior Leader designee, meets weekly to provide oversight of the compliance with the monitoring of follow-up/monitoring measures. This council will continue to oversee the monitoring measures until 100% compliance with stated measures is sustained for two consecutive months. As well as:

- Individual staff member non-compliance will be reported to the appropriate supervisor or manager. Any non-compliance will be addressed with the individual through training, re-education and/or following the human resources corrective action process.
- Individual credential provider non-compliance will be addressed through the professional practice evaluation process and monitored through the ongoing practice evaluation process of the medical staff.
- When 100% compliance is sustained for two consecutive months for the monitoring measures stated in Tag A043, the monitoring will continue on an ongoing basis quarterly with finding continuing to be reported to the stated hospital Committees and the Quality Committee of the Board of Trustees (reports quarterly to the Board of Trustees). If compliance is not sustained quarterly monitoring will go back to weekly monitoring with data aggregated monthly for sustained compliance for at least two consecutive months. Decisions will be made in accordance with national clinical standards and the Conditions of Participation.

CoP Tag #	Plan for correcting the cited deficiency	Procedure for implementing the acceptable plan of correction	Follow-up/Monitoring	Person Responsible Completion Date
A043 (A)	Informed consent training and education has been developed to include tip sheets and videos regarding the correct process for informed consent, including the risks and benefits prior to surgical procedures.	Nursing Leadership conducted training for all nursing staff about the informed consent process, and reinforcement of the policy. This took place across all shifts and practice is reinforced by regular nursing huddles leadership. Training has taken place for all permanent full time and part time nurses and contract	Ten (10) anesthesia informed consent records are audited per week with a monthly aggregate of 40 by the surgical services department to review correct signature and the informed consent process was followed. The findings are	**Responsible Person:** Vice President of Surgical Services **Completion Date:**

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — DATE

Doug Lawson — President — 5/13/19

	The individual identified was re-educated on the process for not proceeding with chemotherapy or a blood product (e.g. IVIG) without verification of informed consent from the ordering provider. All nurses at Kirby Glen will verify documented informed consent from the ordering provider prior to proceeding with chemotherapy or administration of a blood product. The "Disclosure and Consent for Medical and Surgical Procedures (Informed Consent)" policy has been updated to reflect all acceptable methods of documenting informed consent.	nurses. Nursing staff on FMLA or LOA will complete the training prior returning to work. Leadership of Kirby Glen conducted training for all nursing staff reinforcing the process for confirming informed consent has occurred by the ordering provider in accordance with policy "Disclosure and Consent for Medical and Surgical Procedures (Informed Consent)". This took place across all shifts and practice is reinforced by regular nursing huddles leadership. Training has taken place for all permanent full time and part time nurses and contract nurses. Nursing staff on FMLA or LOA will complete the training prior returning to work. Credentialed Providers were reminded of the expectations for informed consent. They were provided education through one or more of the following methods: in-person training, certified letters, online training modules and training at medical staff meetings. Education about the process for informed consent was added to new employee orientation for all nursing staff and the onboarding process for anesthesia providers.	reported monthly to the Vice President of Surgical Services, the Quality of Care Committee, Medical Executive Committee and quarterly to the Quality Committee of the Board of Trustees (reports quarterly to the Board of Trustees) until 100% is sustained for two consecutive months. Monitoring will continue quarterly on an ongoing basis with findings reported to the above stated committees unless non-compliance is identified whereby monitoring will increase in frequency until compliance is restored. Ten (10) records at Kirby Glen are audited per week with a monthly aggregate of forty (40) by leadership at Kirby Glen to review informed consent documentation is present prior to treatment. The findings are reported monthly to the CNO, Quality of Care Committee, Medical Executive Committee and quarterly to the Quality Committee of the Board of Trustees (reports quarterly to the Board of Trustees) until 100% is sustained for two consecutive months. Monitoring will continue quarterly on an ongoing basis with findings reported to the above stated committees unless non-compliance is identified whereby monitoring will increase in frequency until compliance is restored.	6/09/2019
A043 (B)	The "Disclosure and Consent -Anesthesia and/or Perioperative Pain Management (Analgesia)." form was updated to include a place for the anesthesiologist who is administering anesthesia and providing informed consent to print and sign their name on the informed consent document. Informed consent training and education	The Vice President of Surgical Services and the Medical Director of Anesthesiology conducted training for all Anesthesia providers which included the revised anesthesia consent form and the expectations of the anesthesiologist who is administering anesthesia and providing informed consent print and sign his/her name on the informed consent document. Nursing Leadership conducted training for all nursing staff about the informed consent process to include the name of the anesthesiologist, and reinforcement of the policy. This took place across all shifts and	Ten (10) anesthesia informed consent records are audited per week with a monthly aggregate of forty (40) by the surgical services department to review correct printed name and signature of the anesthesia provider. The findings are reported monthly to the View President of Surgical Services, Quality of Care Committee, Medical Executive Committee and quarterly to the Quality Committee of the Board of Trustees (reports quarterly	**Responsible Person**: Vice President of Surgical Services **Completion Date:** 6/09/2019

	has been developed to include tip sheets and videos regarding the correct process for informed consent.	practice is reinforced by regular nursing huddles leadership. Training has taken place for all permanent full time and part time nurses and contract nurses. Nursing staff on FMLA or LOA will complete the training prior returning to work. Education about the process for informed consent was added to new employee orientation as well as annual training for all nursing staff and the onboarding process for anesthesia providers.	to the Board of Trustees) until 100% is sustained for two consecutive months. Monitoring will continue quarterly on an ongoing basis with findings reported to the above stated committees unless non-compliance is identified whereby monitoring will increase in frequency until compliance is restored.	
A043 (C)	Informed consent training and education has been developed to include tip sheets and videos regarding the correct process for informed consent. The individual identified was re-educated on the process for not proceeding with chemotherapy or a blood product (e.g. IVIG) without verification of informed consent from the ordering provider. All nurses at Kirby Glen will verify documented informed consent from the ordering provider prior to proceeding with chemotherapy or administration of a blood product. The "Disclosure and Consent for Medical and Surgical Procedures (Informed Consent)" policy has been updated to reflect all acceptable methods of documenting informed consent.	Leadership of Kirby Glen conducted training for nursing staff reinforcing the process for confirming informed consent has occurred by the ordering provider in accordance with policy "Disclosure and Consent for Medical and Surgical Procedures (Informed Consent)". This took place across all shifts and practice is reinforced by regular nursing huddles leadership. Training has taken place for all permanent full time and part time nurses and contract nurses. Nursing staff on FMLA or LOA will complete the training prior returning to work. Credentialed Providers were reminded of the expectations for informed consent. They were provided education through one or more of the following methods: in-person training, certified letters, online training modules and training at medical staff meetings. Education about the process for informed consent was added to new employee orientation and annual training for all nursing staff.	Ten (10) records at Kirby Glen are audited per week with a monthly aggregate of forty (40) by leadership at Kirby Glen to review informed consent documentation is present prior to treatment. The findings are reported monthly to the CNO, Quality of Care Committee, Medical Executive Committee and quarterly to the Quality Committee of the Board of Trustees (reports quarterly to the Board of Trustees) until 100% is sustained for two consecutive months. Monitoring will continue quarterly on an ongoing basis with findings reported to the above stated committees unless non-compliance is identified whereby monitoring will increase in frequency until compliance is restored.	**Responsible Person**: Chief Nursing Officer **Completion Date:** 6/09/2019
A043 (D)	Immediately, a safety alert was created by the Director of Dialysis to alert staff to the manufacturer requirements of testing and setting up the machine properly with the venous clamp and optical detector door. Additionally, return demonstration validation was implemented on the current shift for all Dialysis Nurses.	The Leadership Team in Dialysis and members of the Infection Prevention Department conducted training for all dialysis nurses on the set up of the hemodialysis machine. This was completed via direct observation whereby each dialysis nurse completed a return demonstration for the setup of the dialysis machine. Nursing staff on FMLA or LOA will complete the training prior to returning to work.	Through direct observation, a member of the Dialysis Leadership will audit 10 events per week with a monthly aggregate of 40 to validate the proper set up of the dialysis machine. The findings are reported monthly to the Vice President of Patient Care –Medical Surgical, Quality of Care Committee, Medical Executive Committee and	**Responsible Person**: Vice President of Patient Care – Medical Surgical **Completion Date:** 6/09/2019

	A hemodialysis machine pre-treatment preparation competency was updated by the Director of Dialysis to include all steps in the preparation process.	New Employee orientation and annual training for dialysis personnel was updated to include return demonstration training for correct set up of the hemodialysis machine.	quarterly to the Quality Committee of the Board of Trustees (reports quarterly to the Board of Trustees) until 100% is sustained for two consecutive months. Monitoring will continue quarterly on an ongoing basis with findings reported to the above stated committees unless non-compliance is identified whereby monitoring will increase in frequency until compliance is restored.	
A043 (E)	Training materials were created for the expectations of weighing patients' pre and post dialysis and documentation expectations in the electronic medical record per policy "Hemodialysis Treatment –Dialysis".	The Leadership Team in Dialysis conducted training for all nursing staff in Dialysis about the expectations of weighing patients' pre and post dialysis and documentation expectations per policy "Hemodialysis Treatment –Dialysis". This took place across all shifts and practice is reinforced by regular nursing huddles leadership. Training has taken place for all permanent full time and part time nurses and contract nurses in Dialysis. Nursing staff on FMLA or LOA will complete the training prior returning to work. New Employee orientation and annual training for dialysis personnel was updated to include training for expectations of weighing patients' pre and post dialysis per policy "Hemodialysis Treatment –Dialysis".	Ten (10) records are audited per week with a monthly aggregate of 40 by Leadership of Dialysis to review a patient's weight was documented pre and post dialysis. The findings are reported monthly to the Vice President of Patient Care – Medical Surgical, Quality of Care Committee, Medical Executive Committee and quarterly to the Quality Committee of the Board of Trustees (reports quarterly to the Board of Trustees) until 100% is sustained for two consecutive months. Monitoring will continue quarterly on an ongoing basis with findings reported to the above stated committees unless non-compliance is identified whereby monitoring will increase in frequency until compliance is restored.	**Responsible Person**: Vice President of Patient Care – Medical Surgical **Completion Date:** 6/09/2019
A043 (F)	An audit tool was created to visually observe all fall precautions are in place. Training materials were created for the expectations of fall prevention techniques as listed in the "Fall Management - Patient Care" policy. Training materials included reiteration that four side rails being up are not to be used as a fall prevention technique. The Chief Nursing Officer (CNO) conducted a series of meetings with nursing leadership to reiterate the leadership accountability expectations to ensure	Nursing Leadership conducted training for all nursing staff about the expectations of fall prevention techniques as listed in the "Fall Management - Patient Care" policy as well as four side rails being up are not to be used as a fall prevention technique. This took place across all shifts and practice is reinforced by regular nursing huddles leadership. Training has taken place for all permanent full time and part time nurses and contract nurses. Nursing staff on FMLA or LOA will complete the training prior returning to work. New Employee orientation and annual training for nursing personnel was updated to reinforce expectations of fall prevention techniques as listed in the "Fall Management - Patient Care" policy. Training materials includes reiteration that four side rails being	Ten (10) high fall risk patients are visually observed per week with a monthly aggregate of 40 by members of nursing and/or quality to review fall prevention techniques are in place and 4 side rails up are not used as a fall prevention technique. The findings are reported to the CNO and monthly to the Quality of Care Committee, Medical Executive Committee and quarterly to the Quality Committee of the Board of Trustees (reports quarterly to the Board of Trustees) until 100% is sustained for two consecutive months. Monitoring will continue quarterly on an ongoing basis	**Responsible Person**: Chief Nursing Officer **Completion Date:** 6/09/2019

	nursing staff's clinical practices are in alignment with the facility policy "Fall Management - Patient Care"	up are not to be used as a fall prevention technique.	with findings reported to the above stated committees unless non-compliance is identified whereby monitoring will increase in frequency until compliance is restored.	
A043 (G)	Pediatric laryngoscopes were changed to disposable in all Pediatric crash carts. This now allows for 3 blades sizes as well as ensuring the proper handle. Additionally the type of laryngoscopes placed in the pediatric carts no longer requires batteries, rendering them ready for use at all times.	All Pharmacy staff was educated, by the Director of Pharmacy, about the equipment to check on pediatric crash cart. All ED providers, Respiratory and Nursing staff were notified via electronic methods and in person education. Any Pharmacy, ED, Respiratory or nursing staff on FMLA or LOA will be notified prior to returning to work.	Each pediatric crash cart will be checked once a month and after each use by Pharmacy to ensure the pediatric crash carts continue to have disposable laryngoscope blades. The findings are reported monthly to the Quality of Care Committee, Medical Executive Committee and quarterly to the Quality Committee of the Board of Trustees (reports quarterly to the Board of Trustees) until 100% is sustained for two consecutive months. Monitoring will continue quarterly on an ongoing basis with findings reported to the above stated committees unless non-compliance is identified whereby monitoring will increase in frequency until compliance is restored.	**Responsible Person**: Vice President of Operations **Completion Date:** 6/09/2019
A043 (H)	The indications for psychotropic medications were revised to require specific reasons for providers to prescribe and for nursing to administer the medication that was within the scope of practice for nursing and to prohibit the use of "as needed" (PRN) use. The electronic health record was revised to remove the indication "agitation" as a reason to give a psychotropic medication and replaced with specific definitive reasons to for providers to prescribe a psychotropic medication that is now within the scope of nursing practice to assess and administer.	Nursing Leadership conducted training for all nursing staff about chemical restraints and not to administer a psychotropic medication as a PRN, "as needed", medication. This took place across all shifts and practice is reinforced by regular nursing huddles leadership. Training has taken place for all permanent full time and part time nurses and contract nurses. Nursing staff on FMLA or LOA will complete the training prior to returning to work. Pharmacy Leadership conducted training for all pharmacists about the expectations of not verifying a psychotropic medication order unless a specific reason was provided. This took place across all shifts and is reinforced by regular Pharmacy leadership rounding to assess implementation. Training has taken place for all permanent full time and part time pharmacists and contract pharmacists. Pharmacists on FMLA or LOA will complete the training prior returning to work. Credentialed Providers were notified of the process	Ten (10) psychotropic medications are audited per week with a monthly aggregate of 40 by members of pharmacy to review appropriate reasons for psychotropic medications were verified correctly with an appropriate indication. The findings are reported monthly to the Director of Pharmacy, Quality of Care Committee, Medical Executive Committee and quarterly to the Quality Committee of the Board of Trustees (reports quarterly to the Board of Trustees) until 100% is sustained for two consecutive months. Monitoring will continue quarterly on an ongoing basis with findings reported to the above stated committees unless non-compliance is identified whereby monitoring will increase in frequency until compliance is restored.	**Responsible Person**: Chief Medical Officer **Completion Date:** 6/09/2019

		change where specific reasons to prescribe psychotropic medications are required and will not be verified by a pharmacist unless provided which included psychotropic medications cannot be ordered as a PRN, “as needed”. They were provided education related to use of psychotropic medications through one or more of these methods: in-person training, certified letters, online training modules and training at medical staff meetings. New Employee orientation and annual training for pharmacists was updated to include training expectations of the verification process for psychotropic medications. New employee orientation and annual training for nursing was updated to include appropriate indications for chemical restraints. Credentialed Provider orientation was updated to include appropriate indications for psychotropic medications.		
A043 (I)	An electronic report has been created that identifies all psychotropic medications and indications used in the hospital. This is used as triggers to investigate if chemical restraints have been used. Use of chemical restraints has been added to the restraint log which already tracks violent and non-violent restraint usage in the hospital. An audit tool was created that monitors the use of violent restraints including chemical restraints and the effectiveness of psychotropic medications. The audit tool includes review of chemical restraints to include evaluation of nursing staff documenting the patients need for the medication, actions performed to de-escalate or meet the patients' needs before a psychotropic medication administration, effects of the medication, nursing reassessment, vital signs documented after the medication	The Quality Department Leadership provided education to the quality team reviewing restraints about the identification of psychotropic medications as a chemical restraint and the expectations of the audits. Quality Department leadership on FMLA or LOA will complete the training prior returning to work. New Employee orientation for the quality staff has been updated to reflect training on the identification and auditing process for chemical restraints.	All violent and chemical restraints are audited by members of the quality team weekly to review compliance with nursing staff documenting the patients need for the medication, actions performed to de-escalate or meet the patients' needs before a psychotropic medication administration, effects of the medication, nursing reassessment, vital signs documented after the medication administration and a face to face assessment completed within 1 hour of the use of a chemical restraint. The findings are reported monthly to the Vice President of Quality, Quality of Care Committee, Medical Executive Committee and quarterly to the Quality Committee of the Board of Trustees (reports quarterly to the Board of Trustees) until 100% is sustained for two consecutive months. Monitoring will continue quarterly on an ongoing basis with findings reported to the above stated committees unless non-compliance is identified whereby	**Responsible Person**: Vice President of Quality **Completion Date:** 6/09/2019

	administration and a face to face assessment completed within 1 hour of the use of a chemical restraint.		monitoring will increase in frequency until compliance is restored.	
A043 (J)	The indications for psychotropic medications were revised to provide specific reasons for providers to prescribe the medication that was within the scope of practice for nursing to administer and prohibited the use of "as needed" (PRN) use. The electronic health record was revised to remove the indication "agitation" as a reason for the provider to prescribe a psychotropic medication and replaced with specific definitive reasons for nurses to administer a psychotropic medication that is now within the scope of nursing practice to assess and administer.	Nursing Leadership conducted training for all nursing staff about the appropriate indications for chemical restraints. This took place across all shifts and practice is reinforced by regular nursing huddles leadership. Training has taken place for all permanent full time and part time nurses and contract nurses. Nursing staff on FMLA or LOA will complete the training prior returning to work. Pharmacy Leadership conducted training for all pharmacists about the expectations of not verifying a psychotropic medication order unless a specific reason was provided. This took place across all shifts and is reinforced by regular Pharmacy leadership rounding to assess implementation. Training has taken place for all permanent full time and part time pharmacists and contract pharmacists. Pharmacists on FMLA or LOA will complete the training prior returning to work. Credentialed Providers were notified of the process change where specific reasons to prescribe psychotropic medications are required and will not be verified by a pharmacist unless provided. They were provided education related to use of psychotropic medications through one or more of these methods: in-person training, certified letters, online training modules and training at medical staff meetings. New Employee orientation and annual training for pharmacists was updated to include training expectations of the verification process for psychotropic medications. New employee orientation and annual training for nursing was updated to include chemical restraints. Credentialed provider orientation was updated to include appropriate indications for psychotropic medications.	Ten (10) psychotropic medications are audited per week with a monthly aggregate of forty (40) by members of pharmacy to review appropriate reasons for psychotropic medications were verified correctly with an appropriate indication. The findings are reported monthly to the Director of Pharmacy, Quality of Care Committee, Medical Executive Committee and quarterly to the Quality Committee of the Board of Trustees (reports quarterly to the Board of Trustees) until 100% is sustained for two consecutive months. Monitoring will continue quarterly on an ongoing basis with findings reported to the above stated committees unless non-compliance is identified whereby monitoring will increase in frequency until compliance is restored.	**Responsible Person**: Chief Medical Officer **Completion Date:** 6/09/2019
A043 (K)	An electronic report has been created that identifies all psychotropic medications and indications used in the hospital. This is used to identify if a chemical restraint has	Nursing Leadership conducted training for all nursing staff about the appropriate indications chemical restraint, documenting the patients need for the medication, actions performed to de-escalate or meet	All violent and chemical restraints are audited by members of the quality team weekly to review compliance with nursing staff documenting the patients need for	**Responsible Person**: Chief Nursing Officer

	been used. Use of chemical restraints has been added to the restraint log which already tracks violent and non-violent restraint usage in the hospital. An audit tool for the use of violent restraints including chemical restraints and the effectiveness of psychotropic medications was created where by a member of the quality department monitors weekly. The audit tool includes review of chemical restraints to include evaluation of nursing staff documenting the patients need for the medication, actions performed to de-escalate or meet the patients' needs before a psychotropic medication administration, effects of the medication, nursing reassessment, vital signs documented after the medication administration and a face to face assessment completed by a credentialed within 1 hour of the use of a chemical restraint. The "Restraint or Seclusion" policy has been updated to provide guidance on the administration of psychotropic medications and the monitoring of the patients by nursing when a psychotropic medication has been administered as a chemical restraint.	the patients' needs before a psychotropic medication administration, effects of the medication, nursing reassessment, vital signs documented after the medication administration and a face to face assessment completed by a credentialed provider within 1 hour of the use of a chemical restraint. This took place across all shifts and practice is reinforced by regular nursing huddles leadership. Training has taken place for all permanent full time and part time nurses and contract nurses. Nursing staff on FMLA or LOA will complete the training prior returning to work. Credentialed Providers were notified of the process change where specific reasons to prescribe psychotropic medications are required and will not be verified by a pharmacist unless provided. They were provided education related to use of psychotropic medications through one or more of these methods: in-person training, certified letters, online training modules and training at medical staff meetings. New Employee orientation and annual training for pharmacists was updated to include training expectations of the verification process for psychotropic medications. New employee orientation and annual training for nursing was updated to include appropriate indications for chemical restraints. Credentialed provider orientation was updated to include appropriate indications for psychotropic medications.	the medication, actions performed to de-escalate or meet the patients' needs before a psychotropic medication administration, effects of the medication, nursing reassessment, vital signs documented after the medication administration and a face to face assessment completed by a credentialed provider within 1 hour of the use of a chemical restraint. The findings are reported monthly to the Chief Nursing Officer, Quality of Care Committee, Medical Executive Committee and quarterly to the Quality Committee of the Board of Trustees (reports quarterly to the Board of Trustees) until 100% is sustained for two consecutive months. Monitoring will continue quarterly on an ongoing basis with findings reported to the above stated committees unless non-compliance is identified whereby monitoring will increase in frequency until compliance is restored.	**Completion Date:** 6/09/2019
A043 (L)	Employees with tenure, who did not have a background check completed and at that time were not required, had a background check screening completed. Ongoing compliance is monitored through OIG sanctions, General Services Administration's System for Award Management (SAM) and Medicaid exclusion report monthly. Our Corporate	Human Resources Leadership conducted educational training for all human resources staff about the policies for "Screening for Excluded Providers" and "Applicant Background Checks" as well as their responsibility to act upon a positive match if the monthly corporate OIG, SAM, and Medicaid exclusion report showed an employee on the list. Training has taken place for all permanent full time, part time and contract Human Resources staff. Human Resources staff on FMLA or LOA will complete the training prior	All incoming new employees will have a background check completed and the OIG, SAM, and Medicaid exclusion report will be ran monthly with all positive matches investigated. Monthly compliance of this process will be checked by the Director of Human Resources. The findings are reported monthly to the Director of Human Resources, Quality of Care Committee,	**Responsible Person**: Director of Human Resources **Completion Date:** 6/09/2019

	Responsibility Policy No. 3 "Screening for Excluded Providers" indicates that all facility employees are screened for OIG sanctions, SAM, and Medicaid exclusion monthly. If an individual is identified by our Corporate Responsibility team through the OIG reporting process, further analysis is completed per the "Screening for Excluded Providers" policy.	to returning to work. New Employee orientation for human resources staff was updated to include review of the policies for "Screening for Excluded Providers" and "Applicant Background Checks".	Medical Executive Committee and quarterly to the Quality Committee of the Board of Trustees (reports quarterly to the Board of Trustees) until 100% is sustained for two consecutive months. Monitoring will continue quarterly on an ongoing basis with findings reported to the above stated committees unless non-compliance is identified whereby monitoring will increase in frequency until compliance is restored.	
A043 (M)	Training materials were created for the reinforcement that the use of four side rails is considered a restraint, is not an appropriate method for fall prevention and must be used in conjunction with a physician order in accordance with the current "Restraint and Seclusion" policy. The fall prevention audit tool was updated to include visualization 4 side rails are not up as fall prevention or utilized without following the restraint guidelines per the hospital's policy "Restraint and Seclusion".	Nursing Leadership conducted training for all nursing staff about the expectations that the use of four side rails is not to be used as a fall prevention technique. This took place across all shifts and practice is reinforced by regular nursing huddles leadership. Training has taken place for all permanent full time and part time nurses and contract nurses. Nursing staff on FMLA or LOA will complete the training prior to returning to work. New Employee orientation and annual training for nursing personnel was updated to reinforce training for expectations within the "Restraint and Seclusion" Policy. Training materials include reiteration that four side rails being up are not to be used as a fall prevention technique.	Ten (10) high fall risk patients are visually observed per week with a monthly aggregate of 40 by members of nursing and/or quality to review four side rails up are not used as a fall prevention technique. The findings are reported monthly to the Chief Nursing Officer, Quality of Care Committee, Medical Executive Committee and quarterly to the Quality Committee of the Board of Trustees (reports quarterly to the Board of Trustees) until 100% is sustained for two consecutive months. Monitoring will continue quarterly on an ongoing basis with findings reported to the above stated committees unless non-compliance is identified whereby monitoring will increase in frequency until compliance is restored.	**Responsible Person**: Chief Nursing Officer **Completion Date:** 6/09/2019
A043 (N)	The hospital's quality management structure has been updated to create a new committee, Quality Outcomes Committee, which is now responsible for coordinating, implementing, and monitoring effective Performance improvement (PI) activities across departments. This committee is chaired by the Chief Medical Officer and the Chief Nursing Officer. Each department has identified performance improvement metrics.	The Quality Outcomes Committee membership has been educated on their roles and responsibilities by a member of the Quality Department Leadership Team. The Hospital Management Council has been oriented to the updated new quality management structure and the expectations of their participation, accountability and engagement in the quality management program of the hospital. New employee orientation has been updated for members in Quality Leadership which includes requirements of the quality management structure	The Quality Outcomes Committee will meet at minimum six times per year with minutes reflecting performance improvement reports and discussions demonstrating the responsibility of coordinating, implementing, and monitoring Performance improvement (PI) was effective. This Committee reports to the Quality of Care Committee, Medical Executive Committee, and the Quality Committee of the Board of Trustees (reports quarterly to the Board	**Responsible Person**: Vice President of Quality **Completion Date:** 6/09/2019

	The Quality Outcomes Committee's charter has been approved by the Quality of Care Committee, Medical Executive Committee and the Board of Trustees Quality Sub-Committee.	and responsibility of coordinating, implementing, and monitoring Performance improvement (PI) is effective.	of Trustees) (reports quarterly to the Board of Trustees).	
A043 (O)	The current surgical count audits that review the process to prevent a retained foreign body were incorporated into the Patient Safety Committee reporting oversight structure. The Patient Safety Committee is a newly chartered committee that reports to the Quality of Care Committee. The Tier huddle approach process has been updated to aggregate trends and report to the Quality Outcomes Committee (newly chartered committee that reports to the Quality of Care Committee). Environmental rounds have been implemented to identify areas in need of repair. Weekly rounds are conducted per the rounding schedule (all patient care areas twice per calendar year and non-patient care areas at least annually) A schedule of environmental rounds has been completed for each area of the hospital. Environmental rounds will be completed in conjunction with infection prevention to identify any ongoing maintenance repairs and infection control concerns.	The Patient Safety Committee members were provided education on their role with the surgical count audit monitoring process. The Quality Outcomes Committee members were provided education on their role the review of trends from the Tier Huddle approach. The Quality Management staff responsible for the data aggregation and reporting has been provided education by the Quality Department Leadership on the process changes and expectations. New employee orientation has been updated for the quality management staff on the process changes and expectations for trending and reporting surgical count audits and the tier huddle approach. The Hospital Safety Officer has given training to all primary and secondary Environment of Care (EOC) surveyors on the expectations for EOC rounds which included rounding, reporting, communicating and correcting of deficiencies. The Hospital Safety Officer acting as the EOC Committee Chair, reinforced with the Committee and EOC surveyors the expectations completing environmental rounds weekly as per the rounding schedule. New employees conducting EOC rounds will be educated by the Hospital Safety Department prior to completing an EOC round. Applicable staff on FMLA or LOA will complete the training prior to returning to work.	The Quality Outcomes Committee will meet at minimum six times per year with minutes reflecting the tracking and trending of the tier huddle approach. This Committee reports to the Quality of Care Committee, Medical Executive Committee, and the Quality Committee of the Board of Trustees (reports quarterly to the Board of Trustees). The Patient Safety Committee will meet at minimum six times per year with minutes reflecting tracking and trending of the current surgical count audits. Environment of Care Program weekly environmental rounds are completed per the rounding schedule. Results of the rounds and action items for gaps will be aggregated weekly and reported to the monthly to the Vice President of Operations and reported quarterly to the Environment of Care and Safety Committee, Quality of Care Committee, Medical Executive Committee and Quality Committee of the Board of Trustees (reports quarterly to the Board of Trustees). Monitoring will continue quarterly on an ongoing basis with findings reported to the above stated committees unless non-compliance is identified whereby monitoring will increase in frequency until compliance is restored.	**Responsible Person**: Vice President of Quality **Completion Date:** 6/09/2019
A043 (P)	The hospital's quality management structure has been updated to create a new committee, Quality Outcomes	The Quality Outcomes Committee membership has been educated on their roles and responsibilities by a member of the Quality Department Leadership Team.	The Quality Outcomes Committee will meet at minimum six times per year with minutes reflecting performance	**Responsible Person**: Vice President of

	Committee, which is responsible for coordinating, implementing, and monitoring Performance improvement (PI) activities across departments is effective. This committee is chaired by the Chief Medical Officer and the Chief Nursing Officer. Each department has identified performance improvement metrics. Department reports will include dietary services, contracted services, infection control, surgical services and pharmacy services. The Committee's charter has been approved by the Quality of Care Committee, Medical Executive Committee and the Board of Trustees Quality Sub-Committee. The Tier huddle approach is evaluated by Senior Leadership monthly with data aggregated and reported to the Quality Outcomes Committee quarterly. The "Controlled Drug Systems and Accountability" policy and procedure was developed and implemented. This policy established a Diversion Prevention Committee who has oversight of the diversion prevention program. The policy addresses diversion prevention, detection and reporting, access, procurement, receiving, secured storage, preparation, distribution and dispensing, administration, waste and returns, discrepancies, and quality assurance reporting. The policy has been approved by Pharmacy and Therapeutic Committee and Medical Executive Committee. A risk assessment was completed with the findings used to develop diversion prevention strategies for reconciling	New employee orientation has been updated for members in Quality Leadership which includes requirements of the quality management structure and responsibility of coordinating, implementing, and monitoring Performance improvement (PI) was effective. The Infection prevention staff were educated by the Director of Infection Prevention the processes to monitor, track and trend the following for the prevention of infections to include Chlorhexidine bathing preoperatively, Nasal decolonization, High level disinfecting- sterilization of equipment, Ultrasound transducers, Transportation of equipment, Equipment cleaning and competencies, and use of durable medical equipment. Nursing Leadership conducted educational training for all nursing staff about the expectations of following the administration of narcotics, preventing diversion and recognizing and reporting diversion in accordance with policy the "Controlled Drug Systems and Accountability". This took place across all shifts and practice is reinforced by regular nursing huddles leadership. Training has taken place for all permanent full time and part time nurses and contract nurses. Nursing staff on FMLA or LOA will complete the training prior returning to work. Pharmacy Leadership conducted educational training for all pharmacists about the expectations of following the administration of narcotics, preventing diversion and recognizing and reporting diversion in accordance with policy the "Controlled Drug Systems and Accountability". This took place across all shifts and is reinforced by regular Pharmacy leadership rounding to assess implementation. Training has taken place for permanent full time and part time pharmacists and contract pharmacists. Pharmacists on FMLA or LOA will complete the training prior returning to work. Credentialed Anesthesia Providers were notified of the	improvement reports and discussions demonstrating the responsibility of coordinating, implementing, and monitoring Performance improvement (PI) was effective as well as a report of the senior leadership rounds and evaluation of the effectiveness of the tier huddle approach. Department reports will include dietary services, contracted services, infection control, surgical services and pharmacy services. This Committee reports to the Quality of Care Committee, Medical Executive Committee, and the Quality Committee of the Board of Trustees (reports quarterly to the Board of Trustees). On an ongoing basis as part of the Infection Prevention Program the following is monitored, tracked and trended with outcomes and action plans for gaps reported at the Infection Prevention and Control Committee at minimum 4 times per year Chlorhexidine bathing preoperatively, Nasal decolonization, High level disinfecting-sterilization of equipment, Ultrasound transducers, Transportation of equipment, Equipment cleaning and competencies, and use of durable medical equipment. Once a week the Kirby Glen Pharmacy Team will audit the transportation and cleaning procedures of chemotherapy drugs with a monthly aggregate of four observations. The findings are reported monthly to the Director of Pharmacy, Quality of Care Committee, Medical Executive Committee and quarterly to the Quality Committee of the Board of Trustees (reports quarterly to the Board of Trustees) until 100% is sustained for	Quality **Completion Date:** 6/09/2019

	inventory of controlled substances, appropriately disposing of controlled substance waste, use of lock boxes and portless tubing to prevent diversion of IV narcotic infusions and controlling access to medication storage areas. Pharmacy Leadership implemented a process to generate a daily report to identify unresolved discrepancies and a report to monitor weekly inventory count. Approved controlled substance waste containers were installed in the hospital to include all off site locations. A charter was created for the Diversion Prevention Committee, comprised of members of the Senior Leadership Committee and Pharmacy Leadership, that outlines the purpose, scope, membership, responsibilities, meeting frequency, and reporting structure. The Diversion Prevention Committee reports to the Pharmacy and Therapeutic Committee of the Hospital. The expectations for evaluating the following items was reinforced by the Vice President of Quality with the current Infection Prevention Leadership. The following items are now being tracked and trended for the prevention of infections to include Chlorhexidine bathing preoperatively, nasal decolonization, high level disinfecting- sterilization of equipment, ultrasound transducers, transportation of equipment, equipment cleaning and competencies, and use of durable medical equipment. Methods and processes to monitor, track and trend the above items were developed and implemented by the Director of Infection	expectations of following the administration of narcotics, preventing diversion and recognizing and reporting diversion in accordance with policy the "Controlled Drug Systems and Accountability". They were provided education through one or more of these methods: in-person training, certified letters, online training modules and discussion at medical staff meetings. New Employee orientation and annual training for members of the medical staff, pharmacists, and nurses has been updated to reinforce the expectations of following the administration of narcotics, preventing diversion and recognizing and reporting diversion in accordance with policy the "Controlled Drug Systems and Accountability". The charter for the Diversion Prevention Committee was reviewed at the initial committee meeting to inform committee members of their responsibilities. Affected pharmacy, nursing and anesthesia staff were educated regarding requirements for daily resolution of discrepancies and weekly inventory counts. This education was reinforced through huddles, e-mail communication, leadership rounding, and feedback from quality monitoring to ensure compliance. New employee orientation and annual training for Pharmacy, Nursing and Anesthesia staff was revised to include training on discrepancy resolution and weekly inventory processes. Affected staff was educated on the use of the approved controlled waste medication containers through onsite education provided by the contracted company. Additionally a one-page flyer from the contracted company was laminated and placed in all applicable departments for quick reference. This flyer was reviewed in huddles and leadership rounds to validate staff knowledge of the information.	two consecutive months. Monitoring will continue quarterly on an ongoing basis with findings reported to the above stated committees unless non-compliance is identified whereby monitoring will increase in frequency until compliance is restored. A report is generated daily by the Pharmacy to identify unresolved discrepancies. Unresolved discrepancies are reported to the appropriate leader for corrective action. Monthly aggregate data and trends are reported on an ongoing basis to the Diversion Prevention Committee, Director of Pharmacy, CNO quarterly to the Pharmacy and Therapeutics Committee, Patient Safety Committee, Quality of Care Committee, Medical Executive Committee and Quality Committee of the Board of Trustees (reports quarterly to the Board of Trustees). Weekly inventory counts for each electronic medication dispensing machine are performed by nursing staff. Compliance with weekly inventory counts is monitored by the Pharmacy staff and noncompliance is reported to unit leadership for investigation and follow-up. Monthly aggregate and trends will be reported on an ongoing basis to the Diversion Prevention Committee, Director of Pharmacy, CNO and quarterly to the Pharmacy and Therapeutics Committee, Quality of Care Committee, Medical Executive Committee and Quality Committee of the Board of Trustees (reports quarterly to the Board of Trustees). Compliance with the use of the approved	

	Prevention.		controlled substance medication waste containers is monitored through the weekly environment of safety rounds. Ten (10) rounds will be completed per week with a monthly aggregate of forty (40) by members of Hospital Leadership to assesses staff knowledge of the use of the containers and the presence of the containers in the area. Results are aggregated and reported weekly to the Pharmacy Director, CNO and quarterly to the P&T Committee, Quality of Care Committee, Medical Executive Committee and quarterly to the Quality Committee of the Board of Trustees (reports quarterly to the Board of Trustees) until 100% is sustained for two consecutive months. Monitoring will continue quarterly on an ongoing basis with findings reported to the above stated committees unless non-compliance is identified whereby monitoring will increase in frequency until compliance is restored.	
A043 (Q)	Electronic temperature track system has been installed on all freezers and refrigerators. The notification when temperatures are out of range are being directed to the Facilities Leadership and Dietary Services Leadership The "Refrigerator and Freezer Monitoring – Patient Care" policy was updated to reflect the correct way to move/dispose of food when the refrigerator or freezer are out of range. Cooler 68 was removed from service with signage placed as well as a lock to signify it is not in use. The equipment parts have been ordered and will be repaired upon arrival of replacement parts.	Dietary staff received education each shift until all were notified of Cooler 68 no longer available for use and any temperature out of range is reported to Facilities immediately. Dietary staff on FMLA or LOA will complete the training prior to returning to work.	On an ongoing basis, a member of the Dietary staff manually checks temperatures twice a day for all refrigerators and freezers. In addition each refrigerator is temperature monitored electronically by Facilities. Any temperature out of range is reported to Facilities immediately in accordance with policy "Refrigerator and Freezer Monitoring – Patient Care". Daily a member of the Dietary Leadership staff inspects the completion of this requirement and that actions were taken if the temperature was out of the acceptable range. Monthly compliance is reported to the Vice President of Operations and quarterly to the Environment of Care and Safety Committee, Quality of Care Committee, Medical Executive Committee and the	**Responsible Person**: Vice President of Operations **Completion Date:** 6/09/2019

			Quality Committee of the Board of Trustees (reports quarterly to the Board of Trustees). Monitoring will continue quarterly on an ongoing basis with findings reported to the above stated committees unless non-compliance is identified whereby monitoring will increase in frequency until compliance is restored.	
A043 (R)	The dishwasher and the pot washer were immediately removed from service. Facilities placed a sign indicating both pieces of equipment were out of commission awaiting repair. Use of disposable dishware and serving containers was immediately implemented. A three-sink station for manually cleaning and sanitizing of non-disposable wash pots and skillets was implemented. A real time audit tool checklist was utilized to observe staff performing cleaning and sanitizing The Facilities work ticket prioritization process has been reviewed, updated and approved by the hospital Chief Operations Officer (COO). Open maintenance logs for the kitchen have been reviewed and prioritized for high risk areas with response times identified. Maintenance has created a report that tracks priority of work orders and response time. Facilities Leadership is sending a weekly report to the Vice President of Operations, the Chief Financial Officer (CFO) and Chief Operations Officer (COO). An external company was contracted to complete an assessment of all kitchen	The Operations Manager of Nutrition Services provided training starting with the current shift and was continued each shift until all Dietary staff were trained on the manual cleaning process. Members of the leadership team for Facilities has been educated on expectations for priority of work orders and timeframes of response by the Chief Operations Officer and Division Director of Facilities. Facility Staff were educated by Facilities Leadership on the operational requirements for the exhaust serving the facility's two large mechanical dish washers. Facility staff on FMLA or LOS will complete the training prior to return to work. New employee orientation Facilities staff was revised to include training on the operational requirements for the exhaust serving the facility's two large mechanical dish washers.	Infection Prevention and Chief Operations Officer (COO) visually confirmed the dishwasher and pot washer have been identified as nonoperational. The pot washer parts were sourced Repair services contracted by the hospital completed the repair of the dishwasher. Infection Prevention and the COO confirmed the equipment was repaired and properly functioning prior to resuming operations. A member of the Quality or Infection Prevention team conducted direct observations three times a shift of the manual cleaning process to ensure it has been completed correctly per the standard operating procedure. Three times a shift 30 utensils, pots or pans manually washed were inspected by a member of the of Quality or Infection Prevention team to ensure they are free from debris. This audit continued until the dishwasher and the pot washer was fully functional. Currently open maintenance work orders are reviewed weekly for appropriate classification, response time and completion by Senior Leadership. Weekly the data is aggregated and reported to the Vice President of Operations to identify trends and develop action plans. Quarterly reports are provided to the	**Responsible Person**: Vice President of Operations **Completion Date:** 6/09/2019

	equipment has been completed which includes the proper categorization of equipment, operational functionality and physical condition, work order history review, recommendation of repair, and recommendation of replacement. All work orders submitted by the kitchen for the past three months were reviewed and issues involving repairs were identified. All identified items are in process of being repaired. The Hospital CFO and COO have met with the contracted dietary services to evaluate the effectiveness of the contracted service. The contracted service's performance improvement indicator list was update to track specific performance indicators as noted in the contract. An external company has been contracted to conduct an evaluation of dietary services. The Exhaust Fans for facility's two large mechanical dish washers were added to a facility rounding log to be completed daily. Signage has been placed on designated equipment as not in use Dietary staff received education each shift until all were notified that the equipment was not in use. The organization notified hospital leadership and staff of the use of disposable dishware until further notice. Patients were notified of the use of disposable dishware by a letter attached to their meal tray during the timeframe of repairs being made.		Quality of Care Committee, Medical Executive Committee, and the Quality Committee of the Board of Trustees (reports quarterly to the Board of Trustees). All kitchen work orders are audited weekly to review appropriate prioritization, work quality, documentation and timeliness of response until 100% compliance is sustained for two consecutive months. When compliance is sustained the auditing process will be reviewed through the 50 random audits per week process. Weekly, facility wide 50 random work orders are audited to review appropriate prioritization, work quality, documentation and timeliness of response on an ongoing basis. The findings are reported monthly to the Vice President of Operations and reported quarterly to the Environment of Care and Safety Committee, Quality of Care Committee, Medical Executive Committee and quarterly to the Quality Committee of the Board of Trustees (reports quarterly to the Board of Trustees) until 100% is sustained for two consecutive months. Monitoring will continue quarterly on an ongoing basis with findings reported to the above stated committees unless non-compliance is identified whereby monitoring will increase in frequency until compliance is restored. Weekly the daily rounding logs compliance is aggregated and reviewed by the Facilities Leadership. The findings are reported monthly to the Quality of Care Committee, Medical Executive Committee and quarterly to the Quality	

			Committee of the Board of Trustees (reports quarterly to the Board of Trustees) until 100% is sustained for two consecutive months. Monitoring will continue quarterly on an ongoing basis with findings reported to the above stated committees unless non-compliance is identified whereby monitoring will increase in frequency until compliance is restored.	
A043 (S)	A Contracted Company was obtained to assess all sewer pipes in the kitchen Sewer pipes were snaked and blockages removed. An assessment of the sewer pipes was completed. A construction plan was created and implemented with sewer pipe sections needing repair completed. All work orders submitted by the kitchen for the past three months were reviewed and issues involving repairs were identified. All identified items are in process of being repaired. Open maintenance logs for the kitchen have been reviewed and prioritized for high risk areas with response times identified. Maintenance has created a report that tracks priority of work orders and response time. Facilities Leadership is sending a weekly report to the Vice President of Operations, the CFO and the COO. Facilities has implemented a standard operating procedure (SOP) for any drain issues in the kitchen. The SOP includes escalation steps for after hours and weekends as well as the sequence of drain	All Dietary staff was provided education by a Leader in Facilities regarding the daily maintenance of the sewer pipes and how to escalate concerns. All Facilities staff was provided education by the Director of Facilities regarding the expectations for responding to the kitchen work orders or requests. Education was provided to the facility staff by the Facility Leadership on the implemented standard operating procedure (SOP) for any drain issues in the kitchen which includes escalation steps for after hours and weekends as well as the sequence of drain treatment per manufacturer recommendations. Facilities staff on FMLA or LOA will complete the training prior to returning to work. New employee orientation Facilities staff was revised to include training on the standard operating procedure (SOP) for any drain issues in the kitchen which includes escalation steps for after hours and weekends as well as the sequence of drain treatment per manufacturer recommendations.	Weekly a member of the Dietary staff inspects the drains for visible blockages. If blockages are identified Facilities is immediately notified and a work order placed. Daily a member of the Facilities staff uses an approved biodegradable solution to pour down the drains to keep blockages from occurring. This continued until the pipes have been repaired and a preventative maintenance schedule was implemented. A member of the Facilities Team is inspecting the Kitchen drains for visible blockages two times per shift. This continued until the pipes were repaired and a preventative maintenance schedule was implemented. Audits are completed three times a week by members of the Infection Prevention or Quality Team to include direct observations of cleanliness of pots/pans, equipment working properly, and infection control practices are in place until 100% compliance achieved. Results are provided monthly to the Dietary Leadership and Vice President of Operations and quarterly to the Environment of Care Committee, Quality of Care Committee, Medical Executive	**Responsible Person**: Vice President of Operations **Completion Date:** 6/09/2019

	treatment per manufacturer recommendations.		Committee, and Quality Committee of the Board of Trustees (reports quarterly to the Board of Trustees). Monitoring will continue quarterly on an ongoing basis with findings reported to the above stated committees unless non-compliance is identified whereby monitoring will increase in frequency until compliance is restored. Currently open maintenance work orders are reviewed weekly for appropriate classification, response time and completion by Senior Leadership. Weekly the data is aggregated and reported to the Vice President of Operations to identify trends and develop action plans. Quarterly reports are provided to the Environment of Care Committee, Quality of Care Committee, Medical Executive Committee and the Quality Committee of the Board of Trustees (reports quarterly to the Board of Trustees). All kitchen work orders are audited weekly to review appropriate prioritization, work quality, documentation and timeliness of response until 100% compliance is sustained for two consecutive months. When compliance is sustained the auditing process will be reviewed through the 50 random audits per week process. Monitoring will continue quarterly on an ongoing basis with findings reported to the above stated committees unless non-compliance is identified whereby monitoring will increase in frequency until compliance is restored. Weekly, facility wide 50 random work orders are audited to review appropriate	

			prioritization, work quality, documentation and timeliness of response on an ongoing basis. The findings are reported monthly to the Vice President of Operations and reported quarterly to the Environment of Care and Safety Committee, Quality of Care Committee, Medical Executive Committee and quarterly to the Quality Committee of the Board of Trustees (reports quarterly to the Board of Trustees) until 100% is sustained for two consecutive months. Monitoring will continue quarterly on an ongoing basis with findings reported to the above stated committees unless non-compliance is identified whereby monitoring will increase in frequency until compliance is restored.	
A043 (T)	The dishwasher and the pot washer were immediately removed from service. Facilities placed a sign indicating both pieces of equipment were out of commission awaiting repair. Use of disposable dishware and serving containers was immediately implemented. A three-sink station for manually cleaning and sanitizing of non-disposable wash pots and skillets was implemented. A real time audit tool checklist was utilized to observe staff performing cleaning and sanitizing The Facilities work ticket prioritization process has been reviewed and approved by the hospital COO. Open maintenance logs for the kitchen have been reviewed and prioritized for high risk areas with response times identified. Maintenance has created a report that	The Operations Manager of Nutrition Services provided training starting with the current shift and was continued each shift until all Dietary staff were trained on the manual cleaning process. Members of the leadership team for Facilities has been educated on expectations for priority of work orders and timeframes of response by the Chief Operations Officer and Division Director of Facilities. Staff on FMLA or LOA will complete the training prior to returning to work. New employee orientation Facilities Management staff was revised to include training on the expectations for priority of work orders and timeframes of response.	Infection Prevention and Chief Operations Officer (COO) visually confirmed the dishwasher and pot washer have been identified as nonoperational. The pot washer parts sourced. Repair services contracted by the hospital completed the repair of the dishwasher. Infection Prevention and the COO confirmed the equipment was repaired and properly functioning prior to resuming operations. A member of the Quality or Infection Prevention team conducted direct observations three times a shift of the manual cleaning process to ensure it has been completed correctly per the standard operating procedure. Three times a shift 30 utensils, pots or pans manually washed were inspected by a member of the of Quality or Infection Prevention team to ensure they are free from debris. This audit continued until the dishwasher and the pot washer was fully functional.	**Responsible Person**: Vice President of Operations **Completion Date:** 6/09/2019

	tracks priority of work orders and response time. Facilities Leadership is now sending a weekly report to the Vice President of Operations, the CFO and the COO. An external company was contracted to complete an assessment of all kitchen equipment has been completed which includes the proper categorization of equipment, operational functionality and physical condition, work order history review, recommendation of repair, and recommendation of replacement. All work orders submitted by the kitchen for the past three months were reviewed and issues involving repairs were identified. All identified items are in process of being repaired. The Hospital CFO and COO have met with the contracted dietary services to evaluate the effectiveness of the contracted service. The contracted services PI indicator list was updated to track specific performance indicators as noted in the contract. An external company has been contracted to conduct an evaluation of dietary services. Signage has been placed on designated equipment as not in use. Dietary staff received education each shift until all were notified the equipment was not in use. The organization notified hospital leadership and staff of the use of disposable dishware until further notice. Patients were notified of the use of disposable dishware by a letter attached to their meal tray during the timeframe of		Currently open maintenance work orders are reviewed weekly for appropriate classification, response time and completion by Senior Leadership. Weekly the data is aggregated and reported to the Vice President of Operations to identify trends and develop action plans. Quarterly results are reported to the Environment of Care Committee, Quality of Care Committee, Medical Executive Committee and the Quality Committee of the Board of Trustees (reports quarterly to the Board of Trustees). All kitchen work orders are audited weekly to review appropriate prioritization, work quality, documentation and timeliness of response until 100% compliance is sustained for two consecutive months. When compliance is sustained the auditing process will be reviewed through the 50 random audits per week process. Weekly, facility wide 50 random work orders are audited to review appropriate prioritization, work quality, documentation and timeliness of response on an ongoing basis. The findings are reported monthly to the Vice President of Operations and reported quarterly to the Environment of Care and Safety Committee, Quality of Care Committee, Medical Executive Committee and quarterly to the Quality Committee of the Board of Trustees (reports quarterly to the Board of Trustees) until 100% is sustained for two consecutive months. Monitoring will continue quarterly on an ongoing basis with findings reported to the above stated committees unless non-compliance is identified whereby	

	repairs being completed.		monitoring will increase in frequency until compliance is restored.	
A043 (U)	A Contracted Company was obtained to assess all sewer pipes in the kitchen Sewer pipes were snaked and blockages removed. An assessment of the sewer pipes was completed. A construction plan was created and implemented with sewer pipe sections needing repair completed. All work orders submitted by the kitchen for the past three months were reviewed and issues involving repairs were identified. All identified items are in process of being repaired. Open maintenance logs for the kitchen have been reviewed and prioritized for high risk areas with response times identified. Maintenance has created a report that tracks priority of work orders and response time. Facilities Leadership is sending a weekly report to the Vice President of Operations, the CFO and the COO. Facilities has implemented a standard operating procedure (SOP) for any drain issues in the kitchen. The SOP includes escalation steps for after hours and weekends as well as the sequence of drain treatment per manufacturer recommendations.	All Dietary staff was provided education by a Leader in Facilities regarding the daily maintenance of the sewer pipes and how to escalate concerns. All Facilities staff was provided education by the Director of Facilities regarding the expectations for responding to the kitchen work orders or requests. New Employee orientation for facilities personnel was updated to reinforce the expectations for responding to kitchen work orders or requests. Education was provided to the facility staff by the Facility Leadership on the implemented standard operating procedure (SOP) for any drain issues in the kitchen which includes escalation steps for after hours and weekends as well as the sequence of drain treatment per manufacturer recommendations. Staff on FMLA or LOA will complete the training prior to returning to work.	Weekly a member of the Dietary staff inspects the drains for visible blockages. If blockages are identified Facilities is immediately notified and a work order placed. Daily a member of the Facilities staff uses an approved biodegradable solution to pour down the drains to keep blockages from occurring. This continued until the pipes were repaired and a preventative maintenance schedule was implemented. A member of the Facilities Team is inspecting the Kitchen drains for visible blockages two times per shift. This continued until the pipes were repaired and a preventative maintenance schedule was implemented. Currently open maintenance work orders are reviewed weekly for appropriate classification, response time and completion by Senior Leadership. Weekly the data is aggregated and reported to the Vice President of Operations to identify trends and develop action plans. Quarterly, results are provided to the Environment of Care Committee, Quality of Care Committee, Medical Executive Committee and the Quality Committee of the Board of Trustees (reports quarterly to the Board of Trustees). All kitchen work orders are audited weekly to review appropriate prioritization, work quality, documentation and timeliness of response until 100% compliance is sustained for two consecutive months. When compliance is sustained the	**Responsible Person**: Vice President of Operations **Completion Date:** 6/09/2019

			auditing process will be reviewed through the 50 random audits per week process. Weekly, facility wide 50 random work orders are audited to review appropriate prioritization, work quality, documentation and timeliness of response on an ongoing basis. The findings are reported monthly to the Vice President of Operations and reported quarterly to the Environment of Care and Safety Committee, Quality of Care Committee, Medical Executive Committee and quarterly to the Quality Committee of the Board of Trustees (reports quarterly to the Board of Trustees) until 100% is sustained for two consecutive months. Monitoring will continue quarterly on an ongoing basis with findings reported to the above stated committees unless non-compliance is identified whereby monitoring will increase in frequency until compliance is restored.	
A043 (V)	Environmental rounds have been implemented to identify areas in need of repair. Weekly rounds are conducted per the rounding schedule (all patient care areas twice per calendar year and non-patient care areas at least annually) A schedule of environmental rounds has been completed for each area of the hospital. Environmental rounds will be completed in conjunction with infection prevention to identify any ongoing maintenance repairs and infection control concerns.	The Hospital Safety Officer has given training to all primary and secondary Environment of Care (EOC) surveyors on the expectations for EOC rounds which included rounding, reporting, communicating and correcting of deficiencies. The Hospital Safety Officer acting as the EOC Committee Chair, reinforced with the Committee and EOC surveyors the expectations completing environmental rounds weekly as per the rounding schedule. Applicable staff on FMLA or LOA will complete the training prior to returning to work. New employees conducting EOC rounds will be educated by the Hospital Safety Department prior to completing an EOC round.	On an ongoing basis as part of the Environment of Care Program weekly environmental rounds are completed per the rounding schedule. Results of the rounds and action items for gaps will be aggregated weekly and reported to the monthly to the Vice President of Operations and reported quarterly to the Environment of Care and Safety Committee, Quality of Care Committee, Medical Executive Committee and Quality Committee of the Board of Trustees (reports quarterly to the Board of Trustees). Monitoring will continue quarterly on an ongoing basis with findings reported to the above stated committees unless non-compliance is identified whereby monitoring will increase in frequency until compliance is restored.	**Responsible Person**: Vice President of Operations **Completion Date:** 6/09/2019

A043 (W)	The power strips for the use on moveable equipment in the Cath Lab have been corrected by properly securing the re-locatable power strip to the equipment with clinical engineering following with a risk assessment using the requirements in NFPA 99 as a guide. The exposed wires were repaired in OR 6 and OR 11. The blanket warmer was identified and a daily log was generated for the equipment. The environment of care rounds includes looking for unsecured power strips and exposed wires.	The Cath Lab and OR Leadership at the Fannin Location were provided education by Facilities Leadership on how to identify when a power strip needs to be secured and identification of exposed wires. They were also educated to place a work order ticket if either has been identified. The Facilities Maintenance staff conducting environment of care rounds were provided education by Facilities Leadership about the expectations to look for unsecured power strips and exposed wires as well as to place a work order ticket if either of the above were found. The Cath Lab Staff were provided education by Cath Lab Leadership on the new daily log requirement for the blanket warmer. New Employee orientation for facilities staff was updated to reinforce the expectations conducting environmental rounds. New Employee orientation for Cath Lab staff was updated to reinforce the expectations completing the blanket warmer temperature log daily. Affected Staff on FMLA or LOA will complete the training prior to returning to work.	On an ongoing basis as part of the Environment of Care Program weekly environmental rounds are completed per the rounding schedule. Results of the rounds and action items for gaps will be aggregated weekly and reported to the monthly to the Vice President of Operations and reported quarterly to the Environment of Care and Safety Committee, Quality of Care Committee, Medical Executive Committee and Quality Committee of the Board of Trustees (reports quarterly to the Board of Trustees). Monitoring will continue quarterly on an ongoing basis with findings reported to the above stated committees unless non-compliance is identified whereby monitoring will increase in frequency until compliance is restored. On an ongoing basis, a member of the Cath Lab staff checks the temperature of the blanket warmer daily. Any temperature out of range is reported to facilities. Weekly a member of the Cath Lab Leadership inspects the completion of this requirement. Monthly compliance is aggregated and reported to the Vice President of CV Services, Quality of Care Committee, Medical Executive Committee and Quality Committee of the Board of Trustees (reports quarterly to the Board of Trustees). Monitoring will continue quarterly on an ongoing basis with findings reported to the above stated committees unless non-compliance is identified whereby monitoring will increase in frequency until compliance is restored.	**Responsible Person**: Vice President of Operations **Completion Date:** 6/09/2019
A043 (X)	Kirby Glen has been provided the correct chemo spill clean-up kit.	The Kirby Glen staff were provided education by Facilities Leadership about the safe use of the chemo spill kits and the proper cleaning of equipment after	Once a week mock drills will be conducted with the Kirby Glen staff to evaluate the proper handling of the	**Responsible Person**: Vice President of

	Training was implemented for the Kirby Glen staff on the proper cleaning of equipment after contamination with chemotherapy drugs in accordance with policy "Handling and Disposal of Hazardous Materials". New red containers that are dedicated to chemotherapy transport were purchased Kirby Glen. Blue containers were purchased for the transport of non-chemotherapy medications. Instructional materials were developed to demonstrate how to clean all transportation bins and ice packs in accordance with policy "Handling and Disposal of Hazardous Materials".	contamination with chemotherapy drugs in accordance with policy "Handling and Disposal of Hazardous Materials" New Employee orientation and annual training for Kirby Glen personnel was updated to include the expectations for use of the chemo spill kits and proper cleaning of equipment after contamination with chemotherapy drugs in accordance with policy "Handling and Disposal of Hazardous Materials". Staff transporting chemotherapy drugs were educated by Pharmacy Leadership on the correct methods of transportation with the new bins and the proper cleaning of the bins and ice packs in accordance with policy "Handling and Disposal of Hazardous Materials". New employee training for staff transporting chemotherapy drugs was updated to reflect the correct methods of transportation with the new bins and the proper cleaning of the bins and ice packs in accordance with policy "Handling and Disposal of Hazardous Materials".	chemo spill clean-up kit and proper cleaning of equipment after contamination with chemotherapy drugs in accordance with policy "Handling and Disposal of Hazardous Materials". The findings are reported monthly to the Quality of Care Committee, Medical Executive Committee and quarterly to the Quality Committee of the Board of Trustees (reports quarterly to the Board of Trustees) until 100% is sustained for two consecutive months. Monitoring will continue quarterly on an ongoing basis with findings reported to the above stated committees unless non-compliance is identified whereby monitoring will increase in frequency until compliance is restored. Once a week the Kirby Glen Pharmacy Team will audit the transportation and cleaning procedures of chemotherapy drugs with a monthly aggregate of four observations. The findings are reported monthly to the Quality of Care Committee, Medical Executive Committee and quarterly to the Quality Committee of the Board of Trustees (reports quarterly to the Board of Trustees) until 100% is sustained for two consecutive months. Monitoring will continue quarterly on an ongoing basis with findings reported to the above stated committees unless non-compliance is identified whereby monitoring will increase in frequency until compliance is restored.	Operations **Completion Date:** 6/09/2019
A043 (Y)	A new process has been implemented where members from Infection Prevention, Quality, and Hospital Leadership, through direct observation, are auditing any personnel entering and exiting an isolation room to ensure	Leaders were educated by infection prevention in the "Train the Trainer" education program for proper process for PPE and equipment cleaning with return demonstration competency assessment for entering and exiting isolation rooms.	Through direct observation, a member of the Quality or Infection Prevention team audits 50 staff, residents or credentialed providers weekly to validate the proper wearing of PPE and cleaning of equipment practices when entering and	**Responsible Person**: Vice President of Quality **Completion Date:**

	compliance with nationally recognized standards of practice for infection prevention, including correct donning, doffing personal protective equipment (PPE), and cleaning of mobile computer carts (WOW) and portable equipment. Auditors in real time are interrupting and coaching when break in process is identified. Infection Prevention developed educational tools and videos on proper procedure for donning, doffing PPE and for cleaning patient care equipment when entering and exiting an isolation room as well as removal of trash. The training for donning, doffing, and cleaning of equipment in an isolation room was updated to require return demonstration. A competency skills fair and train the trainer program was developed and implemented for all staff, residents and providers entering a patient room with standardized consistent evaluations and competency assessments for wearing of PPE and cleaning of equipment when entering and exiting an isolation room. New computer workstations were purchased to dedicate to isolation rooms A new isolation work process was developed for EVS to clean an isolation room. An EVS competency checklist was created and implemented. The policy "Standard and Transmission-Based Precautions" has been updated to provide guidance on patient and visitors wearing PPE in accordance with Society for	All staff, residents and providers have participated in the Isolation and PPE return demonstration training by approved trainers. This will continue to occur until all staff, residents and providers entering and exiting an isolation room have completed the return demonstration training. New Employee and credentialed provider orientation has been updated include return demonstration training for proper wearing of PPE and cleaning of equipment when entering and exiting an isolation room. Direct observations of all staff, residents and providers entering isolation rooms to validate each step of the donning, doffing PPE process and equipment cleaning includes interrupting and coaching when a break in process is identified. Direct observation competency assessments are conducted by EVS leadership concurrently for EVS staff entering isolation rooms to validate each step of the donning and doffing PPE process and equipment cleaning was completed. EVS Director completed the "Train the Trainer" education and return demonstration competency assessment. EVS staff completed the isolation room cleaning education and return demonstration competency assessment. New employee orientation and annual training for the EVS staff has been updated to include the isolation room cleaning education and return demonstration competency assessment. All staff, providers and residents have been provided education on the new isolation signs and patient/visitor requirements for PPE through a variety of methods to include electronic learning modules, one on one education, and just in time training. Visitors are instructed by the hospital staff on the	exiting a room in accordance with hospital policy. The findings are reported bi-monthly to the Infection Prevention and Control Committee, monthly to the Quality of Care Committee, Medical Executive Committee and quarterly to the Quality Committee of the Board of Trustees (reports quarterly to the Board of Trustees) until 100% is sustained for two consecutive months. Monitoring will continue quarterly on an ongoing basis with findings reported to the above stated committees unless non-compliance is identified whereby monitoring will increase in frequency until compliance is restored. Through direct observation, a member of the Quality or Infection Prevention team audits 10 isolation room cleanings per week to validate the proper cleaning process of an isolation room. The findings are reported bi-monthly to the Infection Prevention and Control Committee, monthly to the Quality of Care Committee, Medical Executive Committee and quarterly to the Quality Committee of the Board of Trustees (reports quarterly to the Board of Trustees) until 100% is sustained for two consecutive months. Monitoring will continue quarterly on an ongoing basis with findings reported to the above stated committees unless non-compliance is identified whereby monitoring will increase in frequency until compliance is restored.	6/09/2019

	Healthcare Epidemiology of America (SHEA) guidelines. Isolation signs have been updated to include resources videos for patients and visitors on the proper donning and doffing of PPE.	wearing of PPE recommendations and to watch the video for proper donning and doffing techniques in accordance with policy "Standard and Transmission-Based Precautions". Affected staff on FMLA or LOS will complete the training prior to returning to work.		
A043 (Z)	The pre-cleanse and HLD process for transvaginal probes was reviewed with process steps clarified to define the appropriate disinfectant wipes per manufacturer instructions for use (IFU). The competency assessment for proper disinfection, pre-cleanse and HLD was revised to reflect the IFUs. Laminated Cleaning Instruction cards were created and posted at each HLD disinfection system station. Audit tool was created to validate proper pre-cleanse wipe selection and HLD process per IFU.	Diagnostic Imagining US, Cath Lab Techs and RNs, CT, PV, and echo staff who use transvaginal probes were educated on the proper disinfection, pre-cleanse process and the use of HLD system per IFU by a member of Infection Prevention and the Vice President of CV Services. New employee orientation for the Diagnostic Imagining US, Cath Lab Techs and RNs, CT, PV, and echo staff who use transvaginal probes has been updated to include the leaning education and return demonstration competency assessment for the transvaginal ultrasound transducer probes.	Through direct observation, a member of the Quality, Infection Prevention or Diagnostic Imaging team audits three times per week the proper disinfection and reprocessing of transvaginal probes to validate pre-cleanse and HLD process per IFU. The findings are reported bi-monthly to the Infection Prevention and Control Committee, monthly to the Quality of Care Committee, Medical Executive Committee and quarterly to the Quality Committee of the Board of Trustees (reports quarterly to the Board of Trustees) until 100% is sustained for two consecutive months. Monitoring will continue quarterly on an ongoing basis with findings reported to the above stated committees unless non-compliance is identified whereby monitoring will increase in frequency until compliance is restored.	**Responsible Person**: Vice President of CV Services **Completion Date:** 6/09/2019
A043 (AA)	Education was developed by Pharmacy Leadership for the staff in the new McNair pharmacy reinforcing the process to ensure and maintain sterility of the compounding area. The Director of the Pharmacy reinforced the expectations for maintaining the sterility of the compounding areas with all staff responsible for cleaning and managing the compounding areas. Air and surface monitoring continues to be performed to validate the sterility of the clean rooms.	Pharmacy staff responsible for cleaning and managing the compounding areas were educated by Pharmacy Leadership of the process to ensure and maintain sterility of the compounding area. Pharmacy Staff on FMLA or LOA will complete the training prior to returning to work.	Weekly a member of the Pharmacy Leadership team evaluates the McNair pharmacy staff's ability to follow the process to ensure and maintain sterility of the compounding area. The findings are reported monthly to the Director of Pharmacy, Quality of Care Committee, Medical Executive Committee and quarterly to the Quality Committee of the Board of Trustees (reports quarterly to the Board of Trustees) until 100% is sustained for two consecutive months. Monitoring will continue quarterly on an ongoing basis with findings reported to the above stated committees unless non-	**Responsible Person**: Vice President of Operations **Completion Date:** 6/09/2019

			compliance is identified whereby monitoring will increase in frequency until compliance is restored. On an ongoing basis air and surface quality are tested initially (after training) and then every six months as required by hospital policy. A member of the Pharmacy staff conducts weekly rounds to check the cleaning log of the compounding areas is completed correctly. The findings of air and surface quality are reported to the Director of Pharmacy, and every six months to the Pharmacy and Therapeutic Committee, Quality of Care Committee, Medical Executive Committee and the Quality Committee of the Board of Trustees (reports quarterly to the Board of Trustees) until 100% is sustained for two consecutive months. Monitoring will continue quarterly on an ongoing basis with findings reported to the above stated committees unless non-compliance is identified whereby monitoring will increase in frequency until compliance is restored. The findings of cleaning logs are reported monthly to the Pharmacy Director, Quality of Care Committee, Medical Executive Committee and quarterly to the Quality Committee of the Board of Trustees (reports quarterly to the Board of Trustees) until 100% is sustained for two consecutive months. Monitoring will continue quarterly on an ongoing basis with findings reported to the above stated committees unless non-compliance is identified whereby monitoring will increase in frequency until compliance is restored.	
A043 (BB)	A new isolation work process was developed for EVS to ensure proper cleaning of procedure rooms and patient	EVS Director completed the "Train the Trainer" education and return demonstration competency assessment for how to clean procedure rooms and	Through direct observation, a member of the Quality or Infection Prevention team audits 10 isolation room cleanings per	**Responsible Person**: Vice President of

	rooms following use by patients with the likelihood of infectious disease. An EVS competency checklist was created and implemented.	patient rooms following use by patients with the likelihood of infectious disease include isolation rooms. All EVS staff completed the cleaning education and return demonstration competency assessment. Staff on FMLA or LOA will complete the training prior to returning to work. New employee orientation and annual training for the EVS staff has been updated to include the cleaning education for procedure rooms and patient rooms following use by patients with the likelihood of infectious diseases including isolation rooms and return demonstration competency assessment.	week to validate the proper cleaning process of an isolation room. The findings are reported bi-monthly to the Infection Prevention and Control Committee, monthly to the Quality of Care Committee, Medical Executive Committee and quarterly to the Quality Committee of the Board of Trustees (reports quarterly to the Board of Trustees) until 100% is sustained for two consecutive months. Monitoring will continue quarterly on an ongoing basis with findings reported to the above stated committees unless non-compliance is identified whereby monitoring will increase in frequency until compliance is restored.	Operations **Completion Date:** 6/09/2019
A043 (CC)	A competency skills fair and train the trainer program was developed and implemented for all EVS staff to ensure and maintain isolation precautions including entering a patient room with standardized consistent evaluations and competency assessments for wearing of PPE and cleaning of equipment when entering and exiting an isolation room to prevent cross contamination while conducting housekeeping services.	EVS staff training on processes to ensure and maintain isolation precautions to prevent cross contamination while conducting housekeeping services. Direct observation competency assessments are conducted by EVS leadership concurrently for EVS staff entering isolation rooms to validate each step of the process to maintain isolation precautions to prevent cross contamination while conducting housekeeping services including donning and doffing PPE process and equipment cleaning was completed. EVS Staff on FMLA or LOA will complete the competency assessment prior to returning to work. New employee orientation and annual training for the EVS staff has been updated to include the isolation room cleaning education and return demonstration competency assessment.	Through direct observation, a member of the Quality or Infection Prevention team audits 10 isolation room cleanings per week to validate the proper cleaning process of an isolation room, donning, doffing and equipment cleaning. The findings are reported bi-monthly to the Infection Prevention and Control Committee, monthly to the Quality of Care Committee, Medical Executive Committee and quarterly to the Quality Committee of the Board of Trustees (reports quarterly to the Board of Trustees) until 100% is sustained for two consecutive months. Monitoring will continue quarterly on an ongoing basis with findings reported to the above stated committees unless non-compliance is identified whereby monitoring will increase in frequency until compliance is restored.	**Responsible Person**: Vice President of Operations **Completion Date:** 6/09/2019
A043 (DD)	Immediate competency regarding the standard precautions during the provision of hemodialysis care, including the cleaning process of equipment in between patients in dialysis rooms was re-	The Leadership Team in Dialysis and members of the Infection Prevention Department conducted training and validated learning by directly observing all dialysis nurses and patient care technicians entering and exiting dialysis rooms complete a return	Through direct observation, a member of the Dialysis Leadership audits 30 events per week to validate the standard precautions during the provision of hemodialysis care, including proper	**Responsible Person**: Vice President of Patient Care – Medical Surgical

	implemented by the Director of Dialysis for all applicable staff in the unit. This included a re-demonstration of each applicable staff members knowledge of the cleaning process. Infection Prevention developed educational tools and videos on proper procedure for donning, and doffing personal protective equipment (PPE). The training for donning, and doffing was updated to require return demonstration. A dialysate concentrate adjustment competency was created for return demonstration of competency with using the solution and use of PPE.	demonstration for the standard precautions during the provision of hemodialysis care, including proper donning and doffing procedure for wearing of PPE which included wearing PPE at the initiation and the discontinuation of dialysis. The Leadership Team in Dialysis and members of the Infection Prevention Department conducted training and validated learning by directly observing all dialysis nurses and patient care technicians, via return demonstration, use dialysate concentrate adjustment solution and use of PPE. Dialysis Staff on FMLA or LOA will complete the competency assessment prior to returning to work. New Employee orientation and annual training for dialysis personnel was updated to include return demonstration training for proper wearing of PPE, cleaning of equipment in between patients, and use of dialysate concentrate adjustment solution.	wearing of PPE, cleaning of equipment practices, and use of dialysate concentrate adjustment solution. The findings are reported bi-monthly to the Infection Prevention and Control Committee, monthly to the Quality of Care Committee, Medical Executive Committee and quarterly to the Quality Committee of the Board of Trustees (reports quarterly to the Board of Trustees) until 100% is sustained for two consecutive months. Monitoring will continue quarterly on an ongoing basis with findings reported to the above stated committees unless non-compliance is identified whereby monitoring will increase in frequency until compliance is restored.	**Completion Date:** 6/09/2019
A043 (EE)	Electronic temperature track system has been installed on all freezers and refrigerators. The notification when temperatures are out of range are being directed to the Facilities Leadership and Dietary Services Leadership The "Refrigerator and Freezer Monitoring – Patient Care" policy was updated to reflect the correct way to move/dispose of food when the refrigerator or freezer are out of range. Cooler 68 was removed from service with signage placed as well as a lock to signify it is not in use. The equipment parts have been ordered and will be repaired upon arrival of replacement parts.	Dietary staff received education each shift until all were notified of Cooler 68 no longer available for use and any temperature out of range is reported to Facilities immediately. Dietary staff on FMLA or LOA will complete the training prior to returning to work.	On an ongoing basis, a member of the Dietary staff manually checks temperatures twice a day for all refrigerators and freezers. In addition each refrigerator is temperature monitored electronically by Facilities. Any temperature out of range is reported to Facilities immediately in accordance with policy "Refrigerator and Freezer Monitoring – Patient Care". Daily a member of the Dietary Leadership staff inspects the completion of this requirement and that actions were taken if the temperature was out of the acceptable range. Monthly compliance is reported to the Vice President of Operations and quarterly to the Environment of Care and Safety Committee, Quality of Care Committee, Medical Executive Committee and the Quality Committee of the Board of Trustees (reports quarterly to the Board	**Responsible Person**: Vice President of Operations **Completion Date:** 6/09/2019

			of Trustees). Monitoring will continue quarterly on an ongoing basis with findings reported to the above stated committees unless non-compliance is identified whereby monitoring will increase in frequency until compliance is restored.	
A043 (FF)	Processes were put in place to ensure that mechanical dishwashers are maintained and in good working order. Facilities removed ceiling tiles for inspection and assessment of the exhaust vent was conducted. A condensation trap was reinsulated to address the leak. Ceiling tiles were replaced after the work was completed A facility and infection control assessment of the entire kitchen was performed. All rusted light fixtures were removed and replaced. The rusted, damaged, and soiled equipment were discarded.	The Chief Executive Officer set expectations with the contracted nutrition services Leadership Team of the escalation process in the hospital, expectations of performance to the contract, the "Gold Check Audit" requirements and reporting any concerns or repairs as needed immediately through the established work order process including to ensure the mechanical dishwashers are maintained in good working order. In the event the request represents a potential patient safety issue the leadership team was instructed to follow the hospital's established chain of command until the issue is resolved up to and including notification to the CEO. All Facilities staff was provided education by the Director of Facilities regarding the expectations for responding to the kitchen work orders or requests. The Dietary Leadership received education through completion of the "Gold Check Audit" Tool on the expectations for the kitchen to meet infection control standards. New employee orientation for Facilities was updated to provided education regarding the expectations for responding to the kitchen work orders or requests.	The "Gold Check Audit" was completed by the Operations Manager of Nutrition Services and submitted to the Chief Executive Officer. Action plans were developed and monitored for completion monthly to the Quality of Care Committee, Medical Executive Committee and quarterly to the Quality Committee of the Board of Trustees (reports quarterly to the Board of Trustees) until 100% completed. Once compliance is sustained, the "Gold Check Audit" will be completed per the contract guidelines to ensure performance expectations are continuously met. The results will be reported to the Vice President of Operations, Quality of Care Committee, Medical Executive Committee and the Quality Committee of the Board of Trustees (reports quarterly to the Board of Trustees) on a semi-annual basis. Audits are completed three times a week by members of the Infection Prevention or Quality Team to include direct observations of cleanliness of pots/pans, equipment working properly, and Infection Prevention practices are in place. Results are provided monthly to the Dietary Leadership and Vice President of Operations, Quality of Care Committee, Medical Executive Committee and the Quality Committee of the Board of Trustees (reports quarterly to the Board of Trustees) until 100% is sustained for two consecutive months. Monitoring will	**Responsible Person**: Vice President of Operations **Completion Date:** 6/09/2019

			continue quarterly on an ongoing basis with findings reported to the above stated committees unless non-compliance is identified whereby monitoring will increase in frequency until compliance is restored.	
A043 (GG)	A Contracted Company was obtained to assess all sewer pipes in the kitchen Sewer pipes were snaked and blockages removed. An assessment of the sewer pipes was completed. A construction plan was created and implemented with sewer pipe sections needing repair completed. All work orders submitted by the kitchen for the past three months were reviewed and issues involving repairs were identified. All identified items are in process of being repaired. Open maintenance logs for the kitchen have been reviewed and prioritized for high risk areas with response times identified. Maintenance has created a report that tracks priority of work orders and response time. Facilities Leadership is sending a weekly report to the Vice President of Operations, the CFO and the COO. Facilities has implemented a standard operating procedure (SOP) for any drain issues in the kitchen. The SOP includes escalation steps for after hours and weekends as well as the sequence of drain treatment per manufacturer recommendations.	All Dietary staff was provided education by a Leader in Facilities regarding the daily maintenance of the sewer pipes and how to escalate concerns. All Facilities staff was provided education by the Director of Facilities regarding the expectations for responding to the kitchen work orders or requests. Education was provided to the facility staff by the Facility Leadership on the implemented standard operating procedure (SOP) for any drain issues in the kitchen which includes escalation steps for after hours and weekends as well as the sequence of drain treatment per manufacturer recommendations. Facilities staff on FMLA or LOA will complete the training prior to returning to work. New employee orientation Facilities staff was revised to include training on the standard operating procedure (SOP) for any drain issues in the kitchen which includes escalation steps for after hours and weekends as well as the sequence of drain treatment per manufacturer recommendations.	Weekly a member of the Dietary staff inspects the drains for visible blockages. If blockages are identified Facilities is immediately notified and a work order placed. Daily a member of the Facilities staff uses an approved biodegradable solution to pour down the drains to keep blockages from occurring. This continued until the pipes have been repaired and a preventative maintenance schedule was implemented. A member of the Facilities Team is inspecting the Kitchen drains for visible blockages two times per shift. This continued until the pipes were repaired and a preventative maintenance schedule was implemented. Audits are completed three times a week by members of the Infection Prevention or Quality Team to include direct observations of cleanliness of pots/pans, equipment working properly, and infection control practices are in place until 100% compliance achieved. Results are provided monthly to the Dietary Leadership and Vice President of Operations and quarterly to the Environment of Care Committee, Quality of Care Committee, Medical Executive Committee, and Quality Committee of the Board of Trustees (reports quarterly to the Board of Trustees). Monitoring will continue quarterly on an ongoing basis	**Responsible Person**: Vice President of Operations **Completion Date:** 6/09/2019

			with findings reported to the above stated committees unless non-compliance is identified whereby monitoring will increase in frequency until compliance is restored. Currently open maintenance work orders are reviewed weekly for appropriate classification, response time and completion by Senior Leadership. Weekly the data is aggregated and reported to the Vice President of Operations to identify trends and develop action plans. Quarterly reports are provided to the Environment of Care Committee, Quality of Care Committee, Medical Executive Committee and the Quality Committee of the Board of Trustees (reports quarterly to the Board of Trustees). All kitchen work orders are audited weekly to review appropriate prioritization, work quality, documentation and timeliness of response until 100% compliance is sustained for two consecutive months. When compliance is sustained the auditing process will be reviewed through the 50 random audits per week process. Monitoring will continue quarterly on an ongoing basis with findings reported to the above stated committees unless non-compliance is identified whereby monitoring will increase in frequency until compliance is restored. Weekly, facility wide 50 random work orders are audited to review appropriate prioritization, work quality, documentation and timeliness of response on an ongoing basis. The findings are reported monthly to the Vice	

			President of Operations and reported quarterly to the Environment of Care and Safety Committee, Quality of Care Committee, Medical Executive Committee and quarterly to the Quality Committee of the Board of Trustees (reports quarterly to the Board of Trustees) until 100% is sustained for two consecutive months. Monitoring will continue quarterly on an ongoing basis with findings reported to the above stated committees unless non-compliance is identified whereby monitoring will increase in frequency until compliance is restored.	
A043 (HH)	Systems were changed to ensure that pots and pans are cleaned and stored appropriately. The "Gold Check Audit" was completed jointly by a member of the contracted nutrition services and a member of the hospital senior leadership team. Results of the "Gold Audit Checklist" were reported to the Chief Executive Officer. Effectively immediately, two new positions have been created which includes one individual responsible for implementation of food sanitation standards and the other position responsible for infection control practices specific to the kitchen. A facility and infection control assessment of the entire kitchen was performed. All rusted light fixtures were removed and replaced. The rusted, damaged, and soiled equipment were discarded. Visual inspections by a member of the Quality or Infection Prevention Team of all	The Chief Executive Officer set expectations with the contracted nutrition services Leadership Team of the escalation process in the hospital, expectations of performance to the contract, the "Gold Check Audit" requirements and reporting any concerns or repairs as needed immediately through the established work order process. In the event the request represents a potential patient safety issue the leadership team was instructed to follow the hospital's established chain of command until the issue is resolved up to and including notification to the CEO. All Facilities staff was provided education by the Director of Facilities regarding the expectations for responding to the kitchen work orders or requests. The Dietary Leadership received education through completion of the "Gold Check Audit" Tool on the expectations for the kitchen to meet infection control standards. Dietary staff on FMLA or LOA will complete the education and training prior to returning to work. New employee orientation for Facilities was updated to provided education regarding the expectations for responding to the kitchen work orders or requests.	The "Gold Check Audit" was completed by the Operations Manager of Nutrition Services and submitted to the Chief Executive Officer. Action plans were developed and monitored for completion monthly to the Quality of Care Committee, Medical Executive Committee and quarterly to the Quality Committee of the Board of Trustees (reports quarterly to the Board of Trustees) until 100% completed. Once compliance is sustained, the "Gold Check Audit" will be completed per the contract guidelines to ensure performance expectations are continuously met. The results will be reported to the Vice President of Operations, Quality of Care Committee, Medical Executive Committee and the Quality Committee of the Board of Trustees (reports quarterly to the Board of Trustees) on a semi-annual basis. Audits are completed three times a week by members of the Infection Prevention or Quality Team to include direct observations of cleanliness of pots/pans, equipment working properly, and Infection Prevention practices are in place. Results are provided monthly to	**Responsible Person**: Vice President of Operations **Completion Date:** 6/09/2019

	dishes and materials used in the kitchen were completed prior to being returned back to service to ensure they meet cleanable standards and were free of debris, grease or carbon build up.		the Dietary Leadership and Vice President of Operations, Quality of Care Committee, Medical Executive Committee and the Quality Committee of the Board of Trustees (reports quarterly to the Board of Trustees) until 100% is sustained for two consecutive months. Monitoring will continue quarterly on an ongoing basis with findings reported to the above stated committees unless non-compliance is identified whereby monitoring will increase in frequency until compliance is restored.	
A043 (II)	Processes were put in place to ensure that mechanical dishwashers are maintained and in good working order. Facilities removed ceiling tiles for inspection and assessment of the exhaust vent was conducted. A condensation trap was reinsulated to address the leak. Ceiling tiles were replaced after the work was completed A facility and infection control assessment of the entire kitchen was performed. All rusted light fixtures were removed and replaced. The rusted, damaged, and soiled equipment were discarded.	The Chief Executive Officer set expectations with the contracted nutrition services Leadership Team of the escalation process in the hospital, expectations of performance to the contract, the "Gold Check Audit" requirements and reporting any concerns or repairs as needed immediately through the established work order process including to ensure the mechanical dishwashers are maintained in good working order. In the event the request represents a potential patient safety issue the leadership team was instructed to follow the hospital's established chain of command until the issue is resolved up to and including notification to the CEO. All Facilities staff was provided education by the Director of Facilities regarding the expectations for responding to the kitchen work orders or requests. The Dietary Leadership received education through completion of the "Gold Check Audit" Tool on the expectations for the kitchen to meet infection control standards. New employee orientation for Facilities was updated to provided education regarding the expectations for responding to the kitchen work orders or requests.	The "Gold Check Audit" was completed by the Operations Manager of Nutrition Services and submitted to the Chief Executive Officer. Action plans were developed and monitored for completion monthly to the Quality of Care Committee, Medical Executive Committee and quarterly to the Quality Committee of the Board of Trustees (reports quarterly to the Board of Trustees) until 100% completed. Once compliance is sustained, the "Gold Check Audit" will be completed per the contract guidelines to ensure performance expectations are continuously met. The results will be reported to the Vice President of Operations, Quality of Care Committee, Medical Executive Committee and the Quality Committee of the Board of Trustees (reports quarterly to the Board of Trustees) on a semi-annual basis. Audits are completed three times a week by members of the Infection Prevention or Quality Team to include direct observations of cleanliness of pots/pans, equipment working properly, and Infection Prevention practices are in place. Results are provided monthly to the Dietary Leadership and Vice President	**Responsible Person**: Vice President of Operations **Completion Date:** 6/09/2019

			of Operations, Quality of Care Committee, Medical Executive Committee and the Quality Committee of the Board of Trustees (reports quarterly to the Board of Trustees) until 100% is sustained for two consecutive months. Monitoring will continue quarterly on an ongoing basis with findings reported to the above stated committees unless non-compliance is identified whereby monitoring will increase in frequency until compliance is restored.	
A043 (JJ)	A Contracted Company was obtained to assess all sewer pipes in the kitchen Sewer pipes were snaked and blockages removed. An assessment of the sewer pipes was completed. A construction plan was created and implemented with sewer pipe sections needing repair completed. All work orders submitted by the kitchen for the past three months were reviewed and issues involving repairs were identified. All identified items are in process of being repaired. Open maintenance logs for the kitchen have been reviewed and prioritized for high risk areas with response times identified. Maintenance has created a report that tracks priority of work orders and response time. Facilities Leadership is sending a weekly report to the Vice President of Operations, the CFO and the COO. Facilities has implemented a standard operating procedure (SOP) for any drain issues in the kitchen. The SOP includes	All Dietary staff was provided education by a Leader in Facilities regarding the daily maintenance of the sewer pipes and how to escalate concerns. All Facilities staff was provided education by the Director of Facilities regarding the expectations for responding to the kitchen work orders or requests. Education was provided to the facility staff by the Facility Leadership on the implemented standard operating procedure (SOP) for any drain issues in the kitchen which includes escalation steps for after hours and weekends as well as the sequence of drain treatment per manufacturer recommendations. Facilities staff on FMLA or LOA will complete the training prior to returning to work. New employee orientation Facilities staff was revised to include training on the standard operating procedure (SOP) for any drain issues in the kitchen which includes escalation steps for after hours and weekends as well as the sequence of drain treatment per manufacturer recommendations.	Weekly a member of the Dietary staff inspects the drains for visible blockages. If blockages are identified Facilities is immediately notified and a work order placed. Daily a member of the Facilities staff uses an approved biodegradable solution to pour down the drains to keep blockages from occurring. This continued until the pipes have been repaired and a preventative maintenance schedule was implemented. A member of the Facilities Team is inspecting the Kitchen drains for visible blockages two times per shift. This continued until the pipes were repaired and a preventative maintenance schedule was implemented. Audits are completed three times a week by members of the Infection Prevention or Quality Team to include direct observations of cleanliness of pots/pans, equipment working properly, and infection control practices are in place until 100% compliance achieved. Results are provided monthly to the Dietary Leadership and Vice President of Operations and quarterly to the	**Responsible Person**: Vice President of Operations **Completion Date:** 6/09/2019

	escalation steps for after hours and weekends as well as the sequence of drain treatment per manufacturer recommendations.		Environment of Care Committee, Quality of Care Committee, Medical Executive Committee, and Quality Committee of the Board of Trustees (reports quarterly to the Board of Trustees). Monitoring will continue quarterly on an ongoing basis with findings reported to the above stated committees unless non-compliance is identified whereby monitoring will increase in frequency until compliance is restored. Currently open maintenance work orders are reviewed weekly for appropriate classification, response time and completion by Senior Leadership. Weekly the data is aggregated and reported to the Vice President of Operations to identify trends and develop action plans. Quarterly reports are provided to the Environment of Care Committee, Quality of Care Committee, Medical Executive Committee and the Quality Committee of the Board of Trustees (reports quarterly to the Board of Trustees). All kitchen work orders are audited weekly to review appropriate prioritization, work quality, documentation and timeliness of response until 100% compliance is sustained for two consecutive months. When compliance is sustained the auditing process will be reviewed through the 50 random audits per week process. Monitoring will continue quarterly on an ongoing basis with findings reported to the above stated committees unless non-compliance is identified whereby monitoring will increase in frequency until compliance is restored.	

			Weekly, facility wide 50 random work orders are audited to review appropriate prioritization, work quality, documentation and timeliness of response on an ongoing basis. The findings are reported monthly to the Vice President of Operations and reported quarterly to the Environment of Care and Safety Committee, Quality of Care Committee, Medical Executive Committee and quarterly to the Quality Committee of the Board of Trustees (reports quarterly to the Board of Trustees) until 100% is sustained for two consecutive months. Monitoring will continue quarterly on an ongoing basis with findings reported to the above stated committees unless non-compliance is identified whereby monitoring will increase in frequency until compliance is restored.	
A043 (KK)	The employees missing the Hepatitis B records were notified with records of immunization received. The expectations to follow the onboarding process for Hepatitis B screening in accordance with policy "Vaccine Preventable Diseases – Occupational Health (System)" was reinforced by Human Resources Leadership.	The Occupational Health employees and hospital leadership were educated by the Director of Human Resources on the expectations to follow the policy "Vaccine Preventable Diseases – Occupational Health (System)". New employee orientation for Occupational Health employees was updated to reflect the process expectations as defined in policy "Vaccine Preventable Diseases – Occupational Health (System)".	On an ongoing basis, a member of the Occupational Health staff checks the Hepatitis B vaccination status for all new employees to ensure the process was followed in accordance with policy "Vaccine Preventable Diseases – Occupational Health (System)". Monthly compliance is aggregated and reported to the Director of Human Resources, quarterly to the Quality Outcomes Committee, Medical Executive Committee and Quality Committee of the Board of Trustees (reports quarterly to the Board of Trustees). Monitoring will continue quarterly on an ongoing basis with findings reported to the above stated committees unless non-compliance is identified whereby monitoring will increase in frequency until compliance is restored.	**Responsible Person**: Director of Human Resources **Completion Date:** 6/09/2019
A043 (LL)	The employee missing the Tuberculosis status records was notified with records of status received.	The Occupational Health employees and hospital leadership were educated by the Director of Human Resources on the expectations to follow the policy	On an ongoing basis, a member of the Occupational Health staff checks the Tuberculosis status for all new employees	**Responsible Person**: Director of Human

	The expectations to follow the onboarding process for Tuberculosis screening in accordance with policy "Employee Tuberculosis Screening (System)" was reinforced by Human Resources Leadership.	"Employee Tuberculosis Screening (System)". New employee orientation for Occupational Health employees was updated to reflect the process expectations as defined in policy "Employee Tuberculosis Screening (System)"	to ensure the process was followed in accordance with policy "Employee Tuberculosis Screening (System)". Monthly compliance is aggregated and reported to the Director of Human Resources, quarterly to the Quality Outcomes Committee, Medical Executive Committee and Quality Committee of the Board of Trustees (reports quarterly to the Board of Trustees). Monitoring will continue quarterly on an ongoing basis with findings reported to the above stated committees unless non-compliance is identified whereby monitoring will increase in frequency until compliance is restored.	Resources **Completion Date:** 6/09/2019
A043 (MM)	The Jun-Air compressor filter in the endoscope reprocessing room was changed. The maintenance schedule was updated to reflect changing the Jun-Air compressor filter once a year per the manufacturer's instructions for use. The Rapicide strips were immediately removed and replaced. The Automatic Endoscope Re-processer (AER) instructions for use were checked whereby the AER does the air blow procedure during the process of cleaning. The policy added an extra air blow procedure. The hospital has decided to continue to complete the second air blow process as an extra level of safety.	The Endoscopy Staff were provided education by the Endoscope Leadership about the proper labeling of the expiration dates for the Rapicide strips to include that they expire 4 months after opening or the manufacture expiration date whichever comes first. The Endoscopy staff were educated by Endoscopy Leadership for the maintenance schedule of the Jun-Air compressor filter as well as the policy reinforced to complete the second air blow process of the endoscope after it has been processed through the AER. Endoscopy staff on FMLA or LOA will complete the education and training prior to returning to work. New employee orientation for Endoscopy Staff was updated to provided education about the proper labeling of the expiration dates for the Rapicide strips to include that they expire 4 months after opening or the manufacture expiration date whichever comes first as well as the cleaning process for the endoscope as applicable.	On an ongoing basis, a member of the Endoscopy staff checks the expiration of the Rapicide strips monthly and a member of the Facilities Staff replaces the Jun-Air compressor filter once a year. Monthly compliance is aggregated and reported to the Vice President of Surgical Services, quarterly to the Quality of Care Committee, Medical Executive Committee, and Quality Committee of the Board of Trustees (reports quarterly to the Board of Trustees). Monitoring will continue quarterly on an ongoing basis with findings reported to the above stated committees unless non-compliance is identified whereby monitoring will increase in frequency until compliance is restored. Once a week a member of the Endoscopy or Infection Prevention Team will audit the process to air blow the endoscope after it has been processed through the AER. The findings are reported monthly to the Vice President of Surgical Services, Quality of Care Committee, Medical Executive Committee and quarterly to the	**Responsible Person**: Vice President of Surgical Services **Completion Date:** 6/09/2019

			Quality Committee of the Board of Trustees (reports quarterly to the Board of Trustees) until 100% is sustained for two consecutive months. Monitoring will continue quarterly on an ongoing basis with findings reported to the above stated committees unless non-compliance is identified whereby monitoring will increase in frequency until compliance is restored.	
A043 (NN) &(OO)	Weekly rounding tool was updated to include identification and mitigation of any cleanliness issues, penetrations and nicks in the flooring, mattress integrity, and rust. A rust remediation program was implemented by biomed to systematically replace identified equipment that could not be immediately removed from service. The Automatic Endoscope Re-processer (AER) instructions for use were checked whereby the AER does the air blow procedure during the process of cleaning. The policy added an extra air blow procedure. The hospital has decided to continue to complete the second air blow process as an extra level of safety. Environmental rounds have been implemented which includes weekly rounds per the rounding schedule (all patient care areas twice per calendar year and non-patient care areas at least annually) A schedule of environmental rounds has been completed for each area of the	EVS Supervisor EVS Staff assigned to Jamail were educated by the EVS Supervisor on the terminal cleaning process and completed the terminal cleaning direct observation competency assessment with the Vice President of Operations. Weekly rounding tool and rounding expectations were distributed to Surgical Services department leadership by the Vice President of Surgical Services which included identification and mitigation of any cleanliness issues, penetrations, nicks in flooring, mattress integrity and rust. The Jamail and Fannin OR staff were educated via two Safety Alerts topics included: integrity inspection of OR mattresses and flooring inspection to identify holes or nicks that impact product integrity The Surgical Services patient care assistants were educated to identify and replace all defective mattresses during the room turn-over process. The Endoscopy staff were educated by Endoscopy Leadership for the maintenance schedule of the Jun-Air compressor filter as well as the policy reinforced to complete the second air blow process of the endoscope after it has been processed through the AER.	Through direct observation, a member of the Quality, Infection Prevention, or Surgical Services team will conduct three audits per week, monthly aggregate of twelve, to validate the area is free from penetrations, nicks in flooring, equipment with rust and cleanliness issues. When 100% compliance is sustained for two consecutive months the monitoring will continue on an ongoing basis monthly. The findings are reported monthly to the Vice President of Surgical Services, bi-monthly to the Infection Prevention and Control Committee and quarterly to the Quality of Care Committee, Medical Executive Committee and the Quality Committee of the Board of Trustees (reports quarterly to the Board of Trustees). Monitoring will continue quarterly on an ongoing basis with findings reported to the above stated committees unless non-compliance is identified whereby monitoring will increase in frequency until compliance is restored. Weekly random ATP testing of 12 high touch areas are conducted for one OR	**Responsible Person**: Vice President of Surgical Services **Completion Date:** 6/09/2019

	hospital. Environmental rounds will be completed in conjunction with infection prevention to identify any ongoing maintenance repairs and infection control concerns. Departmental rounds in patient care areas have been implemented monthly to ensure the facility is properly cleaned, equipment is clean and in proper condition. <u>MAIN OR</u> <u>SECTION A STERILE CORE</u> Cleaned affected refrigerator in Sterile core. Removed the bottle of RPMI medium (a pathology fixative). The RPMI medium was relocated to the Pathology department. <u>ORTHOPEDIC CORE</u> The Tissue per manufacturer instructions for use is stored at 15 to 30 degrees Celsius. The temperature within the orthopedic core is continuously monitored. The cabinet that holds the tissue is open to the orthopedic core to ensure storage at the manufacturer's recommendations. <u>UROLOGY-CYSTO ROOM 3</u> The following was removed from service and replaced: the kick bucket, the affected IV (Intravenous) pole, affected stool fluid irrigation warmer basin, affected Velcro attached to OR mattress and affected OR mattress. <u>UROLOGY CORE</u> The equipment cart holding the Olympus Shock Pulse-SE machine was removed from service and replaced.	Endoscopy staff on FMLA or LOA will complete the education and training prior to returning to work. New employee orientation for Endoscopy Staff was updated to provided education about the proper labeling of the expiration dates for the Rapicide strips to include that they expire 4 months after opening or the manufacture expiration date whichever comes first as well as the cleaning process for the endoscope as applicable. The Hospital Safety Officer has given training to all primary and secondary Environment of Care (EOC) surveyors on the expectations for EOC rounds which included rounding, reporting, communicating and correcting of deficiencies. The Hospital Safety Officer acting as the EOC Committee Chair, reinforced with the Committee and EOC surveyors the expectations completing environmental rounds weekly as per the rounding schedule. New employees conducting EOC rounds will be educated by the Hospital Safety Department prior to completing an EOC round. All Surgical Services and Procedural Staff were reeducated on maintenance of a sanitary environment including ensuring the environment of care items free of dust, rust, torn mattresses, cracked floors, holes in walls, and chipped paint. Weekly rounding tool and rounding expectations were distributed to Surgical Services department leadership by the Vice President of Surgical Services which included identification and mitigation of any expired supplies and incomplete logs. Leadership of 6 Tower in conjunction with Infection prevention oversight conducted training for nursing staff reinforcing the process of cleaning WOWs and stethoscopes in between patients. This took place across all shifts and was reinforced by regular nursing huddles and nursing leadership rounds to reinforce	each week. When 100% compliance is sustained for two consecutive months the monitoring will continue on an ongoing basis monthly. The findings are reported monthly to the Vice President of Surgical Services, bi-monthly to the Infection Prevention and Control Committee. Results will be reported quarterly to the Quality of Care Committee, Medical Executive Committee and the Quality Committee of the Board of Trustees (reports quarterly to the Board of Trustees). Monitoring will continue quarterly on an ongoing basis with findings reported to the above stated committees unless non-compliance is identified whereby monitoring will increase in frequency until compliance is restored. Once a week a member of the Endoscopy or Infection Prevention Team will audit the process to air blow the endoscope after it has been processed through the AER. The findings are reported monthly to the Vice President of Surgical Services, Quality of Care Committee, Medical Executive Committee and quarterly to the Quality Committee of the Board of Trustees (reports quarterly to the Board of Trustees) until 100% is sustained for two consecutive months. Monitoring will continue quarterly on an ongoing basis with findings reported to the above stated committees unless non-compliance is identified whereby monitoring will increase in frequency until compliance is restored. Environment of Care Program weekly environmental rounds are completed per the rounding schedule. Results of the rounds and action items for gaps will be	

	OPERATING ROOM 21 The following was removed from service and replaced: suction tubing hanging uncovered on the suction, the affected IV pole, unprotected 4x4 sponges in the anesthesia supply cart, the expired radial artery catheterization set stored in the anesthesia supply cart, irrigation fluid warmer basin, affected stool, and affected metal table. OPERATING ROOM 18 The following was removed from service and replaced: the affected IV pole. The following was repaired: painted affected door and frame and resealed the plasterboard to seal the wood cracks in the operating room door. The following was removed from service and repaired: robotic surgery equipment tower bin that stored the oxygen/gas tanks. HALLWAY OUTSIDE OR 16 The following was repaired: affected wall at the baseboard to sealed exposed plaster and sheetrock. MAIN OR HALLWAY The following was removed from service and repaired: Pentax Endoscopy tower. STERILE PROCESSING DEPARTMENT (SPD) The following was repaired and sealed: affected linoleum flooring and the floor under a metal shelf and next to the water valves. The following was cleaned: metal cabinet that stores green towels and the drawer inside the cabinet. The following was cleaned, repainted and resealed: the base of the wall. The following was replaced: rubber seal on the floor under the metal shelf next to the water valves. This department was terminally cleaned.	practice. Training has been reinforced with the Cath Lab staff on skin preparation procedures, maintaining a sterile field, and demarcation of restricted areas from semi-restricted areas and movement between the two. Through huddles and leadership rounds in the Cath Lab the process for event related sterility (integrity of the package and not time limits) was reinforced. EVS Staff assigned to Jamail were educated by the EVS Supervisor on the terminal cleaning process and completed the terminal cleaning direct observation competency assessment with the Manager of Environmental Services. Weekly rounding tool and rounding expectations were distributed to Surgical Services department leadership by the Vice President of Surgical Services which included identification and mitigation of any cleanliness issues, penetrations, nicks in flooring, mattress integrity and rust. The Surgical Services patient care assistants were educated to identify and replace all defective mattresses during the room turn-over process The EVS Director trained the Ultrasound Supervisor on the new work process to dispose of all trash including regulated medical waste in between patients. The Ultrasound Supervisor trained the ultra sound staff on the new work process to dispose of all trash including regulated medical waste in between patients Kirby Glen was trained by a member of the Infection Prevention Team on the proper handling of blood when it enters the center. Surgical Services Staff and Credentialed providers were notified of the process change for the temperature monitoring in the ORs through one or more of these methods: in-person training, certified letters, online training modules and discussion at	aggregated weekly and reported to the monthly to the Vice President of Operations and reported quarterly to the Environment of Care and Safety Committee, Quality of Care Committee, Medical Executive Committee and Quality Committee of the Board of Trustees (reports quarterly to the Board of Trustees). Monitoring will continue quarterly on an ongoing basis with findings reported to the above stated committees unless non-compliance is identified whereby monitoring will increase in frequency until compliance is restored. Through direct observation, a member of Cath Lab Leadership audits ten (10) cases per week with a monthly aggregate of 40 to validate proper skin preparation, maintenance of a sterile field, and movement between semi-restricted and restricted areas. The findings are reported monthly to the Vice President of CV Services, Quality of Care Committee, Medical Executive Committee, and quarterly to the Quality Committee of the Board of Trustees (reports quarterly to the Board of Trustees) until 100% is sustained for 2 consecutive months. Monitoring will continue quarterly on an ongoing basis with findings reported to the above stated committees unless non-compliance is identified whereby monitoring will increase in frequency until compliance is restored. On an ongoing basis, monthly, department rounds are aggregated, tracked, and trended with monitoring of action plans for gaps by the Quality Department. Outcome data is reported quarterly to the Quality Outcomes	

	FANNIN SURGERY OPERATING ROOM 6 The following was repaired: the base of the affected operating room table, the affected linoleum floor. The OR walls were repainted. The following was removed from service and replaced: the affected OR mattress and the affected linen hamper. OPERATING ROOM 11 The following was repaired: the affected wall, Covidien equipment cart, the affected linoleum floor. The following was removed from service and replaced: the affected stool, affected OR mattress, and the affected cystoscopy OR table attachment. OPERATING ROOM 12 The following was repaired: the baseboard next to the door frame outside of the room. STERILE SUPPLY/EQUIPMENT CORE The following was removed from service and replaced: the metal cart used to transport irrigation fluid to the operating rooms for arthroscopic orthopedic cases. OR HALLWAY The following was removed from service and replaced: the metal rack containing sterile supplies. Two boxes of corrugated cardboard boxes were removed. STERILE SUPPLY CORE The RPMI medium and sperm washing medium (a pathology fixative) were removed and relocated to Pathology. CATH LAB	medical staff meetings. Education was provided to Kirby Glen staff by Kirby Glen leadership on how to identify environmental concerns that should be repaired, replaced, or taken out of service. Staff were reeducated on how to enter a work order through staff huddles and leadership rounds. Education was provided to the pharmacy staff by the Pharmacy Leadership regarding the process change for the acceptance of the crash carts into pharmacy. This was reinforced through regular huddles and leadership rounds to reinforce practice. The contract company provided education to their employees on the changes in standard work and infection prevention principles. Additionally, these employees were trained on proper PPE technique when going into isolation rooms. New employees orientation and annual orientation was updated to reflect care of the facility guidelines.	Committee, Quality of Care Committee, Medical Executive Committee, and Quality Committee of the Board of Trustees (reports quarterly to the Board of Trustees). Monitoring will continue monthly on an ongoing basis with findings reported to the above stated committees unless non-compliance is identified whereby monitoring will increase in frequency until compliance is restored. Once a week department rounds with a monthly aggregate of Four (4) occur at Kirby Glenn by a member of the Facilities or Quality Team to ensure sustainment of corrective actions. The findings are reported monthly to the VP of Operations, Quality of Care Committee, Medical Executive Committee and quarterly to the Quality Committee of the Board of Trustees (reports quarterly to the Board of Trustees) until 100% is sustained for two consecutive months. Monitoring will continue quarterly on an ongoing basis with findings reported to the above stated committees unless non-compliance is identified whereby monitoring will increase in frequency until compliance is restored. A member of the Infection Prevention Department will audit proper wearing of gloves when handling blood products once a month until 100% compliance is achieved for two months. The findings are reported monthly to the Vice President of Quality, Quality of Care Committee, Medical Executive Committee, and quarterly to the Quality Committee of the Board of Trustees (reports quarterly to the Board of Trustees) until 100% is sustained for 2 consecutive months. Monitoring will	

	Training was created for the Cath Lab staff about the IFU for the peel pack time limits. CATH LAB EQUIPMENT ROOM The ultrasound machine and Laser glasses were cleaned. The metal screws, and ceiling tiles above the equipment were replaced. 6 TOWER ROOM 634 was cleaned and placed on a regular cleaning schedule. CATH LAB #10 The space was modified to identify the distinction between the semi restricted and restricted areas. The C-Arm base and air vents were cleaned. The following were removed and repaired: the affected linen hamper, C-Arm base, door frame, walls, metal table, and poles on the table. 6 TOWER COOLEY BUILDING ROOM 627 AND 628 The room was cleaned. The following was removed and replaced: metal trash can. The following was repaired: linoleum flooring. JAMAIL SURGERY CENTER The floors have been repaired and/or replaced. OR1 The luer lock for the ISPAN has been replaced and the surgical 4X4 sponges removed. ENVIRONMENTAL SERICES CLOSET EVS Leadership was changed from a corporate reporting relationship to a local reporting relationship for the ORs in Jamail to ensure consistent practices, standards of work and monitoring in all locations. Pest control company was contracted to		continue quarterly on an ongoing basis with findings reported to the above stated committees unless non-compliance is identified whereby monitoring will increase in frequency until compliance is restored. Once a week, with an aggregate of four (4) per month, a member of the EVS Leadership Team, through direct observation, validates the sharps containers are properly exited and entering the loading dock. The findings are reported monthly to the Quality of Care Committee, Medical Executive Committee, and quarterly to the Quality Committee of the Board of Trustees (reports quarterly to the Board of Trustees) until 100% is sustained for 2 consecutive months. Monitoring will continue quarterly on an ongoing basis with findings reported to the above stated committees unless non-compliance is identified whereby monitoring will increase in frequency until compliance is restored. Through direct observation, a member of Cath Lab Leadership audits ten (10) cases per week with a monthly aggregate of 40 to validate proper skin preparation, maintenance of a sterile field, and movement between semi-restricted and restricted areas. The findings are reported monthly to the Quality of Care Committee, Medical Executive Committee, and quarterly to the Quality Committee of the Board of Trustees (reports quarterly to the Board of Trustees) until 100% is sustained for 2 consecutive months. Monitoring will continue quarterly on an ongoing basis with findings reported to the above	

	assess and treat the Jamail Surgery Center EVS cart was taken out of service and replaced with a new cart. Housekeeping closet was cleaned. Five additional insect light traps were installed for a total of seven. Two in the outer core, two in the clean corridor, and one by the back hallway outside of the surgery center. The weekly rounding tool was revised to include bug light review LINEN CART was removed from service and replaced STERILE PROCESSING DEPARTMENT (SPD) JAMAIL The Microstar Sterile Injectors that were expired were replaced. A log was implemented for the automated washer to be completed daily. The dermatology sets are no longer processed by the facility. TEMPERATURE AND HUMIDITY LOGS The temperature ranges and temperatures for all of the OR suites have been changed to reflect nationally recommended standards. The temperatures can only be changed if related to the clinical needs of the patient and approved by the Surgical Service Leadership. At the end of the case the temperature will be stored back within range. The Cath Lab is now temperature and humidity monitored. MAIN EMERGENCY DEPARTMENT TRIAGE ROOM The EKG (electrocardiogram) machine and the metal supply cart were removed from service and replaced. KIRBY GLEN CENTER		stated committees unless non-compliance is identified whereby monitoring will increase in frequency until compliance is restored. Once a week, with an aggregate of four (4) per month, a member of the Pharmacy Leadership Team, through direct observation, validates crash carts have not entered the pharmacy unless the sharps box has been replaced and the cart has been cleaned. The findings are reported monthly to the Quality of Care Committee, Medical Executive Committee, and quarterly to the Quality Committee of the Board of Trustees (reports quarterly to the Board of Trustees) until 100% is sustained for 2 consecutive months. Monitoring will continue quarterly on an ongoing basis with findings reported to the above stated committees unless non-compliance is identified whereby monitoring will increase in frequency until compliance is restored. On an ongoing basis, a member of the SPD staff checks the automated washer daily and documents on the log. Weekly a member of the SPD Leadership inspects the completion of this requirement. Monthly compliance is aggregated and reported to the Vice President of Surgical Services, Quality of Care Committee, Medical Executive Committee and Quality Committee of the Board of Trustees (reports quarterly to the Board of Trustees). Monitoring will continue quarterly on an ongoing basis with findings reported to the above stated committees unless non-compliance is identified whereby monitoring will	

	Departmental rounds at Kirby Glen have been implemented weekly to ensure the facility is properly cleaned, equipment is clean, rooms are turned over in accordance with policy. Patient Bay #13 was terminally cleaned and the trash in the can was removed. The identified patient recliner was repaired. Patient Bay #12 was terminally cleaned and the trash in the can, including the used gloves were removed. The patient recliner was removed from service and replaced. The infusion pump and pole were cleaned and returned to service. Room #11 was terminally cleaned. All paper and tape were removed from the bedframe and the bedframe was clean. The mattress was removed from service and discarded and replaced with a mattress which was clean and intact. The cartridge was removed from the infusion pump, the pump was cleaned and then returned into service. Patient Bay #10 was inspected and the patient recliner was repaired. The Clean supply room was terminally cleaned. Transfusion Observation – Kirby Glen Infection Prevention educated Kirby Glen employees about appropriate glove use while handling blood. MAIN PHARMACY Identified rolling carts were cleaned and returned to service. The process was changed where pharmacy staff will not allow a crash cart into the pharmacy unless the sharps box has been removed and the cart is clean. PATIENT FLOOR 7 SOUTH 1 AND 2: The medication refrigerator on 7 South was cleaned and defrosted to remove ice build-up. The locked wooden medication cabinets blue bins were cleaned and returned to service.		increase in frequency until compliance is restored.	

	Contents of the locked wooden medication cabinets were removed and discarded. The cabinets and bins were cleaned. The supplies were then replaced. All molding throughout the unit have been repaired and/or replaced The floor/wall area and tile were cleaned. The outside of the automated medication dispensing machine was cleaned and the internal drawers were inspected for cleanliness. The contents of the bottom drawer and the container were removed and discarded, the drawer was cleaned and the container and contents were replaced. <u>7 SOUTH 4/5 NEURO FLOOR:</u> The refrigerator was removed from service and replaced. <u>LOADING DOCK</u> The contract company delivers clean material to the hospital on a clean truck. The truck is terminally cleaned by the contract company prior to loading clean items. Clean storage carts with clean sharps containers are covered with plastic protective covering until they are ready to be transported to the units. At that time, a covering with a Velcro opening is placed on the cart during transport. Sharp containers that were collected from the units are then loaded onto the truck. The contracted company onsite employees have been provided education by EVS Leadership on the proper donning and doffing. Designated staff are also available on units to provide just in time training. <u>KIRBY GLEN UNIT:</u> The formica at the bottom of the wooden cabinet was replaced. The patient nourishment refrigerator was cleaned. Patient Room 6 was			

	terminally cleaned, the stretcher and mattress were removed from the room and cleaned. The IV pole was removed from service and replaced. The pharmacy wooden Dutch Door was repaired. The The grey pharmacy bins were cleaned and returned to service. A new process for receiving of chemo products was developed and delivery of blood products to properly store products. The contents of the medication refrigerator were removed and the refrigerator was removed from service and replaced. <u>MAIN EMERGENCY ROOM:</u> The chairs were removed from service and replaced. <u>THE THORACIC ICU 7 COOLEY A</u> The patient nourishment room was cleaned and the debris and dust were removed. <u>7 South 2</u> The glucometer box was cleaned and supplies were replaced prior to returning to service. The floors on 7 South 2 were cleaned including Bed 11, Bed 14, Bed 15 and Bed 19. <u>24 Tower</u> The Crash Cart #12 was removed from service and replaced. The contents of Crash Cart #12 were removed and the cart was thoroughly cleaned. The cart was restocked and returned to service., <u>Telemetry Unit</u> The crash cart was removed from service and replaced. The contents were removed and the cart was thoroughly cleaned The cart was restocked and returned to service. <u>Jamail Ambulatory Surgical Center</u> The four			

	linen carts were removed from service and replaced. The linen was removed and laundered.			
A084	The Board of Trustees exercises oversight over contracted services to ensure the services are provided in accordance with nationally acceptable standards of practice, including quality indicators to ensure the service provided promote the health and safety of patients. Contracts were inventoried and reviewed to identify measures specific for the evaluation of each contract performance which included the contract for dietary services and compounding pharmaceutical services which included meeting the current Good Manufacturing Practices for compounding. A process was developed to track all current contracts with associated indicators as well as identify new contracts to be added to the process with identified measures. Contracts without performance indicators is in process of having an addendum approved to include performance indicators.	The Quality staff responsible for the contract management process was provided education by the Quality Department Leadership on the expectations for management of the process. The leaders responsible for the contract evaluations were provided education by the Vice President of Quality on the expectations for submitting data on the identified performance measures for each contract. New Employee orientation for Quality staff responsible for the contract evaluations was updated provided education on the expectations for management of the process.	The identified performance indicators for each contract has been reviewed by the Quality Committee of the Board of Trustees (reports quarterly to the Board of Trustees). Annually contracts will be evaluated by the Quality of Care Committee, MEC and Board of Trustees based on the identified contract specific performance indicators. Quarterly the measures identified for contract evaluations will be reviewed by the Quality Outcomes Committee to review progress towards meeting the annual evaluation requirement. The Quality Outcomes Committee reports to the Quality of Care Committee, Medical Executive Committee and the Quality Committee of the Board of Trustees (reports quarterly to the Board of Trustees).	**Responsible Person**: Vice President of Quality **Completion Date:** 6/09/2019

BSLMC has an effective Board of Trustees that is legal responsible for the conduct of the hospital. BSLMC is currently in compliance with the CMS Condition of Participation A115 as evidence by the following specific corrective actions, education and monitoring for compliance.

For all items within Tag A115, the Board of Trustees has been actively engaged in the oversight and implementation of the plan of correction. An Executive Quality Council (EQC), chaired by the President or Senior Leader designee, meets weekly to provide oversight of the compliance with the monitoring of follow-up/monitoring measures. This council will continue to oversee the monitoring measures until 100% compliance with stated measures is sustained for two consecutive months. As well as:

- Individual staff member non-compliance will be reported to the appropriate supervisor or manager. Any non-compliance will be addressed with the individual through training, re-education and/or following the human resources corrective action process.
- Individual credential provider non-compliance will be addressed through the professional practice evaluation process and monitored through the ongoing practice evaluation process of the medical staff.
- When 100% compliance is sustained for two consecutive months for the monitoring measures stated in Tag A115, the monitoring will continue on an ongoing basis

	quarterly with finding continuing to be reported to the stated hospital Committees and the Quality Committee of the Board of Trustees (reports quarterly to the Board of Trustees). If compliance is not sustained quarterly monitoring will go back to weekly monitoring with data aggregated monthly for sustained compliance for at least two consecutive months. Decisions will be made in accordance with national clinical standards and the Conditions of Participation.			
CoP Tag #	**Plan for correcting the cited deficiency**	**Procedure for implementing the acceptable plan of correction**	**Follow-up/Monitoring**	**Person Responsible Completion Date**
A115 (A)	Informed consent training and education has been developed to include tip sheets and videos regarding the correct process for informed consent, including the risks and benefits prior to surgical procedures. The individual identified was re-educated on the process for not proceeding with chemotherapy or a blood product (e.g. IVIG) without verification of informed consent from the ordering provider. All nurses at Kirby Glen will verify documented informed consent from the ordering provider prior to proceeding with chemotherapy or administration of a blood product. The "Disclosure and Consent for Medical and Surgical Procedures (Informed Consent)" policy has been updated to reflect all acceptable methods of documenting informed consent.	Nursing Leadership conducted training for all nursing staff about the informed consent process, and reinforcement of the policy. This took place across all shifts and practice is reinforced by regular nursing huddles leadership. Training has taken place for all permanent full time and part time nurses and contract nurses. Nursing staff on FMLA or LOA will complete the training prior returning to work. Leadership of Kirby Glen conducted training for all nursing staff reinforcing the process for confirming informed consent has occurred by the ordering provider in accordance with policy "Disclosure and Consent for Medical and Surgical Procedures (Informed Consent)". This took place across all shifts and practice is reinforced by regular nursing huddles leadership. Training has taken place for all permanent full time and part time nurses and contract nurses. Nursing staff on FMLA or LOA will complete the training prior returning to work. Credentialed Providers were reminded of the expectations for informed consent. They were provided education through one or more of the following methods: in-person training, certified letters, online training modules and training at medical staff meetings. Education about the process for informed consent was added to new employee orientation for all nursing staff and the onboarding process for anesthesia providers.	Ten (10) anesthesia informed consent records are audited per week with a monthly aggregate of 40 by the surgical services department to review correct signature and the informed consent process was followed. The findings are reported monthly to the Vice President of Surgical Services, the Quality of Care Committee, Medical Executive Committee and quarterly to the Quality Committee of the Board of Trustees (reports quarterly to the Board of Trustees) until 100% is sustained for two consecutive months. Monitoring will continue quarterly on an ongoing basis with findings reported to the above stated committees unless non-compliance is identified whereby monitoring will increase in frequency until compliance is restored. Ten (10) records at Kirby Glen are audited per week with a monthly aggregate of forty (40) by leadership at Kirby Glen to review informed consent documentation is present prior to treatment. The findings are reported monthly to the CNO, Quality of Care Committee, Medical Executive Committee and quarterly to the Quality Committee of the Board of Trustees (reports quarterly to the Board of Trustees) until 100% is sustained for two consecutive months. Monitoring will continue quarterly on an ongoing basis with findings reported to the above stated committees unless non-compliance is identified whereby monitoring will increase in frequency until	**Responsible Person**: Vice President of Surgical Services **Completion Date:** 6/09/2019

			compliance is restored.	
A115 (B)	The "Disclosure and Consent -Anesthesia and/or Perioperative Pain Management (Analgesia)." form was updated to include a place for the anesthesiologist who is administering anesthesia and providing informed consent to print and sign their name on the informed consent document. Informed consent training and education has been developed to include tip sheets and videos regarding the correct process for informed consent.	The Vice President of Surgical Services and the Medical Director of Anesthesiology conducted training for all Anesthesia providers which included the revised anesthesia consent form and the expectations of the anesthesiologist who is administering anesthesia and providing informed consent print and sign his/her name on the informed consent document. Nursing Leadership conducted training for all nursing staff about the informed consent process to include the name of the anesthesiologist, and reinforcement of the policy. This took place across all shifts and practice is reinforced by regular nursing huddles leadership. Training has taken place for all permanent full time and part time nurses and contract nurses. Nursing staff on FMLA or LOA will complete the training prior returning to work. Education about the process for informed consent was added to new employee orientation as well as annual training for all nursing staff and the onboarding process for anesthesia providers.	Ten (10) anesthesia informed consent records are audited per week with a monthly aggregate of forty (40) by the surgical services department to review correct printed name and signature of the anesthesia provider. The findings are reported monthly to the View President of Surgical Services, Quality of Care Committee, Medical Executive Committee and quarterly to the Quality Committee of the Board of Trustees (reports quarterly to the Board of Trustees) until 100% is sustained for two consecutive months. Monitoring will continue quarterly on an ongoing basis with findings reported to the above stated committees unless non-compliance is identified whereby monitoring will increase in frequency until compliance is restored.	**Responsible Person**: Vice President of Surgical Services **Completion Date:** 6/09/2019
A115 (C)	Informed consent training and education has been developed to include tip sheets and videos regarding the correct process for informed consent. The individual identified was re-educated on the process for not proceeding with chemotherapy or a blood product (e.g. IVIG) without verification of informed consent from the ordering provider. All nurses at Kirby Glen will verify documented informed consent from the ordering provider prior to proceeding with chemotherapy or administration of a blood product. The “Disclosure and Consent for Medical and Surgical Procedures (Informed	Leadership of Kirby Glen conducted training for nursing staff reinforcing the process for confirming informed consent has occurred by the ordering provider in accordance with policy “Disclosure and Consent for Medical and Surgical Procedures (Informed Consent)”. This took place across all shifts and practice is reinforced by regular nursing huddles leadership. Training has taken place for all permanent full time and part time nurses and contract nurses. Nursing staff on FMLA or LOA will complete the training prior returning to work. Credentialed Providers were reminded of the expectations for informed consent. They were provided education through one or more of the following methods: in-person training, certified letters, online training modules and training at medical staff meetings.	Ten (10) records at Kirby Glen are audited per week with a monthly aggregate of forty (40) by leadership at Kirby Glen to review informed consent documentation is present prior to treatment. The findings are reported monthly to the CNO, Quality of Care Committee, Medical Executive Committee and quarterly to the Quality Committee of the Board of Trustees (reports quarterly to the Board of Trustees) until 100% is sustained for two consecutive months. Monitoring will continue quarterly on an ongoing basis with findings reported to the above stated committees unless non-compliance is identified whereby monitoring will increase in frequency until compliance is restored.	**Responsible Person**: Chief Nursing Officer **Completion Date:** 6/09/2019

	Consent)" policy has been updated to reflect all acceptable methods of documenting informed consent.	Education about the process for informed consent was added to new employee orientation and annual training for all nursing staff.		
A115 (D)	Immediately, a safety alert was created by the Director of Dialysis to alert staff to the manufacturer requirements of testing and setting up the machine properly with the venous clamp and optical detector door. Additionally, return demonstration validation was implemented on the current shift for all Dialysis Nurses. A hemodialysis machine pre-treatment preparation competency was updated by the Director of Dialysis to include all steps in the preparation process.	The Leadership Team in Dialysis and members of the Infection Prevention Department conducted training for all dialysis nurses on the set up of the hemodialysis machine. This was completed via direct observation whereby each dialysis nurse completed a return demonstration for the setup of the dialysis machine. Nursing staff on FMLA or LOA will complete the training prior to returning to work. New Employee orientation and annual training for dialysis personnel was updated to include return demonstration training for correct set up of the hemodialysis machine.	Through direct observation, a member of the Dialysis Leadership will audit 10 events per week with a monthly aggregate of 40 to validate the proper set up of the dialysis machine. The findings are reported monthly to the Vice President of Patient Care –Medical Surgical, Quality of Care Committee, Medical Executive Committee and quarterly to the Quality Committee of the Board of Trustees (reports quarterly to the Board of Trustees) until 100% is sustained for two consecutive months. Monitoring will continue quarterly on an ongoing basis with findings reported to the above stated committees unless non-compliance is identified whereby monitoring will increase in frequency until compliance is restored.	**Responsible Person**: Vice President of Patient Care – Medical Surgical **Completion Date:** 6/09/2019
A115 (E)	Training materials were created for the expectations of weighing patients' pre and post dialysis and documentation expectations in the electronic medical record per policy "Hemodialysis Treatment –Dialysis".	The Leadership Team in Dialysis conducted training for all nursing staff in Dialysis about the expectations of weighing patients' pre and post dialysis and documentation expectations per policy "Hemodialysis Treatment –Dialysis". This took place across all shifts and practice is reinforced by regular nursing huddles leadership. Training has taken place for all permanent full time and part time nurses and contract nurses in Dialysis. Nursing staff on FMLA or LOA will complete the training prior returning to work. New Employee orientation and annual training for dialysis personnel was updated to include training for expectations of weighing patients' pre and post dialysis per policy "Hemodialysis Treatment –Dialysis".	Ten (10) records are audited per week with a monthly aggregate of 40 by Leadership of Dialysis to review a patient's weight was documented pre and post dialysis. The findings are reported monthly to the Vice President of Patient Care – Medical Surgical, Quality of Care Committee, Medical Executive Committee and quarterly to the Quality Committee of the Board of Trustees (reports quarterly to the Board of Trustees) until 100% is sustained for two consecutive months. Monitoring will continue quarterly on an ongoing basis with findings reported to the above stated committees unless non-compliance is identified whereby monitoring will increase in frequency until compliance is restored.	**Responsible Person**: Vice President of Patient Care – Medical Surgical **Completion Date:** 6/09/2019

A115 (F)	An audit tool was created to visually observe all fall precautions are in place. Training materials were created for the expectations of fall prevention techniques as listed in the "Fall Management - Patient Care" policy. Training materials included reiteration that four side rails being up are not to be used as a fall prevention technique. The Chief Nursing Officer (CNO) conducted a series of meetings with nursing leadership to reiterate the leadership accountability expectations to ensure nursing staff's clinical practices are in alignment with the facility policy "Fall Management - Patient Care"	Nursing Leadership conducted training for all nursing staff about the expectations of fall prevention techniques as listed in the "Fall Management - Patient Care" policy as well as four side rails being up are not to be used as a fall prevention technique. This took place across all shifts and practice is reinforced by regular nursing huddles leadership. Training has taken place for all permanent full time and part time nurses and contract nurses. Nursing staff on FMLA or LOA will complete the training prior returning to work. New Employee orientation and annual training for nursing personnel was updated to reinforce expectations of fall prevention techniques as listed in the "Fall Management - Patient Care" policy. Training materials includes reiteration that four side rails being up are not to be used as a fall prevention technique.	Ten (10) high fall risk patients are visually observed per week with a monthly aggregate of 40 by members of nursing and/or quality to review fall prevention techniques are in place and 4 side rails up are not used as a fall prevention technique. The findings are reported to the CNO and monthly to the Quality of Care Committee, Medical Executive Committee and quarterly to the Quality Committee of the Board of Trustees (reports quarterly to the Board of Trustees) until 100% is sustained for two consecutive months. Monitoring will continue quarterly on an ongoing basis with findings reported to the above stated committees unless non-compliance is identified whereby monitoring will increase in frequency until compliance is restored.	**Responsible Person**: Chief Nursing Officer **Completion Date:** 6/09/2019
A115 (G)	Pediatric laryngoscopes were changed to disposable in all Pediatric crash carts. This now allows for 3 blades sizes as well as ensuring the proper handle. Additionally the type of laryngoscopes placed in the pediatric carts no longer requires batteries, rendering them ready for use at all times.	All Pharmacy staff was educated, by the Director of Pharmacy, about the equipment to check on pediatric crash cart. All ED providers, Respiratory and Nursing staff were notified via electronic methods and in person education. Any Pharmacy, ED, Respiratory or nursing staff on FMLA or LOA will be notified prior to returning to work.	Each pediatric crash cart will be checked once a month and after each use by Pharmacy to ensure the pediatric crash carts continue to have disposable laryngoscope blades. The findings are reported monthly to the Quality of Care Committee, Medical Executive Committee and quarterly to the Quality Committee of the Board of Trustees (reports quarterly to the Board of Trustees) until 100% is sustained for two consecutive months. Monitoring will continue quarterly on an ongoing basis with findings reported to the above stated committees unless non-compliance is identified whereby monitoring will increase in frequency until compliance is restored.	**Responsible Person**: Vice President of Operations **Completion Date:** 6/09/2019
A115 (H)	The indications for psychotropic medications were revised to require specific reasons for providers to prescribe and for nursing to administer the medication that was within the scope of practice for nursing and to prohibit the use	Nursing Leadership conducted training for all nursing staff about chemical restraints and not to administer a psychotropic medication as a PRN, "as needed", medication. This took place across all shifts and practice is reinforced by regular nursing huddles leadership. Training has taken place for all	Ten (10) psychotropic medications are audited per week with a monthly aggregate of 40 by members of pharmacy to review appropriate reasons for psychotropic medications were verified correctly with an appropriate indication.	**Responsible Person**: Chief Medical Officer **Completion Date:** 6/09/2019

	of “as needed” (PRN) use. The electronic health record was revised to remove the indication “agitation” as a reason to give a psychotropic medication and replaced with specific definitive reasons to for providers to prescribe a psychotropic medication that is now within the scope of nursing practice to assess and administer.	permanent full time and part time nurses and contract nurses. Nursing staff on FMLA or LOA will complete the training prior to returning to work. Pharmacy Leadership conducted training for all pharmacists about the expectations of not verifying a psychotropic medication order unless a specific reason was provided. This took place across all shifts and is reinforced by regular Pharmacy leadership rounding to assess implementation. Training has taken place for all permanent full time and part time pharmacists and contract pharmacists. Pharmacists on FMLA or LOA will complete the training prior returning to work. Credentialed Providers were notified of the process change where specific reasons to prescribe psychotropic medications are required and will not be verified by a pharmacist unless provided which included psychotropic medications cannot be ordered as a PRN, “as needed”. They were provided education related to use of psychotropic medications through one or more of these methods: in-person training, certified letters, online training modules and training at medical staff meetings. New Employee orientation and annual training for pharmacists was updated to include training expectations of the verification process for psychotropic medications. New employee orientation and annual training for nursing was updated to include appropriate indications for chemical restraints. Credentialed Provider orientation was updated to include appropriate indications for psychotropic medications.	The findings are reported monthly to the Director of Pharmacy, Quality of Care Committee, Medical Executive Committee and quarterly to the Quality Committee of the Board of Trustees (reports quarterly to the Board of Trustees) until 100% is sustained for two consecutive months. Monitoring will continue quarterly on an ongoing basis with findings reported to the above stated committees unless non-compliance is identified whereby monitoring will increase in frequency until compliance is restored.	
A115 (I)	An electronic report has been created that identifies all psychotropic medications and indications used in the hospital. This is used as triggers to investigate if chemical restraints have been used. Use of chemical restraints has been added to the restraint log which already tracks violent and non-violent restraint usage in	The Quality Department Leadership provided education to the quality team reviewing restraints about the identification of psychotropic medications as a chemical restraint and the expectations of the audits. Quality Department leadership on FMLA or LOA will complete the training prior returning to work. New Employee orientation for the quality staff has been updated to reflect training on the identification	All violent and chemical restraints are audited by members of the quality team weekly to review compliance with nursing staff documenting the patients need for the medication, actions performed to de-escalate or meet the patients' needs before a psychotropic medication administration, effects of the medication, nursing reassessment, vital signs	**Responsible Person**: Vice President of Quality **Completion Date:** 6/09/2019

	the hospital. An audit tool was created that monitors the use of violent restraints including chemical restraints and the effectiveness of psychotropic medications. The audit tool includes review of chemical restraints to include evaluation of nursing staff documenting the patients need for the medication, actions performed to de-escalate or meet the patients' needs before a psychotropic medication administration, effects of the medication, nursing reassessment, vital signs documented after the medication administration and a face to face assessment completed within 1 hour of the use of a chemical restraint.	and auditing process for chemical restraints.	documented after the medication administration and a face to face assessment completed within 1 hour of the use of a chemical restraint. The findings are reported monthly to the Vice President of Quality, Quality of Care Committee, Medical Executive Committee and quarterly to the Quality Committee of the Board of Trustees (reports quarterly to the Board of Trustees) until 100% is sustained for two consecutive months. Monitoring will continue quarterly on an ongoing basis with findings reported to the above stated committees unless non-compliance is identified whereby monitoring will increase in frequency until compliance is restored.	
A115 (J)	The indications for psychotropic medications were revised to provide specific reasons for providers to prescribe the medication that was within the scope of practice for nursing to administer and prohibited the use of "as needed" (PRN) use. The electronic health record was revised to remove the indication "agitation" as a reason for the provider to prescribe a psychotropic medication and replaced with specific definitive reasons for nurses to administer a psychotropic medication that is now within the scope of nursing practice to assess and administer.	Nursing Leadership conducted training for all nursing staff about the appropriate indications for chemical restraints. This took place across all shifts and practice is reinforced by regular nursing huddles leadership. Training has taken place for all permanent full time and part time nurses and contract nurses. Nursing staff on FMLA or LOA will complete the training prior returning to work. Pharmacy Leadership conducted training for all pharmacists about the expectations of not verifying a psychotropic medication order unless a specific reason was provided. This took place across all shifts and is reinforced by regular Pharmacy leadership rounding to assess implementation. Training has taken place for all permanent full time and part time pharmacists and contract pharmacists. Pharmacists on FMLA or LOA will complete the training prior returning to work. Credentialed Providers were notified of the process change where specific reasons to prescribe psychotropic medications are required and will not be verified by a pharmacist unless provided. They were provided education related to use of psychotropic medications through one or more of these methods:	Ten (10) psychotropic medications are audited per week with a monthly aggregate of forty (40) by members of pharmacy to review appropriate reasons for psychotropic medications were verified correctly with an appropriate indication. The findings are reported monthly to the Director of Pharmacy, Quality of Care Committee, Medical Executive Committee and quarterly to the Quality Committee of the Board of Trustees (reports quarterly to the Board of Trustees) until 100% is sustained for two consecutive months. Monitoring will continue quarterly on an ongoing basis with findings reported to the above stated committees unless non-compliance is identified whereby monitoring will increase in frequency until compliance is restored.	**Responsible Person**: Chief Medical Officer **Completion Date:** 6/09/2019

		in-person training, certified letters, online training modules and training at medical staff meetings. New Employee orientation and annual training for pharmacists was updated to include training expectations of the verification process for psychotropic medications. New employee orientation and annual training for nursing was updated to include chemical restraints. Credentialed provider orientation was updated to include appropriate indications for psychotropic medications.		
A115 (K)	An electronic report has been created that identifies all psychotropic medications and indications used in the hospital. This is used to identify if a chemical restraint has been used. Use of chemical restraints has been added to the restraint log which already tracks violent and non-violent restraint usage in the hospital. An audit tool for the use of violent restraints including chemical restraints and the effectiveness of psychotropic medications was created where by a member of the quality department monitors weekly. The audit tool includes review of chemical restraints to include evaluation of nursing staff documenting the patients need for the medication, actions performed to de-escalate or meet the patients' needs before a psychotropic medication administration, effects of the medication, nursing reassessment, vital signs documented after the medication administration and a face to face assessment completed by a credentialed within 1 hour of the use of a chemical restraint. The "Restraint or Seclusion" policy has been updated to provide guidance on the	Nursing Leadership conducted training for all nursing staff about the appropriate indications chemical restraint, documenting the patients need for the medication, actions performed to de-escalate or meet the patients' needs before a psychotropic medication administration, effects of the medication, nursing reassessment, vital signs documented after the medication administration and a face to face assessment completed by a credentialed provider within 1 hour of the use of a chemical restraint. This took place across all shifts and practice is reinforced by regular nursing huddles leadership. Training has taken place for all permanent full time and part time nurses and contract nurses. Nursing staff on FMLA or LOA will complete the training prior returning to work. Credentialed Providers were notified of the process change where specific reasons to prescribe psychotropic medications are required and will not be verified by a pharmacist unless provided. They were provided education related to use of psychotropic medications through one or more of these methods: in-person training, certified letters, online training modules and training at medical staff meetings. New Employee orientation and annual training for pharmacists was updated to include training expectations of the verification process for psychotropic medications. New employee orientation and annual training for nursing was updated to include appropriate indications for chemical restraints. Credentialed provider orientation was updated to include appropriate indications for psychotropic	All violent and chemical restraints are audited by members of the quality team weekly to review compliance with nursing staff documenting the patients need for the medication, actions performed to de-escalate or meet the patients' needs before a psychotropic medication administration, effects of the medication, nursing reassessment, vital signs documented after the medication administration and a face to face assessment completed by a credentialed provider within 1 hour of the use of a chemical restraint. The findings are reported monthly to the Chief Nursing Officer, Quality of Care Committee, Medical Executive Committee and quarterly to the Quality Committee of the Board of Trustees (reports quarterly to the Board of Trustees) until 100% is sustained for two consecutive months. Monitoring will continue quarterly on an ongoing basis with findings reported to the above stated committees unless non-compliance is identified whereby monitoring will increase in frequency until compliance is restored.	**Responsible Person**: Chief Nursing Officer **Completion Date:** 6/09/2019

	administration of psychotropic medications and the monitoring of the patients by nursing when a psychotropic medication has been administered as a chemical restraint.	medications.		
A115 (L)	Employees with tenure, who did not have a background check completed and at that time were not required, had a background check screening completed. Ongoing compliance is monitored through OIG sanctions, General Services Administration's System for Award Management (SAM) and Medicaid exclusion report monthly. Our Corporate Responsibility Policy No. 3 "Screening for Excluded Providers" indicates that all facility employees are screened for OIG sanctions, SAM, and Medicaid exclusion monthly. If an individual is identified by our Corporate Responsibility team through the OIG reporting process, further analysis is completed per the "Screening for Excluded Providers" policy.	Human Resources Leadership conducted educational training for all human resources staff about the policies for "Screening for Excluded Providers" and "Applicant Background Checks" as well as the requirement for the OIG, SAM, and Medicaid exclusion report to be ran monthly. Training has taken place for all permanent full time, part time and contract Human Resources staff. Human Resources staff on FMLA or LOA will complete the training prior to returning to work. New Employee orientation for human resources staff was updated to include review of the policies for "Screening for Excluded Providers" and "Applicant Background Checks".	All incoming new employees will have a background check completed and the OIG, SAM, and Medicaid exclusion report will be ran monthly with all positive matches investigated. Monthly compliance will be this process is checked by the Director of Human Resources. The findings are reported monthly to the Director of Human Resources, Quality of Care Committee, Medical Executive Committee and quarterly to the Quality Committee of the Board of Trustees (reports quarterly to the Board of Trustees) until 100% is sustained for two consecutive months. Monitoring will continue quarterly on an ongoing basis with findings reported to the above stated committees unless non-compliance is identified whereby monitoring will increase in frequency until compliance is restored.	**Responsible Person**: Director of Human Resources **Completion Date:** 6/09/2019
A115 (M)	Training materials were created for the reinforcement that the use of four side rails is considered a restraint, is not an appropriate method for fall prevention and must be used in conjunction with a physician order in accordance with the current "Restraint and Seclusion" policy. The fall prevention audit tool was updated to include visualization 4 side rails are not up as fall prevention or utilized without following the restraint guidelines per the hospital's policy "Restraint and Seclusion".	Nursing Leadership conducted training for all nursing staff about the expectations that the use of four side rails is not to be used as a fall prevention technique. This took place across all shifts and practice is reinforced by regular nursing huddles leadership. Training has taken place for all permanent full time and part time nurses and contract nurses. Nursing staff on FMLA or LOA will complete the training prior to returning to work. New Employee orientation and annual training for nursing personnel was updated to reinforce training for expectations within the "Restraint and Seclusion" Policy. Training materials include reiteration that four side rails being up are not to be used as a fall prevention technique.	Ten (10) high fall risk patients are visually observed per week with a monthly aggregate of 40 by members of nursing and/or quality to review four side rails up are not used as a fall prevention technique. The findings are reported monthly to the Chief Nursing Officer, Quality of Care Committee, Medical Executive Committee and quarterly to the Quality Committee of the Board of Trustees (reports quarterly to the Board of Trustees) until 100% is sustained for two consecutive months. Monitoring will continue quarterly on an ongoing basis with findings reported to the above stated committees unless non-	**Responsible Person**: Chief Nursing Officer **Completion Date:** 6/09/2019

			compliance is identified whereby monitoring will increase in frequency until compliance is restored.	

BSLMC has an effective Board of Trustees that is legal responsible for the conduct of the hospital. BSLMC is currently in compliance with the CMS Condition of Participation A131 as evidence by the following specific corrective actions, education and monitoring for compliance.

For all items within Tag A131, the Board of Trustees has been actively engaged in the oversight and implementation of the plan of correction. An Executive Quality Council (EQC), chaired by the President or Senior Leader designee, meets weekly to provide oversight of the compliance with the monitoring of follow-up/monitoring measures. This council will continue to oversee the monitoring measures until 100% compliance with stated measures is sustained for two consecutive months. As well as:

- Individual staff member non-compliance will be reported to the appropriate supervisor or manager. Any non-compliance will be addressed with the individual through training, re-education and/or following the human resources corrective action process.
- Individual credential provider non-compliance will be addressed through the professional practice evaluation process and monitored through the ongoing practice evaluation process of the medical staff.
- When 100% compliance is sustained for two consecutive months for the monitoring measures stated in Tag A131, the monitoring will continue on an ongoing basis quarterly with finding continuing to be reported to the stated hospital Committees and the Quality Committee of the Board of Trustees (reports quarterly to the Board of Trustees). If compliance is not sustained quarterly monitoring will go back to weekly monitoring with data aggregated monthly for sustained compliance for at least two consecutive months. Decisions will be made in accordance with national clinical standards and the Conditions of Participation.

CoP Tag #	Plan for correcting the cited deficiency	Procedure for implementing the acceptable plan of correction	Follow-up/Monitoring	Person Responsible Completion Date
A131 (A)	Informed consent training and education has been developed to include tip sheets and videos regarding the correct process for informed consent, including the risks and benefits prior to surgical procedures. The individual identified was re-educated on the process for not proceeding with chemotherapy or a blood product (e.g. IVIG) without verification of informed consent from the ordering provider. All nurses at Kirby Glen will verify documented informed consent from the ordering provider prior to proceeding with chemotherapy or administration of a blood product. The "Disclosure and Consent for Medical and Surgical Procedures (Informed Consent)" policy has been updated to reflect all acceptable methods of	Nursing Leadership conducted training for all nursing staff about the informed consent process, and reinforcement of the policy. This took place across all shifts and practice is reinforced by regular nursing huddles leadership. Training has taken place for all permanent full time and part time nurses and contract nurses. Nursing staff on FMLA or LOA will complete the training prior returning to work. Leadership of Kirby Glen conducted training for all nursing staff reinforcing the process for confirming informed consent has occurred by the ordering provider in accordance with policy "Disclosure and Consent for Medical and Surgical Procedures (Informed Consent)". This took place across all shifts and practice is reinforced by regular nursing huddles leadership. Training has taken place for all permanent full time and part time nurses and contract nurses. Nursing staff on FMLA or LOA will complete the training prior returning to work.	Ten (10) anesthesia informed consent records are audited per week with a monthly aggregate of 40 by the surgical services department to review correct signature and the informed consent process was followed. The findings are reported monthly to the Vice President of Surgical Services, the Quality of Care Committee, Medical Executive Committee and quarterly to the Quality Committee of the Board of Trustees (reports quarterly to the Board of Trustees) until 100% is sustained for two consecutive months. Monitoring will continue quarterly on an ongoing basis with findings reported to the above stated committees unless non-compliance is identified whereby monitoring will increase in frequency until compliance is restored. Ten (10) records at Kirby Glen are audited	**Responsible Person**: Vice President of Surgical Services **Completion Date:** 6/09/2019

	documenting informed consent.	Credentialed Providers were reminded of the expectations for informed consent. They were provided education through one or more of the following methods: in-person training, certified letters, online training modules and training at medical staff meetings. Education about the process for informed consent was added to new employee orientation for all nursing staff and the onboarding process for anesthesia providers.	per week with a monthly aggregate of forty (40) by leadership at Kirby Glen to review informed consent documentation is present prior to treatment. The findings are reported monthly to the CNO, Quality of Care Committee, Medical Executive Committee and quarterly to the Quality Committee of the Board of Trustees (reports quarterly to the Board of Trustees) until 100% is sustained for two consecutive months. Monitoring will continue quarterly on an ongoing basis with findings reported to the above stated committees unless non-compliance is identified whereby monitoring will increase in frequency until compliance is restored.	
A131 (B)	The "Disclosure and Consent -Anesthesia and/or Perioperative Pain Management (Analgesia)." form was updated to include a place for the anesthesiologist who is administering anesthesia and providing informed consent to print and sign their name on the informed consent document. Informed consent training and education has been developed to include tip sheets and videos regarding the correct process for informed consent.	The Vice President of Surgical Services and the Medical Director of Anesthesiology conducted training for all Anesthesia providers which included the revised anesthesia consent form and the expectations of the anesthesiologist who is administering anesthesia and providing informed consent print and sign his/her name on the informed consent document. Anesthesia providers on FMLA or LOA will complete the training prior returning to work. Nursing Leadership conducted training for all nursing staff about the informed consent process to include the name of the anesthesiologist, and reinforcement of the policy. This took place across all shifts and practice is reinforced by regular nursing huddles leadership. Training has taken place for all permanent full time and part time nurses and contract nurses. Nursing staff on FMLA or LOA will complete the training prior returning to work. Education about the process for informed consent was added to new employee orientation as well as annual training for all nursing staff and the onboarding process for anesthesia providers.	Ten (10) anesthesia informed consent records are audited per week with a monthly aggregate of forty (40) by the surgical services department to review correct printed name and signature of the anesthesia provider. The findings are reported monthly to the View President of Surgical Services, Quality of Care Committee, Medical Executive Committee and quarterly to the Quality Committee of the Board of Trustees (reports quarterly to the Board of Trustees) until 100% is sustained for two consecutive months. Monitoring will continue quarterly on an ongoing basis with findings reported to the above stated committees unless non-compliance is identified whereby monitoring will increase in frequency until compliance is restored.	**Responsible Person**: Vice President of Surgical Services **Completion Date:** 6/09/2019

A131 (C)	Informed consent training and education has been developed to include tip sheets and videos regarding the correct process for informed consent. The individual identified was re-educated on the process for not proceeding with chemotherapy or a blood product (e.g. IVIG) without verification of informed consent from the ordering provider. All nurses at Kirby Glen will verify documented informed consent from the ordering provider prior to proceeding with chemotherapy or administration of a blood product. The "Disclosure and Consent for Medical and Surgical Procedures (Informed Consent)" policy has been updated to reflect all acceptable methods of documenting informed consent.	Leadership of Kirby Glen conducted training for nursing staff reinforcing the process for confirming informed consent has occurred by the ordering provider in accordance with policy "Disclosure and Consent for Medical and Surgical Procedures (Informed Consent)". This took place across all shifts and practice is reinforced by regular nursing huddles leadership. Training has taken place for all permanent full time and part time nurses and contract nurses. Nursing staff on FMLA or LOA will complete the training prior returning to work. Credentialed Providers were reminded of the expectations for informed consent. They were provided education through one or more of the following methods: in-person training, certified letters, online training modules and training at medical staff meetings. Education about the process for informed consent was added to new employee orientation and annual training for all nursing staff.	Ten (10) records at Kirby Glen are audited per week with a monthly aggregate of forty (40) by leadership at Kirby Glen to review informed consent documentation is present prior to treatment. The findings are reported monthly to the CNO, Quality of Care Committee, Medical Executive Committee and quarterly to the Quality Committee of the Board of Trustees (reports quarterly to the Board of Trustees) until 100% is sustained for two consecutive months. Monitoring will continue quarterly on an ongoing basis with findings reported to the above stated committees unless non-compliance is identified whereby monitoring will increase in frequency until compliance is restored.	**Responsible Person**: Chief Nursing Officer **Completion Date:** 6/09/2019

BSLMC has an effective Board of Trustees that is legal responsible for the conduct of the hospital. BSLMC is currently in compliance with the CMS Condition of Participation A144 as evidence by the following specific corrective actions, education and monitoring for compliance.

For all items within Tag A144, the Board of Trustees has been actively engaged in the oversight and implementation of the plan of correction. An Executive Quality Council (EQC), chaired by the President or Senior Leader designee, meets weekly to provide oversight of the compliance with the monitoring of follow-up/monitoring measures. This council will continue to oversee the monitoring measures until 100% compliance with stated measures is sustained for two consecutive months. As well as:

- Individual staff member non-compliance will be reported to the appropriate supervisor or manager. Any non-compliance will be addressed with the individual through training, re-education and/or following the human resources corrective action process.
- Individual credential provider non-compliance will be addressed through the professional practice evaluation process and monitored through the ongoing practice evaluation process of the medical staff.
- When 100% compliance is sustained for two consecutive months for the monitoring measures stated in Tag A144, the monitoring will continue on an ongoing basis quarterly with finding continuing to be reported to the stated hospital Committees and the Quality Committee of the Board of Trustees (reports quarterly to the Board of Trustees). If compliance is not sustained quarterly monitoring will go back to weekly monitoring with data aggregated monthly for sustained compliance for at least two consecutive months. Decisions will be made in accordance with national clinical standards and the Conditions of Participation.

CoP Tag #	**Plan for correcting the cited deficiency**	**Procedure for implementing the acceptable plan of correction**	**Follow-up/Monitoring**	**Person Responsible Completion Date**

A144 (A)	Immediately, a safety alert was created by the Director of Dialysis to alert staff to the manufacturer requirements of testing and setting up the machine properly with the venous clamp and optical detector door. Additionally, return demonstration validation was implemented on the current shift for all Dialysis Nurses. A hemodialysis machine pre-treatment preparation competency was updated by the Director of Dialysis to include all steps in the preparation process.	The Leadership Team in Dialysis and members of the Infection Prevention Department conducted training for all dialysis nurses on the set up of the hemodialysis machine. This was completed via direct observation whereby each dialysis nurse completed a return demonstration for the setup of the dialysis machine. Nursing staff on FMLA or LOA will complete the training prior to returning to work. New Employee orientation and annual training for dialysis personnel was updated to include return demonstration training for correct set up of the hemodialysis machine.	Through direct observation, a member of the Dialysis Leadership will audit 10 events per week with a monthly aggregate of 40 to validate the proper set up of the dialysis machine. The findings are reported monthly to the Vice President of Patient Care –Medical Surgical, Quality of Care Committee, Medical Executive Committee and quarterly to the Quality Committee of the Board of Trustees (reports quarterly to the Board of Trustees) until 100% is sustained for two consecutive months. Monitoring will continue quarterly on an ongoing basis with findings reported to the above stated committees unless non-compliance is identified whereby monitoring will increase in frequency until compliance is restored.	**Responsible Person**: Vice President of Patient Care – Medical Surgical **Completion Date:** 6/09/2019
A144 (B)	Training materials were created for the expectations of weighing patients' pre and post dialysis and documentation expectations in the electronic medical record per policy "Hemodialysis Treatment –Dialysis".	The Leadership Team in Dialysis conducted training for all nursing staff in Dialysis about the expectations of weighing patients' pre and post dialysis and documentation expectations per policy "Hemodialysis Treatment –Dialysis". This took place across all shifts and practice is reinforced by regular nursing huddles leadership. Training has taken place for all permanent full time and part time nurses and contract nurses in Dialysis. Nursing staff on FMLA or LOA will complete the training prior returning to work. New Employee orientation and annual training for dialysis personnel was updated to include training for expectations of weighing patients' pre and post dialysis per policy "Hemodialysis Treatment –Dialysis".	Ten (10) records are audited per week with a monthly aggregate of 40 by Leadership of Dialysis to review a patient's weight was documented pre and post dialysis. The findings are reported monthly to the Vice President of Patient Care – Medical Surgical, Quality of Care Committee, Medical Executive Committee and quarterly to the Quality Committee of the Board of Trustees (reports quarterly to the Board of Trustees) until 100% is sustained for two consecutive months. Monitoring will continue quarterly on an ongoing basis with findings reported to the above stated committees unless non-compliance is identified whereby monitoring will increase in frequency until compliance is restored.	**Responsible Person**: Vice President of Patient Care – Medical Surgical **Completion Date:** 6/09/2019
A144 (C)	An audit tool was created to visually observe all fall precautions are in place. Training materials were created for the expectations of fall prevention techniques as listed in the "Fall Management - Patient	Nursing Leadership conducted training for all nursing staff about the expectations of fall prevention techniques as listed in the "Fall Management - Patient Care" policy as well as four side rails being up are not to be used as a fall prevention technique. This took place across all shifts and practice is reinforced by	Ten (10) high fall risk patients are visually observed per week with a monthly aggregate of 40 by members of nursing and/or quality to review fall prevention techniques are in place and 4 side rails up are not used as a fall prevention	**Responsible Person**: Chief Nursing Officer **Completion Date:** 6/09/2019

	Care" policy. Training materials included reiteration that four side rails being up are not to be used as a fall prevention technique. The Chief Nursing Officer (CNO) conducted a series of meetings with nursing leadership to reiterate the leadership accountability expectations to ensure nursing staff's clinical practices are in alignment with the facility policy "Fall Management - Patient Care"	regular nursing huddles leadership. Training has taken place for all permanent full time and part time nurses and contract nurses. Nursing staff on FMLA or LOA will complete the training prior returning to work. New Employee orientation and annual training for nursing personnel was updated to reinforce expectations of fall prevention techniques as listed in the "Fall Management - Patient Care" policy. Training materials includes reiteration that four side rails being up are not to be used as a fall prevention technique.	technique. The findings are reported to the CNO and monthly to the Quality of Care Committee, Medical Executive Committee and quarterly to the Quality Committee of the Board of Trustees (reports quarterly to the Board of Trustees) until 100% is sustained for two consecutive months. Monitoring will continue quarterly on an ongoing basis with findings reported to the above stated committees unless non-compliance is identified whereby monitoring will increase in frequency until compliance is restored.	
A144 (D)	Pediatric laryngoscopes were changed to disposable in all Pediatric crash carts. This now allows for 3 blades sizes as well as ensuring the proper handle. Additionally the type of laryngoscopes placed in the pediatric carts no longer requires batteries, rendering them ready for use at all times.	All Pharmacy staff was educated, by the Director of Pharmacy, about the equipment to check on pediatric crash cart. All ED providers, Respiratory and Nursing staff were notified via electronic methods and in person education. Any Pharmacy, ED, Respiratory or nursing staff on FMLA or LOA will be notified prior to returning to work.	Each pediatric crash cart will be checked once a month and after each use by Pharmacy to ensure the pediatric crash carts continue to have disposable laryngoscope blades. The findings are reported monthly to the Quality of Care Committee, Medical Executive Committee and quarterly to the Quality Committee of the Board of Trustees (reports quarterly to the Board of Trustees) until 100% is sustained for two consecutive months. Monitoring will continue quarterly on an ongoing basis with findings reported to the above stated committees unless non-compliance is identified whereby monitoring will increase in frequency until compliance is restored.	**Responsible Person**: Vice President of Operations **Completion Date:** 6/09/2019
A144 (E)	The indications for psychotropic medications were revised to require specific reasons for providers to prescribe and for nursing to administer the medication that was within the scope of practice for nursing and to prohibit the use of "as needed" (PRN) use. The electronic health record was revised to remove the indication "agitation" as a reason to give a psychotropic medication and replaced with specific definitive	Nursing Leadership conducted training for all nursing staff about chemical restraints and not to administer a psychotropic medication as a PRN, "as needed", medication. This took place across all shifts and practice is reinforced by regular nursing huddles leadership. Training has taken place for all permanent full time and part time nurses and contract nurses. Nursing staff on FMLA or LOA will complete the training prior to returning to work. Pharmacy Leadership conducted training for all pharmacists about the expectations of not verifying a psychotropic medication order unless a specific	Ten (10) psychotropic medications are audited per week with a monthly aggregate of 40 by members of pharmacy to review appropriate reasons for psychotropic medications were verified correctly with an appropriate indication. The findings are reported monthly to the Director of Pharmacy, Quality of Care Committee, Medical Executive Committee and quarterly to the Quality Committee of the Board of Trustees (reports quarterly to the Board of Trustees) until 100% is	**Responsible Person**: Chief Medical Officer **Completion Date:** 6/09/2019

	reasons to for providers to prescribe a psychotropic medication that is now within the scope of nursing practice to assess and administer.	reason was provided. This took place across all shifts and is reinforced by regular Pharmacy leadership rounding to assess implementation. Training has taken place for all permanent full time and part time pharmacists and contract pharmacists. Pharmacists on FMLA or LOA will complete the training prior returning to work. Credentialed Providers were notified of the process change where specific reasons to prescribe psychotropic medications are required and will not be verified by a pharmacist unless provided which included psychotropic medications cannot be ordered as a PRN, "as needed". They were provided education related to use of psychotropic medications through one or more of these methods: in-person training, certified letters, online training modules and training at medical staff meetings. New Employee orientation and annual training for pharmacists was updated to include training expectations of the verification process for psychotropic medications. New employee orientation and annual training for nursing was updated to include appropriate indications for chemical restraints. Credentialed Provider orientation was updated to include appropriate indications for psychotropic medications.	sustained for two consecutive months. Monitoring will continue quarterly on an ongoing basis with findings reported to the above stated committees unless non-compliance is identified whereby monitoring will increase in frequency until compliance is restored.	
A144 (F)	An electronic report has been created that identifies all psychotropic medications and indications used in the hospital. This is used as triggers to investigate if chemical restraints have been used. Use of chemical restraints has been added to the restraint log which already tracks violent and non-violent restraint usage in the hospital. An audit tool was created that monitors the use of violent restraints including chemical restraints and the effectiveness of psychotropic medications. The audit tool includes review of chemical restraints	The Quality Department Leadership provided education to the quality team reviewing restraints about the identification of psychotropic medications as a chemical restraint and the expectations of the audits. Quality Department leadership on FMLA or LOA will complete the training prior returning to work. New Employee orientation for the quality staff has been updated to reflect training on the identification and auditing process for chemical restraints.	All violent and chemical restraints are audited by members of the quality team weekly to review compliance with nursing staff documenting the patients need for the medication, actions performed to de-escalate or meet the patients' needs before a psychotropic medication administration, effects of the medication, nursing reassessment, vital signs documented after the medication administration and a face to face assessment completed within 1 hour of the use of a chemical restraint. The findings are reported monthly to the Vice President of Quality, Quality of Care Committee, Medical Executive Committee	**Responsible Person**: Vice President of Quality **Completion Date:** 6/09/2019

	to include evaluation of nursing staff documenting the patients need for the medication, actions performed to de-escalate or meet the patients' needs before a psychotropic medication administration, effects of the medication, nursing reassessment, vital signs documented after the medication administration and a face to face assessment completed within 1 hour of the use of a chemical restraint.		and quarterly to the Quality Committee of the Board of Trustees (reports quarterly to the Board of Trustees) until 100% is sustained for two consecutive months. Monitoring will continue quarterly on an ongoing basis with findings reported to the above stated committees unless non-compliance is identified whereby monitoring will increase in frequency until compliance is restored.	
A144 (G)	The indications for psychotropic medications were revised to provide specific reasons for providers to prescribe the medication that was within the scope of practice for nursing to administer and prohibited the use of "as needed" (PRN) use. The electronic health record was revised to remove the indication "agitation" as a reason for the provider to prescribe a psychotropic medication and replaced with specific definitive reasons for nurses to administer a psychotropic medication that is now within the scope of nursing practice to assess and administer.	Nursing Leadership conducted training for all nursing staff about the appropriate indications for chemical restraints. This took place across all shifts and practice is reinforced by regular nursing huddles leadership. Training has taken place for all permanent full time and part time nurses and contract nurses. Nursing staff on FMLA or LOA will complete the training prior returning to work. Pharmacy Leadership conducted training for all pharmacists about the expectations of not verifying a psychotropic medication order unless a specific reason was provided. This took place across all shifts and is reinforced by regular Pharmacy leadership rounding to assess implementation. Training has taken place for all permanent full time and part time pharmacists and contract pharmacists. Pharmacists on FMLA or LOA will complete the training prior returning to work. Credentialed Providers were notified of the process change where specific reasons to prescribe psychotropic medications are required and will not be verified by a pharmacist unless provided. They were provided education related to use of psychotropic medications through one or more of these methods: in-person training, certified letters, online training modules and training at medical staff meetings. New Employee orientation and annual training for pharmacists was updated to include training expectations of the verification process for psychotropic medications. New employee orientation and annual training for nursing was updated to include	Ten (10) psychotropic medications are audited per week with a monthly aggregate of forty (40) by members of pharmacy to review appropriate reasons for psychotropic medications were verified correctly with an appropriate indication. The findings are reported monthly to the Director of Pharmacy, Quality of Care Committee, Medical Executive Committee and quarterly to the Quality Committee of the Board of Trustees (reports quarterly to the Board of Trustees) until 100% is sustained for two consecutive months. Monitoring will continue quarterly on an ongoing basis with findings reported to the above stated committees unless non-compliance is identified whereby monitoring will increase in frequency until compliance is restored.	**Responsible Person**: Chief Medical Officer **Completion Date:** 6/09/2019

		chemical restraints. Credentialed provider orientation was updated to include appropriate indications for psychotropic medications.		
A144 (H)	An electronic report has been created that identifies all psychotropic medications and indications used in the hospital. This is used to identify if a chemical restraint has been used. Use of chemical restraints has been added to the restraint log which already tracks violent and non-violent restraint usage in the hospital. An audit tool for the use of violent restraints including chemical restraints and the effectiveness of psychotropic medications was created where by a member of the quality department monitors weekly. The audit tool includes review of chemical restraints to include evaluation of nursing staff documenting the patients need for the medication, actions performed to de-escalate or meet the patients' needs before a psychotropic medication administration, effects of the medication, nursing reassessment, vital signs documented after the medication administration and a face to face assessment completed by a credentialed within 1 hour of the use of a chemical restraint. The "Restraint or Seclusion" policy has been updated to provide guidance on the administration of psychotropic medications and the monitoring of the patients by nursing when a psychotropic medication has been administered as a chemical restraint.	Nursing Leadership conducted training for all nursing staff about the appropriate indications chemical restraint, documenting the patients need for the medication, actions performed to de-escalate or meet the patients' needs before a psychotropic medication administration, effects of the medication, nursing reassessment, vital signs documented after the medication administration and a face to face assessment completed by a credentialed provider within 1 hour of the use of a chemical restraint. This took place across all shifts and practice is reinforced by regular nursing huddles leadership. Training has taken place for all permanent full time and part time nurses and contract nurses. Nursing staff on FMLA or LOA will complete the training prior returning to work. Credentialed Providers were notified of the process change where specific reasons to prescribe psychotropic medications are required and will not be verified by a pharmacist unless provided. They were provided education related to use of psychotropic medications through one or more of these methods: in-person training, certified letters, online training modules and training at medical staff meetings. New Employee orientation and annual training for pharmacists was updated to include training expectations of the verification process for psychotropic medications. New employee orientation and annual training for nursing was updated to include appropriate indications for chemical restraints. Credentialed provider orientation was updated to include appropriate indications for psychotropic medications.	All violent and chemical restraints are audited by members of the quality team weekly to review compliance with nursing staff documenting the patients need for the medication, actions performed to de-escalate or meet the patients' needs before a psychotropic medication administration, effects of the medication, nursing reassessment, vital signs documented after the medication administration and a face to face assessment completed by a credentialed provider within 1 hour of the use of a chemical restraint. The findings are reported monthly to the Chief Nursing Officer, Quality of Care Committee, Medical Executive Committee and quarterly to the Quality Committee of the Board of Trustees (reports quarterly to the Board of Trustees) until 100% is sustained for two consecutive months. Monitoring will continue quarterly on an ongoing basis with findings reported to the above stated committees unless non-compliance is identified whereby monitoring will increase in frequency until compliance is restored.	**Responsible Person**: Chief Nursing Officer **Completion Date:** 6/09/2019

BSLMC has an effective Board of Trustees that is legal responsible for the conduct of the hospital. BSLMC is currently in compliance with the CMS Condition of Participation A145 as evidence by the following specific corrective actions, education and monitoring for compliance.

For all items within Tag A145, the Board of Trustees has been actively engaged in the oversight and implementation of the plan of correction. An Executive Quality Council (EQC), chaired by the President or Senior Leader designee, meets weekly to provide oversight of the compliance with the monitoring of follow-up/monitoring measures. This council will continue to oversee the monitoring measures until 100% compliance with stated measures is sustained for two consecutive months. As well as:

- Individual staff member non-compliance will be reported to the appropriate supervisor or manager. Any non-compliance will be addressed with the individual through training, re-education and/or following the human resources corrective action process.
- Individual credential provider non-compliance will be addressed through the professional practice evaluation process and monitored through the ongoing practice evaluation process of the medical staff.
- When 100% compliance is sustained for two consecutive months for the monitoring measures stated in Tag A145, the monitoring will continue on an ongoing basis quarterly with finding continuing to be reported to the stated hospital Committees and the Quality Committee of the Board of Trustees (reports quarterly to the Board of Trustees). If compliance is not sustained quarterly monitoring will go back to weekly monitoring with data aggregated monthly for sustained compliance for at least two consecutive months. Decisions will be made in accordance with national clinical standards and the Conditions of Participation.

CoP Tag #	Plan for correcting the cited deficiency	Procedure for implementing the acceptable plan of correction	Follow-up/Monitoring	Person Responsible Completion Date
A145	Employees with tenure, who did not have a background check completed and at that time were not required, had a background check screening completed. Ongoing compliance is monitored through OIG sanctions, General Services Administration's System for Award Management (SAM) and Medicaid exclusion report monthly. Our Corporate Responsibility Policy No. 3 "Screening for Excluded Providers" indicates that all facility employees are screened for OIG sanctions, SAM, and Medicaid exclusion monthly. If an individual is identified by our Corporate Responsibility team through the OIG reporting process, further analysis is completed per the "Screening for Excluded Providers" policy.	Human Resources Leadership conducted educational training for all human resources staff about the policies for "Screening for Excluded Providers" and "Applicant Background Checks" as well as their responsibility to act upon a positive match if the monthly corporate OIG, SAM, and Medicaid exclusion report showed an employee on the list. Training has taken place for all permanent full time, part time and contract Human Resources staff. Human Resources staff on FMLA or LOA will complete the training prior to returning to work. New Employee orientation for human resources staff was updated to include review of the policies for "Screening for Excluded Providers" and "Applicant Background Checks".	All incoming new employees will have a background check completed and the OIG, SAM, and Medicaid exclusion report will be ran monthly with all positive matches investigated. Monthly compliance of this process will be checked by the Director of Human Resources. The findings are reported monthly to the Director of Human Resources, Quality of Care Committee, Medical Executive Committee and quarterly to the Quality Committee of the Board of Trustees (reports quarterly to the Board of Trustees) until 100% is sustained for two consecutive months. Monitoring will continue quarterly on an ongoing basis with findings reported to the above stated committees unless non-compliance is identified whereby monitoring will increase in frequency until compliance is restored.	**Responsible Person**: Director of Human Resources **Completion Date:** 6/09/2019

BSLMC has an effective Board of Trustees that is legal responsible for the conduct of the hospital. BSLMC is currently in compliance with the CMS Condition of Participation A161 as evidence by the following specific corrective actions, education and monitoring for compliance.

For all items within Tag A161, the Board of Trustees has been actively engaged in the oversight and implementation of the plan of correction. An Executive Quality Council (EQC), chaired by the President or Senior Leader designee, meets weekly to provide oversight of the compliance with the monitoring of follow-up/monitoring measures. This council will continue to oversee the monitoring measures until 100% compliance with stated measures is sustained for two consecutive months. As well as:

- Individual staff member non-compliance will be reported to the appropriate supervisor or manager. Any non-compliance will be addressed with the individual through training, re-education and/or following the human resources corrective action process.
- Individual credential provider non-compliance will be addressed through the professional practice evaluation process and monitored through the ongoing practice evaluation process of the medical staff.
- When 100% compliance is sustained for two consecutive months for the monitoring measures stated in Tag A161, the monitoring will continue on an ongoing basis quarterly with finding continuing to be reported to the stated hospital Committees and the Quality Committee of the Board of Trustees (reports quarterly to the Board of Trustees). If compliance is not sustained quarterly monitoring will go back to weekly monitoring with data aggregated monthly for sustained compliance for at least two consecutive months. Decisions will be made in accordance with national clinical standards and the Conditions of Participation.

CoP Tag #	Plan for correcting the cited deficiency	Procedure for implementing the acceptable plan of correction	Follow-up/Monitoring	Person Responsible Completion Date
A161	Training materials were created for the reinforcement that the use of four side rails is considered a restraint, is not an appropriate method for fall prevention and must be used in conjunction with a physician order in accordance with the current "Restraint and Seclusion" policy. The fall prevention audit tool was updated to include visualization 4 side rails are not up as fall prevention or utilized without following the restraint guidelines per the hospital's policy "Restraint and Seclusion".	Nursing Leadership conducted training for all nursing staff about the expectations that the use of four side rails is not to be used as a fall prevention technique. This took place across all shifts and practice is reinforced by regular nursing huddles leadership. Training has taken place for all permanent full time and part time nurses and contract nurses. Nursing staff on FMLA or LOA will complete the training prior to returning to work. New Employee orientation and annual training for nursing personnel was updated to reinforce training for expectations within the "Restraint and Seclusion" Policy. Training materials include reiteration that four side rails being up are not to be used as a fall prevention technique.	Ten (10) high fall risk patients are visually observed per week with a monthly aggregate of 40 by members of nursing and/or quality to review four side rails up are not used as a fall prevention technique. The findings are reported monthly to the Chief Nursing Officer, Quality of Care Committee, Medical Executive Committee and quarterly to the Quality Committee of the Board of Trustees (reports quarterly to the Board of Trustees) until 100% is sustained for two consecutive months. Monitoring will continue quarterly on an ongoing basis with findings reported to the above stated committees unless non-compliance is identified whereby monitoring will increase in frequency until compliance is restored.	**Responsible Person**: Chief Nursing Officer **Completion Date:** 6/09/2019

BSLMC has an effective Board of Trustees that is legal responsible for the conduct of the hospital. BSLMC is currently in compliance with the CMS Condition of Participation A263 as evidence by the following specific corrective actions, education and monitoring for compliance.

For all items within Tag A263, the Board of Trustees has been actively engaged in the oversight and implementation of the plan of correction. An Executive Quality Council (EQC), chaired by the President or Senior Leader designee, meets weekly to provide oversight of the compliance with the monitoring of follow-up/monitoring measures. This

council will continue to oversee the monitoring measures until 100% compliance with stated measures is sustained for two consecutive months. As well as:

- Individual staff member non-compliance will be reported to the appropriate supervisor or manager. Any non-compliance will be addressed with the individual through training, re-education and/or following the human resources corrective action process.
- Individual credential provider non-compliance will be addressed through the professional practice evaluation process and monitored through the ongoing practice evaluation process of the medical staff.
- When 100% compliance is sustained for two consecutive months for the monitoring measures stated in Tag A263, the monitoring will continue on an ongoing basis quarterly with finding continuing to be reported to the stated hospital Committees and the Quality Committee of the Board of Trustees (reports quarterly to the Board of Trustees). If compliance is not sustained quarterly monitoring will go back to weekly monitoring with data aggregated monthly for sustained compliance for at least two consecutive months. Decisions will be made in accordance with national clinical standards and the Conditions of Participation.

CoP Tag #	Plan for correcting the cited deficiency	Procedure for implementing the acceptable plan of correction	Follow-up/Monitoring	Person Responsible Completion Date
A263	The hospital's quality management structure has been updated to create a new committee, Quality Outcomes Committee, which is now responsible for coordinating, implementing, and monitoring effective Performance improvement (PI) activities across departments. This committee is chaired by the Chief Medical Officer and the Chief Nursing Officer. Each department has identified performance improvement metrics that have been incorporated into the Tier Huddle approach for monitoring by the committee. The Quality Outcomes Committee's charter has been approved by the Quality of Care Committee, Medical Executive Committee and the Board of Trustees Quality Sub-Committee. The Board of Trustees exercises oversight over contracted services to ensure the services are provided in accordance with nationally acceptable standards of practice, including quality indicators to ensure the service provided promote the health and safety of patients. Contracts were inventoried and reviewed to identify measures specific for the	The Quality Outcomes Committee membership has been educated on their roles and responsibilities by a member of the Quality Department Leadership Team. New employee orientation has been updated for members in Quality Leadership which includes requirements of the quality management structure and responsibility of coordinating, implementing, and monitoring Performance improvement (PI) is effective. The Infection prevention staff were educated by the Director of Infection Prevention the process to monitor, track and trend the following for the prevention of infections, this included Chlorhexidine bathing preoperatively, Nasal decolonization, High level disinfecting- sterilization of equipment, Ultrasound transducers, Transportation of equipment, Equipment cleaning and competencies, and use of durable medical equipment. The Quality staff responsible for the contract evaluations was provided education by the Quality Department Leadership on the expectations for management of the process. The leaders responsible for the contracts were provided education by the Vice President of Quality on the expectations for submitting data on the identified performance measures for each contract. The Patient Safety Committee and Quality Outcomes Committee members were provided education on	The Quality Outcomes Committee will meet at minimum six times per year with minutes reflecting performance improvement reports and discussions demonstrating the responsibility of coordinating, implementing, and monitoring Performance improvement (PI) was effective. This Committee reports to the Quality of Care Committee, Medical Executive Committee, and the Quality Committee of the Board of Trustees (reports quarterly to the Board of Trustees). On an ongoing basis as part of the Infection Prevention Program the following is monitored, tracked and trended with outcomes and action plans for gaps reported at the Infection Prevention and Control Committee at minimum 4 times per year: Chlorhexidine bathing preoperatively, Nasal decolonization, High level disinfecting-sterilization of equipment, Ultrasound transducers, Transportation of equipment, Equipment cleaning and competencies, and use of durable medical equipment. Findings are reported quarterly to the Infection Prevention and Control Committee, Quality of Care Committee, Medical	**Responsible Person**: Vice President of Quality **Completion Date:** 6/09/2019

	evaluation of each contract performance which included the contract for dietary services and compounding pharmaceutical services which included meeting the current Good Manufacturing Practices for compounding. A process was developed to track all current contracts with associated indicators as well as identify new contracts to be added to the process with identified measures. Contracts without performance indicators is in process of having an addendum approved to include performance indicators. The current surgical count audits that review the process to prevent a retained foreign body were incorporated into the Patient Safety Committee reporting oversight structure. The expectations for evaluating the following items was reinforced by the Vice President of Quality with the current Infection Prevention Leadership. The following items are now being tracked and trended for the prevention of infections to include: Chlorhexidine bathing preoperatively, Nasal decolonization, High level disinfecting- sterilization of equipment, Ultrasound transducers, Transportation of equipment, Equipment cleaning and competencies, and use of durable medical equipment. Methods and process to monitor, track and trend the above items were developed and implemented by the Director of Infection Prevention. The "Controlled Drug Systems and Accountability" policy and procedure was	their role with the surgical count audit monitoring process and the review of trends from the Tier Huddle approach. Nursing Leadership conducted educational training for all nursing staff about the expectations of following the administration of narcotics, preventing diversion and recognizing and reporting diversion in accordance with policy the "Controlled Drug Systems and Accountability". This took place across all shifts and practice is reinforced by regular nursing huddles leadership. Training has taken place for all permanent full time and part time nurses and contract nurses. Nursing staff on FMLA or LOA will complete the training prior returning to work. Pharmacy Leadership conducted educational training for all pharmacists about the expectations of following the administration of narcotics, preventing diversion and recognizing and reporting diversion in accordance with policy the "Controlled Drug Systems and Accountability". This took place across all shifts and is reinforced by regular Pharmacy leadership rounding to assess implementation. Training has taken place for permanent full time and part time pharmacists and contract pharmacists. Pharmacists on FMLA or LOA will complete the training prior returning to work. Credentialed Anesthesia Providers were notified of the expectations of following the administration of narcotics, preventing diversion and recognizing and reporting diversion in accordance with policy the "Controlled Drug Systems and Accountability". They were provided education through one or more of these methods: in-person training, certified letters, online training modules and discussion at medical staff meetings. New Employee orientation and annual training for members of the medical staff, pharmacists, and nurses has been updated to reinforce the expectations of following the administration of narcotics, preventing diversion and recognizing and reporting diversion in accordance with policy the "Controlled Drug Systems and Accountability".	Executive Committee and the Quality Committee of the Board of Trustees (reports quarterly to the Board of Trustees). The identified performance indicators for each contract has been reviewed by the Quality Committee of the Board of Trustees (reports quarterly to the Board of Trustees). Annually contracts will be evaluated by the Quality of Care Committee, MEC and Board of Trustees based on the identified contract specific performance indicators. Quarterly the measures identified for contract evaluations will be reviewed by the Quality Outcomes Committee to review progress towards meeting the annual evaluation requirement. The Quality Outcomes Committee reports to the Quality of Care Committee, Medical Executive Committee and the Quality Committee of the Board of Trustees (reports quarterly to the Board of Trustees). The Patient Safety Committee will meet at minimum six times per year with minutes reflecting tracking and trending of the current surgical count audits. Weekly inventory counts for each electronic medication dispensing machine are performed by nursing staff. Compliance with weekly inventory counts is monitored by the Pharmacy staff and noncompliance is reported to unit leadership for investigation and follow-up. Monthly aggregate and trends will be reported on an ongoing basis to the Diversion Prevention Committee, Director of Pharmacy, CNO and quarterly to the	

	developed and implemented. This policy established a Diversion Prevention Committee who has oversight of the diversion prevention program. The policy addresses diversion prevention, detection and reporting, access, procurement, receiving, secured storage, preparation, distribution and dispensing, administration, waste and returns, discrepancies, and quality assurance reporting. The policy has been approved by Pharmacy and Therapeutic Committee and Medical Executive Committee. A risk assessment was completed with the findings used to develop diversion prevention strategies for reconciling inventory of controlled substances, appropriately disposing of controlled substance waste, use of lock boxes and portless tubing to prevent diversion of IV narcotic infusions and controlling access to medication storage areas. Pharmacy Leadership implemented a process to generate a daily report to identify unresolved discrepancies and a report to monitor weekly inventory count. Approved controlled substance waste containers were installed in the hospital to include all off site locations. A charter was created for the Diversion Prevention Committee, comprised of members of the Senior Leadership Committee and Pharmacy Leadership, that outlines the purpose, scope, membership, responsibilities, meeting frequency, and reporting structure. The Diversion Prevention Committee reports to the Pharmacy and Therapeutic Committee of the Hospital.	The charter for the Diversion Prevention Committee was reviewed at the initial committee meeting to inform committee members of their responsibilities. Affected pharmacy, nursing and anesthesia staff were educated regarding requirements for daily resolution of discrepancies and weekly inventory counts. This education was reinforced through huddles, e-mail communication, leadership rounding, and feedback from quality monitoring to ensure compliance. New employee orientation and annual training for Pharmacy, Nursing and Anesthesia staff was revised to include training on discrepancy resolution and weekly inventory processes. Affected staff was educated on the use of the approved controlled waste medication containers through onsite education provided by the contracted company. Additionally a one-page flyer from the contracted company was laminated and placed in all applicable departments for quick reference. This flyer was reviewed in huddles and leadership rounds to validate staff knowledge of the information. The Hospital Safety Officer has given training to all primary and secondary Environment of Care (EOC) surveyors on the expectations for EOC rounds which included rounding, reporting, communicating and correcting of deficiencies. The Hospital Safety Officer acting as the EOC Committee Chair, reinforced with the Committee and EOC surveyors the expectations completing environmental rounds weekly as per the rounding schedule. New employees conducting EOC rounds will be educated by the Hospital Safety Department prior to completing an EOC round.	Pharmacy and Therapeutics Committee, Quality of Care Committee, Medical Executive Committee and Quality Committee of the Board of Trustees (reports quarterly to the Board of Trustees). A report is generated daily by the Pharmacy to identify unresolved discrepancies. Unresolved discrepancies are reported to the appropriate leader for corrective action. Monthly aggregate data and trends are reported on an ongoing basis to the Diversion Prevention Committee, Director of Pharmacy, CNO quarterly to the Pharmacy and Therapeutics Committee, Patient Safety Committee, Quality of Care Committee, Medical Executive Committee and Quality Committee of the Board of Trustees (reports quarterly to the Board of Trustees). Compliance with the use of the approved controlled substance medication waste containers is monitored through the weekly environment of safety rounds. Ten (10) rounds will be completed per week with a monthly aggregate of forty (40) by members of Hospital Leadership to assesses staff knowledge of the use of the containers and the presence of the containers in the area. Results are aggregated and reported weekly to the Pharmacy Director, CNO and quarterly to the P&T Committee, Quality of Care Committee, Medical Executive Committee and quarterly to the Quality Committee of the Board of Trustees (reports quarterly to the Board of Trustees) until 100% is sustained for two consecutive months. Monitoring will continue quarterly on an ongoing basis with findings reported to the above stated committees unless non-	

	Environmental rounds have been implemented which includes weekly rounds per the rounding schedule (all patient care areas twice per calendar year and non-patient care areas at least annually) A schedule of environmental rounds has been completed for each area of the hospital. Environmental rounds will be completed in conjunction with infection prevention to identify any ongoing maintenance repairs and infection control concerns.		compliance is identified whereby monitoring will increase in frequency until compliance is restored. Environment of Care Program weekly environmental rounds are completed per the rounding schedule. Results of the rounds and action items for gaps will be aggregated weekly and reported to the monthly to the Vice President of Operations and reported quarterly to the Environment of Care and Safety Committee, Quality of Care Committee, Medical Executive Committee and Quality Committee of the Board of Trustees (reports quarterly to the Board of Trustees). Monitoring will continue quarterly on an ongoing basis with findings reported to the above stated committees unless non-compliance is identified whereby monitoring will increase in frequency until compliance is restored.	

BSLMC has an effective Board of Trustees that is legal responsible for the conduct of the hospital. BSLMC is currently in compliance with the CMS Condition of Participation A283 as evidence by the following specific corrective actions, education and monitoring for compliance.

For all items within Tag A283, the Board of Trustees has been actively engaged in the oversight and implementation of the plan of correction. An Executive Quality Council (EQC), chaired by the President or Senior Leader designee, meets weekly to provide oversight of the compliance with the monitoring of follow-up/monitoring measures. This council will continue to oversee the monitoring measures until 100% compliance with stated measures is sustained for two consecutive months. As well as:

- Individual staff member non-compliance will be reported to the appropriate supervisor or manager. Any non-compliance will be addressed with the individual through training, re-education and/or following the human resources corrective action process.
- Individual credential provider non-compliance will be addressed through the professional practice evaluation process and monitored through the ongoing practice evaluation process of the medical staff.
- When 100% compliance is sustained for two consecutive months for the monitoring measures stated in Tag A283, the monitoring will continue on an ongoing basis quarterly with finding continuing to be reported to the stated hospital Committees and the Quality Committee of the Board of Trustees (reports quarterly to the Board of Trustees). If compliance is not sustained quarterly monitoring will go back to weekly monitoring with data aggregated monthly for sustained compliance for at least two consecutive months. Decisions will be made in accordance with national clinical standards and the Conditions of Participation.

CoP Tag #	Plan for correcting the cited deficiency	Procedure for implementing the acceptable plan of correction	Follow-up/Monitoring	Person Responsible Completion Date

A283	The hospital's quality management structure has been updated to create a new committee, Quality Outcomes Committee, which is now responsible for coordinating, implementing, and monitoring effective Performance improvement (PI) activities across departments. This committee is chaired by the Chief Medical Officer and the Chief Nursing Officer. Each department has identified performance improvement metrics that have been incorporated into the Tier Huddle approach for monitoring by the committee. This Committee reports to the Quality of Care Committee, Medical Executive Committee, and the Quality Committee of the Board of Trustees (reports quarterly to the Board of Trustees). The Quality Outcomes Committee's charter has been approved by the Quality of Care Committee, Medical Executive Committee and the Board of Trustees Quality Sub-Committee. The Board of Trustees exercises oversight over contracted services to ensure the services are provided in accordance with nationally acceptable standards of practice, including quality indicators to ensure the service provided promote the health and safety of patients. Contracts were inventoried and reviewed to identify measures specific for the evaluation of each contract performance which included the contract for dietary services and compounding pharmaceutical services which included meeting the current Good Manufacturing Practices for compounding.	The Quality Outcomes Committee membership has been educated on their roles and responsibilities by a member of the Quality Department Leadership Team. New employee orientation has been updated for members in Quality Leadership which includes requirements of the quality management structure and responsibility of coordinating, implementing, and monitoring Performance improvement (PI) is effective. The Infection prevention staff were educated by the Director of Infection Prevention the process to monitor, track and trend the following for the prevention of infections, this included Chlorhexidine bathing preoperatively, Nasal decolonization, High level disinfecting- sterilization of equipment, Ultrasound transducers, Transportation of equipment, Equipment cleaning and competencies, and use of durable medical equipment. The Quality staff responsible for the contract evaluations was provided education by the Quality Department Leadership on the expectations for management of the process. The leaders responsible for the contracts were provided education by the Vice President of Quality on the expectations for submitting data on the identified performance measures for each contract. The Patient Safety Committee and Quality Outcomes Committee members were provided education on their role with the surgical count audit monitoring process and the review of trends from the Tier Huddle approach. Nursing Leadership conducted educational training for all nursing staff about the expectations of following the administration of narcotics, preventing diversion and recognizing and reporting diversion in accordance with policy the "Controlled Drug Systems and Accountability". This took place across all shifts and practice is reinforced by regular nursing huddles leadership. Training has taken place for all permanent full time and part time nurses and contract nurses.	The Quality Outcomes Committee will meet at minimum six times per year with minutes reflecting performance improvement reports and discussions demonstrating the responsibility of coordinating, implementing, and monitoring Performance improvement (PI) was effective. This Committee reports to the Quality of Care Committee, Medical Executive Committee, and the Quality Committee of the Board of Trustees (reports quarterly to the Board of Trustees). On an ongoing basis as part of the Infection Prevention Program the following is monitored, tracked and trended with outcomes and action plans for gaps reported at the Infection Prevention and Control Committee at minimum 4 times per year: Chlorhexidine bathing preoperatively, Nasal decolonization, High level disinfecting-sterilization of equipment, Ultrasound transducers, Transportation of equipment, Equipment cleaning and competencies, and use of durable medical equipment. Findings are reported quarterly to the Infection Prevention and Control Committee, Quality of Care Committee, Medical Executive Committee and the Quality Committee of the Board of Trustees (reports quarterly to the Board of Trustees). The identified performance indicators for each contract has been reviewed by the Quality Committee of the Board of Trustees (reports quarterly to the Board of Trustees). Annually contracts will be evaluated by	**Responsible Person**: Vice President of Quality **Completion Date:** 6/09/2019

	A process was developed to track all current contracts with associated indicators as well as identify new contracts to be added to the process with identified measures. Contracts without performance indicators is in process of having an addendum approved to include performance indicators. The current surgical count audits that review the process to prevent a retained foreign body were incorporated into the Patient Safety Committee reporting oversight structure. The expectations for evaluating the following items was reinforced by the Vice President of Quality with the current Infection Prevention Leadership. The following items are now being tracked and trended for the prevention of infections to include: Chlorhexidine bathing preoperatively, Nasal decolonization, High level disinfecting- sterilization of equipment, Ultrasound transducers, Transportation of equipment, Equipment cleaning and competencies, and use of durable medical equipment. Methods and process to monitor, track and trend the above items were developed and implemented by the Director of Infection Prevention. The "Controlled Drug Systems and Accountability" policy and procedure was developed and implemented. This policy established a Diversion Prevention Committee who has oversight of the diversion prevention program. The policy addresses diversion prevention, detection and reporting, access, procurement, receiving, secured storage, preparation,	Nursing staff on FMLA or LOA will complete the training prior returning to work. Pharmacy Leadership conducted educational training for all pharmacists about the expectations of following the administration of narcotics, preventing diversion and recognizing and reporting diversion in accordance with policy the "Controlled Drug Systems and Accountability". This took place across all shifts and is reinforced by regular Pharmacy leadership rounding to assess implementation. Training has taken place for permanent full time and part time pharmacists and contract pharmacists. Pharmacists on FMLA or LOA will complete the training prior returning to work. Credentialed Anesthesia Providers were notified of the expectations of following the administration of narcotics, preventing diversion and recognizing and reporting diversion in accordance with policy the "Controlled Drug Systems and Accountability". They were provided education through one or more of these methods: in-person training, certified letters, online training modules and discussion at medical staff meetings. New Employee orientation and annual training for members of the medical staff, pharmacists, and nurses has been updated to reinforce the expectations of following the administration of narcotics, preventing diversion and recognizing and reporting diversion in accordance with policy the "Controlled Drug Systems and Accountability". The charter for the Diversion Prevention Committee was reviewed at the initial committee meeting to inform committee members of their responsibilities. Affected pharmacy, nursing and anesthesia staff were educated regarding requirements for daily resolution of discrepancies and weekly inventory counts. This education was reinforced through huddles, e-mail communication, leadership rounding, and feedback from quality monitoring to ensure compliance. New employee orientation and annual training for	the Quality of Care Committee, MEC and Board of Trustees based on the identified contract specific performance indicators. Quarterly the measures identified for contract evaluations will be reviewed by the Quality Outcomes Committee to review progress towards meeting the annual evaluation requirement. The Quality Outcomes Committee reports to the Quality of Care Committee, Medical Executive Committee and the Quality Committee of the Board of Trustees (reports quarterly to the Board of Trustees). The Patient Safety Committee will meet at minimum six times per year with minutes reflecting tracking and trending of the current surgical count audits. This Committee reports to the Quality of Care Committee, Medical Executive Committee, and the Quality Committee of the Board of Trustees (reports quarterly to the Board of Trustees). Weekly inventory counts for each electronic medication dispensing machine are performed by nursing staff. Compliance with weekly inventory counts is monitored by the Pharmacy staff and noncompliance is reported to unit leadership for investigation and follow-up. Monthly aggregate and trends will be reported on an ongoing basis to the Diversion Prevention Committee, Director of Pharmacy, CNO and quarterly to the Pharmacy and Therapeutics Committee, Quality of Care Committee, Medical Executive Committee and Quality Committee of the Board of Trustees (reports quarterly to the Board of Trustees).	

	distribution and dispensing, administration, waste and returns, discrepancies, and quality assurance reporting. The policy has been approved by Pharmacy and Therapeutic Committee and Medical Executive Committee. A risk assessment was completed with the findings used to develop diversion prevention strategies for reconciling inventory of controlled substances, appropriately disposing of controlled substance waste, use of lock boxes and portless tubing to prevent diversion of IV narcotic infusions and controlling access to medication storage areas. Pharmacy Leadership implemented a process to generate a daily report to identify unresolved discrepancies and a report to monitor weekly inventory count. Approved controlled substance waste containers were installed in the hospital to include all off site locations. A charter was created for the Diversion Prevention Committee, comprised of members of the Senior Leadership Committee and Pharmacy Leadership, that outlines the purpose, scope, membership, responsibilities, meeting frequency, and reporting structure. The Diversion Prevention Committee reports to the Pharmacy and Therapeutic Committee of the Hospital. Environmental rounds have been implemented which includes weekly rounds per the rounding schedule (all patient care areas twice per calendar year and non-patient care areas at least annually)	Pharmacy, Nursing and Anesthesia staff was revised to include training on discrepancy resolution and weekly inventory processes. Affected staff was educated on the use of the approved controlled waste medication containers through onsite education provided by the contracted company. Additionally a one-page flyer from the contracted company was laminated and placed in all applicable departments for quick reference. This flyer was reviewed in huddles and leadership rounds to validate staff knowledge of the information. The Hospital Safety Officer has given training to all primary and secondary Environment of Care (EOC) surveyors on the expectations for EOC rounds which included rounding, reporting, communicating and correcting of deficiencies. The Hospital Safety Officer acting as the EOC Committee Chair, reinforced with the Committee and EOC surveyors the expectations completing environmental rounds weekly as per the rounding schedule. New employees conducting EOC rounds will be educated by the Hospital Safety Department prior to completing an EOC round.	A report is generated daily by the Pharmacy to identify unresolved discrepancies. Unresolved discrepancies are reported to the appropriate leader for corrective action. Monthly aggregate data and trends are reported on an ongoing basis to the Diversion Prevention Committee, Director of Pharmacy, CNO quarterly to the Pharmacy and Therapeutics Committee, Patient Safety Committee, Quality of Care Committee, Medical Executive Committee and Quality Committee of the Board of Trustees (reports quarterly to the Board of Trustees). Compliance with the use of the approved controlled substance medication waste containers is monitored through the weekly environment of safety rounds. Ten (10) rounds will be completed per week with a monthly aggregate of forty (40) by members of Hospital Leadership to assesses staff knowledge of the use of the containers and the presence of the containers in the area. Results are aggregated and reported weekly to the Pharmacy Director, CNO and quarterly to the P&T Committee, Quality of Care Committee, Medical Executive Committee and quarterly to the Quality Committee of the Board of Trustees (reports quarterly to the Board of Trustees) until 100% is sustained for two consecutive months. Monitoring will continue quarterly on an ongoing basis with findings reported to the above stated committees unless non-compliance is identified whereby monitoring will increase in frequency until compliance is restored. Environment of Care Program weekly environmental rounds are completed per the rounding schedule. Results of the	

	A schedule of environmental rounds has been completed for each area of the hospital. Environmental rounds will be completed in conjunction with infection prevention to identify any ongoing maintenance repairs and infection control concerns.		rounds and action items for gaps will be aggregated weekly and reported to the monthly to the Vice President of Operations and reported quarterly to the Environment of Care and Safety Committee, Quality of Care Committee, Medical Executive Committee and Quality Committee of the Board of Trustees (reports quarterly to the Board of Trustees). Monitoring will continue quarterly on an ongoing basis with findings reported to the above stated committees unless non-compliance is identified whereby monitoring will increase in frequency until compliance is restored.	

BSLMC has an effective Board of Trustees that is legal responsible for the conduct of the hospital. BSLMC is currently in compliance with the CMS Condition of Participation A386 as evidence by the following specific corrective actions, education and monitoring for compliance.

For all items within Tag A386, the Board of Trustees has been actively engaged in the oversight and implementation of the plan of correction. An Executive Quality Council (EQC), chaired by the President or Senior Leader designee, meets weekly to provide oversight of the compliance with the monitoring of follow-up/monitoring measures. This council will continue to oversee the monitoring measures until 100% compliance with stated measures is sustained for two consecutive months. As well as:

- Individual staff member non-compliance will be reported to the appropriate supervisor or manager. Any non-compliance will be addressed with the individual through training, re-education and/or following the human resources corrective action process.
- Individual credential provider non-compliance will be addressed through the professional practice evaluation process and monitored through the ongoing practice evaluation process of the medical staff.
- When 100% compliance is sustained for two consecutive months for the monitoring measures stated in Tag A386, the monitoring will continue on an ongoing basis quarterly with finding continuing to be reported to the stated hospital Committees and the Quality Committee of the Board of Trustees (reports quarterly to the Board of Trustees). If compliance is not sustained quarterly monitoring will go back to weekly monitoring with data aggregated monthly for sustained compliance for at least two consecutive months. Decisions will be made in accordance with national clinical standards and the Conditions of Participation.

CoP Tag #	Plan for correcting the cited deficiency	Procedure for implementing the acceptable plan of correction	Follow-up/Monitoring	Person Responsible Completion Date
A386 (1)	The individual identified was re-educated on the process for acknowledging and following physician orders in accordance with the "Physicians Orders: Processing/Patient Care" procedure policy as well as documentation in the electronic health record.	Nursing Leadership conducted educational training for all nursing staff about the expectations of following physician orders as listed in the "Physicians Order:; Processing/Patient Care" procedure policy. This took place across all shifts and practice is reinforced by regular nursing huddles leadership. Training has taken place for all permanent full time and part time nurses and contract nurses. Nursing staff on FMLA or LOA will	Ten (10) physician orders to collect stools for occult blood and the application of intermittent pneumatic compression device are audited per week with a monthly aggregate of 40 by the quality department. The findings are reported monthly to the CNO, Quality of Care Committee, Medical Executive Committee	**Responsible Person**: Chief Nursing Officer **Completion Date:** 6/09/2019

	Training materials were created for the expectations of following physician orders in accordance with the "Physicians Orders: Processing/Patient Care" procedure policy. Training materials included reiteration of the process for acknowledging and following physician orders in the electronic health record. New orders should be reviewed by two RNs each shift or with the change of caregivers by reviewing the active orders list in the electronic medical record. The CNO conducted a series of meetings with nursing leadership to reiterate the leadership accountability expectations to ensure nursing staff's clinical practices are in alignment with the facility "Physicians Orders: Processing/Patient Care" procedure" policy.	complete the training prior returning to work. New Employee orientation and annual training for nursing personnel was updated to reinforce expectations of following physician orders as listed in the "Physicians Orders: Processing/Patient Care" procedure policy.	and quarterly to the Quality Committee of the Board of Trustees (reports quarterly to the Board of Trustees) until 100% is sustained for two consecutive months. Monitoring will continue quarterly on an ongoing basis with findings reported to the above stated committees unless non-compliance is identified whereby monitoring will increase in frequency until compliance is restored.	
A386 (2)	Training materials were created for the expectations of pain assessment on admission, throughout the stay and at discharge in accordance with policy "Pain and Opioid Management". Report tools were created from the electronic health record to assist in the evaluation of compliance with expectations of pain assessment on admission, throughout the stay and at discharge in accordance with policy "Pain and Opioid Management". The CNO conducted a series of meetings with nursing leadership to reiterate the leadership accountability expectations to ensure nursing staff's clinical practices are in alignment with the facility "Pain and Opioid Management" policy.	Nursing Leadership conducted educational training for nursing staff about the expectations of pain assessment on admission, throughout the stay and at discharge in accordance with policy "Pain and Opioid Management". This took place across all shifts and practice is reinforced by regular nursing huddles leadership. Training has taken place for all permanent full time and part time nurses and contract nurses. Nursing staff on FMLA or LOA will complete the training prior returning to work. Emergency Department (ED) Nursing Leadership conducted educational training for all ED nursing staff about the expectations of pain assessment at discharge in accordance with the policy "Pain and Opioid Management". This took place across all shifts and practice is reinforced by regular nursing huddles and nursing leadership rounds. Training has taken place for all permanent full time and part time nurses and contract nurses. Nursing staff on FMLA or LOA will complete the training prior returning to work. New Employee orientation and annual training for nursing personnel was updated to reinforce	Twenty (20) patients are audited weekly with a monthly aggregate of 80 by members of the nursing or quality team to review compliance with pain assessment on admission, throughout the stay, and at discharge in accordance with policy "Pain and Opioid Management". The findings are reported monthly to the CNO, Quality of Care Committee, Medical Executive Committee and quarterly to the Quality Committee of the Board of Trustees (reports quarterly to the Board of Trustees) until 100% is sustained for two consecutive months. Monitoring will continue quarterly on an ongoing basis with findings reported to the above stated committees unless non-compliance is identified whereby monitoring will increase in frequency until compliance is restored.	**Responsible Person**: Chief Nursing Officer **Completion Date:** 6/09/2019

		expectations of pain assessment on admission, throughout the stay and at discharge in accordance with policy "Pain and Opioid Management".		

BSLMC has an effective Board of Trustees that is legal responsible for the conduct of the hospital. BSLMC is currently in compliance with the CMS Condition of Participation A392 as evidence by the following specific corrective actions, education and monitoring for compliance.

For all items within Tag A392, the Board of Trustees has been actively engaged in the oversight and implementation of the plan of correction. An Executive Quality Council (EQC), chaired by the President or Senior Leader designee, meets weekly to provide oversight of the compliance with the monitoring of follow-up/monitoring measures. This council will continue to oversee the monitoring measures until 100% compliance with stated measures is sustained for two consecutive months. As well as:

- Individual staff member non-compliance will be reported to the appropriate supervisor or manager. Any non-compliance will be addressed with the individual through training, re-education and/or following the human resources corrective action process.
- Individual credential provider non-compliance will be addressed through the professional practice evaluation process and monitored through the ongoing practice evaluation process of the medical staff.
- When 100% compliance is sustained for two consecutive months for the monitoring measures stated in Tag A392, the monitoring will continue on an ongoing basis quarterly with finding continuing to be reported to the stated hospital Committees and the Quality Committee of the Board of Trustees (reports quarterly to the Board of Trustees). If compliance is not sustained quarterly monitoring will go back to weekly monitoring with data aggregated monthly for sustained compliance for at least two consecutive months. Decisions will be made in accordance with national clinical standards and the Conditions of Participation.

CoP Tag #	Plan for correcting the cited deficiency	Procedure for implementing the acceptable plan of correction	Follow-up/Monitoring	Person Responsible Completion Date
A392	The Chief Nursing Officer met with the leadership and staff at Kirby Glen to review the scope of services and staffing plan. The staffing plan and scope of service for Kirby Glen was updated to align with the correct staffing needs. The Chief Nursing Officer and the Vice President of Operations have reviewed the Kirby Glen staffing plan. A request for an additional RN has been approved and the position was posted. Oncology Director for BSLMC and Director of Outpatient Services developed staff sharing options to ensure qualified chemotherapy certified nurses are available.	The Director of Outpatient Services was educated by the Chief Nursing Officer of the correct staffing patterns in compliance with national standards. In addition the process to escalate if the staffing needs are not met.	Weekly the Director of Outpatient Services will provide the Chief Nursing Officer a report of the current staffing patterns and the anticipated staffing schedule. The findings are reported monthly to the Quality of Care Committee, Medical Executive Committee and quarterly to the Quality Committee of the Board of Trustees (reports quarterly to the Board of Trustees) until 100% is sustained for two consecutive months. Monitoring will continue quarterly on an ongoing basis with findings reported to the above stated committees unless non-compliance is identified whereby monitoring will increase in frequency until compliance is restored. Staffing is reviewed annually by Clinical Nursing Staff Council and Nursing	**Responsible Person**: Chief Nursing Officer **Completion Date:** 6/09/2019

			Leadership per the Nurse Staffing Plan: Nursing Services Policy.	

BSLMC has an effective Board of Trustees that is legal responsible for the conduct of the hospital. BSLMC is currently in compliance with the CMS Condition of Participation A392 as evidence by the following specific corrective actions, education and monitoring for compliance.

For all items within Tag A392, the Board of Trustees has been actively engaged in the oversight and implementation of the plan of correction. An Executive Quality Council (EQC), chaired by the President or Senior Leader designee, meets weekly to provide oversight of the compliance with the monitoring of follow-up/monitoring measures. This council will continue to oversee the monitoring measures until 100% compliance with stated measures is sustained for two consecutive months. As well as:

- Individual staff member non-compliance will be reported to the appropriate supervisor or manager. Any non-compliance will be addressed with the individual through training, re-education and/or following the human resources corrective action process.
- Individual credential provider non-compliance will be addressed through the professional practice evaluation process and monitored through the ongoing practice evaluation process of the medical staff.
- When 100% compliance is sustained for two consecutive months for the monitoring measures stated in Tag A392, the monitoring will continue on an ongoing basis quarterly with finding continuing to be reported to the stated hospital Committees and the Quality Committee of the Board of Trustees (reports quarterly to the Board of Trustees). If compliance is not sustained quarterly monitoring will go back to weekly monitoring with data aggregated monthly for sustained compliance for at least two consecutive months. Decisions will be made in accordance with national clinical standards and the Conditions of Participation.

CoP Tag #	Plan for correcting the cited deficiency	Procedure for implementing the acceptable plan of correction	Follow-up/Monitoring	Person Responsible Completion Date
A395 (A)	The staffing plans for Kirby Glen were reviewed to ensure the compliance with the policy "Transfusion of Blood Products" can be achieved. The Chief Nursing Officer met with the leadership and staff at Kirby Glen to review the scope of services and staffing plan. The staffing plan and scope of service for Kirby Glen was updated to align with the correct staffing needs. The Chief Nursing Officer and the Vice President of Operations have reviewed the Kirby Glen staffing plan. A request for an additional RN has been approved and the position was posted. Oncology Director for BSLMC and Director of Outpatient Services developed staff sharing options to ensure qualified chemotherapy certified nurses are available.	The Director of Outpatient Services was educated by the Chief Nursing Officer of the correct staffing patterns in compliance with national standards. In addition the process to escalate if the staffing needs is not met. All nursing staff at Kirby Glen attended a mandatory training in blood transfusion policy and procedure.	Weekly the Director of Outpatient Services will provide the Chief Nursing Officer a report of the current staffing patterns and the anticipated staffing schedule. The findings are reported monthly to the Quality of Care Committee, Medical Executive Committee and quarterly to the Quality Committee of the Board of Trustees (reports quarterly to the Board of Trustees) until 100% is sustained for two consecutive months. Monitoring will continue quarterly on an ongoing basis with findings reported to the above stated committees unless non-compliance is identified whereby monitoring will increase in frequency until compliance is restored. Staffing is reviewed annually by Clinical Nursing Staff Council and Nursing Leadership per the Nurse Staffing Plan: Nursing Services Policy.	**Responsible Person**: Chief Nursing Officer **Completion Date:** 6/09/2019

			All blood transfusion administration records are audited per week by Kirby Glen leadership administration of blood in accordance with hospital policy. The findings are reported monthly to the CNO, Transfusion Committee, Quality of Care Committee, Medical Executive Committee and quarterly to the Quality Committee of the Board of Trustees (reports quarterly to the Board of Trustees) until 100% is sustained for two consecutive months. Monitoring will continue quarterly on an ongoing basis with findings reported to the above stated committees unless non-compliance is identified whereby monitoring will increase in frequency until compliance is restored.	
A395 (B)	New permanent Director of the Emergency Department (ED) has been hired. The Director of the ED conducted a series of meetings with ED Staff to reiterate the expectations of clinical practices are in alignment with facility policies "Treatment and reassessment guidelines" and "Triage-Emergency Department" Training materials were created for the ED Staff on the expectations of current practice standards within the polices "Treatment and reassessment guidelines" and "Triage-Emergency Department" These policies include assessment, reassessment and timeliness of physician orders and the process for triaging patients within the national emergency management guidelines. Staffing patterns were updated to Increase staffing during high-volume times with short-hour RN and PCA shifts (4, 6, 8 hour shifts) in order monitor and ensure	Emergency Department (ED) Nursing Leadership conducted educational training for all ED nursing staff about the requirements for the triage process, carrying out physician orders timely and the expectations for assessment/reassessment in accordance with the following policies "Treatment and reassessment guidelines" and "Triage-Emergency Department This took place across all shifts and practice is reinforced by regular nursing huddles leadership. Training has taken place for all permanent full time and part time nurses and contract nurses. Nursing staff on FMLA or LOA will complete the training prior to returning to work. New Employee orientation and annual training for ED nursing personnel was updated to reinforce the requirements for the triage process, following the ESI scale, carrying out physician orders timely and the expectations for assessment/reassessment in accordance with the following policies Treatment and reassessment guidelines" and "Triage-Emergency Department".	Twenty (20) patients are audited weekly with a monthly aggregate of 80 by members of the ED Leadership team to review compliance with the requirements for the triage process, carrying out physician orders timely and the expectations for assessment/reassessment in accordance with the following policies "Treatment and reassessment guidelines" and "Triage-Emergency Department". The findings are reported monthly to the ED Director, CNO, Emergency Department Committee, Quality of Care Committee, Medical Executive Committee and quarterly to the Quality Committee of the Board of Trustees (reports quarterly to the Board of Trustees) until 100% is sustained for two consecutive months. Monitoring will continue quarterly on an ongoing basis with findings reported to the above stated committees unless non-compliance is identified whereby monitoring will increase in frequency until	**Responsible Person**: Chief Nursing Officer **Completion Date:** 6/09/2019

	patients in the lobby are provided assessments and completion of orders within the hospital's policy guidelines and nationally recognized standards.		compliance is restored.	
A395 (C)	The individuals identified was re-educated on the process for pain medication orders containing physician directive for use in accordance with policy "Pain and Opioid Management". Training materials were created for the expectations of pain medication orders containing physician directive for use in accordance with policy "Pain and Opioid Management". Report tools were created from the electronic health record to assist in the evaluation of compliance with expectations of pain medication orders containing physician directive for use in accordance with policy "Pain and Opioid Management". The CNO conducted a series of meetings with nursing leadership to reiterate the leadership accountability expectations to ensure nursing staff's clinical practices are in alignment with the facility "Pain and Opioid Management" policy.	Nursing Leadership conducted educational training for all nursing staff about the expectations of pain medication orders containing physician directive for use in accordance with policy "Pain and Opioid Management". This took place across all shifts and practice is reinforced by regular nursing huddles and nursing leadership rounds. Training has taken place for all permanent full time and part time nurses and contract nurses. Nursing staff on FMLA or LOA will complete the training prior returning to work. Pharmacy Leadership conducted educational training for all pharmacists about the expectations of not verifying a pain medication order unless a specific reason was provided in accordance with policy "Pain and Opioid Management". This took place across all shifts and is reinforced by regular Pharmacy leadership rounding to assess implementation. Training has taken place for permanent full time and part time pharmacists and contract pharmacists. Pharmacists on FMLA or LOA will complete the training prior returning to work. Credentialed Providers were notified of the expectation of pain medication orders containing physician directive for use in accordance with policy "Pain and Opioid Management" and that pain medications will not be verified by a pharmacist unless provided. They were provided education through one or more of these methods: in-person training, certified letters, online training modules and training at medical staff meetings. New Employee orientation and annual training for pharmacists and nurses has been updated to reinforce the expectations of pain medication orders containing physician directive for use in accordance with policy "Pain and Opioid Management". Credentialed provider orientation has been updated to include	Twenty (10) pain medications are audited per week with a monthly aggregate of 80 by members of pharmacy to review appropriate reasons for pain medications were verified. The findings are reported monthly to the Director of Pharmacy, Quality of Care Committee, Medical Executive Committee and quarterly to the Quality Committee of the Board of Trustees (reports quarterly to the Board of Trustees) until 100% is sustained for two consecutive months. Monitoring will continue quarterly on an ongoing basis with findings reported to the above stated committees unless non-compliance is identified whereby monitoring will increase in frequency until compliance is restored.	**Responsible Person**: Chief Medical Officer **Completion Date:** 6/09/2019

		accepted indications for ordering pain medications.		

BSLMC has an effective Board of Trustees that is legal responsible for the conduct of the hospital. BSLMC is currently in compliance with the CMS Condition of Participation A396 as evidence by the following specific corrective actions, education and monitoring for compliance.

For all items within Tag A396, the Board of Trustees has been actively engaged in the oversight and implementation of the plan of correction. An Executive Quality Council (EQC), chaired by the President or Senior Leader designee, meets weekly to provide oversight of the compliance with the monitoring of follow-up/monitoring measures. This council will continue to oversee the monitoring measures until 100% compliance with stated measures is sustained for two consecutive months. As well as:

- Individual staff member non-compliance will be reported to the appropriate supervisor or manager. Any non-compliance will be addressed with the individual through training, re-education and/or following the human resources corrective action process.
- Individual credential provider non-compliance will be addressed through the professional practice evaluation process and monitored through the ongoing practice evaluation process of the medical staff.
- When 100% compliance is sustained for two consecutive months for the monitoring measures stated in Tag A396, the monitoring will continue on an ongoing basis quarterly with finding continuing to be reported to the stated hospital Committees and the Quality Committee of the Board of Trustees (reports quarterly to the Board of Trustees). If compliance is not sustained quarterly monitoring will go back to weekly monitoring with data aggregated monthly for sustained compliance for at least two consecutive months. Decisions will be made in accordance with national clinical standards and the Conditions of Participation.

CoP Tag #	Plan for correcting the cited deficiency	Procedure for implementing the acceptable plan of correction	Follow-up/Monitoring	Person Responsible Completion Date
A396	The individuals identified was re-educated on the process of documenting and maintain a current up-to-date nursing care plan in accordance with policy "Nursing Assessment and Plan of Care". Training materials were created for the expectations of documenting and maintaining a current up-to-date nursing care plan in accordance with policy "Nursing Assessment and Plan of Care". Report tools were created from the electronic health record to assist in the evaluation of compliance with the process for documenting and maintain a current up-to-date nursing care plan in accordance with policy "Nursing Assessment and Plan of Care". The CNO conducted a series of meetings with nursing leadership to reiterate the	Nursing Leadership conducted educational training for all nursing staff about the expectations of documenting and maintains a current up-to-date nursing care plan in accordance with policy "Nursing Assessment and Plan of Care". This took place across all shifts and practice is reinforced by regular nursing huddles and nursing leadership rounds. Training has taken place for all permanent full time and part time nurses and contract nurses. Nursing staff on FMLA or LOA will complete the training prior returning to work. New Employee orientation and annual training for nursing personnel was updated to reinforce expectations on the process of documenting and maintain a current up-to-date nursing care plan in accordance with policy "Nursing Assessment and Plan of Care".	Twenty (20) patients are audited weekly with a monthly aggregate of 80 by members of the nursing or quality team to review compliance with process documenting and maintain a current up-to-date nursing care plan in accordance with policy "Nursing Assessment and Plan of Care". The findings are reported monthly to the CNO, Quality of Care Committee, Medical Executive Committee and quarterly to the Quality Committee of the Board of Trustees (reports quarterly to the Board of Trustees) until 100% is sustained for two consecutive months. Monitoring will continue quarterly on an ongoing basis with findings reported to the above stated committees unless non-compliance is identified whereby monitoring will increase in frequency until compliance is restored.	**Responsible Person**: Chief Nursing Officer **Completion Date:** 6/09/2019

	leadership accountability expectations to ensure nursing staff's clinical practices are in alignment with the facility "Nursing Assessment and Plan of Care" policy.			

BSLMC has an effective Board of Trustees that is legal responsible for the conduct of the hospital. BSLMC is currently in compliance with the CMS Condition of Participation A405 as evidence by the following specific corrective actions, education and monitoring for compliance.

For all items within Tag A405, the Board of Trustees has been actively engaged in the oversight and implementation of the plan of correction. An Executive Quality Council (EQC), chaired by the President or Senior Leader designee, meets weekly to provide oversight of the compliance with the monitoring of follow-up/monitoring measures. This council will continue to oversee the monitoring measures until 100% compliance with stated measures is sustained for two consecutive months. As well as:

- Individual staff member non-compliance will be reported to the appropriate supervisor or manager. Any non-compliance will be addressed with the individual through training, re-education and/or following the human resources corrective action process.
- Individual credential provider non-compliance will be addressed through the professional practice evaluation process and monitored through the ongoing practice evaluation process of the medical staff.
- When 100% compliance is sustained for two consecutive months for the monitoring measures stated in Tag A405, the monitoring will continue on an ongoing basis quarterly with finding continuing to be reported to the stated hospital Committees and the Quality Committee of the Board of Trustees (reports quarterly to the Board of Trustees). If compliance is not sustained quarterly monitoring will go back to weekly monitoring with data aggregated monthly for sustained compliance for at least two consecutive months. Decisions will be made in accordance with national clinical standards and the Conditions of Participation.

CoP Tag #	Plan for correcting the cited deficiency	Procedure for implementing the acceptable plan of correction	Follow-up/Monitoring	Person Responsible Completion Date
A405	Training materials were created for the expectations of pain re-assessment accordance with policy "Pain and Opioid Management". Report tools were created from the electronic health record to assist in the evaluation of compliance with expectations of pain re-assessment in accordance with policy "Pain and Opioid Management". The CNO conducted a series of meetings with nursing leadership to reiterate the leadership accountability expectations to ensure nursing staff's clinical practices are in alignment with the facility "Pain and Opioid Management" policy.	Nursing Leadership conducted educational training for all nursing staff about the expectations of pain re-assessment in accordance with policy "Pain and Opioid Management". This took place across all shifts and practice is reinforced by regular nursing huddles leadership. Training has taken place for permanent all full time and part time nurses and contract nurses. Nursing staff on FMLA or LOA will complete the training prior returning to work. New Employee orientation and annual training for nursing personnel was updated to reinforce expectations of pain re-assessment in accordance with policies "Pain and Opioid Management".	Twenty (20) patients are audited weekly with a monthly aggregate of 80 by members of the nursing or quality team to review compliance with pain re-assessment in accordance with policies "Pain and Opioid Management". The findings are reported monthly to the CNO, Quality of Care Committee, Medical Executive Committee and quarterly to the Quality Committee of the Board of Trustees (reports quarterly to the Board of Trustees) until 100% is sustained for two consecutive months. Monitoring will continue quarterly on an ongoing basis with findings reported to the above stated committees unless non-compliance is identified whereby monitoring will increase in frequency until compliance is restored.	**Responsible Person**: Chief Nursing Officer **Completion Date:** 6/09/2019

BSLMC has an effective Board of Trustees that is legal responsible for the conduct of the hospital. BSLMC is currently in compliance with the CMS Condition of Participation A438 as evidence by the following specific corrective actions, education and monitoring for compliance.

For all items within Tag A438, the Board of Trustees has been actively engaged in the oversight and implementation of the plan of correction. An Executive Quality Council (EQC), chaired by the President or Senior Leader designee, meets weekly to provide oversight of the compliance with the monitoring of follow-up/monitoring measures. This council will continue to oversee the monitoring measures until 100% compliance with stated measures is sustained for two consecutive months. As well as:

- Individual staff member non-compliance will be reported to the appropriate supervisor or manager. Any non-compliance will be addressed with the individual through training, re-education and/or following the human resources corrective action process.
- Individual credential provider non-compliance will be addressed through the professional practice evaluation process and monitored through the ongoing practice evaluation process of the medical staff.
- When 100% compliance is sustained for two consecutive months for the monitoring measures stated in Tag A438, the monitoring will continue on an ongoing basis quarterly with finding continuing to be reported to the stated hospital Committees and the Quality Committee of the Board of Trustees (reports quarterly to the Board of Trustees). If compliance is not sustained quarterly monitoring will go back to weekly monitoring with data aggregated monthly for sustained compliance for at least two consecutive months. Decisions will be made in accordance with national clinical standards and the Conditions of Participation.

CoP Tag #	Plan for correcting the cited deficiency	Procedure for implementing the acceptable plan of correction	Follow-up/Monitoring	Person Responsible Completion Date
A438	The electronic health record was updated to create standardized templates for history and physicals as well as discharge summaries to reduce the errors for inaccurate documentation. Training materials were created for the expectations of complete history and physicals and discharge summaries in accordance with the medical staff rules and regulations. Compliance with a complete history and physical and discharge summary has been incorporated into the ongoing professional practice evaluation for physicians as part of the credentialing process.	Credentialed Providers were notified of the expectations of a complete history and physical and discharge summary in accordance with the medical staff rules and regulations. They were provided education through one or more of these methods: in-person training, certified letters, online training modules and training at medical staff meetings.	Twenty (20) patients are audited weekly with a monthly aggregate of 80 by members of the medical records or quality team to review compliance of complete history and physicals and discharge summaries in accordance with the medical staff rules and regulations. The findings are reported monthly to the Quality of Care Committee, Medical Executive Committee and quarterly to the Quality Committee of the Board of Trustees (reports quarterly to the Board of Trustees) until 100% is sustained for two consecutive months. Trends with providers will be handled through the Professional Practice Evaluation Committee. Continued sustainment of compliance will be addressed through the ongoing professional practice evaluation process of the medical staff. Monitoring will continue quarterly on an ongoing basis with findings reported to the above stated committees unless non-compliance is identified whereby monitoring will increase in frequency until compliance is restored.	**Responsible Person**: Chief Medical Officer **Completion Date:** 6/09/2019

BSLMC has an effective Board of Trustees that is legal responsible for the conduct of the hospital. BSLMC is currently in compliance with the CMS Condition of Participation A491 as evidence by the following specific corrective actions, education and monitoring for compliance.

For all items within Tag A491, the Board of Trustees has been actively engaged in the oversight and implementation of the plan of correction. An Executive Quality Council (EQC), chaired by the President or Senior Leader designee, meets weekly to provide oversight of the compliance with the monitoring of follow-up/monitoring measures. This council will continue to oversee the monitoring measures until 100% compliance with stated measures is sustained for two consecutive months. As well as:

- Individual staff member non-compliance will be reported to the appropriate supervisor or manager. Any non-compliance will be addressed with the individual through training, re-education and/or following the human resources corrective action process.
- Individual credential provider non-compliance will be addressed through the professional practice evaluation process and monitored through the ongoing practice evaluation process of the medical staff.
- When 100% compliance is sustained for two consecutive months for the monitoring measures stated in Tag A491, the monitoring will continue on an ongoing basis quarterly with finding continuing to be reported to the stated hospital Committees and the Quality Committee of the Board of Trustees (reports quarterly to the Board of Trustees). If compliance is not sustained quarterly monitoring will go back to weekly monitoring with data aggregated monthly for sustained compliance for at least two consecutive months. Decisions will be made in accordance with national clinical standards and the Conditions of Participation.

CoP Tag #	Plan for correcting the cited deficiency	Procedure for implementing the acceptable plan of correction	Follow-up/Monitoring	Person Responsible Completion Date
A491	New red containers that are dedicated to chemotherapy transport were purchased for Kirby Glen. Blue containers were purchased for the transport of non-chemotherapy medications. Instructional materials were developed to demonstrate how to clean all transportation bins and ice packs in accordance with policy "Handling and Disposal of Hazardous Materials". The "Controlled Drug Systems and Accountability" policy and procedure was developed and implemented. This policy established a Diversion Prevention Committee who has oversight of the diversion prevention program. The policy addresses diversion prevention, detection and reporting, access, procurement, receiving, secured storage, preparation, distribution and dispensing, administration, waste and returns, discrepancies, and quality assurance	Staff transporting chemotherapy drugs were educated by Pharmacy Leadership on the correct methods of transportation with the new bins and the proper cleaning of the bins and ice packs in accordance with policy "Handling and Disposal of Hazardous Materials". Nursing Leadership conducted educational training for nursing staff about the expectations of following the administration of narcotics, preventing diversion and recognizing and reporting diversion in accordance with policy the "Controlled Drug Systems and Accountability". This took place across all shifts and practice is reinforced by regular nursing huddles leadership. Training has taken place for permanent full time and part time nurses and contract nurses. Nursing staff on FMLA or LOA will complete the training prior returning to work. Pharmacy Leadership conducted educational training for all pharmacists about the expectations of following the administration of narcotics, preventing diversion and recognizing and reporting diversion in accordance with policy the "Controlled Drug Systems and Accountability". This took place across all shifts and is reinforced by regular Pharmacy leadership rounding to	Once a week the Kirby Glen Pharmacy Team will audit the transportation and cleaning procedures of chemotherapy drugs with a monthly aggregate of four observations. The findings are reported monthly to the Director of Pharmacy, Quality of Care Committee, Medical Executive Committee and quarterly to the Quality Committee of the Board of Trustees (reports quarterly to the Board of Trustees) until 100% is sustained for two consecutive months. Monitoring will continue quarterly on an ongoing basis with findings reported to the above stated committees unless non-compliance is identified whereby monitoring will increase in frequency until compliance is restored. A report is generated daily by the Pharmacy to identify unresolved discrepancies. Unresolved discrepancies are reported to the appropriate leader for corrective action. Monthly aggregate	**Responsible Person**: Vice President of Operations **Completion Date:** 6/09/2019

	reporting. The policy has been approved by Pharmacy and Therapeutic Committee and Medical Executive Committee. A risk assessment was completed with the findings used to develop diversion prevention strategies for reconciling inventory of controlled substances, appropriately disposing of controlled substance waste, use of lock boxes and portless tubing to prevent diversion of IV narcotic infusions and controlling access to medication storage areas. Pharmacy Leadership implemented a process to generate a daily report to identify unresolved discrepancies and a report to monitor weekly inventory count. Approved controlled substance waste containers were installed in the hospital to include all off site locations. Access to the medication storage locations at the community emergency centers was restricted to nursing staff. Signage was posted to instruct staff that non-nursing staff must be accompanied by a member of the nursing staff. The dialysate solution for 7 South 1 and 2 was placed in a separate electronic dispensing machine in order to segregate the different concentrations. When the nurse accesses the cabinet to remove the ordered concentration the cabinet opens to that item to guide appropriate selection of medications. The nurse then uses the hospital's barcode scanning process for administration of the dialysate solution. A charter was created for the Diversion Prevention Committee, comprised of	assess implementation. Training has taken place for permanent full time and part time pharmacists and contract pharmacists. Pharmacists on FMLA or LOA will complete the training prior returning to work. Credentialed Anesthesia Providers were trained on the expectations of following the administration of narcotics, preventing diversion and recognizing and reporting diversion in accordance with policy the "Controlled Drug Systems and Accountability". They were provided education through one or more of these methods: in-person training, certified letters, online training modules and training at medical staff meetings. New Employee orientation and annual training for members of the medical staff, pharmacists, and nurses has been updated to reinforce the expectations of following the administration of narcotics, preventing diversion and recognizing and reporting diversion in accordance with policy the "Controlled Drug Systems and Accountability". The charter for the Diversion Prevention Committee was reviewed at the initial committee meeting to inform committee members of their responsibilities. Affected pharmacy, nursing and anesthesia staff were educated regarding requirements for daily resolution of discrepancies and weekly inventory counts. This education was reinforced through huddles, e-mail communication, leadership rounding, and feedback from quality monitoring to ensure compliance. New employee orientation and annual training for Pharmacy, Nursing and Anesthesia staff was revised to include training on discrepancy resolution and weekly inventory processes. Affected staff were educated on the use of the approved controlled waste medication containers through onsite education provided by the contracted company. Additionally a one-page flyer from the contracted company was laminated and placed in all applicable departments for quick reference. This flyer	data and trends are reported on an ongoing basis to the Diversion Prevention Committee, Director of Pharmacy, CNO quarterly to the Pharmacy and Therapeutics Committee, Patient Safety Committee, Quality of Care Committee, Medical Executive Committee and Quality Committee of the Board of Trustees (reports quarterly to the Board of Trustees). Weekly inventory counts for each electronic medication dispensing machine are performed by nursing staff. Compliance with weekly inventory counts is monitored by the Pharmacy staff and noncompliance is reported to unit leadership for investigation and follow-up. Monthly aggregate and trends will be reported on an ongoing basis to the Diversion Prevention Committee, Director of Pharmacy, CNO and quarterly to the Pharmacy and Therapeutics Committee, Quality of Care Committee, Medical Executive Committee and Quality Committee of the Board of Trustees (reports quarterly to the Board of Trustees). Monitoring will continue quarterly on an ongoing basis with findings reported to the above stated committees unless non-compliance is identified whereby monitoring will increase in frequency until compliance is restored. Compliance with the use of the approved controlled substance medication waste containers is monitored through the weekly environment of safety rounds. Ten (10) rounds will be completed per week with a monthly aggregate of forty (40) by members of Hospital Leadership to assesses staff knowledge of the use of	

	members of the Senior Leadership Committee and Pharmacy Leadership, that outlines the purpose, scope, membership, responsibilities, meeting frequency, and reporting structure. The Diversion Prevention Committee reports to the Pharmacy and Therapeutic Committee of the Hospital.	was reviewed in huddles and leadership rounds to validate staff knowledge of the information. Through huddles and leadership rounds ED staff at the freestanding ED were educated on the requirement that all non-nursing staff must be accompanied by a member of the nursing staff if they need to enter a secured medication storage location. Through huddles and leadership rounds, nursing and pharmacy staff were notified regarding the change of location for the dialysate solution.	the containers and the presence of the containers in the area. Results are aggregated and reported weekly to the Pharmacy Director, CNO and quarterly to the P&T Committee, Quality of Care Committee, Medical Executive Committee and quarterly to the Quality Committee of the Board of Trustees (reports quarterly to the Board of Trustees) until 100% is sustained for two consecutive months. Monitoring will continue quarterly on an ongoing basis with findings reported to the above stated committees unless non-compliance is identified whereby monitoring will increase in frequency until compliance is restored. Compliance of the stocking of dialysate solution in the appropriate bins inside the automated medication dispensing machine is monitored by Pharmacy Leadership three times a week with a monthly aggregate of twelve (12). Results are aggregated and reported weekly to the Pharmacy Director, CNO and quarterly to the P&T Committee, Quality of Care Committee, Medical Executive Committee and to the Quality Committee of the Board of Trustees (reports quarterly to the Board of Trustees) until 100% is sustained for two consecutive months. Monitoring will continue quarterly on an ongoing basis with findings reported to the above stated committees unless non-compliance is identified whereby monitoring will increase in frequency until compliance is restored. Compliance of the monitoring for access to the medication room at the Community Emergency Clinics is monitored by the Director of the	

			Emergency Centers three (3) times a week with a monthly aggregate of twelve (12). Results are aggregated and reported weekly to the Director of Pharmacy, quarterly to the P&T Committee, Quality of Care Committee, Medical Executive Committee and the Quality Committee of the Board of Trustees (reports quarterly to the Board of Trustees) until 100% is sustained for two consecutive months. Monitoring will continue quarterly on an ongoing basis with findings reported to the above stated committees unless non-compliance is identified whereby monitoring will increase in frequency until compliance is restored.	

BSLMC has an effective Board of Trustees that is legal responsible for the conduct of the hospital. BSLMC is currently in compliance with the CMS Condition of Participation A618 as evidence by the following specific corrective actions, education and monitoring for compliance.

For all items within Tag A618, the Board of Trustees has been actively engaged in the oversight and implementation of the plan of correction. An Executive Quality Council (EQC), chaired by the President or Senior Leader designee, meets weekly to provide oversight of the compliance with the monitoring of follow-up/monitoring measures. This council will continue to oversee the monitoring measures until 100% compliance with stated measures is sustained for two consecutive months. As well as:

- Individual staff member non-compliance will be reported to the appropriate supervisor or manager. Any non-compliance will be addressed with the individual through training, re-education and/or following the human resources corrective action process.
- Individual credential provider non-compliance will be addressed through the professional practice evaluation process and monitored through the ongoing practice evaluation process of the medical staff.
- When 100% compliance is sustained for two consecutive months for the monitoring measures stated in Tag A618, the monitoring will continue on an ongoing basis quarterly with finding continuing to be reported to the stated hospital Committees and the Quality Committee of the Board of Trustees (reports quarterly to the Board of Trustees). If compliance is not sustained quarterly monitoring will go back to weekly monitoring with data aggregated monthly for sustained compliance for at least two consecutive months. Decisions will be made in accordance with national clinical standards and the Conditions of Participation.

CoP Tag #	Plan for correcting the cited deficiency	Procedure for implementing the acceptable plan of correction	Follow-up/Monitoring	Person Responsible Completion Date
A618 (A)	Electronic temperature track system has been installed on all freezers and refrigerators. The notification when temperatures are out of range are being directed to the Facilities Leadership and Dietary Services Leadership	Dietary staff received education each shift until all were notified of Cooler 68 no longer available for use and any temperature out of range is reported to Facilities immediately. Dietary staff on FMLA or LOA will complete the training prior to returning to work.	On an ongoing basis, a member of the Dietary staff manually checks temperatures twice a day for all refrigerators and freezers. In addition each refrigerator is temperature monitored electronically by Facilities. Any temperature out of range is reported to	**Responsible Person**: Vice President of Operations **Completion Date:** 6/09/2019

	The "Refrigerator and Freezer Monitoring – Patient Care" policy was updated to reflect the correct way to move/dispose of food when the refrigerator or freezer are out of range. Cooler 68 was removed from service with signage placed as well as a lock to signify it is not in use. The equipment parts have been ordered and will be repaired upon arrival of replacement parts.		Facilities immediately in accordance with policy "Refrigerator and Freezer Monitoring – Patient Care". Daily a member of the Dietary Leadership staff inspects the completion of this requirement and that actions were taken if the temperature was out of the acceptable range. Monthly compliance is reported to the Vice President of Operations and quarterly to the Environment of Care and Safety Committee, Quality of Care Committee, Medical Executive Committee and the Quality Committee of the Board of Trustees (reports quarterly to the Board of Trustees). Monitoring will continue quarterly on an ongoing basis with findings reported to the above stated committees unless non-compliance is identified whereby monitoring will increase in frequency until compliance is restored.	
A618 (B)	The dishwasher and the pot washer were immediately removed from service. Facilities placed a sign indicating both pieces of equipment were out of commission awaiting repair. Use of disposable dishware and serving containers was immediately implemented. A three-sink station for manually cleaning and sanitizing of non-disposable wash pots and skillets was implemented. A real time audit tool checklist was utilized to observe staff performing cleaning and sanitizing The Facilities work ticket prioritization process has been reviewed, updated and approved by the hospital Chief Operations Officer (COO). Open maintenance logs for the kitchen	The Operations Manager of Nutrition Services provided training starting with the current shift and was continued each shift until all Dietary staff were trained on the manual cleaning process. Members of the leadership team for Facilities has been educated on expectations for priority of work orders and timeframes of response by the Chief Operations Officer and Division Director of Facilities. Facility Staff were educated by Facilities Leadership on the operational requirements for the exhaust serving the facility's two large mechanical dish washers. Facility staff on FMLA or LOS will complete the training prior to return to work. New employee orientation Facilities staff was revised to include training on the operational requirements for the exhaust serving the facility's two large mechanical dish washers.	Infection Prevention and Chief Operations Officer (COO) visually confirmed the dishwasher and pot washer have been identified as nonoperational. The pot washer parts were sourced Repair services contracted by the hospital completed the repair of the dishwasher. Infection Prevention and the COO confirmed the equipment was repaired and properly functioning prior to resuming operations. A member of the Quality or Infection Prevention team conducted direct observations three times a shift of the manual cleaning process to ensure it has been completed correctly per the standard operating procedure. Three times a shift 30 utensils, pots or pans manually washed were inspected by a member of the of Quality or Infection	**Responsible Person**: Vice President of Operations **Completion Date:** 6/09/2019

	have been reviewed and prioritized for high risk areas with response times identified. Maintenance has created a report that tracks priority of work orders and response time. Facilities Leadership is sending a weekly report to the Vice President of Operations, the Chief Financial Officer (CFO) and Chief Operations Officer (COO). An external company was contracted to complete an assessment of all kitchen equipment has been completed which includes the proper categorization of equipment, operational functionality and physical condition, work order history review, recommendation of repair, and recommendation of replacement. All work orders submitted by the kitchen for the past three months were reviewed and issues involving repairs were identified. All identified items are in process of being repaired. The Hospital CFO and COO have met with the contracted dietary services to evaluate the effectiveness of the contracted service. The contracted service's performance improvement indicator list was update to track specific performance indicators as noted in the contract. An external company has been contracted to conduct an evaluation of dietary services. The Exhaust Fans for facility's two large mechanical dish washers were added to a facility rounding log to be completed daily. Signage has been placed on designated		Prevention team to ensure they are free from debris. This audit continued until the dishwasher and the pot washer was fully functional. Currently open maintenance work orders are reviewed weekly for appropriate classification, response time and completion by Senior Leadership. Weekly the data is aggregated and reported to the Vice President of Operations to identify trends and develop action plans. Quarterly reports are provided to the Quality of Care Committee, Medical Executive Committee, and the Quality Committee of the Board of Trustees (reports quarterly to the Board of Trustees). All kitchen work orders are audited weekly to review appropriate prioritization, work quality, documentation and timeliness of response until 100% compliance is sustained for two consecutive months. When compliance is sustained the auditing process will be reviewed through the 50 random audits per week process. Weekly, facility wide 50 random work orders are audited to review appropriate prioritization, work quality, documentation and timeliness of response on an ongoing basis. The findings are reported monthly to the Vice President of Operations and reported quarterly to the Environment of Care and Safety Committee, Quality of Care Committee, Medical Executive Committee and quarterly to the Quality Committee of the Board of Trustees (reports quarterly to the Board of Trustees) until 100% is sustained for two consecutive months.	

	equipment as not in use Dietary staff received education each shift until all were notified that the equipment was not in use. The organization notified hospital leadership and staff of the use of disposable dishware until further notice. Patients were notified of the use of disposable dishware by a letter attached to their meal tray during the timeframe of repairs being made.		Monitoring will continue quarterly on an ongoing basis with findings reported to the above stated committees unless non-compliance is identified whereby monitoring will increase in frequency until compliance is restored. Weekly the daily rounding logs compliance is aggregated and reviewed by the Facilities Leadership. The findings are reported monthly to the Quality of Care Committee, Medical Executive Committee and quarterly to the Quality Committee of the Board of Trustees (reports quarterly to the Board of Trustees) until 100% is sustained for two consecutive months. Monitoring will continue quarterly on an ongoing basis with findings reported to the above stated committees unless non-compliance is identified whereby monitoring will increase in frequency until compliance is restored.	
A618 (C)	A Contracted Company was obtained to assess all sewer pipes in the kitchen Sewer pipes were snaked and blockages removed. An assessment of the sewer pipes was completed. A construction plan was created and implemented with sewer pipe sections needing repair completed. All work orders submitted by the kitchen for the past three months were reviewed and issues involving repairs were identified. All identified items are in process of being repaired. Open maintenance logs for the kitchen have been reviewed and prioritized for high risk areas with response times	All Dietary staff was provided education by a Leader in Facilities regarding the daily maintenance of the sewer pipes and how to escalate concerns. All Facilities staff was provided education by the Director of Facilities regarding the expectations for responding to the kitchen work orders or requests. Education was provided to the facility staff by the Facility Leadership on the implemented standard operating procedure (SOP) for any drain issues in the kitchen which includes escalation steps for after hours and weekends as well as the sequence of drain treatment per manufacturer recommendations. Facilities staff on FMLA or LOA will complete the training prior to returning to work.	Weekly a member of the Dietary staff inspects the drains for visible blockages. If blockages are identified Facilities is immediately notified and a work order placed. Daily a member of the Facilities staff uses an approved biodegradable solution to pour down the drains to keep blockages from occurring. This continued until the pipes have been repaired and a preventative maintenance schedule was implemented. A member of the Facilities Team is inspecting the Kitchen drains for visible blockages two times per shift. This continued until the pipes were repaired and a preventative maintenance schedule was implemented.	**Responsible Person**: Vice President of Operations **Completion Date:** 6/09/2019

	identified. Maintenance has created a report that tracks priority of work orders and response time. Facilities Leadership is sending a weekly report to the Vice President of Operations, the CFO and the COO. Facilities has implemented a standard operating procedure (SOP) for any drain issues in the kitchen. The SOP includes escalation steps for after hours and weekends as well as the sequence of drain treatment per manufacturer recommendations.	New employee orientation Facilities staff was revised to include training on the standard operating procedure (SOP) for any drain issues in the kitchen which includes escalation steps for after hours and weekends as well as the sequence of drain treatment per manufacturer recommendations.	Audits are completed three times a week by members of the Infection Prevention or Quality Team to include direct observations of cleanliness of pots/pans, equipment working properly, and infection control practices are in place until 100% compliance achieved. Results are provided monthly to the Dietary Leadership and Vice President of Operations and quarterly to the Environment of Care Committee, Quality of Care Committee, Medical Executive Committee, and Quality Committee of the Board of Trustees (reports quarterly to the Board of Trustees). Monitoring will continue quarterly on an ongoing basis with findings reported to the above stated committees unless non-compliance is identified whereby monitoring will increase in frequency until compliance is restored. Currently open maintenance work orders are reviewed weekly for appropriate classification, response time and completion by Senior Leadership. Weekly the data is aggregated and reported to the Vice President of Operations to identify trends and develop action plans. Quarterly reports are provided to the Environment of Care Committee, Quality of Care Committee, Medical Executive Committee and the Quality Committee of the Board of Trustees (reports quarterly to the Board of Trustees). All kitchen work orders are audited weekly to review appropriate prioritization, work quality, documentation and timeliness of response until 100% compliance is sustained for two consecutive months.	

			When compliance is sustained the auditing process will be reviewed through the 50 random audits per week process. Monitoring will continue quarterly on an ongoing basis with findings reported to the above stated committees unless non-compliance is identified whereby monitoring will increase in frequency until compliance is restored. Weekly, facility wide 50 random work orders are audited to review appropriate prioritization, work quality, documentation and timeliness of response on an ongoing basis. The findings are reported monthly to the Vice President of Operations and reported quarterly to the Environment of Care and Safety Committee, Quality of Care Committee, Medical Executive Committee and quarterly to the Quality Committee of the Board of Trustees (reports quarterly to the Board of Trustees) until 100% is sustained for two consecutive months. Monitoring will continue quarterly on an ongoing basis with findings reported to the above stated committees unless non-compliance is identified whereby monitoring will increase in frequency until compliance is restored.	
A618 (D)	The dishwasher and the pot washer were immediately removed from service. Facilities placed a sign indicating both pieces of equipment were out of commission awaiting repair. Use of disposable dishware and serving containers was immediately implemented. A three-sink station for manually cleaning and sanitizing of non-disposable wash pots and skillets was implemented. A real time	The Operations Manager of Nutrition Services provided training starting with the current shift and was continued each shift until all Dietary staff were trained on the manual cleaning process. Members of the leadership team for Facilities has been educated on expectations for priority of work orders and timeframes of response by the Chief Operations Officer and Division Director of Facilities. Staff on FMLA or LOA will complete the training prior to returning to work.	Infection Prevention and Chief Operations Officer (COO) visually confirmed the dishwasher and pot washer have been identified as nonoperational. The pot washer parts sourced. Repair services contracted by the hospital completed the repair of the dishwasher. Infection Prevention and the COO confirmed the equipment was repaired and properly functioning prior to resuming operations.	**Responsible Person**: Vice President of Operations **Completion Date:** 6/09/2019

	audit tool checklist was utilized to observe staff performing cleaning and sanitizing The Facilities work ticket prioritization process has been reviewed and approved by the hospital COO. Open maintenance logs for the kitchen have been reviewed and prioritized for high risk areas with response times identified. Maintenance has created a report that tracks priority of work orders and response time. Facilities Leadership is now sending a weekly report to the Vice President of Operations, the CFO and the COO. An external company was contracted to complete an assessment of all kitchen equipment has been completed which includes the proper categorization of equipment, operational functionality and physical condition, work order history review, recommendation of repair, and recommendation of replacement. All work orders submitted by the kitchen for the past three months were reviewed and issues involving repairs were identified. All identified items are in process of being repaired. The Hospital CFO and COO have met with the contracted dietary services to evaluate the effectiveness of the contracted service. The contracted services PI indicator list was updated to track specific performance indicators as noted in the contract. An external company has been contracted to conduct an evaluation of dietary services.	New employee orientation Facilities Management staff was revised to include training on the expectations for priority of work orders and timeframes of response.	A member of the Quality or Infection Prevention team conducted direct observations three times a shift of the manual cleaning process to ensure it has been completed correctly per the standard operating procedure. Three times a shift 30 utensils, pots or pans manually washed were inspected by a member of the of Quality or Infection Prevention team to ensure they are free from debris. This audit continued until the dishwasher and the pot washer was fully functional. Currently open maintenance work orders are reviewed weekly for appropriate classification, response time and completion by Senior Leadership. Weekly the data is aggregated and reported to the Vice President of Operations to identify trends and develop action plans. Quarterly results are reported to the Environment of Care Committee, Quality of Care Committee, Medical Executive Committee and the Quality Committee of the Board of Trustees (reports quarterly to the Board of Trustees). All kitchen work orders are audited weekly to review appropriate prioritization, work quality, documentation and timeliness of response until 100% compliance is sustained for two consecutive months. When compliance is sustained the auditing process will be reviewed through the 50 random audits per week process. Weekly, facility wide 50 random work orders are audited to review appropriate prioritization, work quality, documentation and timeliness of response on an ongoing basis. The	

	Signage has been placed on designated equipment as not in use. Dietary staff received education each shift until all were notified the equipment was not in use. The organization notified hospital leadership and staff of the use of disposable dishware until further notice. Patients were notified of the use of disposable dishware by a letter attached to their meal tray during the timeframe of repairs being completed.		findings are reported monthly to the Vice President of Operations and reported quarterly to the Environment of Care and Safety Committee, Quality of Care Committee, Medical Executive Committee and quarterly to the Quality Committee of the Board of Trustees (reports quarterly to the Board of Trustees) until 100% is sustained for two consecutive months. Monitoring will continue quarterly on an ongoing basis with findings reported to the above stated committees unless non-compliance is identified whereby monitoring will increase in frequency until compliance is restored.	

BSLMC has an effective Board of Trustees that is legal responsible for the conduct of the hospital. BSLMC is currently in compliance with the CMS Condition of Participation A619 as evidence by the following specific corrective actions, education and monitoring for compliance.

For all items within Tag A619, the Board of Trustees has been actively engaged in the oversight and implementation of the plan of correction. An Executive Quality Council (EQC), chaired by the President or Senior Leader designee, meets weekly to provide oversight of the compliance with the monitoring of follow-up/monitoring measures. This council will continue to oversee the monitoring measures until 100% compliance with stated measures is sustained for two consecutive months. As well as:

- Individual staff member non-compliance will be reported to the appropriate supervisor or manager. Any non-compliance will be addressed with the individual through training, re-education and/or following the human resources corrective action process.
- Individual credential provider non-compliance will be addressed through the professional practice evaluation process and monitored through the ongoing practice evaluation process of the medical staff.
- When 100% compliance is sustained for two consecutive months for the monitoring measures stated in Tag A619, the monitoring will continue on an ongoing basis quarterly with finding continuing to be reported to the stated hospital Committees and the Quality Committee of the Board of Trustees (reports quarterly to the Board of Trustees). If compliance is not sustained quarterly monitoring will go back to weekly monitoring with data aggregated monthly for sustained compliance for at least two consecutive months. Decisions will be made in accordance with national clinical standards and the Conditions of Participation.

CoP Tag #	Plan for correcting the cited deficiency	Procedure for implementing the acceptable plan of correction	Follow-up/Monitoring	Person Responsible Completion Date
A619 (A)	Electronic temperature track system has been installed on all freezers and refrigerators. The notification when temperatures are out of range are being directed to the Facilities Leadership and Dietary Services Leadership The "Refrigerator and Freezer Monitoring – Patient Care" policy was updated to	Dietary staff received education each shift until all were notified of Cooler 68 no longer available for use and any temperature out of range is reported to Facilities immediately. Dietary staff on FMLA or LOA will complete the training prior to returning to work.	On an ongoing basis, a member of the Dietary staff manually checks temperatures twice a day for all refrigerators and freezers. In addition each refrigerator is temperature monitored electronically by Facilities. Any temperature out of range is reported to Facilities immediately in accordance with policy "Refrigerator and Freezer	**Responsible Person**: Vice President of Operations **Completion Date:** 6/09/2019

	reflect the correct way to move/dispose of food when the refrigerator or freezer are out of range. Cooler 68 was removed from service with signage placed as well as a lock to signify it is not in use. The equipment parts have been ordered and will be repaired upon arrival of replacement parts.		Monitoring – Patient Care". Daily a member of the Dietary Leadership staff inspects the completion of this requirement and that actions were taken if the temperature was out of the acceptable range. Monthly compliance is reported to the Vice President of Operations and quarterly to the Environment of Care and Safety Committee, Quality of Care Committee, Medical Executive Committee and the Quality Committee of the Board of Trustees (reports quarterly to the Board of Trustees). Monitoring will continue quarterly on an ongoing basis with findings reported to the above stated committees unless non-compliance is identified whereby monitoring will increase in frequency until compliance is restored.	
A619 (B)	The dishwasher and the pot washer were immediately removed from service. Facilities placed a sign indicating both pieces of equipment were out of commission awaiting repair. Use of disposable dishware and serving containers was immediately implemented. A three-sink station for manually cleaning and sanitizing of non-disposable wash pots and skillets was implemented. A real time audit tool checklist was utilized to observe staff performing cleaning and sanitizing The Facilities work ticket prioritization process has been reviewed, updated and approved by the hospital Chief Operations Officer (COO). Open maintenance logs for the kitchen have been reviewed and prioritized for high risk areas with response times	The Operations Manager of Nutrition Services provided training starting with the current shift and was continued each shift until all Dietary staff were trained on the manual cleaning process. Members of the leadership team for Facilities has been educated on expectations for priority of work orders and timeframes of response by the Chief Operations Officer and Division Director of Facilities. Facility Staff were educated by Facilities Leadership on the operational requirements for the exhaust serving the facility's two large mechanical dish washers. Facility staff on FMLA or LOS will complete the training prior to return to work. New employee orientation Facilities staff was revised to include training on the operational requirements for the exhaust serving the facility's two large mechanical dish washers.	Infection Prevention and Chief Operations Officer (COO) visually confirmed the dishwasher and pot washer have been identified as nonoperational. The pot washer parts were sourced Repair services contracted by the hospital completed the repair of the dishwasher. Infection Prevention and the COO confirmed the equipment was repaired and properly functioning prior to resuming operations. A member of the Quality or Infection Prevention team conducted direct observations three times a shift of the manual cleaning process to ensure it has been completed correctly per the standard operating procedure. Three times a shift 30 utensils, pots or pans manually washed were inspected by a member of the of Quality or Infection Prevention team to ensure they are free from debris. This audit continued until	**Responsible Person**: Vice President of Operations **Completion Date:** 6/09/2019

	identified. Maintenance has created a report that tracks priority of work orders and response time. Facilities Leadership is sending a weekly report to the Vice President of Operations, the Chief Financial Officer (CFO) and Chief Operations Officer (COO). An external company was contracted to complete an assessment of all kitchen equipment has been completed which includes the proper categorization of equipment, operational functionality and physical condition, work order history review, recommendation of repair, and recommendation of replacement. All work orders submitted by the kitchen for the past three months were reviewed and issues involving repairs were identified. All identified items are in process of being repaired. The Hospital CFO and COO have met with the contracted dietary services to evaluate the effectiveness of the contracted service. The contracted service's performance improvement indicator list was update to track specific performance indicators as noted in the contract. An external company has been contracted to conduct an evaluation of dietary services. The Exhaust Fans for facility's two large mechanical dish washers were added to a facility rounding log to be completed daily. Signage has been placed on designated equipment as not in use Dietary staff received education each shift until all were		the dishwasher and the pot washer was fully functional. Currently open maintenance work orders are reviewed weekly for appropriate classification, response time and completion by Senior Leadership. Weekly the data is aggregated and reported to the Vice President of Operations to identify trends and develop action plans. Quarterly reports are provided to the Quality of Care Committee, Medical Executive Committee, and the Quality Committee of the Board of Trustees (reports quarterly to the Board of Trustees). All kitchen work orders are audited weekly to review appropriate prioritization, work quality, documentation and timeliness of response until 100% compliance is sustained for two consecutive months. When compliance is sustained the auditing process will be reviewed through the 50 random audits per week process. Weekly, facility wide 50 random work orders are audited to review appropriate prioritization, work quality, documentation and timeliness of response on an ongoing basis. The findings are reported monthly to the Vice President of Operations and reported quarterly to the Environment of Care and Safety Committee, Quality of Care Committee, Medical Executive Committee and quarterly to the Quality Committee of the Board of Trustees (reports quarterly to the Board of Trustees) until 100% is sustained for two consecutive months. Monitoring will continue quarterly on an ongoing basis with findings reported to	

	notified that the equipment was not in use. The organization notified hospital leadership and staff of the use of disposable dishware until further notice. Patients were notified of the use of disposable dishware by a letter attached to their meal tray during the timeframe of repairs being made.		the above stated committees unless non-compliance is identified whereby monitoring will increase in frequency until compliance is restored. Weekly the daily rounding logs compliance is aggregated and reviewed by the Facilities Leadership. The findings are reported monthly to the Quality of Care Committee, Medical Executive Committee and quarterly to the Quality Committee of the Board of Trustees (reports quarterly to the Board of Trustees) until 100% is sustained for two consecutive months. Monitoring will continue quarterly on an ongoing basis with findings reported to the above stated committees unless non-compliance is identified whereby monitoring will increase in frequency until compliance is restored.	
A619 (C)	A Contracted Company was obtained to assess all sewer pipes in the kitchen Sewer pipes were snaked and blockages removed. An assessment of the sewer pipes was completed. A construction plan was created and implemented with sewer pipe sections needing repair completed. All work orders submitted by the kitchen for the past three months were reviewed and issues involving repairs were identified. All identified items are in process of being repaired. Open maintenance logs for the kitchen have been reviewed and prioritized for high risk areas with response times identified.	All Dietary staff was provided education by a Leader in Facilities regarding the daily maintenance of the sewer pipes and how to escalate concerns. All Facilities staff was provided education by the Director of Facilities regarding the expectations for responding to the kitchen work orders or requests. Education was provided to the facility staff by the Facility Leadership on the implemented standard operating procedure (SOP) for any drain issues in the kitchen which includes escalation steps for after hours and weekends as well as the sequence of drain treatment per manufacturer recommendations. Facilities staff on FMLA or LOA will complete the training prior to returning to work. New employee orientation Facilities staff was revised to include training on the standard operating	Weekly a member of the Dietary staff inspects the drains for visible blockages. If blockages are identified Facilities is immediately notified and a work order placed. Daily a member of the Facilities staff uses an approved biodegradable solution to pour down the drains to keep blockages from occurring. This continued until the pipes have been repaired and a preventative maintenance schedule was implemented. A member of the Facilities Team is inspecting the Kitchen drains for visible blockages two times per shift. This continued until the pipes were repaired and a preventative maintenance schedule was implemented. Audits are completed three times a week	**Responsible Person**: Vice President of Operations **Completion Date:** 6/09/2019

	Maintenance has created a report that tracks priority of work orders and response time. Facilities Leadership is sending a weekly report to the Vice President of Operations, the CFO and the COO. Facilities has implemented a standard operating procedure (SOP) for any drain issues in the kitchen. The SOP includes escalation steps for after hours and weekends as well as the sequence of drain treatment per manufacturer recommendations.	procedure (SOP) for any drain issues in the kitchen which includes escalation steps for after hours and weekends as well as the sequence of drain treatment per manufacturer recommendations.	by members of the Infection Prevention or Quality Team to include direct observations of cleanliness of pots/pans, equipment working properly, and infection control practices are in place until 100% compliance achieved. Results are provided monthly to the Dietary Leadership and Vice President of Operations and quarterly to the Environment of Care Committee, Quality of Care Committee, Medical Executive Committee, and Quality Committee of the Board of Trustees (reports quarterly to the Board of Trustees). Monitoring will continue quarterly on an ongoing basis with findings reported to the above stated committees unless non-compliance is identified whereby monitoring will increase in frequency until compliance is restored. Currently open maintenance work orders are reviewed weekly for appropriate classification, response time and completion by Senior Leadership. Weekly the data is aggregated and reported to the Vice President of Operations to identify trends and develop action plans. Quarterly reports are provided to the Environment of Care Committee, Quality of Care Committee, Medical Executive Committee and the Quality Committee of the Board of Trustees (reports quarterly to the Board of Trustees). All kitchen work orders are audited weekly to review appropriate prioritization, work quality, documentation and timeliness of response until 100% compliance is sustained for two consecutive months. When compliance is sustained the auditing process will be reviewed through	

			the 50 random audits per week process. Monitoring will continue quarterly on an ongoing basis with findings reported to the above stated committees unless non-compliance is identified whereby monitoring will increase in frequency until compliance is restored. Weekly, facility wide 50 random work orders are audited to review appropriate prioritization, work quality, documentation and timeliness of response on an ongoing basis. The findings are reported monthly to the Vice President of Operations and reported quarterly to the Environment of Care and Safety Committee, Quality of Care Committee, Medical Executive Committee and quarterly to the Quality Committee of the Board of Trustees (reports quarterly to the Board of Trustees) until 100% is sustained for two consecutive months. Monitoring will continue quarterly on an ongoing basis with findings reported to the above stated committees unless non-compliance is identified whereby monitoring will increase in frequency until compliance is restored.	
A619 (D)	The dishwasher and the pot washer were immediately removed from service. Facilities placed a sign indicating both pieces of equipment were out of commission awaiting repair. Use of disposable dishware and serving containers was immediately implemented. A three-sink station for manually cleaning and sanitizing of non-disposable wash pots and skillets was implemented. A real time audit tool checklist was utilized to observe staff performing cleaning and sanitizing	The Operations Manager of Nutrition Services provided training starting with the current shift and was continued each shift until all Dietary staff were trained on the manual cleaning process. Members of the leadership team for Facilities has been educated on expectations for priority of work orders and timeframes of response by the Chief Operations Officer and Division Director of Facilities. Staff on FMLA or LOA will complete the training prior to returning to work. New employee orientation Facilities Management	Infection Prevention and Chief Operations Officer (COO) visually confirmed the dishwasher and pot washer have been identified as nonoperational. The pot washer parts sourced. Repair services contracted by the hospital completed the repair of the dishwasher. Infection Prevention and the COO confirmed the equipment was repaired and properly functioning prior to resuming operations. A member of the Quality or Infection Prevention team conducted direct	**Responsible Person**: Vice President of Operations **Completion Date:** 6/09/2019

	The Facilities work ticket prioritization process has been reviewed and approved by the hospital COO. Open maintenance logs for the kitchen have been reviewed and prioritized for high risk areas with response times identified. Maintenance has created a report that tracks priority of work orders and response time. Facilities Leadership is now sending a weekly report to the Vice President of Operations, the CFO and the COO. An external company was contracted to complete an assessment of all kitchen equipment has been completed which includes the proper categorization of equipment, operational functionality and physical condition, work order history review, recommendation of repair, and recommendation of replacement. All work orders submitted by the kitchen for the past three months were reviewed and issues involving repairs were identified. All identified items are in process of being repaired. The Hospital CFO and COO have met with the contracted dietary services to evaluate the effectiveness of the contracted service. The contracted services PI indicator list was updated to track specific performance indicators as noted in the contract. An external company has been contracted to conduct an evaluation of dietary services. Signage has been placed on designated	staff was revised to include training on the expectations for priority of work orders and timeframes of response.	observations three times a shift of the manual cleaning process to ensure it has been completed correctly per the standard operating procedure. Three times a shift 30 utensils, pots or pans manually washed were inspected by a member of the of Quality or Infection Prevention team to ensure they are free from debris. This audit continued until the dishwasher and the pot washer was fully functional. Currently open maintenance work orders are reviewed weekly for appropriate classification, response time and completion by Senior Leadership. Weekly the data is aggregated and reported to the Vice President of Operations to identify trends and develop action plans. Quarterly results are reported to the Environment of Care Committee, Quality of Care Committee, Medical Executive Committee and the Quality Committee of the Board of Trustees (reports quarterly to the Board of Trustees). All kitchen work orders are audited weekly to review appropriate prioritization, work quality, documentation and timeliness of response until 100% compliance is sustained for two consecutive months. When compliance is sustained the auditing process will be reviewed through the 50 random audits per week process. Weekly, facility wide 50 random work orders are audited to review appropriate prioritization, work quality, documentation and timeliness of response on an ongoing basis. The findings are reported monthly to the Vice President of Operations and reported	

	equipment as not in use. Dietary staff received education each shift until all were notified the equipment was not in use. The organization notified hospital leadership and staff of the use of disposable dishware until further notice. Patients were notified of the use of disposable dishware by a letter attached to their meal tray during the timeframe of repairs being completed.		quarterly to the Environment of Care and Safety Committee, Quality of Care Committee, Medical Executive Committee and quarterly to the Quality Committee of the Board of Trustees (reports quarterly to the Board of Trustees) until 100% is sustained for two consecutive months. Monitoring will continue quarterly on an ongoing basis with findings reported to the above stated committees unless non-compliance is identified whereby monitoring will increase in frequency until compliance is restored.	

BSLMC has an effective Board of Trustees that is legal responsible for the conduct of the hospital. BSLMC is currently in compliance with the CMS Condition of Participation A700 as evidence by the following specific corrective actions, education and monitoring for compliance.

For all items within Tag A700, the Board of Trustees has been actively engaged in the oversight and implementation of the plan of correction. An Executive Quality Council (EQC), chaired by the President or Senior Leader designee, meets weekly to provide oversight of the compliance with the monitoring of follow-up/monitoring measures. This council will continue to oversee the monitoring measures until 100% compliance with stated measures is sustained for two consecutive months. As well as:

- Individual staff member non-compliance will be reported to the appropriate supervisor or manager. Any non-compliance will be addressed with the individual through training, re-education and/or following the human resources corrective action process.
- Individual credential provider non-compliance will be addressed through the professional practice evaluation process and monitored through the ongoing practice evaluation process of the medical staff.
- When 100% compliance is sustained for two consecutive months for the monitoring measures stated in Tag A700, the monitoring will continue on an ongoing basis quarterly with finding continuing to be reported to the stated hospital Committees and the Quality Committee of the Board of Trustees (reports quarterly to the Board of Trustees). If compliance is not sustained quarterly monitoring will go back to weekly monitoring with data aggregated monthly for sustained compliance for at least two consecutive months. Decisions will be made in accordance with national clinical standards and the Conditions of Participation.

CoP Tag #	**Plan for correcting the cited deficiency**	**Procedure for implementing the acceptable plan of correction**	**Follow-up/Monitoring**	**Person Responsible Completion Date**
A700 (A)	A Contracted Company was obtained to assess all sewer pipes in the kitchen Sewer pipes were snaked and blockages removed. An assessment of the sewer pipes was completed. A construction plan was created and implemented with sewer pipe sections needing repair completed.	All Dietary staff was provided education by a Leader in Facilities regarding the daily maintenance of the sewer pipes and how to escalate concerns. All Facilities staff was provided education by the Director of Facilities regarding the expectations for responding to the kitchen work orders or requests. Education was provided to the facility staff by the	Weekly a member of the Dietary staff inspects the drains for visible blockages. If blockages are identified Facilities is immediately notified and a work order placed. Daily a member of the Facilities staff uses an approved biodegradable solution to pour down the drains to keep blockages from occurring. This continued until the	**Responsible Person**: Vice President of Operations **Completion Date:** 6/09/2019

	All work orders submitted by the kitchen for the past three months were reviewed and issues involving repairs were identified. All identified items are in process of being repaired. Open maintenance logs for the kitchen have been reviewed and prioritized for high risk areas with response times identified. Maintenance has created a report that tracks priority of work orders and response time. Facilities Leadership is sending a weekly report to the Vice President of Operations, the CFO and the COO. Facilities has implemented a standard operating procedure (SOP) for any drain issues in the kitchen. The SOP includes escalation steps for after hours and weekends as well as the sequence of drain treatment per manufacturer recommendations.	Facility Leadership on the implemented standard operating procedure (SOP) for any drain issues in the kitchen which includes escalation steps for after hours and weekends as well as the sequence of drain treatment per manufacturer recommendations. Facilities staff on FMLA or LOA will complete the training prior to returning to work. New employee orientation Facilities staff was revised to include training on the standard operating procedure (SOP) for any drain issues in the kitchen which includes escalation steps for after hours and weekends as well as the sequence of drain treatment per manufacturer recommendations.	pipes have been repaired and a preventative maintenance schedule was implemented. A member of the Facilities Team is inspecting the Kitchen drains for visible blockages two times per shift. This continued until the pipes were repaired and a preventative maintenance schedule was implemented. Audits are completed three times a week by members of the Infection Prevention or Quality Team to include direct observations of cleanliness of pots/pans, equipment working properly, and infection control practices are in place until 100% compliance achieved. Results are provided monthly to the Dietary Leadership and Vice President of Operations and quarterly to the Environment of Care Committee, Quality of Care Committee, Medical Executive Committee, and Quality Committee of the Board of Trustees (reports quarterly to the Board of Trustees). Monitoring will continue quarterly on an ongoing basis with findings reported to the above stated committees unless non-compliance is identified whereby monitoring will increase in frequency until compliance is restored. Currently open maintenance work orders are reviewed weekly for appropriate classification, response time and completion by Senior Leadership. Weekly the data is aggregated and reported to the Vice President of Operations to identify trends and develop action plans. Quarterly reports are provided to the Environment of Care Committee, Quality of Care Committee, Medical Executive	

			Committee and the Quality Committee of the Board of Trustees (reports quarterly to the Board of Trustees). All kitchen work orders are audited weekly to review appropriate prioritization, work quality, documentation and timeliness of response until 100% compliance is sustained for two consecutive months. When compliance is sustained the auditing process will be reviewed through the 50 random audits per week process. Monitoring will continue quarterly on an ongoing basis with findings reported to the above stated committees unless non-compliance is identified whereby monitoring will increase in frequency until compliance is restored. Weekly, facility wide 50 random work orders are audited to review appropriate prioritization, work quality, documentation and timeliness of response on an ongoing basis. The findings are reported monthly to the Vice President of Operations and reported quarterly to the Environment of Care and Safety Committee, Quality of Care Committee, Medical Executive Committee and quarterly to the Quality Committee of the Board of Trustees (reports quarterly to the Board of Trustees) until 100% is sustained for two consecutive months. Monitoring will continue quarterly on an ongoing basis with findings reported to the above stated committees unless non-compliance is identified whereby monitoring will increase in frequency until compliance is restored.	
A700 (B)	Environmental rounds have been implemented to identify areas in need of repair. Weekly rounds are conducted per	The Hospital Safety Officer has given training to all primary and secondary Environment of Care (EOC) surveyors on the expectations for EOC rounds which	On an ongoing basis as part of the Environment of Care Program weekly environmental rounds are completed per	**Responsible Person**: Vice President of

	the rounding schedule (all patient care areas twice per calendar year and non-patient care areas at least annually) A schedule of environmental rounds has been completed for each area of the hospital. Environmental rounds will be completed in conjunction with infection prevention to identify any ongoing maintenance repairs and infection control concerns.	included rounding, reporting, communicating and correcting of deficiencies. The Hospital Safety Officer acting as the EOC Committee Chair, reinforced with the Committee and EOC surveyors the expectations completing environmental rounds weekly as per the rounding schedule. Applicable staff on FMLA or LOA will complete the training prior to returning to work. New employees conducting EOC rounds will be educated by the Hospital Safety Department prior to completing an EOC round.	the rounding schedule. Results of the rounds and action items for gaps will be aggregated weekly and reported to the monthly to the Vice President of Operations and reported quarterly to the Environment of Care and Safety Committee, Quality of Care Committee, Medical Executive Committee and Quality Committee of the Board of Trustees (reports quarterly to the Board of Trustees). Monitoring will continue quarterly on an ongoing basis with findings reported to the above stated committees unless non-compliance is identified whereby monitoring will increase in frequency until compliance is restored.	Operations **Completion Date:** 6/09/2019
A700 (C)	The power strips for the use on moveable equipment in the Cath Lab have been corrected by properly securing the re-locatable power strip to the equipment with clinical engineering following with a risk assessment using the requirements in NFPA 99 as a guide. The exposed wires were repaired in OR 6 and OR 11. The blanket warmer was identified and a daily log was generated for the equipment. The environment of care rounds includes looking for unsecured power strips and exposed wires.	The Cath Lab and OR Leadership at the Fannin Location were provided education by Facilities Leadership on how to identify when a power strip needs to be secured and identification of exposed wires. They were also educated to place a work order ticket if either has been identified. The Facilities Maintenance staff conducting environment of care rounds were provided education by Facilities Leadership about the expectations to look for unsecured power strips and exposed wires as well as to place a work order ticket if either of the above were found. The Cath Lab Staff were provided education by Cath Lab Leadership on the new daily log requirement for the blanket warmer. New Employee orientation for facilities staff was updated to reinforce the expectations conducting environmental rounds. New Employee orientation for Cath Lab staff was updated to reinforce the expectations completing the blanket warmer temperature log daily. Affected Staff on FMLA or LOA will complete the training prior to returning to work.	On an ongoing basis as part of the Environment of Care Program weekly environmental rounds are completed per the rounding schedule. Results of the rounds and action items for gaps will be aggregated weekly and reported to the monthly to the Vice President of Operations and reported quarterly to the Environment of Care and Safety Committee, Quality of Care Committee, Medical Executive Committee and Quality Committee of the Board of Trustees (reports quarterly to the Board of Trustees). Monitoring will continue quarterly on an ongoing basis with findings reported to the above stated committees unless non-compliance is identified whereby monitoring will increase in frequency until compliance is restored. On an ongoing basis, a member of the Cath Lab staff checks the temperature of the blanket warmer daily. Any temperature out of range is reported to facilities. Weekly a member of the Cath	**Responsible Person**: Vice President of Operations **Completion Date:** 6/09/2019

			Lab Leadership inspects the completion of this requirement. Monthly compliance is aggregated and reported to the Vice President of CV Services, Quality of Care Committee, Medical Executive Committee and Quality Committee of the Board of Trustees (reports quarterly to the Board of Trustees). Monitoring will continue quarterly on an ongoing basis with findings reported to the above stated committees unless non-compliance is identified whereby monitoring will increase in frequency until compliance is restored.	
A700 (D)	Kirby Glen has been provided the correct chemo spill clean-up kit. Training was implemented for the Kirby Glen staff on the proper cleaning of equipment after contamination with chemotherapy drugs in accordance with policy "Handling and Disposal of Hazardous Materials". New red containers that are dedicated to chemotherapy transport were purchased Kirby Glen. Blue containers were purchased for the transport of non-chemotherapy medications. Instructional materials were developed to demonstrate how to clean all transportation bins and ice packs in accordance with policy "Handling and Disposal of Hazardous Materials".	The Kirby Glen staff were provided education by Facilities Leadership about the safe use of the chemo spill kits and the proper cleaning of equipment after contamination with chemotherapy drugs in accordance with policy "Handling and Disposal of Hazardous Materials" New Employee orientation and annual training for Kirby Glen personnel was updated to include the expectations for use of the chemo spill kits and proper cleaning of equipment after contamination with chemotherapy drugs in accordance with policy "Handling and Disposal of Hazardous Materials". Staff transporting chemotherapy drugs were educated by Pharmacy Leadership on the correct methods of transportation with the new bins and the proper cleaning of the bins and ice packs in accordance with policy "Handling and Disposal of Hazardous Materials". New employee training for staff transporting chemotherapy drugs was updated to reflect the correct methods of transportation with the new bins and the proper cleaning of the bins and ice packs in accordance with policy "Handling and Disposal of Hazardous Materials".	Once a week mock drills will be conducted with the Kirby Glen staff to evaluate the proper handling of the chemo spill clean-up kit and proper cleaning of equipment after contamination with chemotherapy drugs in accordance with policy "Handling and Disposal of Hazardous Materials". The findings are reported monthly to the Quality of Care Committee, Medical Executive Committee and quarterly to the Quality Committee of the Board of Trustees (reports quarterly to the Board of Trustees) until 100% is sustained for two consecutive months. Monitoring will continue quarterly on an ongoing basis with findings reported to the above stated committees unless non-compliance is identified whereby monitoring will increase in frequency until compliance is restored. Once a week the Kirby Glen Pharmacy Team will audit the transportation and cleaning procedures of chemotherapy drugs with a monthly aggregate of four observations. The findings are reported monthly to the Quality of Care	**Responsible Person**: Vice President of Operations **Completion Date:** 6/09/2019

			Committee, Medical Executive Committee and quarterly to the Quality Committee of the Board of Trustees (reports quarterly to the Board of Trustees) until 100% is sustained for two consecutive months. Monitoring will continue quarterly on an ongoing basis with findings reported to the above stated committees unless non-compliance is identified whereby monitoring will increase in frequency until compliance is restored.	

BSLMC has an effective Board of Trustees that is legal responsible for the conduct of the hospital. BSLMC is currently in compliance with the CMS Condition of Participation A701 as evidence by the following specific corrective actions, education and monitoring for compliance.

For all items within Tag A701, the Board of Trustees has been actively engaged in the oversight and implementation of the plan of correction. An Executive Quality Council (EQC), chaired by the President or Senior Leader designee, meets weekly to provide oversight of the compliance with the monitoring of follow-up/monitoring measures. This council will continue to oversee the monitoring measures until 100% compliance with stated measures is sustained for two consecutive months. As well as:

- Individual staff member non-compliance will be reported to the appropriate supervisor or manager. Any non-compliance will be addressed with the individual through training, re-education and/or following the human resources corrective action process.
- Individual credential provider non-compliance will be addressed through the professional practice evaluation process and monitored through the ongoing practice evaluation process of the medical staff.
- When 100% compliance is sustained for two consecutive months for the monitoring measures stated in Tag A701, the monitoring will continue on an ongoing basis quarterly with finding continuing to be reported to the stated hospital Committees and the Quality Committee of the Board of Trustees (reports quarterly to the Board of Trustees). If compliance is not sustained quarterly monitoring will go back to weekly monitoring with data aggregated monthly for sustained compliance for at least two consecutive months. Decisions will be made in accordance with national clinical standards and the Conditions of Participation.

CoP Tag #	Plan for correcting the cited deficiency	Procedure for implementing the acceptable plan of correction	Follow-up/Monitoring	Person Responsible Completion Date
A701 (A)	A Contracted Company was obtained to assess all sewer pipes in the kitchen Sewer pipes were snaked and blockages removed. An assessment of the sewer pipes was completed. A construction plan was created and implemented with sewer pipe sections needing repair completed. All work orders submitted by the kitchen for the past three months were reviewed	All Dietary staff was provided education by a Leader in Facilities regarding the daily maintenance of the sewer pipes and how to escalate concerns. All Facilities staff was provided education by the Director of Facilities regarding the expectations for responding to the kitchen work orders or requests. Education was provided to the facility staff by the Facility Leadership on the implemented standard operating procedure (SOP) for any drain issues in the	Weekly a member of the Dietary staff inspects the drains for visible blockages. If blockages are identified Facilities is immediately notified and a work order placed. Daily a member of the Facilities staff uses an approved biodegradable solution to pour down the drains to keep blockages from occurring. This continued until the pipes have been repaired and a preventative maintenance schedule was	**Responsible Person**: Vice President of Operations **Completion Date:** 6/09/2019

	and issues involving repairs were identified. All identified items are in process of being repaired. Open maintenance logs for the kitchen have been reviewed and prioritized for high risk areas with response times identified. Maintenance has created a report that tracks priority of work orders and response time. Facilities Leadership is sending a weekly report to the Vice President of Operations, the CFO and the COO. Facilities has implemented a standard operating procedure (SOP) for any drain issues in the kitchen. The SOP includes escalation steps for after hours and weekends as well as the sequence of drain treatment per manufacturer recommendations.	kitchen which includes escalation steps for after hours and weekends as well as the sequence of drain treatment per manufacturer recommendations. Facilities staff on FMLA or LOA will complete the training prior to returning to work. New employee orientation Facilities staff was revised to include training on the standard operating procedure (SOP) for any drain issues in the kitchen which includes escalation steps for after hours and weekends as well as the sequence of drain treatment per manufacturer recommendations.	implemented. A member of the Facilities Team is inspecting the Kitchen drains for visible blockages two times per shift. This continued until the pipes were repaired and a preventative maintenance schedule was implemented. Audits are completed three times a week by members of the Infection Prevention or Quality Team to include direct observations of cleanliness of pots/pans, equipment working properly, and infection control practices are in place until 100% compliance achieved. Results are provided monthly to the Dietary Leadership and Vice President of Operations and quarterly to the Environment of Care Committee, Quality of Care Committee, Medical Executive Committee, and Quality Committee of the Board of Trustees (reports quarterly to the Board of Trustees). Monitoring will continue quarterly on an ongoing basis with findings reported to the above stated committees unless non-compliance is identified whereby monitoring will increase in frequency until compliance is restored. Currently open maintenance work orders are reviewed weekly for appropriate classification, response time and completion by Senior Leadership. Weekly the data is aggregated and reported to the Vice President of Operations to identify trends and develop action plans. Quarterly reports are provided to the Environment of Care Committee, Quality of Care Committee, Medical Executive Committee and the Quality Committee of the Board of Trustees (reports quarterly	

			to the Board of Trustees). All kitchen work orders are audited weekly to review appropriate prioritization, work quality, documentation and timeliness of response until 100% compliance is sustained for two consecutive months. When compliance is sustained the auditing process will be reviewed through the 50 random audits per week process. Monitoring will continue quarterly on an ongoing basis with findings reported to the above stated committees unless non-compliance is identified whereby monitoring will increase in frequency until compliance is restored. Weekly, facility wide 50 random work orders are audited to review appropriate prioritization, work quality, documentation and timeliness of response on an ongoing basis. The findings are reported monthly to the Vice President of Operations and reported quarterly to the Environment of Care and Safety Committee, Quality of Care Committee, Medical Executive Committee and quarterly to the Quality Committee of the Board of Trustees (reports quarterly to the Board of Trustees) until 100% is sustained for two consecutive months. Monitoring will continue quarterly on an ongoing basis with findings reported to the above stated committees unless non-compliance is identified whereby monitoring will increase in frequency until compliance is restored.	
A701 (B)	Environmental rounds have been implemented to identify areas in need of repair. Weekly rounds are conducted per the rounding schedule (all patient care	The Hospital Safety Officer has given training to all primary and secondary Environment of Care (EOC) surveyors on the expectations for EOC rounds which included rounding, reporting, communicating and	On an ongoing basis as part of the Environment of Care Program weekly environmental rounds are completed per the rounding schedule. Results of the	**Responsible Person**: Vice President of Operations

	areas twice per calendar year and non-patient care areas at least annually) A schedule of environmental rounds has been completed for each area of the hospital. Environmental rounds will be completed in conjunction with infection prevention to identify any ongoing maintenance repairs and infection control concerns.	correcting of deficiencies. The Hospital Safety Officer acting as the EOC Committee Chair, reinforced with the Committee and EOC surveyors the expectations completing environmental rounds weekly as per the rounding schedule. Applicable staff on FMLA or LOA will complete the training prior to returning to work. New employees conducting EOC rounds will be educated by the Hospital Safety Department prior to completing an EOC round.	rounds and action items for gaps will be aggregated weekly and reported to the monthly to the Vice President of Operations and reported quarterly to the Environment of Care and Safety Committee, Quality of Care Committee, Medical Executive Committee and Quality Committee of the Board of Trustees (reports quarterly to the Board of Trustees). Monitoring will continue quarterly on an ongoing basis with findings reported to the above stated committees unless non-compliance is identified whereby monitoring will increase in frequency until compliance is restored.	**Completion Date:** 6/09/2019
A701 (C)	The power strips for the use on moveable equipment in the Cath Lab have been corrected by properly securing the re-locatable power strip to the equipment with clinical engineering following with a risk assessment using the requirements in NFPA 99 as a guide. The exposed wires were repaired in OR 6 and OR 11. The blanket warmer was identified and a daily log was generated for the equipment. The environment of care rounds includes looking for unsecured power strips and exposed wires.	The Cath Lab and OR Leadership at the Fannin Location were provided education by Facilities Leadership on how to identify when a power strip needs to be secured and identification of exposed wires. They were also educated to place a work order ticket if either has been identified. The Facilities Maintenance staff conducting environment of care rounds were provided education by Facilities Leadership about the expectations to look for unsecured power strips and exposed wires as well as to place a work order ticket if either of the above were found. The Cath Lab Staff were provided education by Cath Lab Leadership on the new daily log requirement for the blanket warmer. New Employee orientation for facilities staff was updated to reinforce the expectations conducting environmental rounds. New Employee orientation for Cath Lab staff was updated to reinforce the expectations completing the blanket warmer temperature log daily. Affected Staff on FMLA or LOA will complete the training prior to returning to work.	On an ongoing basis as part of the Environment of Care Program weekly environmental rounds are completed per the rounding schedule. Results of the rounds and action items for gaps will be aggregated weekly and reported to the monthly to the Vice President of Operations and reported quarterly to the Environment of Care and Safety Committee, Quality of Care Committee, Medical Executive Committee and Quality Committee of the Board of Trustees (reports quarterly to the Board of Trustees). Monitoring will continue quarterly on an ongoing basis with findings reported to the above stated committees unless non-compliance is identified whereby monitoring will increase in frequency until compliance is restored. On an ongoing basis, a member of the Cath Lab staff checks the temperature of the blanket warmer daily. Any temperature out of range is reported to facilities. Weekly a member of the Cath Lab Leadership inspects the completion of	**Responsible Person**: Vice President of Operations **Completion Date:** 6/09/2019

			this requirement. Monthly compliance is aggregated and reported to the Vice President of CV Services, Quality of Care Committee, Medical Executive Committee and Quality Committee of the Board of Trustees (reports quarterly to the Board of Trustees). Monitoring will continue quarterly on an ongoing basis with findings reported to the above stated committees unless non-compliance is identified whereby monitoring will increase in frequency until compliance is restored.	

BSLMC has an effective Board of Trustees that is legal responsible for the conduct of the hospital. BSLMC is currently in compliance with the CMS Condition of Participation A724 as evidence by the following specific corrective actions, education and monitoring for compliance.

For all items within Tag A724, the Board of Trustees has been actively engaged in the oversight and implementation of the plan of correction. An Executive Quality Council (EQC), chaired by the President or Senior Leader designee, meets weekly to provide oversight of the compliance with the monitoring of follow-up/monitoring measures. This council will continue to oversee the monitoring measures until 100% compliance with stated measures is sustained for two consecutive months. As well as:

- Individual staff member non-compliance will be reported to the appropriate supervisor or manager. Any non-compliance will be addressed with the individual through training, re-education and/or following the human resources corrective action process.
- Individual credential provider non-compliance will be addressed through the professional practice evaluation process and monitored through the ongoing practice evaluation process of the medical staff.
- When 100% compliance is sustained for two consecutive months for the monitoring measures stated in Tag A724, the monitoring will continue on an ongoing basis quarterly with finding continuing to be reported to the stated hospital Committees and the Quality Committee of the Board of Trustees (reports quarterly to the Board of Trustees). If compliance is not sustained quarterly monitoring will go back to weekly monitoring with data aggregated monthly for sustained compliance for at least two consecutive months. Decisions will be made in accordance with national clinical standards and the Conditions of Participation.

CoP Tag #	Plan for correcting the cited deficiency	Procedure for implementing the acceptable plan of correction	Follow-up/Monitoring	Person Responsible Completion Date
A724	Kirby Glen has been provided the correct chemo spill clean-up kit. Training was implemented for the Kirby Glen staff on the proper cleaning of equipment after contamination with chemotherapy drugs in accordance with policy "Handling and Disposal of Hazardous Materials". New red containers that are dedicated to	The Kirby Glen staff were provided education by Facilities Leadership about the safe use of the chemo spill kits and the proper cleaning of equipment after contamination with chemotherapy drugs in accordance with policy "Handling and Disposal of Hazardous Materials" New Employee orientation and annual training for Kirby Glen personnel was updated to include the expectations for use of the chemo spill kits and proper cleaning of equipment after contamination with	Once a week mock drills will be conducted with the Kirby Glen staff to evaluate the proper handling of the chemo spill clean-up kit and proper cleaning of equipment after contamination with chemotherapy drugs in accordance with policy "Handling and Disposal of Hazardous Materials". The findings are reported monthly to the Quality of Care Committee, Medical Executive Committee and quarterly to the	**Responsible Person**: Vice President of Operations **Completion Date:** 6/09/2019

	chemotherapy transport were purchased Kirby Glen. Blue containers were purchased for the transport of non-chemotherapy medications. Instructional materials were developed to demonstrate how to clean all transportation bins and ice packs in accordance with policy "Handling and Disposal of Hazardous Materials".	chemotherapy drugs in accordance with policy "Handling and Disposal of Hazardous Materials". Staff transporting chemotherapy drugs were educated by Pharmacy Leadership on the correct methods of transportation with the new bins and the proper cleaning of the bins and ice packs in accordance with policy "Handling and Disposal of Hazardous Materials". New employee training for staff transporting chemotherapy drugs was updated to reflect the correct methods of transportation with the new bins and the proper cleaning of the bins and ice packs in accordance with policy "Handling and Disposal of Hazardous Materials".	Quality Committee of the Board of Trustees (reports quarterly to the Board of Trustees) until 100% is sustained for two consecutive months. Monitoring will continue quarterly on an ongoing basis with findings reported to the above stated committees unless non-compliance is identified whereby monitoring will increase in frequency until compliance is restored. Once a week the Kirby Glen Pharmacy Team will audit the transportation and cleaning procedures of chemotherapy drugs with a monthly aggregate of four observations. The findings are reported monthly to the Quality of Care Committee, Medical Executive Committee and quarterly to the Quality Committee of the Board of Trustees (reports quarterly to the Board of Trustees) until 100% is sustained for two consecutive months. Monitoring will continue quarterly on an ongoing basis with findings reported to the above stated committees unless non-compliance is identified whereby monitoring will increase in frequency until compliance is restored.	

BSLMC has an effective Board of Trustees that is legal responsible for the conduct of the hospital. BSLMC is currently in compliance with the CMS Condition of Participation A747 as evidence by the following specific corrective actions, education and monitoring for compliance.

For all items within Tag A747, the Board of Trustees has been actively engaged in the oversight and implementation of the plan of correction. An Executive Quality Council (EQC), chaired by the President or Senior Leader designee, meets weekly to provide oversight of the compliance with the monitoring of follow-up/monitoring measures. This council will continue to oversee the monitoring measures until 100% compliance with stated measures is sustained for two consecutive months. As well as:

- Individual staff member non-compliance will be reported to the appropriate supervisor or manager. Any non-compliance will be addressed with the individual through training, re-education and/or following the human resources corrective action process.
- Individual credential provider non-compliance will be addressed through the professional practice evaluation process and monitored through the ongoing practice evaluation process of the medical staff.
- When 100% compliance is sustained for two consecutive months for the monitoring measures stated in Tag A747, the monitoring will continue on an ongoing basis quarterly with finding continuing to be reported to the stated hospital Committees and the Quality Committee of the Board of Trustees (reports quarterly to the Board

	of Trustees). If compliance is not sustained quarterly monitoring will go back to weekly monitoring with data aggregated monthly for sustained compliance for at least two consecutive months. Decisions will be made in accordance with national clinical standards and the Conditions of Participation.			
CoP Tag #	**Plan for correcting the cited deficiency**	**Procedure for implementing the acceptable plan of correction**	**Follow-up/Monitoring**	**Person Responsible Completion Date**
A747 (A)	A new process has been implemented where members from Infection Prevention, Quality, and Hospital Leadership, through direct observation, are auditing any personnel entering and exiting an isolation room to ensure compliance with nationally recognized standards of practice for infection prevention, including correct donning, doffing personal protective equipment (PPE), and cleaning of mobile computer carts (WOW) and portable equipment. Auditors in real time are interrupting and coaching when break in process is identified. Infection Prevention developed educational tools and videos on proper procedure for donning, doffing PPE and for cleaning patient care equipment when entering and exiting an isolation room as well as removal of trash. The training for donning, doffing, and cleaning of equipment in an isolation room was updated to require return demonstration. A competency skills fair and train the trainer program was developed and implemented for all staff, residents and providers entering a patient room with standardized consistent evaluations and competency assessments for wearing of PPE and cleaning of equipment when entering and exiting an isolation room. New computer workstations were	Leaders were educated by infection prevention in the "Train the Trainer" education program for proper process for PPE and equipment cleaning with return demonstration competency assessment for entering and exiting isolation rooms. All staff, residents and providers have participated in the Isolation and PPE return demonstration training by approved trainers. This will continue to occur until all staff, residents and providers entering and exiting an isolation room have completed the return demonstration training. New Employee and credentialed provider orientation has been updated include return demonstration training for proper wearing of PPE and cleaning of equipment when entering and exiting an isolation room. Direct observations of all staff, residents and providers entering isolation rooms to validate each step of the donning, doffing PPE process and equipment cleaning includes interrupting and coaching when a break in process is identified. All staff, providers and residents have been provided education on the new isolation signs and patient/visitor requirements for PPE through a variety of methods to include electronic learning modules, one on one education, and just in time training. Visitors are instructed by the hospital staff on the wearing of PPE recommendations and to watch the video for proper donning and doffing techniques in accordance with policy "Standard and Transmission-Based Precautions". Affected staff on FMLA or LOS will complete the training prior to returning to work.	Through direct observation, a member of the Quality or Infection Prevention team audits 50 staff, residents or credentialed providers weekly to validate the proper wearing of PPE and cleaning of equipment practices when entering and exiting a room in accordance with hospital policy. The findings are reported bi-monthly to the Infection Prevention and Control Committee, monthly to the Quality of Care Committee, Medical Executive Committee and quarterly to the Quality Committee of the Board of Trustees (reports quarterly to the Board of Trustees) until 100% is sustained for two consecutive months. Monitoring will continue quarterly on an ongoing basis with findings reported to the above stated committees unless non-compliance is identified whereby monitoring will increase in frequency until compliance is restored.	**Responsible Person**: Vice President of Quality **Completion Date:** 6/09/2019

	purchased to dedicate to isolation rooms The policy "Standard and Transmission-Based Precautions" has been updated to provide guidance on patient and visitors wearing PPE in accordance with Society for Healthcare Epidemiology of America (SHEA) guidelines. Isolation signs have been updated to include resources videos for patients and visitors on the proper donning and doffing of PPE.			
A747 (B)	The pre-cleanse and HLD process for transvaginal probes was reviewed with process steps clarified to define the appropriate disinfectant wipes per manufacturer instructions for use (IFU). The competency assessment for proper disinfection, pre-cleanse and HLD was revised to reflect the IFUs. Laminated Cleaning Instruction cards were created and posted at each HLD disinfection system station. Audit tool was created to validate proper pre-cleanse wipe selection and HLD process per IFU.	Diagnostic Imagining US, Cath Lab Techs and RNs, CT, PV, and echo staff who use transvaginal probes were educated on the proper disinfection, pre-cleanse process and the use of HLD system per IFU by a member of Infection Prevention and the Vice President of CV Services. New employee orientation for the Diagnostic Imagining US, Cath Lab Techs and RNs, CT, PV, and echo staff who use transvaginal probes has been updated to include the leaning education and return demonstration competency assessment for the transvaginal ultrasound transducer probes.	Through direct observation, a member of the Quality, Infection Prevention or Diagnostic Imaging team audits three times per week the proper disinfection and reprocessing of transvaginal probes to validate pre-cleanse and HLD process per IFU. The findings are reported bi-monthly to the Infection Prevention and Control Committee, monthly to the Quality of Care Committee, Medical Executive Committee and quarterly to the Quality Committee of the Board of Trustees (reports quarterly to the Board of Trustees) until 100% is sustained for two consecutive months. Monitoring will continue quarterly on an ongoing basis with findings reported to the above stated committees unless non-compliance is identified whereby monitoring will increase in frequency until compliance is restored.	**Responsible Person**: Vice President of CV Services **Completion Date:** 6/09/2019
A747 (C)	Education was developed by Pharmacy Leadership for the staff in the new McNair pharmacy reinforcing the process to ensure and maintain sterility of the compounding area. The Director of the Pharmacy reinforced the expectations for maintaining the sterility of the compounding areas with all	Pharmacy staff responsible for cleaning and managing the compounding areas were educated by Pharmacy Leadership of the process to ensure and maintain sterility of the compounding area. Pharmacy Staff on FMLA or LOA will complete the training prior to returning to work.	Weekly a member of the Pharmacy Leadership team evaluates the McNair pharmacy staff's ability to follow the process to ensure and maintain sterility of the compounding area. The findings are reported monthly to the Director of Pharmacy, Quality of Care Committee, Medical Executive Committee and quarterly to the Quality Committee of the	**Responsible Person**: Vice President of Operations **Completion Date:** 6/09/2019

	staff responsible for cleaning and managing the compounding areas. Air and surface monitoring continues to be performed to validate the sterility of the clean rooms.		Board of Trustees (reports quarterly to the Board of Trustees) until 100% is sustained for two consecutive months. Monitoring will continue quarterly on an ongoing basis with findings reported to the above stated committees unless non-compliance is identified whereby monitoring will increase in frequency until compliance is restored. On an ongoing basis air and surface quality are tested initially (after training) and then every six months as required by hospital policy. A member of the Pharmacy staff conducts weekly rounds to check the cleaning log of the compounding areas is completed correctly. The findings of air and surface quality are reported to the Director of Pharmacy, and every six months to the Pharmacy and Therapeutic Committee, Quality of Care Committee, Medical Executive Committee and the Quality Committee of the Board of Trustees (reports quarterly to the Board of Trustees) until 100% is sustained for two consecutive months. Monitoring will continue quarterly on an ongoing basis with findings reported to the above stated committees unless non-compliance is identified whereby monitoring will increase in frequency until compliance is restored. The findings of cleaning logs are reported monthly to the Pharmacy Director, Quality of Care Committee, Medical Executive Committee and quarterly to the Quality Committee of the Board of Trustees (reports quarterly to the Board of Trustees) until 100% is sustained for two consecutive months. Monitoring will continue quarterly on an ongoing basis with findings reported to the above stated committees unless non-	

			compliance is identified whereby monitoring will increase in frequency until compliance is restored.	
A747 (D) & (E)	A new isolation work process was developed for EVS to clean an isolation room. An EVS competency checklist was created and implemented. EVS Supervisor EVS Staff assigned to Jamail were educated by the EVS Supervisor on the terminal cleaning process and completed the terminal cleaning direct observation competency assessment with the Vice President of Operations.	Direct observation competency assessments are conducted by EVS leadership concurrently for EVS staff entering isolation rooms to validate each step of the donning and doffing PPE process and equipment cleaning was completed. EVS Director completed the "Train the Trainer" education and return demonstration competency assessment. EVS staff completed the isolation room cleaning education and return demonstration competency assessment. New employee orientation and annual training for the EVS staff has been updated to include the isolation room cleaning education and return demonstration competency assessment.	Through direct observation, a member of the Quality or Infection Prevention team audits 10 isolation room cleanings per week to validate the proper cleaning process of an isolation room. The findings are reported bi-monthly to the Infection Prevention and Control Committee, monthly to the Quality of Care Committee, Medical Executive Committee and quarterly to the Quality Committee of the Board of Trustees (reports quarterly to the Board of Trustees) until 100% is sustained for two consecutive months. Monitoring will continue quarterly on an ongoing basis with findings reported to the above stated committees unless non-compliance is identified whereby monitoring will increase in frequency until compliance is restored. Weekly random ATP testing of 12 high touch areas are conducted for one OR each week. When 100% compliance is sustained for two consecutive months the monitoring will continue on an ongoing basis monthly. The findings are reported monthly to the Vice President of Surgical Services, bi-monthly to the Infection Prevention and Control Committee. Results will be reported quarterly to the Quality of Care Committee, Medical Executive Committee and the Quality Committee of the Board of Trustees (reports quarterly to the Board of Trustees). Monitoring will continue quarterly on an ongoing basis with findings reported to the above stated committees unless non-compliance is identified whereby monitoring will increase in frequency until compliance is	**Responsible Person**: Vice President of Quality **Completion Date:** 6/09/2019

			restored.	

BSLMC has an effective Board of Trustees that is legal responsible for the conduct of the hospital. BSLMC is currently in compliance with the CMS Condition of Participation A749 as evidence by the following specific corrective actions, education and monitoring for compliance.

For all items within Tag A749, the Board of Trustees has been actively engaged in the oversight and implementation of the plan of correction. An Executive Quality Council (EQC), chaired by the President or Senior Leader designee, meets weekly to provide oversight of the compliance with the monitoring of follow-up/monitoring measures. This council will continue to oversee the monitoring measures until 100% compliance with stated measures is sustained for two consecutive months. As well as:

- Individual staff member non-compliance will be reported to the appropriate supervisor or manager. Any non-compliance will be addressed with the individual through training, re-education and/or following the human resources corrective action process.
- Individual credential provider non-compliance will be addressed through the professional practice evaluation process and monitored through the ongoing practice evaluation process of the medical staff.
- When 100% compliance is sustained for two consecutive months for the monitoring measures stated in Tag A749, the monitoring will continue on an ongoing basis quarterly with finding continuing to be reported to the stated hospital Committees and the Quality Committee of the Board of Trustees (reports quarterly to the Board of Trustees). If compliance is not sustained quarterly monitoring will go back to weekly monitoring with data aggregated monthly for sustained compliance for at least two consecutive months. Decisions will be made in accordance with national clinical standards and the Conditions of Participation.

CoP Tag #	Plan for correcting the cited deficiency	Procedure for implementing the acceptable plan of correction	Follow-up/Monitoring	Person Responsible Completion Date

A749 (A)	A new process has been implemented where members from Infection Prevention, Quality, and Hospital Leadership, through direct observation, are auditing any personnel entering and exiting an isolation room to ensure compliance with nationally recognized standards of practice for infection prevention, including correct donning, doffing personal protective equipment (PPE), and cleaning of mobile computer carts (WOW) and portable equipment. Auditors in real time are interrupting and coaching when break in process is identified. Infection Prevention developed educational tools and videos on proper procedure for donning, doffing PPE and for cleaning patient care equipment when entering and exiting an isolation room as well as removal of trash. The training for donning, doffing, and cleaning of equipment in an isolation room was updated to require return demonstration. A competency skills fair and train the trainer program was developed and implemented for all staff, residents and providers entering a patient room with standardized consistent evaluations and competency assessments for wearing of PPE and cleaning of equipment when entering and exiting an isolation room. New computer workstations were purchased to dedicate to isolation rooms The policy "Standard and Transmission-Based Precautions" has been updated to provide guidance on patient and visitors	Leaders were educated by infection prevention in the "Train the Trainer" education program for proper process for PPE and equipment cleaning with return demonstration competency assessment for entering and exiting isolation rooms. All staff, residents and providers have participated in the Isolation and PPE return demonstration training by approved trainers. This will continue to occur until all staff, residents and providers entering and exiting an isolation room have completed the return demonstration training. New Employee and credentialed provider orientation has been updated include return demonstration training for proper wearing of PPE and cleaning of equipment when entering and exiting an isolation room. Direct observations of all staff, residents and providers entering isolation rooms to validate each step of the donning, doffing PPE process and equipment cleaning includes interrupting and coaching when a break in process is identified. All staff, providers and residents have been provided education on the new isolation signs and patient/visitor requirements for PPE through a variety of methods to include electronic learning modules, one on one education, and just in time training. Visitors are instructed by the hospital staff on the wearing of PPE recommendations and to watch the video for proper donning and doffing techniques in accordance with policy "Standard and Transmission-Based Precautions". Affected staff on FMLA or LOS will complete the training prior to returning to work.	Through direct observation, a member of the Quality or Infection Prevention team audits 50 staff, residents or credentialed providers weekly to validate the proper wearing of PPE and cleaning of equipment practices when entering and exiting a room in accordance with hospital policy. The findings are reported bi-monthly to the Infection Prevention and Control Committee, monthly to the Quality of Care Committee, Medical Executive Committee and quarterly to the Quality Committee of the Board of Trustees (reports quarterly to the Board of Trustees) until 100% is sustained for two consecutive months. Monitoring will continue quarterly on an ongoing basis with findings reported to the above stated committees unless non-compliance is identified whereby monitoring will increase in frequency until compliance is restored.	**Responsible Person**: Vice President of Quality **Completion Date:** 6/09/2019

	wearing PPE in accordance with Society for Healthcare Epidemiology of America (SHEA) guidelines. Isolation signs have been updated to include resources videos for patients and visitors on the proper donning and doffing of PPE.			
A749 (B)	The pre-cleanse and HLD process for transvaginal probes was reviewed with process steps clarified to define the appropriate disinfectant wipes per manufacturer instructions for use (IFU). The competency assessment for proper disinfection, pre-cleanse and HLD was revised to reflect the IFUs. Laminated Cleaning Instruction cards were created and posted at each HLD disinfection system station. Audit tool was created to validate proper pre-cleanse wipe selection and HLD process per IFU.	Diagnostic Imagining US, Cath Lab Techs and RNs, CT, PV, and echo staff who use transvaginal probes were educated on the proper disinfection, pre-cleanse process and the use of HLD system per IFU by a member of Infection Prevention and the Vice President of CV Services. New employee orientation for the Diagnostic Imagining US, Cath Lab Techs and RNs, CT, PV, and echo staff who use transvaginal probes has been updated to include the leaning education and return demonstration competency assessment for the transvaginal ultrasound transducer probes.	Through direct observation, a member of the Quality, Infection Prevention or Diagnostic Imaging team audits three times per week the proper disinfection and reprocessing of transvaginal probes to validate pre-cleanse and HLD process per IFU. The findings are reported bi-monthly to the Infection Prevention and Control Committee, monthly to the Quality of Care Committee, Medical Executive Committee and quarterly to the Quality Committee of the Board of Trustees (reports quarterly to the Board of Trustees) until 100% is sustained for two consecutive months. Monitoring will continue quarterly on an ongoing basis with findings reported to the above stated committees unless non-compliance is identified whereby monitoring will increase in frequency until compliance is restored.	**Responsible Person**: Vice President of CV Services **Completion Date:** 6/09/2019

A749 (C)	Education was developed by Pharmacy Leadership for the staff in the new McNair pharmacy reinforcing the process to ensure and maintain sterility of the compounding area. The Director of the Pharmacy reinforced the expectations for maintaining the sterility of the compounding areas with all staff responsible for cleaning and managing the compounding areas. Air and surface monitoring continues to be performed to validate the sterility of the clean rooms.	Pharmacy staff responsible for cleaning and managing the compounding areas were educated by Pharmacy Leadership of the process to ensure and maintain sterility of the compounding area. Pharmacy Staff on FMLA or LOA will complete the training prior to returning to work.	Weekly a member of the Pharmacy Leadership team evaluates the McNair pharmacy staff's ability to follow the process to ensure and maintain sterility of the compounding area. The findings are reported monthly to the Director of Pharmacy, Quality of Care Committee, Medical Executive Committee and quarterly to the Quality Committee of the Board of Trustees (reports quarterly to the Board of Trustees) until 100% is sustained for two consecutive months. Monitoring will continue quarterly on an ongoing basis with findings reported to the above stated committees unless non-compliance is identified whereby monitoring will increase in frequency until compliance is restored. On an ongoing basis air and surface quality are tested initially (after training) and then every six months as required by hospital policy. A member of the Pharmacy staff conducts weekly rounds to check the cleaning log of the compounding areas is completed correctly. The findings of air and surface quality are reported to the Director of Pharmacy, and every six months to the Pharmacy and Therapeutic Committee, Quality of Care Committee, Medical Executive Committee and the Quality Committee of the Board of Trustees (reports quarterly to the Board of Trustees) until 100% is sustained for two consecutive months. Monitoring will continue quarterly on an ongoing basis with findings reported to the above stated committees unless non-compliance is identified whereby monitoring will increase in frequency until compliance is restored. The findings of cleaning logs are reported monthly to the	**Responsible Person**: Vice President of Operations **Completion Date:** 6/09/2019

			Pharmacy Director, Quality of Care Committee, Medical Executive Committee and quarterly to the Quality Committee of the Board of Trustees (reports quarterly to the Board of Trustees) until 100% is sustained for two consecutive months. Monitoring will continue quarterly on an ongoing basis with findings reported to the above stated committees unless non-compliance is identified whereby monitoring will increase in frequency until compliance is restored.	
A749 (E)	A new isolation work process was developed for EVS to clean an isolation room. An EVS competency checklist was created and implemented.	Direct observation competency assessments are conducted by EVS leadership concurrently for EVS staff entering isolation rooms to validate each step of the donning and doffing PPE process and equipment cleaning was completed. EVS Director completed the "Train the Trainer" education and return demonstration competency assessment. EVS staff completed the isolation room cleaning education and return demonstration competency assessment. New employee orientation and annual training for the EVS staff has been updated to include the isolation room cleaning education and return demonstration competency assessment.	Through direct observation, a member of the Quality or Infection Prevention team audits 10 isolation room cleanings per week to validate the proper cleaning process of an isolation room. The findings are reported bi-monthly to the Infection Prevention and Control Committee, monthly to the Quality of Care Committee, Medical Executive Committee and quarterly to the Quality Committee of the Board of Trustees (reports quarterly to the Board of Trustees) until 100% is sustained for two consecutive months. Monitoring will continue quarterly on an ongoing basis with findings reported to the above stated committees unless non-compliance is identified whereby monitoring will increase in frequency until compliance is restored.	**Responsible Person**: Vice President of Quality **Completion Date:** 6/09/2019

A749 (F)	Immediate competency regarding the standard precautions during the provision of hemodialysis care, including the cleaning process of equipment in between patients in dialysis rooms was re-implemented by the Director of Dialysis for all applicable staff in the unit. This included a re-demonstration of each applicable staff members knowledge of the cleaning process.	The Leadership Team in Dialysis and members of the Infection Prevention Department conducted training and validated learning by directly observing all dialysis nurses and patient care technicians entering and exiting dialysis rooms complete a return demonstration for the standard precautions during the provision of hemodialysis care, including proper donning and doffing procedure for wearing of PPE which included wearing PPE at the initiation and the discontinuation of dialysis. Dialysis Staff on FMLA or LOA will complete the competency assessment prior to returning to work. New Employee orientation and annual training for dialysis personnel was updated to include return demonstration training for proper wearing of PPE.	Through direct observation, a member of the Dialysis Leadership audits 30 events per week to validate the standard precautions during the provision of hemodialysis care, including proper wearing of PPE. The findings are reported bi-monthly to the Infection Prevention and Control Committee, monthly to the Quality of Care Committee, Medical Executive Committee and quarterly to the Quality Committee of the Board of Trustees (reports quarterly to the Board of Trustees) until 100% is sustained for two consecutive months. Monitoring will continue quarterly on an ongoing basis with findings reported to the above stated committees unless non-compliance is identified whereby monitoring will increase in frequency until compliance is restored.	**Responsible Person**: Vice President of Patient Care – Medical Surgical **Completion Date:** 6/09/2019
A749 (G)	The employees missing the Hepatitis B records were notified with records of immunization received. The expectations to follow the onboarding process for Hepatitis B screening in accordance with policy "Vaccine Preventable Diseases – Occupational Health (System)" was reinforced by Human Resources Leadership.	The Occupational Health employees and hospital leadership were educated by the Director of Human Resources on the expectations to follow the policy "Vaccine Preventable Diseases – Occupational Health (System)". New employee orientation for Occupational Health employees was updated to reflect the process expectations as defined in policy "Vaccine Preventable Diseases – Occupational Health (System)".	On an ongoing basis, a member of the Occupational Health staff checks the Hepatitis B vaccination status for all new employees to ensure the process was followed in accordance with policy "Vaccine Preventable Diseases – Occupational Health (System)". Monthly compliance is aggregated and reported to the Director of Human Resources, quarterly to the Quality Outcomes Committee, Medical Executive Committee and Quality Committee of the Board of Trustees (reports quarterly to the Board of Trustees). Monitoring will continue quarterly on an ongoing basis with findings reported to the above stated committees unless non-compliance is identified whereby monitoring will increase in frequency until compliance is restored.	**Responsible Person**: Director of Human Resources **Completion Date:** 6/09/2019

A749 (H)	The employee missing the Tuberculosis status records was notified with records of status received. The expectations to follow the onboarding process for Tuberculosis screening in accordance with policy "Employee Tuberculosis Screening (System)" was reinforced by Human Resources Leadership.	The Occupational Health employees and hospital leadership were educated by the Director of Human Resources on the expectations to follow the policy "Employee Tuberculosis Screening (System)". New employee orientation for Occupational Health employees was updated to reflect the process expectations as defined in policy "Employee Tuberculosis Screening (System)"	On an ongoing basis, a member of the Occupational Health staff checks the Tuberculosis status for all new employees to ensure the process was followed in accordance with policy "Employee Tuberculosis Screening (System)". Monthly compliance is aggregated and reported to the Director of Human Resources, quarterly to the Quality Outcomes Committee, Medical Executive Committee and Quality Committee of the Board of Trustees (reports quarterly to the Board of Trustees). Monitoring will continue quarterly on an ongoing basis with findings reported to the above stated committees unless non-compliance is identified whereby monitoring will increase in frequency until compliance is restored.	**Responsible Person**: Director of Human Resources **Completion Date:** 6/09/2019
A749 (I)	The Jun-Air compressor filter in the endoscope reprocessing room was changed. The maintenance schedule was updated to reflect changing the Jun-Air compressor filter once a year per the manufacturer's instructions for use. The Rapicide strips were immediately removed and replaced.	The Endoscopy Staff were provided education by the Endoscope Leadership about the proper labeling of the expiration dates for the Rapicide strips to include that they expire 4 months after opening or the manufacture expiration date whichever comes first. The Endoscopy staff were educated by Endoscopy Leadership for the maintenance schedule of the Jun-Air compressor filter as well as the policy reinforced to complete the second air blow process of the endoscope after it has been processed through the AER. Endoscopy staff on FMLA or LOA will complete the education and training prior to returning to work. New employee orientation for Endoscopy Staff was updated to provided education about the proper labeling of the expiration dates for the Rapicide strips to include that they expire 4 months after opening or the manufacture expiration date whichever comes first.	On an ongoing basis, a member of the Endoscopy staff checks the expiration of the Rapicide strips monthly and a member of the Facilities Staff replaces the Jun-Air compressor filter once a year. Monthly compliance is aggregated and reported to the Vice President of Surgical Services, quarterly to the Quality of Care Committee, Medical Executive Committee, and Quality Committee of the Board of Trustees (reports quarterly to the Board of Trustees). Monitoring will continue quarterly on an ongoing basis with findings reported to the above stated committees unless non-compliance is identified whereby monitoring will increase in frequency until compliance is restored.	
A749 (D, J, K)	Weekly rounding tool was updated to include identification and mitigation of any	EVS Supervisor EVS Staff assigned to Jamail were educated by the EVS Supervisor on the terminal	Through direct observation, a member of the Quality, Infection Prevention, or	**Responsible Person**: Vice

	cleanliness issues, penetrations and nicks in the flooring, mattress integrity, and rust. A rust remediation program was implemented by biomed to systematically replace identified equipment that could not be immediately removed from service. The Automatic Endoscope Re-processer (AER) instructions for use were checked whereby the AER does the air blow procedure during the process of cleaning. The policy added an extra air blow procedure. The hospital has decided to continue to complete the second air blow process as an extra level of safety. Environmental rounds have been implemented which includes weekly rounds per the rounding schedule (all patient care areas twice per calendar year and non-patient care areas at least annually) A schedule of environmental rounds has been completed for each area of the hospital. Environmental rounds will be completed in conjunction with infection prevention to identify any ongoing maintenance repairs and infection control concerns. Departmental rounds in patient care areas have been implemented monthly to ensure the facility is properly cleaned, equipment is clean and in proper condition. <u>MAIN OR</u> <u>SECTION A STERILE CORE</u> Cleaned affected refrigerator in Sterile core. Removed the bottle of RPMI	cleaning process and completed the terminal cleaning direct observation competency assessment with the Vice President of Operations. Weekly rounding tool and rounding expectations were distributed to Surgical Services department leadership by the Vice President of Surgical Services which included identification and mitigation of any cleanliness issues, penetrations, nicks in flooring, mattress integrity and rust. The Jamail and Fannin OR staff were educated via two Safety Alerts topics included: integrity inspection of OR mattresses and flooring inspection to identify holes or nicks that impact product integrity The Surgical Services patient care assistants were educated to identify and replace all defective mattresses during the room turn-over process. The Endoscopy staff were educated by Endoscopy Leadership for the maintenance schedule of the Jun-Air compressor filter as well as the policy reinforced to complete the second air blow process of the endoscope after it has been processed through the AER. Endoscopy staff on FMLA or LOA will complete the education and training prior to returning to work. New employee orientation for Endoscopy Staff was updated to provided education about the proper labeling of the expiration dates for the Rapicide strips to include that they expire 4 months after opening or the manufacture expiration date whichever comes first as well as the cleaning process for the endoscope as applicable. The Hospital Safety Officer has given training to all primary and secondary Environment of Care (EOC) surveyors on the expectations for EOC rounds which included rounding, reporting, communicating and correcting of deficiencies.	Surgical Services team will conduct three audits per week, monthly aggregate of twelve, to validate the area is free from penetrations, nicks in flooring, equipment with rust and cleanliness issues. When 100% compliance is sustained for two consecutive months the monitoring will continue on an ongoing basis monthly. The findings are reported monthly to the Vice President of Surgical Services, bi-monthly to the Infection Prevention and Control Committee and quarterly to the Quality of Care Committee, Medical Executive Committee and the Quality Committee of the Board of Trustees (reports quarterly to the Board of Trustees). Monitoring will continue quarterly on an ongoing basis with findings reported to the above stated committees unless non-compliance is identified whereby monitoring will increase in frequency until compliance is restored. Weekly random ATP testing of 12 high touch areas are conducted for one OR each week. When 100% compliance is sustained for two consecutive months the monitoring will continue on an ongoing basis monthly. The findings are reported monthly to the Vice President of Surgical Services, bi-monthly to the Infection Prevention and Control Committee. Results will be reported quarterly to the Quality of Care Committee, Medical Executive Committee and the Quality Committee of the Board of Trustees (reports quarterly to the Board of Trustees). Monitoring will continue quarterly on an ongoing basis with findings reported to the above stated committees unless non-compliance is identified whereby monitoring will	President of Operations **Completion Date:** 6/09/2019

	medium (a pathology fixative). The RPMI medium was relocated to the Pathology department. <u>ORTHOPEDIC CORE</u> The Tissue per manufacturer instructions for use is stored at 15 to 30 degrees Celsius. The temperature within the orthopedic core is continuously monitored. The cabinet that holds the tissue is open to the orthopedic core to ensure storage at the manufacturer's recommendations. <u>UROLOGY-CYSTO ROOM 3</u> The following was removed from service and replaced: the kick bucket, the affected IV (Intravenous) pole, affected stool fluid irrigation warmer basin, affected Velcro attached to OR mattress and affected OR mattress. <u>UROLOGY CORE</u> The equipment cart holding the Olympus Shock Pulse-SE machine was removed from service and replaced. <u>OPERATING ROOM 21</u> The following was removed from service and replaced: suction tubing hanging uncovered on the suction, the affected IV pole, unprotected 4x4 sponges in the anesthesia supply cart, the expired radial artery catheterization set stored in the anesthesia supply cart, irrigation fluid warmer basin, affected stool, and affected metal table. <u>OPERATING ROOM 18</u> The following was removed from service and replaced: the affected IV pole. The following was repaired: painted affected door and frame and resealed the plasterboard to seal the wood cracks in the	The Hospital Safety Officer acting as the EOC Committee Chair, reinforced with the Committee and EOC surveyors the expectations completing environmental rounds weekly as per the rounding schedule. New employees conducting EOC rounds will be educated by the Hospital Safety Department prior to completing an EOC round. All Surgical Services and Procedural Staff were reeducated on maintenance of a sanitary environment including ensuring the environment of care items free of dust, rust, torn mattresses, cracked floors, holes in walls, and chipped paint. Weekly rounding tool and rounding expectations were distributed to Surgical Services department leadership by the Vice President of Surgical Services which included identification and mitigation of any expired supplies and incomplete logs. Leadership of 6 Tower in conjunction with Infection prevention oversight conducted training for nursing staff reinforcing the process of cleaning WOWs and stethoscopes in between patients. This took place across all shifts and was reinforced by regular nursing huddles and nursing leadership rounds to reinforce practice. Training has been reinforced with the Cath Lab staff on skin preparation procedures, maintaining a sterile field, and demarcation of restricted areas from semi-restricted areas and movement between the two. Through huddles and leadership rounds in the Cath Lab the process for event related sterility (integrity of the package and not time limits) was reinforced. EVS Staff assigned to Jamail were educated by the EVS Supervisor on the terminal cleaning process and completed the terminal cleaning direct observation competency assessment with the Manager of Environmental Services. Weekly rounding tool and rounding expectations were	increase in frequency until compliance is restored. Once a week a member of the Endoscopy or Infection Prevention Team will audit the process to air blow the endoscope after it has been processed through the AER. The findings are reported monthly to the Vice President of Surgical Services, Quality of Care Committee, Medical Executive Committee and quarterly to the Quality Committee of the Board of Trustees (reports quarterly to the Board of Trustees) until 100% is sustained for two consecutive months. Monitoring will continue quarterly on an ongoing basis with findings reported to the above stated committees unless non-compliance is identified whereby monitoring will increase in frequency until compliance is restored. Environment of Care Program weekly environmental rounds are completed per the rounding schedule. Results of the rounds and action items for gaps will be aggregated weekly and reported to the monthly to the Vice President of Operations and reported quarterly to the Environment of Care and Safety Committee, Quality of Care Committee, Medical Executive Committee and Quality Committee of the Board of Trustees (reports quarterly to the Board of Trustees). Monitoring will continue quarterly on an ongoing basis with findings reported to the above stated committees unless non-compliance is identified whereby monitoring will increase in frequency until compliance is restored. Through direct observation, a member of	

	operating room door. The following was removed from service and repaired: robotic surgery equipment tower bin that stored the oxygen/gas tanks. HALLWAY OUTSIDE OR 16 The following was repaired: affected wall at the baseboard to sealed exposed plaster and sheetrock. MAIN OR HALLWAY The following was removed from service and repaired: Pentax Endoscopy tower. STERILE PROCESSING DEPARTMENT (SPD) The following was repaired and sealed: affected linoleum flooring and the floor under a metal shelf and next to the water valves. The following was cleaned: metal cabinet that stores green towels and the drawer inside the cabinet. The following was cleaned, repainted and resealed: the base of the wall. The following was replaced: rubber seal on the floor under the metal shelf next to the water valves. This department was terminally cleaned. FANNIN SURGERY OPERATING ROOM 6 The following was repaired: the base of the affected operating room table, the affected linoleum floor. The OR walls were repainted. The following was removed from service and replaced: the affected OR mattress and the affected linen hamper. OPERATING ROOM 11 The following was repaired: the affected wall, Covidien equipment cart, the affected linoleum floor. The following was removed from service and replaced: the affected stool, affected OR mattress, and	distributed to Surgical Services department leadership by the Vice President of Surgical Services which included identification and mitigation of any cleanliness issues, penetrations, nicks in flooring, mattress integrity and rust. The Surgical Services patient care assistants were educated to identify and replace all defective mattresses during the room turn-over process The EVS Director trained the Ultrasound Supervisor on the new work process to dispose of all trash including regulated medical waste in between patients. The Ultrasound Supervisor trained the ultra sound staff on the new work process to dispose of all trash including regulated medical waste in between patients Kirby Glen was trained by a member of the Infection Prevention Team on the proper handling of blood when it enters the center. Surgical Services Staff and Credentialed providers were notified of the process change for the temperature monitoring in the ORs through one or more of these methods: in-person training, certified letters, online training modules and discussion at medical staff meetings. Education was provided to Kirby Glen staff by Kirby Glen leadership on how to identify environmental concerns that should be repaired, replaced, or taken out of service. Staff were reeducated on how to enter a work order through staff huddles and leadership rounds. Education was provided to the pharmacy staff by the Pharmacy Leadership regarding the process change for the acceptance of the crash carts into pharmacy. This was reinforced through regular huddles and leadership rounds to reinforce practice. The contract company provided education to their employees on the changes in standard work and infection prevention principles. Additionally, these	Cath Lab Leadership audits ten (10) cases per week with a monthly aggregate of 40 to validate proper skin preparation, maintenance of a sterile field, and movement between semi-restricted and restricted areas. The findings are reported monthly to the Vice President of CV Services, Quality of Care Committee, Medical Executive Committee, and quarterly to the Quality Committee of the Board of Trustees (reports quarterly to the Board of Trustees) until 100% is sustained for 2 consecutive months. Monitoring will continue quarterly on an ongoing basis with findings reported to the above stated committees unless non-compliance is identified whereby monitoring will increase in frequency until compliance is restored. On an ongoing basis, monthly, department rounds are aggregated, tracked, and trended with monitoring of action plans for gaps by the Quality Department. Outcome data is reported quarterly to the Quality Outcomes Committee, Quality of Care Committee, Medical Executive Committee, and Quality Committee of the Board of Trustees (reports quarterly to the Board of Trustees). Monitoring will continue monthly on an ongoing basis with findings reported to the above stated committees unless non-compliance is identified whereby monitoring will increase in frequency until compliance is restored. Once a week department rounds with a monthly aggregate of Four (4) occur at Kirby Glenn by a member of the Facilities or Quality Team to ensure sustainment of corrective actions. The findings are reported monthly to the VP of	

	the affected cystoscopy OR table attachment. OPERATING ROOM 12 The following was repaired: the baseboard next to the door frame outside of the room. STERILE SUPPLY/EQUIPMENT CORE The following was removed from service and replaced: the metal cart used to transport irrigation fluid to the operating rooms for arthroscopic orthopedic cases. OR HALLWAY The following was removed from service and replaced: the metal rack containing sterile supplies. Two boxes of corrugated cardboard boxes were removed. STERILE SUPPLY CORE The RPMI medium and sperm washing medium (a pathology fixative) were removed and relocated to Pathology. CATH LAB Training was created for the Cath Lab staff about the IFU for the peel pack time limits. CATH LAB EQUIPMENT ROOM The ultrasound machine and Laser glasses were cleaned. The metal screws, and ceiling tiles above the equipment were replaced. 6 TOWER ROOM 634 was cleaned and placed on a regular cleaning schedule. CATH LAB #10 The space was modified to identify the distinction between the semi restricted and restricted areas. The C-Arm base and air vents were cleaned. The following were removed and repaired: the affected linen	employees were trained on proper PPE technique when going into isolation rooms. New employees orientation and annual orientation was updated to reflect care of the facility guidelines.	Operations, Quality of Care Committee, Medical Executive Committee and quarterly to the Quality Committee of the Board of Trustees (reports quarterly to the Board of Trustees) until 100% is sustained for two consecutive months. Monitoring will continue quarterly on an ongoing basis with findings reported to the above stated committees unless non-compliance is identified whereby monitoring will increase in frequency until compliance is restored. A member of the Infection Prevention Department will audit proper wearing of gloves when handling blood products once a month until 100% compliance is achieved for two months. The findings are reported monthly to the Vice President of Quality, Quality of Care Committee, Medical Executive Committee, and quarterly to the Quality Committee of the Board of Trustees (reports quarterly to the Board of Trustees) until 100% is sustained for 2 consecutive months. Monitoring will continue quarterly on an ongoing basis with findings reported to the above stated committees unless non-compliance is identified whereby monitoring will increase in frequency until compliance is restored. Once a week, with an aggregate of four (4) per month, a member of the EVS Leadership Team, through direct observation, validates the sharps containers are properly exited and entering the loading dock. The findings are reported monthly to the Quality of Care Committee, Medical Executive Committee, and quarterly to the Quality Committee of the Board of Trustees	

	hamper, C-Arm base, door frame, walls, metal table, and poles on the table. <u>6 TOWER COOLEY BUILDING</u> <u>ROOM 627 AND 628</u> The room was cleaned. The following was removed and replaced: metal trash can. The following was repaired: linoleum flooring. <u>JAMAIL SURGERY CENTER</u> The floors have been repaired and/or replaced. <u>OR1</u> The luer lock for the ISPAN has been replaced and the surgical 4X4 sponges removed. <u>ENVIRONMENTAL SERICES CLOSET</u> EVS Leadership was changed from a corporate reporting relationship to a local reporting relationship for the ORs in Jamail to ensure consistent practices, standards of work and monitoring in all locations. Pest control company was contracted to assess and treat the Jamail Surgery Center EVS cart was taken out of service and replaced with a new cart. Housekeeping closet was cleaned. Five additional insect light traps were installed for a total of seven. Two in the outer core, two in the clean corridor, and one by the back hallway outside of the surgery center. The weekly rounding tool was revised to include bug light review <u>LINEN CART</u> was removed from service and replaced <u>STERILE PROCESSING DEPARTMENT (SPD) JAMAIL</u> The Microstar Sterile Injectors that were		(reports quarterly to the Board of Trustees) until 100% is sustained for 2 consecutive months. Monitoring will continue quarterly on an ongoing basis with findings reported to the above stated committees unless non-compliance is identified whereby monitoring will increase in frequency until compliance is restored. Through direct observation, a member of Cath Lab Leadership audits ten (10) cases per week with a monthly aggregate of 40 to validate proper skin preparation, maintenance of a sterile field, and movement between semi-restricted and restricted areas. The findings are reported monthly to the Quality of Care Committee, Medical Executive Committee, and quarterly to the Quality Committee of the Board of Trustees (reports quarterly to the Board of Trustees) until 100% is sustained for 2 consecutive months. Monitoring will continue quarterly on an ongoing basis with findings reported to the above stated committees unless non-compliance is identified whereby monitoring will increase in frequency until compliance is restored. Once a week, with an aggregate of four (4) per month, a member of the Pharmacy Leadership Team, through direct observation, validates crash carts have not entered the pharmacy unless the sharps box has been replaced and the cart has been cleaned. The findings are reported monthly to the Quality of Care Committee, Medical Executive Committee, and quarterly to the Quality Committee of the Board of Trustees	

	expired were replaced. A log was implemented for the automated washer to be completed daily. The dermatology sets are no longer processed by the facility. TEMPERATURE AND HUMIDITY LOGS The temperature ranges and temperatures for all of the OR suites have been changed to reflect nationally recommended standards. The temperatures can only be changed if related to the clinical needs of the patient and approved by the Surgical Service Leadership. At the end of the case the temperature will be stored back within range. The Cath Lab is now temperature and humidity monitored. MAIN EMERGENCY DEPARTMENT TRIAGE ROOM The EKG (electrocardiogram) machine and the metal supply cart were removed from service and replaced. KIRBY GLEN CENTER Departmental rounds at Kirby Glen have been implemented weekly to ensure the facility is properly cleaned, equipment is clean, rooms are turned over in accordance with policy. Patient Bay #13 was terminally cleaned and the trash in the can was removed. The identified patient recliner was repaired. Patient Bay #12 was terminally cleaned and the trash in the can, including the used gloves were removed. The patient recliner was removed from service and replaced. The infusion pump and pole were cleaned and returned to service. Room #11 was terminally cleaned. All paper and tape were removed from the bedframe and the bedframe was clean. The mattress was		(reports quarterly to the Board of Trustees) until 100% is sustained for 2 consecutive months. Monitoring will continue quarterly on an ongoing basis with findings reported to the above stated committees unless non-compliance is identified whereby monitoring will increase in frequency until compliance is restored. On an ongoing basis, a member of the SPD staff checks the automated washer daily and documents on the log. Weekly a member of the SPD Leadership inspects the completion of this requirement. Monthly compliance is aggregated and reported to the Vice President of Surgical Services, Quality of Care Committee, Medical Executive Committee and Quality Committee of the Board of Trustees (reports quarterly to the Board of Trustees). Monitoring will continue quarterly on an ongoing basis with findings reported to the above stated committees unless non-compliance is identified whereby monitoring will increase in frequency until compliance is restored.	

	removed from service and discarded and replaced with a mattress which was clean and intact. The cartridge was removed from the infusion pump, the pump was cleaned and then returned into service. Patient Bay #10 was inspected and the patient recliner was repaired. The Clean supply room was terminally cleaned. Transfusion Observation – Kirby Glen Infection Prevention educated Kirby Glen employees about appropriate glove use while handling blood. MAIN PHARMACY Identified rolling carts were cleaned and returned to service. The process was changed where pharmacy staff will not allow a crash cart into the pharmacy unless the sharps box has been removed and the cart is clean. PATIENT FLOOR 7 SOUTH 1 AND 2: The medication refrigerator on 7 South was cleaned and defrosted to remove ice build-up. The locked wooden medication cabinets blue bins were cleaned and returned to service. Contents of the locked wooden medication cabinets were removed and discarded. The cabinets and bins were cleaned. The supplies were then replaced. All molding throughout the unit have been repaired and/or replaced The floor/wall area and tile were cleaned. The outside of the automated medication dispensing machine was cleaned and the internal drawers were inspected for cleanliness. The contents of the bottom drawer and the container were removed and discarded, the drawer was cleaned and the container and contents were replaced.			

	7 SOUTH 4/5 NEURO FLOOR: The refrigerator was removed from service and replaced. LOADING DOCK The contract company delivers clean material to the hospital on a clean truck. The truck is terminally cleaned by the contract company prior to loading clean items. Clean storage carts with clean sharps containers are covered with plastic protective covering until they are ready to be transported to the units. At that time, a covering with a Velcro opening is placed on the cart during transport. Sharp containers that were collected from the units are then loaded onto the truck. The contracted company onsite employees have been provided education by EVS Leadership on the proper donning and doffing. Designated staff are also available on units to provide just in time training. KIRBY GLEN UNIT: The formica at the bottom of the wooden cabinet was replaced. The patient nourishment refrigerator was cleaned. Patient Room 6 was terminally cleaned, the stretcher and mattress were removed from the room and cleaned. The IV pole was removed from service and replaced. The pharmacy wooden Dutch Door was repaired. The The grey pharmacy bins were cleaned and returned to service. A new process for receiving of chemo products was developed and delivery of blood products to properly store products. The contents of the medication refrigerator were removed and the refrigerator was removed from service and replaced.			

	MAIN EMERGENCY ROOM: The chairs were removed from service and replaced. THE THORACIC ICU 7 COOLEY A The patient nourishment room was cleaned and the debris and dust were removed. 7 South 2 The glucometer box was cleaned and supplies were replaced prior to returning to service. The floors on 7 South 2 were cleaned including Bed 11, Bed 14, Bed 15 and Bed 19. 24 Tower The Crash Cart #12 was removed from service and replaced. The contents of Crash Cart #12 were removed and the cart was thoroughly cleaned. The cart was restocked and returned to service., Telemetry Unit The crash cart was removed from service and replaced. The contents were removed and the cart was thoroughly cleaned The cart was restocked and returned to service. Jamail Ambulatory Surgical Center The four linen carts were removed from service and replaced. The linen was removed and laundered.			