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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	450451	A. BUILDING _____ B. WING _____	C 12/15/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLEN ROSE MEDICAL CENTER	1021 HOLDEN STREET GLEN ROSE, TX 76043

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 000	INITIAL COMMENTS Note: The CMS-2567 (Statement of Deficiencies) is an official, legal document. All information must remain unchanged except for entering the plan of correction, correction dates, and the signature space. Any discrepancy in the original deficiency citation(s) will be reported to the Dallas Regional Office (RO) for referral to the Office of the Inspector General (OIG) for possible fraud. If information is inadvertently changed by the provider/supplier, the State Survey Agency (SA) should be notified immediately. An unannounced survey for complaint TX00207801 was conducted on site. An entrance conference was held with the hospital representatives the afternoon of 12/10/14. The hospital representatives were informed this survey would be conducted according to the survey protocol in the State Operations Manual, Chapter 5, section 5100 and Appendix A, and according to 42 CFR 482 the Conditions of Participation for Hospitals. Survey findings were presented at an exit conference the afternoon of 12/01/2014 with hospital representatives. An opportunity was provided for the facility to ask questions and provide evidence of compliance with those requirements for which noncompliance was found. No further evidence was provided. Complaint TX00207801 was substantiated with deficiencies cited.	A 000	A-119 Current policy related to Complaint/ Grievance resolution- Patient/Family will be Reviewed and amended if necessary to assure that all complaints/grievances are resolved in a timely manner. Policy and any amendments to policy will be reviewed and approved by the CEO by January 9, 2015. Amendments to the complaint/ Grievance resolution will include provisions that all complaints/grievances are reviewed by the Governing Board Quality Committee at its monthly meeting and a summary of all complaints/grievances are presented to the Governing Board and to the Medical Staff Executive committee twice each year.	1/09/15
A 119	482.13(a)(2) PATIENT RIGHTS: REVIEW OF GRIEVANCES [The hospital must establish a process for prompt	A 119	**A-286** Incident Reporting policy will be reviewed and amended to assure that incident reports are prepared in the event of all incidents by patients, personnel or visitors. The policy will provide that all incidents reports are turned into the Quality/Risk Mgr who will review and log each incident report. Within two (2) business days Quality/Risk Mgr will refer incident report to the appropriate department, committee, or medical staff for further action and resolution. The policy will include a provision that all incident reports will be summarized and reported to the Governing Board in Executive	1/7/15

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

K. Gomez | CEO | 1-7-2015

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

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A 119	Continued From page 1 resolution of patient grievances and must inform each patient whom to contact to file a grievance.] The hospital's governing body must approve and be responsible for the effective operation of the grievance process, and must review and resolve grievances, unless it delegates the responsibility in writing to a grievance committee. This STANDARD is not met as evidenced by: Based on record review and interview, the hospital's governing body failed to ensure the operation of the grievance process, in that, 1 of 3 grievances (Patient #11) was not reviewed by the governing body and a timely letter sent to the complainant. Findings Included The 2/24/14 documented grievance for Patient #11 did not have a complainant letter until 4/02/14. The 11/18/13 through 11/20/14 "Somervell Hospital District Board" (Governing Body) meeting minutes were reviewed. There is no evidence in the minutes the complaints or grievances are investigated or reported. During a telephone interview on 12/16/14 ending at 4:24 PM, Personnel #6 was asked about the incidents not being reported through the Governing Body. Personnel #6 acknowledged they were not being reported through Governing Body and stated, "We knew that it was a need and I hadn't gotten to it fast enough." Personnel #6 was asked if the letter was sent timely. Personnel #6 stated, "No."	A 119	session on a quarterly basis. The amended incident reporting policy will be reviewed and approved by the Board Quality Committee at its regular meeting on January 6, 2015. Policy will then be approved by the CEO and become effectiveby January 7, 2015. First Governing Board review of the summary of incident reports will be in Executive session of its March 26, 2015 board meeting. Unsuccesful code blues are referred to Nurse peer review committee for nurse review and Physicians peer review for physicians. All unsuccessful code blues are referred from peer review to the Quality/ Risk Mgr who takes the reports to Medical Staff Executive committee for assessment and further action if required. **A-395 A-C** A current policy and procedure that addresses admit assessments of patients, shift assessment by nurse and reassessment of patient is in place. The RN Medical Surgical managerand the Quality/Risk mgr will develop a Performance Improvement (PI) plan to assure compliance with current policy and procedure. Medical Surgical manager will performa a minimum of thirty (30) chart reviews each month to audit and assure that performance related to timeliness of assessments are completed. The PI results will be presented at least quarterly at the hospital Department and Quality meeting which is held monthly.	1/15/15

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A 119	Continued From page 2 The January 2014 "Complaint/Grievance Resolution - Patient/Family" policy required, "Grievance...receive immediate priority and must be investigated...timely resolution with the intent that on average all grievances will be resolved during a 7 business day timeframe...a letter will be sent to the patient...Quality Managements' analysis...reported to the Medical Executive...Governing Board...twice a year..."	A 119	RN Medical Surgical manager will meet with the Medical Staff Executive Committee at its January meeting to establish guidelines related to appropriate reporting of abnormal values. Recommendations from the Medical Staff Executive Committed related to appropriate reporting by nurses of abnormal values will be implemented by January 26, 2015	
A 286	482.21(a), (c)(2), (e)(3) PATIENT SAFETY (a) Standard: Program Scope (1) The program must include, but not be limited to, an ongoing program that shows measurable improvement in indicators for which there is evidence that it will ... identify and reduce medical errors. (2) The hospital must measure, analyze, and track ...adverse patient events ... (c) Program Activities ..... (2) Performance improvement activities must track medical errors and adverse patient events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the hospital. (e) Executive Responsibilities, The hospital's governing body (or organized group or individual who assumes full legal authority and responsibility for operations of the hospital), medical staff, and administrative officials are responsible and accountable for ensuring the following: ... (3) That clear expectations for safety are established.	A 286	**395-D** RN Medical Surgical Manager will present policy related to administration of Dopamine at January Medical Staff Executive Committee and all staff will be educated on the new policy by January 28, 2015. **395-E** Health Information Management and Quality/Risk Mgr will develop a Performance Improvement (PI) plan to assure that code blue records are complete, including physician documentation, and in the patients chart. Performance Improvement results will be presented at least quarterly at the Hospital Department and Quality Meeting which is held monthly.	1/15/15

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A 286	Continued From page 3 This STANDARD is not met as evidenced by: Based on record review and interview, the Hospital's Quality Assessment and Performance Improvement program failed to measure, analyze and track adverse patients' events, in that, the 1/08/14 through 11/12/14 Quality Meeting Minutes did not document the reporting of incidents to the Quality Committee. Findings Included There was no incident report for the 11/28/13, 10/10/14 and 10/13/14 unsuccessful code blues. The 1/08/14 through 11/12/14 Department Director and Quality Management" minutes were reviewed. The 1/27/14 through 11/04/14 "Board Quality Committee" Minutes were reviewed. There was no evidence in the minutes that incidents are tracked, trended or analyzed for improvement opportunities except for falls. During a telephone interview on 12/16/14 ending at 4:24 PM, Personnel #6 was asked about the incidents not being reported through Quality. Personnel #6 acknowledged they were not being reported through Quality and stated, "We knew that it was a need and I hadn't gotten to it fast enough." The March 2006 "Incident / Event Reporting Policy" required, "...Incident Report Form be completed...turned into the department supervisor...Quality/Risk Manager who then	A 286		

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A 286	Continued From page 4 reviews the incident and refers the incident to the appropriate department, committee, or to the medical staff within 48 hours for further action and resolution..." The March 2013 "Incident Reporting Protocol" required, "...all incidents...patient, personnel, or visitor...Unsuccessful Code Blue...All sections of the incident report must be completed...Risk Management to supply the...Committee with a quarterly summary of patient incidents..."	A 286		
A 395	482.23(b)(3) RN SUPERVISION OF NURSING CARE A registered nurse must supervise and evaluate the nursing care for each patient. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to have a registered nurse supervise and evaluate the nursing care, in that, A) 1 of 3 coded patients (Patient #1) did not have an initial admit assessment; B) 2 of 3 coded patients (Patient #2 and #3) had at least one missing shift assessment by their nurse; C) 3 of 3 coded patients (Patient # 1, #2, and #3) had abnormal vital signs (Blood Pressure - B/P, Heart Rate - HR, Respiratory Rate - RR, Oxygen Saturation - SaO2) without documented physician notification of the patient's issue; D) 1 of 3 coded patients (Patient #3) was administered Dopamine and had no blood pressure and heart rate documented by the staff	A 395		

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A 395	Continued From page 5 for over 12 hours; and E) 1 of 3 coded patients (Patient #3) had no nursing documentation and/or code blue record of what occurred during the code, and no documentation from the physician who directed the code. Findings Included The Electronic Medical Records were navigated by Personnel #17 in her office on 12/12/14 from 9:00 AM through 1:00 PM. Personnel #17 was able to show the surveyor all records requested except the following items that she confirmed were not completed or missing: A) Patient #1's record was missing an initial admit assessment on 11/27/13. B) Patient #2's record was missing the 10/10/14 AM Shift assessment. Patient #3's record was missing the 10/10/14 AM Shift assessment. C) Patient #1's record reflected, "11/28/13 12:00 AM HR 122 RR 35 SaO2 90%, 3:29 AM HR 130 RR 36 SaO2 90%, 4:00 AM HR 134 RR 35 SaO2 86%, 4:32 AM HR 130, SaO2 87%." Patient #1's record did not document any physician notification of the patient's abnormal vital signs. (Blood Pressure - B/P, Heart Rate - HR, Respiratory Rate - RR, and Oxygen Saturation - SaO2.) Patient #2's record reflected, "10/11/14 12:00 AM B/P 98/53 SaO2 90%, 9:13 AM B/P 80/46 HR 96, 10/12/14 4:00 AM B/P 97/55 HR 95." Patient #2's	A 395		

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A 395	Continued From page 6 record did not document any physician notification of the patient's abnormal vital signs. Patient #3's record reflected, "10/09/14 4:44 AM B/P 81/57, 5:15 AM B/P 80/55 HR 110." Patient #3's record did not document any physician notification of the patient's abnormal vital signs. D) Patient #3's record documented she was administered Dopamine. There was no blood pressure and heart rate documented on 10/09/14 by the staff from 8:00 AM through 8:37 PM. The vitals signs were recorded for 10/09/14 8:00 AM and 8:37 PM. E) Patient #3's record reflected a code blue on 10/10/14 and she passed. There is no nursing documentation and/or code blue record of what occurred during the code, and no documentation from the physician who directed the code. The hospital did not have policies for the Administration of Intravenous Dopamine, Vital Signs - abnormal versus reportable, and Physician Notifications. The February 2014 "Scope of Practice and Delivery of Care Methodology for Medical Surgical Nursing Unit" required, "All admissions to the Medical Surgical Unit are reviewed for appropriateness...patient experience a worsening of his/her condition (ie, a medical or surgical emergency, life threatening event), the patient will be transferred to a more intensive level of care, designed to provide the level of service necessary to address the patient's condition..." The "Admission Assessment, Shift Assessment & Reassessment" policy required, "Admission	A 395		

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A 395	Continued From page 7 Assessment Time Frames...Assessment...initial 30 minutes...completion 12 hours...shift assessment 12 hours...Any change in the patient's conditions hall (sp - shall) require an immediate reassessment with changes in the plan of care reflecting the change in conditions...Registered nurse: collects and analyzes data about the patient, determines the need for additional data, the patient's healthcare and or treatment needs and the care of the patient."	A 395		

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Texas Department of State Health Services

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	810183	A. BUILDING: _____ B. WING _____	C 12/15/2014

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X 000	INITIAL COMMENTS Note: The State Form is an official, legal document. All information must remain unchanged except for entering the plan of correction, correction dates, and the signature space. Any discrepancy in the original deficiency citation(s) will be referred to the Office of the Texas Attorney General (OAG) for possible fraud. If information is inadvertently changed by the provider/supplier, the State Survey Agency (SA) should be notified immediately. An unannounced complaint survey was conducted at Glenrose Medical Center 1021 Holden Street Glenrose, Texas 76043. An entrance conference was held on 12/10/14 at 2:50 PM with the Hospital representatives. The purpose and process of the survey was explained to them and that the complaint survey would be conducted to determine the facility's compliance per the Texas Administrative Code, Chapter 133 Hospital Licensing Rules. An exit conference was held on 12/15/14 at 1:55 PM with the Hospital representatives at which time the findings of the survey were explained. The Hospital representatives were given an opportunity to provide evidence of compliance with those requirements of which non-compliance had been found. None was provided. Instructions were provided on writing plans of correction with instructions to return the plans of correction to the Arlington zone office within 10 days. This report was sent to the facility electronically. Complaint TX00207801 was substantiated with deficiencies cited.	X 000		
X 368	133.41(o)(2)(D) Staffing: supervise and evaluate care	X 368	**X 368 133.41(o)(2)(D)** A current policy and procedure that addresses admit assessments of patients, shift assessment by nurse and reassessment of patients is in place. The RN Medical Surgical managerand the Quality/Risk mgr will develop a Performance Improvement (PI) plan to assure compliance with current policy and procedure. Medical Surgical manager will performa a minimum of thirty (30) chart reviews each month to audit and assure that performance related to timeliness of assessments are completed. The PI results will be presented at least quarterly at the hospital Department and Quality meeting which is held monthly. RN Medical Surgical manager will meet with the Medical Staff Executive Committee at its January meeting to establish guidelines related to appropriate reporting of abnormal values. Recommendations from the Medical Staff Executive Committed related to appropriate reporting by nurses of abnormal values will be implemented by Jan 26, 2015 RN Medical Surgical Manager will present policy related to administration of Dopamine at January Medical Staff Executive Committee and all staff will be educated on the new policy by January 28, 2015. Health Information Management and Quality/Risk Mgr will develop a Performance Improvement (PI) plan to assure that code blue records are complete, including physician documentation, and in the patients chart.	1/20/15

SOD - State Form

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: CEO — (X6) DATE: 1-7-2015

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Texas Department of State Health Services

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X 368	Continued From page 1 Nursing Services. Staffing and delivery of care. (D) The RN shall supervise and evaluate the nursing care for each patient and assign the nursing care to other nursing personnel in accordance with the patient's needs and the specialized qualifications and competence of the nursing staff available. This Requirement is not met as evidenced by: Based on record review and interview, the facility failed to have a registered nurse supervise and evaluate the nursing care, in that, A) 1 of 3 coded patients (Patient #1) did not have an initial admit assessment; B) 2 of 3 coded patients (Patient #2 and #3) had at least one missing shift assessment by their nurse; C) 3 of 3 coded patients (Patient # 1, #2, and #3) had abnormal vital signs (Blood Pressure - B/P, Heart Rate - HR, Respiratory Rate - RR, Oxygen Saturation - SaO2) without documented physician notification of the patient's issue; D) 1 of 3 coded patients (Patient #3) was administered Dopamine and had no blood pressure and heart rate documented by the staff for over 12 hours; and	X 368	**X 378 133.41(o)(2)(G)(iv)** Charge nurses will be educated to review staffing grid and documentation related to staffing variances and activities to call in or flex staff to match patient levels. Charge nurse shall make review of staffing grid and documentation of variances a part of shift change report. All staffing sheets will be reviewed by the Chief Nurse Officer (CNO) weekly and taken to Nurse Staffing Committee for review monthly and audit to ssure proper documentation of staffing sheets. Staffing committee will begin review of staffing sheets at its January 28, 2015 meeting. **X 424 133.41(o)(5)** Peer review members and chairperson of nurse peer review committee have been identified and selected. Chairperson is currently working on policies and procedures for nurse peer review committee. Organizational meeting of nurse peer review will be held in January. Policies of committee will be reviewed and approved by committee January 28, 2015 Nurse peer review committee will meet at least monthly and will be functional by January 28, 2015 **X 493 133.41(r)(1)(E)** Incident Reporting policy will be reviewed and amended to assure that incident reports are prepared in the event of all incidents by patients, personnel or visitors. The policy will provide that all incidents	1/15/15 1/28/15 1/7/15

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X 368	Continued From page 2 E) 1 of 3 coded patients (Patient #3) had no nursing documentation and/or code blue record of what occurred during the code, and no documentation from the physician who directed the code. Findings Included The Electronic Medical Records were navigated by Personnel #17 in her office on 12/12/14 from 9:00 AM through 1:00 PM. Personnel #17 was able to show the surveyor all records requested except the following items that she confirmed were not completed or missing: A) Patient #1's record was missing an initial admit assessment on 11/27/13. B) Patient #2's record was missing the 10/10/14 AM Shift assessment. Patient #3's record was missing the 10/10/14 AM Shift assessment. C) Patient #1's record reflected, "11/28/13 12:00 AM HR 122 RR 35 SaO2 90%, 3:29 AM HR 130 RR 36 SaO2 90%, 4:00 AM HR 134 RR 35 SaO2 86%, 4:32 AM HR 130, SaO2 87%." Patient #1's record did not document any physician notification of the patient's abnormal vital signs. (Blood Pressure - B/P, Heart Rate - HR, Respiratory Rate - RR, and Oxygen Saturation - SaO2.) Patient #2's record reflected, "10/11/14 12:00 AM B/P 98/53 SaO2 90%, 9:13 AM B/P 80/46 HR 96, 10/12/14 4:00 AM B/P 97/55 HR 95." Patient #2's record did not document any physician notification of the patient's abnormal vital signs.	X 368	reports are turned into the Quality/Risk Mgr who will reiview and log each incident report. Within two (2) business days Quality/Risk Mgr will refer incident report to the appropriate department, committee, or medical staff for further action and resolution. The policy will include a provision that all incident reports will be summarized and reported to the Governing Board in Executive session on a quarterly basis. The amended incident reporting policy will be reviewed and approved by the Board Quality Committee at its regular meeting on January 6, 2015. Policy will then be approved by the CEO and will be effective January 7, 2015 First Governing Board review of the summary of incident reports will be in Executive session of its March 26, 2015 board meeting. Unsuccesful code blues are referred to Nurse peer review committee for nurse review and Physicians peer review for physicians. All unsuccessful code blues are referred from peer review to the Quality/Risk Mgr who takes the reports to Medical Staff Executive committee for assessment and further action if required.	1/7/15

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X 368	Continued From page 3 Patient #3's record reflected, "10/09/14 4:44 AM B/P 81/57, 5:15 AM B/P 80/55 HR 110." Patient #3's record did not document any physician notification of the patient's abnormal vital signs. D) Patient #3's record documented she was administered Dopamine. There was no blood pressure and heart rate documented on 10/09/14 by the staff from 8:00 AM through 8:37 PM. The vitals signs were recorded for 10/09/14 8:00 AM and 8:37 PM. E) Patient #3's record reflected a code blue on 10/10/14 and she passed. There is no nursing documentation and/or code blue record of what occurred during the code, and no documentation from the physician who directed the code. The hospital did not have policies for the Administration of Intravenous Dopamine, Vital Signs - abnormal versus reportable, and Physician Notifications. The February 2014 "Scope of Practice and Delivery of Care Methodology for Medical Surgical Nursing Unit" required, "All admissions to the Medical Surgical Unit are reviewed for appropriateness...patient experience a worsening of his/her condition (ie, a medical or surgical emergency, life threatening event), the patient will be transferred to a more intensive level of care, designed to provide the level of service necessary to address the patient's condition..." The "Admission Assessment, Shift Assessment & Reassessment" policy required, "Admission Assessment Time Frames...Assessment...initial 30 minutes...completion 12 hours...shift assessment 12 hours...Any change in the patient's conditions hall (sp - shall) require an	X 368		

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	810183	A. BUILDING: _____ B. WING _____	C 12/15/2014

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X 368	Continued From page 4 immediate reassessment with changes in the plan of care reflecting the change in conditions...Registered nurse: collects and analyzes data about the patient, determines the need for additional data, the patient's healthcare and or treatment needs and the care of the patient."	X 368		
X 378	133.41(o)(2)(G)(iv) Reporting to advisory committee Nursing Services. Staffing and delivery of care. (G)The hospital shall adopt, implement and enforce a written process for setting staffing levels that takes into account the critical factors specified in subparagraph (F) of this paragraph. (iv) The process shall include reporting to the advisory committee, as referenced in subparagraph (H) of this paragraph, showing variance between desired and actual staffing levels, and an explanation for the variance. The reports shall be confidential and not subject to disclosure under Government Code, Chapter 552, and not subject to disclosure, discovery, subpoena or other means of legal compulsion for their release. This Requirement is not met as evidenced by: Based on record review and interview, the hospital failed to enforce it's staffing level policy, in that, on 11/17/14, 11/30/14, and 12/07/14 the Medical Surgical (Med-Surg) floor was short a	X 378		

Texas Department of State Health Services

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X 378	Continued From page 5 Patient Care Technician (PCT) and the variance between desired staffing, actual staffing levels and an explanation for the variance was not completed and/or reported. Findings included The "Glenrose Medical Center Medical Surgical Staffing Grid" required, "Census 6...CN/RN 1 (Charge nurse/registered nurse)...RN/LVN 1...PCT 1...Census 6...CN/RN 1...RN/LVN 1...PCT 1...Census 9...CN/RN 1...RN/LVN 1...PCT 1..." The 11/17/14 Med-Surg Staffing Report reflected 6 patients with 1 CN and 1 LVN. There was no PCT. The 11/30/14 Med-Surg Staffing Report reflected 8 patients with 1 CN and 1 RN. There was no PCT. The 12/07/14 Med-Surg Staffing Report reflected 9 patients with 1 CN and 1 LVN. There was no PCT. There were no variance reports for 11/17/14, 11/30/14, and 12/07/14. During an interview in the conference room on 12/11/14 ending at 11:30 AM, Personnel #3 was shown the staffing reports for 11/17/14, 11/30/14, and 12/07/14 that reflect less staff than the staffing plan required (short a patient care technician) for the number of patients in house on the PM shift. Personnel #3 reviewed the staffing sheets and confirmed the shortage of staff. Personnel #3 stated, "I did not know they (Med-Surg) were understaffed on those nights." Personnel #3 was asked for the staffing variance	X 378		

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X 378	Continued From page 6 reports for those days. Personnel #3 stated, "They are supposed to fill in the (variance) area on the staffing sheets if there are variances and they did not fill it in." Personnel #3 was asked if the staffing sheets were audited. Personnel #3 stated they were not. The January 2014 "Nursing Staffing Plan" required, "Each unit will keep daily reports indicating required and actual staffing patterns. Variances will be examined and action plans devised as necessary..."	X 378		
X 424	133.41(o)(5) Reporting & peer review of a nurse Nursing Services. Reporting and peer review of a vocational or registered nurse. A hospital shall adopt, implement, and enforce a policy to ensure that the hospital complies with the Occupations Code §§301.401 - 301.403, 301.405 and Chapter 303 (relating to Grounds for Reporting Nurse, Duty of Nurse to Report, Duty of Peer Review Committee to Report, Duty of Person Employing Nurse to Report, and Nursing Peer Review respectively), and with the rules adopted by the Board of Nurse Examiners in 22 TAC §217.16 (relating to Minor Incidents), §217.19 (relating to Incident-Based Nursing Peer Review), and §217.20 (relating to Safe Harbor Peer Review for Nurses). This Requirement is not met as evidenced by: Based on record review and interview, the hospital did not adopt, implement, and enforce a	X 424		

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X 424	Continued From page 7 policy to ensure that the hospital complies with the Occupations Code §§301.401 - 301.403, 301.405 and Chapter 303 (relating to Grounds for Reporting Nurse, Duty of Nurse to Report, Duty of Peer Review Committee to Report, Duty of Person Employing Nurse to Report, and Nursing Peer Review respectively), and with the rules adopted by the Board of Nurse Examiners in 22 TAC §217.16 (relating to Minor Incidents), §217.19 (relating to Incident-Based Nursing Peer Review), and §217.20 (relating to Safe Harbor Peer Review for Nurses), in that, the hospital did not have a Peer Review policy or process. Findings Included There was no peer review committee minutes and no peer review policy to review. During an interview in the conference room on 12/11/14 ending at 11:30 AM, Personnel #3 was asked if the hospital had a nurse peer review committee. Personnel #3 stated, "No, There was no peer review committee. They (the hospital) are in the process of developing a policy and the members have been chosen. There have been no meetings."	X 424		
X 493	133.41(r)(1)(E) Quality indicators Quality Assessment and Performance Improvement. Program scope. The hospital-wide QAPI program shall reflect the complexity of the hospital's organization and services and have a written plan of	X 493		

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X 493	Continued From page 8 implementation. The program must include an ongoing program that shows measurable improvements in the indicators for which there is evidence that they will improve health outcomes, and identify and reduce medical errors. (E) The program must measure, analyze and track quality indicators, including adverse patients' events, and other aspects of performance that assess processes of care, hospital services and operations. This Requirement is not met as evidenced by: Based on record review and interview, the Hospital's Quality Assessment and Performance Improvement program failed to measure, analyze and track adverse patients' events, in that, the 1/08/14 through 11/12/14 Quality Meeting Minutes did not document the reporting of incidents to the Quality Committee. Findings Included There was no incident report for the 11/28/13, 10/10/14 and 10/13/14 unsuccessful code blues. The 1/08/14 through 11/12/14 Department Director and Quality Management" minutes were reviewed. The 1/27/14 through 11/04/14 "Board Quality Committee" Minutes were reviewed. There was no evidence in the minutes that incidents are tracked, trended or analyzed for improvement opportunities except for falls.	X 493		

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X 493	Continued From page 9 During a telephone interview on 12/16/14 ending at 4:24 PM, Personnel #6 was asked about the incidents not being reported through Quality. Personnel #6 acknowledged they were not being reported through Quality and stated, "We knew that it was a need and I hadn't gotten to it fast enough." The March 2006 "Incident / Event Reporting Policy" required, "...Incident Report Form be completed...turned into the department supervisor...Quality/Risk Manager who then reviews the incident and refers the incident to the appropriate department, committee, or to the medical staff within 48 hours for further action and resolution..." The March 2013 "Incident Reporting Protocol" required, "...all incidents...patient, personnel, or visitor...Unsuccessful Code Blue...All sections of the incident report must be completed...Risk Management to supply the...Committee with a quarterly summary of patient incidents..."	X 493		

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