



April 11, 2025

VIA ELECTRONIC MAIL: Douglas.Middlebrooks@vdh.virginia.gov

Dr. Douglas Middlebrooks
Acute Care Supervisor
Office of Licensure and Certification
9960 Mayland Drive, Suite 401
Henrico, VA 23233-1485
804.367.2164

Re: CMS Certification Number: 490118, Event ID/Survey Date URG811, January 24, 2025

Dear Dr. Middlebrooks,

Enclosed is Henrico Doctors' Hospital ("HDH") Plan of Correction ("PoC") in response to your letter March 14, 2025, notice that CMS found HDH in violation of several Medicare Conditions of Participation, specifically 42 C.F.R. §§ 482.12, 482.13, 482.21, 482.23 and 482.42.

Henrico Doctors' Hospital (HDH), holds the safety of all patients, staff, and visitors as its highest priority. As such, we assure you that we take this incident very seriously. In November 2024, immediately upon discovery of the events related to babies in the Neonatal Intensive Care Unit (NICU), HDH's executive leadership team, including its Chief Executive Officer, reviewed the events that took place in the NICU. Our intensive analysis included a review of all the NICU patients' medical records and policies and procedures that were in place at the time, interviews of individuals involved in the care of the NICU patients as well as a comprehensive review of video footage of each baby.

HDH has examined this situation and identified areas for continued improvement as set forth in the PoC. As you will see, the attached PoC outlines actions that we believe will improve our NICU services, and more particularly tangible steps in ensuring that our youngest and most vulnerable population is safely cared for 24/7 in our NICU.

This letter and its attachments detail the actions HDH has taken and will continue to take to ensure staff provides the safest care possible. We believe the PoC and the actions included provide credible evidence of full compliance with all of the Medicare Conditions of Coverage/Participation and regulations related to these Sections.

HDH respectfully requests a survey as soon as possible so that a redetermination can be accomplished by your office prior to June 12, 2025.

If you require additional information or if we can be of further assistance, please do not hesitate to call me at 804.289.5638.

Sincerely,



Ryan Jensen, FACHE

Chief Executive Officer

Henrico Doctors' Hospital

Enclosure: CMS-2567

cc: NEDACCComp@cms.hhs.gov (with enclosures) via electronic mail

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

PRINTED: 03/13/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 490118		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/24/2025	
NAME OF PROVIDER OR SUPPLIER HENRICO DOCTORS' HOSPITAL				STREET ADDRESS, CITY, STATE, ZIP CODE 1602 SKIPWITH ROAD RICHMOND, VA 23229			
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A 000	INITIAL COMMENTS This report is the result of an unannounced on-site Complaint survey completed on January 24, 2025. It was determined that the facility was not in substantial compliance with the requirements of CFR, Title 42, Part 482 - Conditions of Participation for Hospitals. In addition, on December 18, 2024, at 3:40 PM, an Immediate Jeopardy (IJ) was identified and was removed on January 8, 2025 at 3:04 PM, after the State Survey Agency verified onsite that the hospital implemented immediate corrective actions addressing the IJ.			A 000	Immediately on identification of a potential noncompliance with standards, the executive leadership convened an intensive review of practices to identify contributing factors. Corrective action was implemented as described below along with monitoring to ensure ongoing compliance with CFR, Title 42, Part 482 – Conditions of Participation for Hospitals. Henrico Doctors' Hospital (HDH) holds the safety of all patients, staff, and visitors as its highest priority. Immediately on receipt of survey findings, the senior leadership team met and initiated intensive review and analysis of each of the findings, formulating a plan of correction to fully address all tags identified as out of compliance, resulting in prevention of reoccurrence as identified within this report. The following team of interdisciplinary leadership has contributed to review and implementation of the correction plan provided: Chief Executive Officer (CEO), Chief Nursing Officer (CNO), Chief Medical Officer (CMO), Vice President of Quality (VPQ), Patient Safety Director (PSD), NICU Nursing Director, Division Chief Medical Officer (DCMO), and Division Associate Vice President of Quality and Resource Management.		
A 043	GOVERNING BODY CFR(s): 482.12 There must be an effective governing body that is legally responsible for the conduct of the hospital. If a hospital does not have an organized governing body, the persons legally responsible for the conduct of the hospital must carry out the functions specified in this part that pertain to the governing body ... This CONDITION is not met as evidenced by: Based on review of videos, medical records (MR), facility documents and interview with staff (EMP), it was determined that the hospital failed to have an effective Governing Body as evidenced by: failure to identify and investigate discrepancies in contracted radiologist reports (A084); failure to ensure consent was obtained prior to administering a vaccine (A0131); failure to ensure safe handling of infants in the Neonatal Intensive Care Unit (NICU) to prevent injury and failure to validate the identification of visitors entering the NICU (A0144); failure to prevent abuse, identify injuries of unknown origin as				The Chairman of the Board of Trustees (BOT) was notified via phone by the CEO		3/17/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE



CEO

4/11/2025

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 043	Continued From page 1 indicators of potential abuse, report and investigate injuries of unknown origin, implement actions to protect patients from abuse and neglect, and educate all health care professionals on abuse and neglect (A0145, A0283); failed to provide oversight of the Quality Assessment Performance Improvement (QAPI) activities to ensure complete and thorough analysis of events to determine the cause of injuries so that appropriate preventive actions could be implemented to prevent reoccurrence. In addition, QAPI failed to track and investigate injuries of unknown origin, analyze or document the progress of the analysis of NICU patients with multiple fractures of unknown origin, identify potential indicators of abuse and neglect, perform investigations to rule out abuse and neglect, and analyze patient deaths (A0263, A0286); failure to ensure implementation of a well-organized nursing service (A0385); and failure to provide oversight of the QAPI efforts for infection prevention and control measures related to a Methicillin-resistant Staphylococcus Aureus (MRSA- a bacteria resistant to antibiotics) outbreak in the NICU (A0770). Cross Reference: §482.12(e)(1) Governing Body: Contracted Services §482.13 Condition of Participation: Patient's Rights §482.21 Condition of Participation: Quality Assessment and Performance Improvement Program §482.21(b)(2)(ii), 482.21(c)(1) & 482.21 (c)(3) §482.21(b)(2) Quality Assessment and Performance Improvement: Program Data §§482.21(a)(1), 482.21(a)(2), 482.21(c)(2), &		Summary of policies/guidelines and any other documents reviewed or revised during Plan of Correction (POC) development: • Infant Security (14064594) • Sentinel Event (17226259) • Infection Prevention in Neonatal Intensive Care Unit (NICU) (17338427) • Assessment and Reassessment of Patients (15229276) • Clinical Nursing Documentation (17822780) • Suctioning Neonate: Oral, Nasopharyngeal (11881635) • Focused Professional Practice Evaluation (17315908) • Metabolic Bone Disease Protocol Results of all audits will be reported through Quality Council/Patient Safety Committee, Medical Executive Committee and the BOT monthly. <u>SUBJECT OF DEFICIENCY:</u> A 043 The hospital failed to have an effective Governing Body. <u>Corrective Actions:</u> Henrico Doctors' Hospital recognizes that the Governing Body (Board of Trustees – BOT) is legally responsible for the conduct of the hospital. To that end, under the direction of the CEO, 100% of the BOT members reviewed their respective roles and responsibilities as defined by the BOT Policy and within the hospital's governance structure. To ensure sustained compliance, every new member of the BOT completed training on their roles and responsibilities.		3/24/2025
					2/20/2025

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A 043	Continued From page 2 482.21(e)(3) Quality Assessment and Performance Improvement: Patient Safety, Medical Errors & Adverse Events §482.23 Condition of Participation: Nursing Services §482.42(c)(1) Infection Prevention: Leadership responsibilities	A 043	The BOT is fully informed of the Conditions of Participation deficiencies cited herein and will continue with the oversight necessary to fully address these deficiencies. The BOT believes that the multidisciplinary leadership team used to formulate this plan of correction fully addressed all CMS tags identified as out of compliance and monitoring/auditing to prevent reoccurrence remains in place to achieve continued compliance. The plan of correction demonstrates the facility's commitment to compliance with all applicable conditions of participation requirements.		
A 084	CONTRACTED SERVICES CFR(s): 482.12(e)(1) The governing body must ensure that the services performed under a contract are provided in a safe and effective manner. This STANDARD is not met as evidenced by: Based on review of facility documents, review of medial records (MR) and interviews with staff (EMP) it was determined the facility failed to identify and investigate discrepancies in contracted radiologist reports (MR2). Findings: Review of facility document, titled "Board of Trustees Bylaws", revised October 2022, revealed "... 7.6 Contracted Services. 7.6.1 The Hospital shall retain overall responsibility and authority for services furnished under a contract ...7.6.3 The Board shall ensure that contracted services are performed safely and effectively through implementation and participation of contracted services in of the performance improvement program, and through mechanisms used to ensure that contracted services staff are qualified and competent. .." Review of document, titled "Professional Services Agreement," dated November 2021,		The BOT was notified of the survey deficiencies on 3/17/25. Monitoring: The highly engaged governing body will provide active and continued oversight of the plan of correction implementation and sustained improvements. All ongoing actions, monitoring activities and results will be reported monthly to the Quality Council/ Patient Safety Committee and all other appropriate committees and the MEC/BOT monthly. If the team identifies deviation from the POC then MEC/BOT will be informed as soon as possible and will create an appropriate course of action. This reporting structure will be maintained for four months and continue as indicted to maintain compliance. Responsible Leader: CEO		4/15/25

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A 084	Continued From page 3 and signed by a hospital representative on June 5, 2023, revealed " ...This professional services agreement (the "Agreement") is made and entered into by and between HCA Health Services of Virginia, Inc. d/b/a Henrico Doctors' Hospital ("Facility") and [name of contracting perinatal radiology group] ...F. Contractor and Contractor's Representative shall furnish any and all information, records and other documents related to Services furnished hereunder which Facility may reasonably request in furtherance of its quality assurance, utilization review, risk management, and any other plans and/or programs adopted by the facility to assess, improve the quality and efficiency of Facility's services....." Review of MR2 revealed that the patient had an X-ray on November 20, 2024. Review of the radiologist's report indicated a finding of "bones normal." However, on November 21, 2024, the patient had an another X-ray and this time the radiologist reported that "the fractures were unchanged." This contradicted the radiologist's report of findings from the previous day. Further review revealed no documented evidence that the radiologist reported the discrepancy to the hospital or the Chief Medical Officer (CMO)." Interview on January 23, 2025, at 10:44 AM, EMP80 indicated all NICU radiology is performed by a group of radiologists contracted by the hospital. EMP80 indicated the facility only reviewed a radiology report if something was reported missed or almost missed, and these reviews occurred monthly. EMP80 indicated they were not aware of a discrepancy between MR2's November 20, 2024, and November 21, 2024	A 084	<u>SUBJECT OF DEFICIENCY:</u> The facility failed to identify and investigate discrepancies in contracted radiologist reports. Corrective Actions: Radiology Actions: - A sub-specialty (board certified radiologist with sub-specialty fellowship training consistent with type of x-ray imaging) radiologist will complete the first read on all skeletal surveys performed in the NICU for three months. - A sub-specialty (board certified radiologist with sub-specialty fellowship training consistent with type of x-ray imaging) radiologist will complete a final read on all x-rays performed in the NICU for three months. - Auditing for missed fractures on NICU x-rays will be performed weekly for three months - All discrepancies identified will be communicated to the original interpreting physician - Monthly discrepancy reports will be reviewed with the contracted group and HDH facility leadership for three months. Trends and frequencies are reported to Quality/Patient Safety, MEC & BOT.	12/21/24	12/21/24	04/15/25	12/21/24	04/15/25

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FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: URG811 Facility ID: VA0542 If continuation sheet Page 5 of 97

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A 115	Continued From page 5 This CONDITION is not met as evidenced by: Based on observations, video review, review of medical records (MR), review of documents and interview with staff (EMP) it was determined that the facility failed to: ensure consent was obtained prior to administering a vaccine, ensure safe handling of infants in the NICU to prevent injury, validate the identification of visitors entering the NICU (A0144); prevent abuse, identify injuries of unknown origins as indicators of potential abuse, report and investigate injuries of unknown origin, implement actions to protect patients from abuse and neglect, and educate all health care professionals on abuse and neglect (A0145, A0286). This failure resulted in an Immediate Jeopardy (IJ), posing a serious risk of harm to the patients. The facility was notified of IJ on December 18, 2024, at 3:40 PM. The facility IJ removal plan immediate interventions included: suspension of admissions to the NICU; all NICU staff will have a trained observer when in patient rooms; formalize clinical guidance for metabolic bone disease; skeletal survey of all current NICU babies with parent's consent to be read by a pediatric radiologist; education of mandated reporting and abuse and neglect policy and reporting for targeted clinical groups; education on safe handling of neonates for targeted clinical groups; review of physician files to ensure all neonatologists (NEO - a physician contracted for neonatology services by the facility) had required background checks; black boxes (an area on the video that is not visible and covered with a black square) removed from video camera feed; leadership safety rounds in the NICU twice daily; ongoing review of video footage in a structured	A 084	Numerator = number of skeletal surveys read by sub-specialty radiologist initially. Denominator = number of skeletal surveys performed. Numerator = other x-rays performed in the NICU as an overread by a sub-specialty radiologist. Denominator = number of NICU x-rays performed. Monthly discrepancy reports will be reviewed with the contracted group and HDH facility leadership for three months Responsible Leader: CMO <u>SUBJECT OF DEFICIENCY:</u> The facility failed to ensure consent was obtained prior to administering a vaccine, ensure safe handling of infants in the NICU to prevent injury, validate the identification of visitors entering the NICU; prevent abuse, identify injuries of unknown origin, implement actions to protect patients from abuse and neglect, and educate all health care professionals on abuse and neglect.	4/15/25	
A 115					

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A 115	Continued From page 6 fashion; and daily head-to-toe assessments of all babies in the NICU completed by a NEO. Cross Reference: §482.13(b)(2) Patient Rights: Informed Consent §482.13(c)(2) Patient Rights: Care in a Safe Setting §482.13(c)(3) Patient Rights: Free From Abuse/Harassment §482.21 Condition of Participation: Quality Assessment and Performance Improvement Program	A 115	Corrective Actions Education Education was provided to currently working eligible/targeted staff and/or providers using multiple mechanisms. These mechanisms included email, HealthStream modules, huddles, one on one education, skills fairs, and/or huddle cards used by department leaders with the assistance of the NICU Educator. Competency is validated prior to or on start of first shift for all staff, including float staff. Staff who have not completed the required education, on paid time off (PTO), and leave of absence will complete education prior to and/or during their first shift returning back to work. Education has been incorporated into new hire and contract staff education. Education will be provided to 100% of the clinical staff (regardless of prior education or background) that provide care to the NICU population initially as well as annually to include:		
A 131	PATIENT RIGHTS: INFORMED CONSENT CFR(s): 482.13(b)(2) The patient or his or her representative (as allowed under State law) has the right to make informed decisions regarding his or her care. The patient's rights include being informed of his or her health status, being involved in care planning and treatment, and being able to request or refuse treatment. This right must not be construed as a mechanism to demand the provision of treatment or services deemed medically unnecessary or inappropriate. This STANDARD is not met as evidenced by: Based on review of medical records (MR), review of documents and interview with staff (EMP) it was determined that the hospital failed to ensure consent was obtained prior to administering a vaccine (MR5). Findings: Review of facility policy titled "Immunizations: Neonates and Infants," effective 2/1998, revised		• Safe handling of fragile babies • NICU Fragile Bone Protocol • Patient safety during lab draws and other procedures		

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A 131	Continued From page 7 07/2018, revealed "...The most current Vaccine Information Statement (VIS) will be given to the parent/guardian and written/verbal consent will be obtained prior to administering vaccination.... Procedure. A. Gather equipment.... 9. Signed parental consent form. ..."	A 115	- Best practices for avoiding unnecessary trauma and injury - Fall prevention including crib safety - Oral and nasopharyngeal suctioning of neonates (nursing and respiratory therapists only) - Abuse and neglect - Rapid debrief process - NICU infant security policy (includes visitor validation) - Obtaining orders for wound care - Documentation of skin assessments - Hand Hygiene - Donning and Doffing of proper PPE and proper isolation precautions - Travelers, "float staff" or staff who work in the NICU will receive this education during their first shift	4/15/25	
	Review of MR5 "Informed Consent for Newborn Hepatitis-B Vaccination," signed by MR5's parent September 1, 2024, revealed, "I DO NOT give my permission to have the Hepatitis B vaccine administered to my infant." Nursing documentation, dated September 1, 2024 at 6:55 PM, revealed a notation that the infant's parents declined the hepatitis B vaccine. The medication administration record revealed MR5 received a hepatitis B vaccine on September 2, 2024 at 12:35 AM. The medical record contained no documentation that the parents gave consent to administer the vaccine to MR5.		Additional education included:	12/31/24	
A 144	Interview on November 25, 2024 at 12:08 PM, EMP106 confirmed the parent of MR5 declined the vaccine and documentation in the medical record indicated the vaccine was administered. PATIENT RIGHTS: CARE IN SAFE SETTING CFR(s): 482.13(c)(2) The patient has the right to receive care in a safe setting. This STANDARD is not met as evidenced by: Based on review of videos, review of facility documents and interview with staff (EMP), it was determined the facility failed to ensure safe handling of infants in the NICU to prevent injury (MR1, MR11) and failed to validate the identification of visitors entering the NICU.		- Mother/Baby Unit (MBU) nurses will receive education on consent for vaccine administration. - All patient facing healthcare professionals will be current on abuse and neglect SQ Rights and Responsibilities - Patient Facing by April 1, 2025	4/1/25	
			Additional actions and monitoring are listed under the appropriate tags: A 131 A 144 A 145 Responsible leader: CNO/CMO		

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A 144	Continued From page 8 Findings: Review of document, titled "NICU Fragile Bone Protocol," created July 3, 2024, revealed "...Stabilizing hand support and slow movement transitions during routine caregiving tasks shall be used for infants with fragile bones, infusion lines and tubes, and ventilatory support or respiratory equipment ...preparation for body alignment with swaddling should include ...keeping neck and trunk alignment neutral without flexion or extension ...Diapering. Do not lift infant from ankles. Do not raise hips above level of head ... Picking up and holding. Option 1: Holding at shoulder - Caregiver bends over supine lying infant so that caregiver's shoulder touches infant. Caregiver slides one open hand under infant's back and head and the other under infant's bottom. Caregiver lifts the infant onto shoulder while straightening into upright position. Option 2: Cradling in arms. Caregiver places one hand with fingers wide apart under infant's head and body. Caregiver places other hand with fingers wide apart under infant's buttocks and back. Caregiver uses forearms to support the infant's limbs so limbs do not dangle. Caregiver leans close to infant and gently lifts infant to caregiver's chest. Do not lift infant from under arms... " Review of facility policy, titled "Newborn Fall Prevention Protocol," last revised June 2023, revealed "... All newborns are considered at risk for falls/drops and the following precautions are to implemented: 1. Keep warmer/crib rails raised unless directly providing care " Interview on November 25, 2024, at 10:57 AM,	A 131	<u>SUBJECT OF DEFICIENCY</u> The hospital failed to ensure consent was obtained prior to administering a vaccine Corrective Actions The Mother Baby Unit (MBU) team reinforced an established process of verifying consent prior to administration of vaccines. Staff will confirm that an informed consent form has been completed prior to the administration of the vaccine. Education 100% of the nursing staff in the MBU has received education regarding the process for vaccine administration, documentation and consent. Monitoring To ensure ongoing compliance with the vaccine administration process, the MBU leader will complete an audit of 20 infant vaccine administrations per each month for three (3) months with 100% remediation of outliers. Numerator = # of vaccine administrations with consent. Denominator = 20/month Responsible Leader: CNO <u>SUBJECT OF DEFICIENCY:</u>		
		A144	Facility failed to ensure safe handling of infants in the NICU to prevent injury and failed to validate the identification of visitors entering the NICU.		

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A 144	Continued From page 9 EMP1 indicated that the facility did not provide safe handling training to neonatologists (NEO) or occupational therapists (OT) in the NICU. On November 26, 2024, at 1:48 PM, EMP8 confirmed that the facility did not train or observe the NEO or OT for safe handling techniques. Video review and interview on December 26, 2024 at 2:50 PM, with EMP8 of EMP67 providing care to MR 1 on September 17, 2024, at 3:51 AM, revealed EMP67 lifted the infant by both ankles, placing a swaddle blanket under the infant. Only the crown of infant's head remained on the bed and the infant's neck was flexed (head bent toward chest) at an approximately 45 degree angle. EMP67 then dropped the infant's legs onto the bed. EMP8 appeared surprised to see this and indicated that EMP67 did not perform swaddling as they are taught. EMP8 further indicated the correct way to swaddle an infant is to use both hands to carefully lift the infant supporting the head and neck and ensuring no limbs were dangling, then carefully placing the infant on the blanket. Interview on January 3, 2025, at 5:05 PM, EMP8 indicated that on December 31, 2024, following review of the above video, they notified EMP5 about a plan to discuss education with EMP67, but EMP8 was waiting to see if there were any other staff that would need education before meeting with EMP67. EMP8 indicated they met with EMP67 on January 3, 2025, eight days after becoming aware of the inappropriate handling of MR1 in the video. Video review with EMP5 and EMP8 on January 21, 2025 at 9:50 AM, of EMP67 providing care to			A 144	Corrective Action - The NICU staff will be validating visitors as per NICU Infant Security policy. - Visitors will be validated by ID band or by photo identification if they do not have a band. - The NICU will maintain a visitor log sheet throughout the individual patient's stay. Clinical daily documentation of physical exam and assessment is concordant Education Education was provided to currently working eligible/targeted staff and/or providers using multiple mechanisms. These mechanisms included email, HealthStream modules, huddles, one to one education, skills fairs, and/or huddle cards used by department leaders with the assistance of the NICU Educator. Competency is validated prior to or on start of first shift for all staff, including float staff. Staff who have not completed the required education, on paid time off (PTO), and leave of absence will complete education prior to and/or during their first shift returning back to work. Education has been incorporated into new hire and contract staff education. Education will be provided to 100% of the clinical staff (regardless of prior education or background) that provide care to the NICU population initially and annually to include: - Safe handling of fragile babies - NICU Fragile Bone Protocol - Patient safety during lab draws and other procedures		3/24/25
							4/15/25

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A 144	Continued From page 10 MR1 on September 17, 2024, at 3:51 AM. EMP5 indicated the lifting technique used by EMP67 was not developmentally appropriate and could be stressful for an infant. EMP8 indicated they were surprised when they previously reviewed the video of EMP67 providing care to MR1, and they were unsure if flexion of the neck at that angle could cause injury to an infant. EMP8 confirmed MR1 was lifted too far off the bed, noting the infant's head was the only part of the baby on the bed. Video review on December 30, 2024, at 10:02 AM, of EMP11 providing care to MR1 on November 10, 2024, at 11:45 AM, revealed EMP11 forcefully pushed the infant's legs towards the abdomen with the feet almost touching the infant's face. EMP11 releases the legs and then repeats the action again. EMP11 walks away from the crib while the infant is lying unattended in the crib multiple times, without raising the crib rails. EMP11 then picks up the infant with one hand and carries the infant to the rocker using only one hand. Video review on December 30, 2024, at 10:47 AM, of EMP11 providing care to MR11 on October 29, 2024, at 1:50 PM, revealed EMP11 changing the infant's diaper and raised both of the infant's legs, pushed them towards the abdomen and held them there for a few seconds. Video review on December 30, 2024, of EMP11 providing care to MR1 from November 10, 2024, at 5:47 PM, revealed the infant was in an open crib. EMP11 left the crib rail down and walked away from the crib to throw away a diaper. EMP11 then picked the infant up with one hand	A 144	• Best practices for avoiding unnecessary trauma and injury • Fall prevention including crib safety • Oral and nasopharyngeal suctioning of the neonate • Abuse and neglect • Rapid debrief process • NICU infant security policy (includes visitor validation) • Obtaining orders for wound care • Documentation of skin assessments • Hand Hygiene • Donning and Doffing of proper PPE and proper isolation precautions • Travelers "float staff "or staff who work in the NICU will receive this education during their first shift Monitoring <i>Safe care</i> To ensure that neonates are receiving appropriate safe care, concurrent video review will be completed on 40 encounters per month with a focus on: • Safe handling • Crib safety and fall prevention • Prevention of abuse, injuries and neglect Video review audits will be completed monthly for three months and then as needed for event analysis and investigation with 100% remediation of any outliers.	12/20/24	

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A 144	Continued From page 12 body to reposition. EMP5 indicated the nurse should not be pulling the infant's head back in that manner and should not use the positioning aid to keep a pacifier in a infant's mouth. EMP5 indicated staff are not supposed to hold the pacifier in the infant's mouth unless the baby keeps it there themselves. EMP5 indicated when lifting a infant, the nurse should support the infant's neck and picking up a infant by the head and one leg was not supportive. EMP5 indicated when EMP11 was pushing MR1's legs into their abdomen they were trying to help relieve gas, and added "it seems like a lot of pressure." EMP5 indicated "you can tell the baby is not tolerating that well when the nurse is holding the baby's legs into the baby's stomach" because MR1's heart rate [on the monitor] was in the 170s (normal 120-160), and oxygen saturation was in the 70s (normal 90-95). Review of facility policy, titled "Suctioning neonate: Oral, nasopharyngeal" last revised May 2016, revealed " ...Guidelines ... For nasal suctioning, place bulb gently but snugly into the nostril after suction is created... " Video review with EMP1, EMP3, and EMP5 on January 2, 2025, at 10:09 AM, of EMP11 providing care to MR1 on November 13, 2024, at 2:33 PM, revealed EMP11 administered medication into the infant's mouth, the infant was lying on their back and appeared to be coughing. EMP11 positioned the infant by grabbing the infant by the arm farthest away and flipped the infant onto the stomach by pulling the infant's arm toward the nurse. EMP11 stepped away from the crib and left the siderail down. EMP11 returned to the crib and pushed the infant's legs	A 145	Corrective Actions An observer program was established to ensure safe and proper handling during care provided for neonates. The observer program remained in place until retrospective video review was completed. During the daily physical exams, the provider will perform a focused exam to look for potential injuries. Imaging may be performed as necessary based on clinical findings. Any concerning findings or incidents that could indicate abuse or neglect will be reported directly to senior leadership for immediate follow up. A rapid debrief process was created for when staff identify an injury of unknown origin with escalation to neonatology for immediate assessment of the situation utilizing the debriefing tool which will be entered into the incident reporting system. Prompt notification to leadership of the rapid debrief will occur for additional review to ensure timely intervention (protecting patient safety), investigation and identify any staff related Human Resources matters. HDH will follow hospital's policies for documentation and reporting. 100% of Serious Safety Event investigations will be completed within 30 business days unless an extension is approved by the BOT, because further analysis is warranted for the investigation. Education All patient facing healthcare professionals will be current on abuse and neglect SQ Rights and Responsibilities- Patient Facing by April 1 2025.	12/18/24 12/20/24 2/5/25 3/1/25 4/15/25	

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A 144	Continued From page 13 into the infant's abdomen. EMP5 indicated that this is not how staff would try to remove gas. EMP11 then picked the infant up with one hand, holding the infant away from their body with one hand, arm outstretched. EMP5 confirmed during video review that staff should not be picking up the infant with one outstretched arm. At 2:38 PM, EMP11 was observed using a flexible suction catheter to suction the infant's nose. EMP11 forcefully inserted the suction catheter into the infant's nostril and advanced the catheter deeply into the nostril. EMP5 indicated that EMP11 was using the incorrect type of suction device for the nose. EMP5 stated the type of suction device EMP11 was using was to be used on an intubated (tube inserted into the windpipe to assist breathing) infant to clear secretions in the back of the throat (MR1 was not intubated). EMP5 further indicated a "mushroom" type suction device (device with a special tip) should be used for nasal suction to prevent the suction catheter from being inserted too far into the infant's nose. EMP5 indicated that they would have taken over care of the infant from EMP11 and had a conversation with them about not doing those things. On the video at approximately 3:50 PM, EMP11 was observed using a positioning device to prop a pacifier in place in the infant's mouth in a way that the infant would be unable to remove the pacifier. EMP5 confirmed no device should be used to keep a pacifier in an infant's mouth. Video review with EMP1, EMP3, and EMP5 on January 24, 2025, at 3:03 PM, of EMP11 providing care to MR1 on November 13, 2024, at 4:40 PM, revealed EMP11 sitting on the floor feeding MR1. EMP11 slides their body	A 145	Monitoring Safe Care To ensure that neonates are receiving appropriate safe care, concurrent video review will be completed on 40 encounters per month with a focus on: • Safe handling • Crib safety and fall prevention • Prevention of abuse, injuries and neglect Video review audits will be completed monthly for three months and then as needed for event analysis and investigation with 100% remediation of any outliers. Remediation will consist of immediate escalation to the director with coaching and education to occur as soon as possible. Numerator = # of encounters observed in which appropriate safety handling was observed Denominator = 40/month Physical Exams A weekly audit will be performed to ensure neonatologist physical exam documentation. The audit will be performed on 30 records monthly for three months and then random audits will be performed quarterly for the subsequent three quarters with 100% remediation of outliers. Numerator = # physical exams that have been completed and documented Denominator = 30/month	12/20/24	12/20/24

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A 144	Continued From page 14 backwards on the floor to sit back against the chair and while EMP11 is sliding themselves across the floor they hold the infant by the head only, with one hand on the bottle in the infant's mouth and their other hand on back of the infant's neck/head, while the rest of infant's body dangled with no support provided. EMP5 indicated the way EMP11 held the infant only by the head while moving across the floor was not appropriate. Review of facility policy, titled "Infant Security," last revised July 2023, revealed "... 7. Unit Visitors. A. Upon entrance to Perinatal and Neonatal units, all visitors are to be greeted and validated. Facilities should restrict and monitor visitor entrance, especially within restricted areas on the Perinatal and Neonatal units, such as ORs, Well-Nurseries and NICUs. B. Perinatal Units should have a process for visitor ID validation, visitors receive a distinctive visitor wristband or name tag allowing entry to the unit, etc.) If a visitor wristband is utilized, it should be a cut away, non-transferable, disposable band with no patient identification. C. Unit colleagues will log visitors of patients. The log is maintained per record retention policy. The patient or colleagues may limit visitors. D. External vendors and/or agency representatives who are required to interact with the infant and/or parents need to be appropriately identified upon arrival to unit and introduced to parents/primary caregivers by the primary care nurse...." Review of facility safety report on January 16, 2025, revealed on August 5, 2024, at 3:50 PM, "Visitor came to NICU saying [the visitor] was a lactation consultant, was let in by an employee	A 145	Rapid Debriefs The PSD or designated team member will review all rapid debriefs to ensure they are completed. Video review will be completed, as needed, for investigational purposes to ensure thorough investigations are performed. The PSD will also ensure that events are investigated timely and the analysis is completed per policy. - Twice a month review of open serious safety events by leadership to ensure timely completion of investigations will continue for three months. - Routine Vigilanz report emailed to hospital leadership to validate timely investigation and measures taken. Intense Analysis/SEAs - Unit/departamental leadership accountability for timely event investigation, actions, and MOS in partnership with Quality/Patient Safety/Risk team - Lessons learned and best practices shared via case studies at monthly Patient Safety Committee Responsible Leader: CMO	2/5/25	

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A 144	Continued From page 15 that let [the visitor] in without verifying badge." The investigation revealed that all staff should be reminded to not allow visitors onto secure unit unless they can be verified. Review of security incident report for the same incident revealed that an individual without authorization was let into the NICU by a technician that was floating from a different unit. Interview on January 17, 2025, at 12:51 PM, EMP94 indicated that the event occurred over a weekend and EMP94 was made aware because pictures were pulled from the video surveillance to identify the person who should not have been on the unit. Interview on January 23, 2025, at 10:53 AM, EMP5 indicated that prior to entering the NICU, family members must show their wrist band and read the number to the staff to verify their identity. EMP5 indicated there is a video camera in the NICU lobby that allows staff to view visitors at the unit door on a monitor at the nurses' station and the doors to the unit are locked and require an employee badge to enter. Interview on January 23, 2025, at 11:00 AM, EMP94 indicated that upon the birth of an infant, two designated family members, typically the mother and father, will be assigned wrist bands with a number that matches the number on the infant's wrist band. EMP94 indicated upon arrival to the NICU lobby, the family members come to the NICU window and pick up the phone to let the staff know which patient they are visiting. EMP94 indicated the family member reads the number on the security band to the staff on the phone and then shows the band to the video camera for staff to view. EMP94 confirmed that they do not ask for identification (for example, a	A 263	<u>SUBJECT OF DEFICIENCY</u> Facility failed to: document significant findings, actions or steps taken to improve performance, effectiveness of actions/steps, or goals in the NICU or measure, analyze, and track quality indicators related to a MRSA outbreak in the NICU; complete a thorough analysis of events to determine the cause of an injury so that appropriate preventive actions could be implemented to prevent reoccurrence, failed to track and investigate injuries of unknown origin, failed to analyze or document the progress of an analysis of NICU patients with multiple fractures of unknown origin, failed to train staff to identify potential indicators of abuse and neglect, failed to perform investigations to rule out abuse and neglect, and failed to analyze patient deaths. Corrective Actions: <i>Track quality indicators related to MRSA</i> The hospital acknowledges that the Infection Control Committee is responsible for implementing strategies to prevent the transmission and control the spread of infections. This includes monitoring and tracking infection prevention activities that are currently being implemented in the NICU to address the MRSA outbreak. In February 2025, a multidisciplinary team created a scorecard that is currently being used to monitor all actions taken to reduce the spread of MRSA in the NICU.	2/26/25	

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A 144	Continued From page 16 state or government issued identification), "just the band number" and compares it to the patient and band number documented in the logbook at the nurses' station. EMP94 indicated if the visitor is someone they have not seen before, they will ask the nurse and check the logbook for a visitor exception form that must be approved by the charge nurse. EMP94 indicated there are other staff members that work at the desk and provide visitor access to the NICU using the same procedure at night and on the weekends. EMP94 indicated that staff can look in the electronic medical record to verify the patient's parent's first name. EMP94 indicated that the log contains the infant's last name and the band number, it does not contain the name of the person assigned to the band.	A 263	This plan effectively tracks all infection prevention activities, implementation strategies, and progress toward process improvements and includes: • Hand hygiene non-compliance immediately addressed • "Bare below the elbows" policy non-compliance immediately addressed • ATP testing of rooms after patient discharge non-compliance immediately addressed <i>Investigation and analysis of injuries of unknown origin</i>	2/26/25	
A 145	PATIENT RIGHTS: FREE FROM ABUSE/HARASSMENT CFR(s): 482.13(c)(3) The patient has the right to be free from all forms of abuse or harassment. This STANDARD is not met as evidenced by: Based on review of medical records (MR), review of documents and interview with staff (EMP) it was determined that the facility failed to protect patients from abuse and neglect. Specifically, the hospital failed to prevent abuse, identify injuries of unknown origin as indicators of potential abuse or neglect, report and investigate injuries of unknown origin (MR1, MR2, MR11, MR12, MR34, MR44), implement actions to protect patients from abuse and neglect, and educate all health care professionals on abuse and neglect.		Immediately after the discovery of injuries of unknown origin in the NICU during 2023 and 2024, the hospital's quality team collaborated with NICU leaders and executive leaders to investigate these incidents. A sentinel event analysis for the injuries that occurred in 2023 was completed on December 4, 2023. Additionally, separate sentinel event analyses were conducted for each injury reported in 2024 on February 7, 16, and 17. To ensure all injuries of unknown origin are investigated, a rapid debriefing process was created for when staff identify an injury of unknown origin with escalation for immediate assessment of the situation utilizing the debriefing tool.	2/5/25	

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A 145	Continued From page 18 following objectives in cases of suspected or confirmed abuse, neglect ...Upon initial assessment: A. Identify those victims seen in the hospital setting who have been abused, neglected ...B. Provide appropriate medical care and interventional services within the hospital to protect and support the victim ...Identifying Criteria: Criteria for identification includes but is not limited to the following: ... B. Child Abuse (see Attachment B) ... Staff Education and Protection: Education is provided to new Nursing employees during orientation and offered thereafter on a periodic basis on the indicators for adult and child abuse, neglect, and exploitation, reporting requirements, and intervention services. This will be maintained in their educational file...." Review of facility document, titled "Attachment B - Child Abuse," undated, revealed ". 1. Physical Abuse - Child. A Physical Indicators. 1. Questionable burns, bites, bruises, broken bone(s), black eyes, lacerations, or abrasions. 2. Fractures in various stages of healing. 3. Unexplained injuries not accounted for by explanation by parent or guardian... " Review of document, titled "NICU Fragile Bone Protocol," created July 3, 2024, revealed "...Stabilizing hand support and slow movement transitions during routine caregiving tasks shall be used for infants with fragile bones, infusion lines and tubes, and ventilatory support or respiratory equipment... preparation for body alignment with swaddling should include ...keeping neck and trunk alignment neutral without flexion or extension ... Diapering. Do not lift infant from ankles. Do not raise hips above	A 263	Monitoring <i>Track quality indicators related to MRSA</i> The NICU MRSA task force will continue to monitor ongoing compliance using the "NICU Infection Prevention Action Plan" scorecard for the next three months, and this monitoring will be reimplemented as necessary. The scorecard will be reviewed for approval as part of the hospital-wide infection prevention efforts. During a 12-week surveillance period (ended on 2/22/25) by VDH there were no hospital acquired MRSA cases in the NICU. These measures are reviewed biweekly to assess ongoing compliance and progress toward established goals <i>Investigation and Analysis of injuries of unknown origin</i> The PSD or designated team member will review all rapid debriefs when completed to ensure they are complete. The PSD will also ensure that events are immediately investigated in a timely manner and that the analysis is carried out according to policy. A monthly analysis of all rapid debriefs, as well as any action plans implemented in response to identified trends or instances of noncompliance, will be presented to the NICU Multidisciplinary Committee. This process will enable the team to confirm that appropriate action plans are in place to address the root causes and to make corrections if the action items prove to be ineffective.	2/26/25	2/5/25

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A 145	Continued From page 19 level of head ... Picking up and holding. Option 1: Holding at shoulder - Caregiver bends over supine lying infant so that caregiver's shoulder touches infant. Caregiver slides one open hand under infant's back and head and the other under infant's bottom. Caregiver lifts the infant onto shoulder while straightening into upright position. Option 2: Cradling in arms. Caregiver places one hand with fingers wide apart under infant's head and body. Caregiver places other hand with fingers wide apart under infant's buttocks and back. Caregiver uses forearms to support the infant's limbs so limbs do not dangle. Caregiver leans close to infant and gently lifts infant to caregiver's chest. Do not lift infant from under arms... " Review of Child Protective Services (CPS) letter, addressed to the Hospital, dated September 26, 2024, revealed ". The report was received on September 21st, 2023, alleging Physical Abuse of [names of four NICU patients]. Following a thorough investigation, a disposition of FOUNDED, LEVEL ONE, has been made in this matter for the Physical Abuse of the children by an Unknown Abuser. During the investigation, enough information was obtained to determine that the alleged abuser was an employee in the Henrico Doctor's Hospital NICU. A founded disposition means a review of the facts shows by a preponderance of the evidence that child abuse/neglect occurred. A level one finding indicates that the injuries/conditions, real or threatened, did or were likely to have resulted in serious harm to the child(ren)... " There was no evidence that after receipt of the CPS findings, the facility implemented actions to prevent abuse, identify injuries of unknown origin as indicators of	A 263	Compliance with the rapid debriefing process and event analysis will be reported monthly to Quality Council/Patient Safety, MEC and BOT. Responsible Leader: CMO		4/15/25
		A 283	<u>SUBJECT OF DEFICIENCY</u> Failed to document significant findings, actions or steps taken to improve performance, effectiveness of actions/steps, or goals in the NICU or measure, analyze, and track quality indicators related to a MRSA outbreak in the NICU. <i>Track quality indicators related to MRSA</i> The hospital acknowledges that the Infection Control Committee is responsible for implementing strategies to prevent the transmission and control the spread of infections. This includes monitoring and tracking infection prevention activities to address the MRSA outbreak in the NICU. In February 2025, the team created a scorecard to monitor all actions taken to prevent the spread of MRSA in the NICU. This plan effectively tracks all infection prevention activities, implementation strategies, and progress toward process improvements and includes: Hand hygiene non-compliance immediately addressed		2/26/25

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A 145	Continued From page 20 potential abuse, report and investigate all injuries of unknown origin, implement actions to protect patients from abuse and neglect, or educate all health care professionals on abuse and neglect. Review of facility document, "NICU Occurrence Report," from May 1, 2024, to January 15, 2025, revealed that there were 135 events reported in the NICU. Six of the 135 reported events involved reports of fractures and identified areas of swelling on five patients (MR1, MR2, MR11, MR12, MR44). The document did not contain or annotate any events as abuse or under investigation to rule out abuse. There was limited and incomplete documentation describing the events, actions taken by the facility related to the event, as well as the facility's "Investigative Methods" into the events. Review of MR1's medical record revealed on July 21, 2024, at 3 AM, nursing documented bruising on the right shin. On July 21, 2024, at 9 AM, nursing documented right lower extremity bruising, including two sites on shin and left lower extremity bruising, length of shin and back of calf. On November 22, 2024, MR1 was found to have swelling in the left thigh and a subsequent x-ray revealed an "impacted distal left femoral metaphyseal fracture [broken bone in the lower part of the thigh- caused when one broken end of the bone is driven into the other bone] with some evidence of healing." MR1's x-ray report, titled "RAD FEMUR LT 2 VWS," dated November 22, 2024, revealed "correlation with the history of this fracture is needed as this is an atypical fracture for this patient age in the absence of a known underlying trauma." The Nursing Clinical Note from November 22, 2024, at 5:48 AM, revealed			A 283	"Bare below the elbows" policy non-compliance immediately addressed - ATP testing of rooms after patient discharge non-compliance immediately addressed Monitoring <i>Track quality indicators related to MRSA</i> The NICU MRSA task force will review the measures every two weeks to assess ongoing compliance and progress toward the goals outlined in the NICU Infection Prevention scorecard including compliance with hand hygiene, bare below the elbows and ATP testing of equipment with 100% immediate remediation of non-compliance. If the team identifies ineffective actions or an increase in MRSA-positive patients, they will conduct a thorough analysis to determine the root cause and implement additional action items or necessary corrections. The NICU Infection Prevention scorecard will be reviewed monthly by the Quality Council/Patient Safety team and quarterly by Infection Prevention to monitor compliance with process improvements. - Numerator: Number of scorecards reviewed every two weeks that show compliance with the three key performance indicators - Denominator every other week Responsible leader: CMO		2/26/25

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A 145	Continued From page 21 "No obvious mechanism of injury known " Additionally, the "Consultation Report," dated November 23, 2024, revealed left distal femur fracture with callous [indicator of healing], right proximal tibia and fibular fracture with abundant callus, both well healed with no displacement." Review of the medical record and facility documents revealed no documented evidence staff identified the cause of the injuries, reported the bruising through the event reporting system, or investigated the injuries and three fractures for potential indicators of abuse. Interview on November 25, 2024 at 3:04 PM, EMP5 confirmed that the facility does not review video from the cameras installed in the NICU to audit or perform observations of care, the video has only been reviewed to look at some hand hygiene and if there was a complaint. Interview on November 25, 2024, at 10:57 AM, EMP1 indicated that daily physician musculoskeletal head-to-toe assessments were completed on NICU infants routinely until late July or August 2024. EMP1 indicated the facility was unable to track every staff member that had contact with MR1, only a list of staff who had documented in the record, and this list would not be inclusive of all employees who may have had contact. EMP1 further indicated additional undocumented staff may included staff assisting with routine care, such as feeding, and the only way to determine who had contact with MR1 would be to watch video recordings retroactively. EMP1 further indicated the facility did not train or observe the neonatologists (NEO) or occupational therapists (OT) to ensure safe handling of infants in the NICU.	A 286	<u>SUBJECT OF DEFICIENCY:</u> Failed to have an effective and on-going Quality Assurance and Performance Improvement (QAPI) program that adequately tracked and analyzed events, including injuries of unknown origin, to identify patterns and causes so that appropriate measures could be implemented to reduce reoccurrence and improve quality of services and patient safety. In addition, the hospital failed to monitor and ensure the consistent implementation, and adherence to, preventative actions to mitigate the risk of events resulting in harm to patients. Corrective Actions: <i>Investigation and analysis of injuries of unknown origin</i> A rapid debrief process was created for when staff identify an injury of unknown origin with escalation to neonatology for immediate assessment of the situation utilizing the debriefing tool which will be entered into the incident reporting system. Prompt notification to leadership of the rapid debrief will occur for additional review to ensure timely intervention (protecting patient safety), investigation and identify any staff related HR matters. HDH will follow hospital's policies for documentation and reporting. If an event meets sentinel event criteria per policy, the event will be tracked and analyzed as such, and a sentinel event analysis will be completed within 30 business days along with a corrective action plan to reduce the risk of a similar event.		2/5/25

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A 145	Continued From page 22 Review of MR11 revealed on December 16, 2024, it was discovered MR11 had fractures of the right and left femur, and per the radiology report, there was "concern for nonaccidental trauma." On December 17, 2024, it was discovered MR11 also had fractures of the right ulna (forearm bone), radius (forearm bone) and metacarpal (bone in palm of hand), and left ulna and radius. There was no documented evidence the seven fractures were investigated for potential indicators of abuse. On December 20, 2024, at 3:00 PM, EMP1 confirmed the facility has used the video for hand hygiene data, but they are "not doing a ton of review of video." Interview on December 23, 2024, at 11:25 AM, NEO57 indicated prior to August 2024, they would contact the Chief Medical Officer (CMO) every Monday to notify them if there were any concerns with the NICU infants based on the daily assessments. NEO57 indicated there had been no concerns since the first fractures were identified in 2023. Video review and interview on December 26, 2024 at 2:50 PM, with EMP8 revealed on September 17, 2024, at 3:51 AM, EMP67 lifted MR1 by both ankles, placing a swaddle under the baby. Only the crown of the infant's head remained on the bed and the infant's neck was flexed (head bent toward chest) at an approximately 45 degree angle. EMP67 then dropped the infant's legs onto the bed. EMP8 appeared surprised to see this and indicated that EMP67 did not perform swaddling as they are	A286	The Quality Council/Patient Safety Committee will monitor these corrective plans monthly to ensure they are complete. Monitoring: The PSD or designated team member will review all rapid debriefs to ensure they are completed. Video review will be completed, as needed, for investigational purposes to ensure thorough investigations are performed. The PSD will also ensure that events are investigated timely and the analysis is completed per policy. - Twice a month review of open serious safety events by leadership to ensure timely completion of investigations will continue for three months. - Routine Vigilanz report emailed to hospital leadership to validate timely investigation and measures taken. Intense Analysis/SEAs - Unit/departmental leadership accountability for timely event investigation, actions, and MOS in partnership with Quality/Patient Safety/Risk team - Lessons learned and best practices shared via case studies at monthly Patient Safety Committee Responsible Leader: CMO <u>SUBJECT OF DEFICIENCY:</u> Failure to ensure that nurses from another hospital had onboarding training or	2/5/25	
		A 385			

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A 145	Continued From page 23 taught. EMP8 further indicated the correct way to swaddle the infant is to use both hands to carefully lift the infant supporting the head and neck and ensuring no limbs were dangling, then carefully placing the infant on the blanket. On January 3, 2025, at 2:31 PM, EMP3 indicated that the video cameras were installed to provide back up if anything "like this" were to occur and to provide reassurance of excellent care. EMP19 indicated that the facility also installed a secondary camera system for parents to stream and watch their infant. EMP1 and EMP2 indicated that the facility had no plan to use the video cameras as an audit tool prior to the patient fractures identified in November 2024. Review of video with EMP5 and EMP8 on January 21, 2025, at 9:50 AM, of EMP67 providing care to MR1 on September 17, 2024, at 3:51 AM. EMP5 indicated the lifting technique used by EMP67 was not developmentally appropriate and could be stressful for an infant. EMP8 indicated they were surprised when they previously reviewed the video from of EMP67 providing care to MR1, and they were unsure if flexion of the neck at that angle could cause injury to an infant. EMP8 confirmed MR1 was lifted too far off the bed, noting the infant's head was the only part of the infant on the bed. There was no documented evidence the facility reviewed or investigated this incident for potential neglect. Review of MR34's NICU Shift Assessment, dated November 9, 2024 at 9 AM, revealed nurses documented bruising on right shin, left elbow and at 3 PM, revealed bruises on right foot, left thigh	A 385	competencies prior to performing their shifts; failure to ensure nurses adhered to policies for fall prevention, wound care and expired formula, and failed to accurately document skin assessments and notify physician of abnormal assessments. Corrective Actions: <i>Onboarding of staff that travel from another hospital</i> To ensure effective onboarding for staff traveling from another facility to the NICU, the NICU Director, CNO, and other nursing leaders, in collaboration with the NICU educator, have developed a new procedure for onboarding to include a comprehensive competency checklist. This checklist includes a validation of competencies for accessing unit resources, environment of care, safety process and procedures, workflow and unit processes, and equipment function and location. In addition, the traveling staff will also receive education on fall prevention, wound care orders, safe handling, the rapid debrief process, and the process for handling formula. The completion of this competency checklist will occur prior to or during the staff member's first shift on the unit. In addition to the competency checklist, the Director has created a NICU resource sheet that contains unit-specific practices and other critical information. This resource is provided to all staff members who work in the NICU. Additional actions and monitoring are listed under the appropriate tag: A 398	3/2/25	

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A 145	Continued From page 24 and back. November 10, 2024, at 9 AM and 9PM, revealed bruising to right shin, right ankle, left thigh, left elbow and back. November 11, 2024 at 9AM, revealed bruising to right shin, left thigh and left arm, bruising/abrasion to right foot and ankle and left foot. November 12, 2024 at 9AM, revealed bruising on right shin, left thigh, left wrist, back and feet. November 13, 2024 at 9 AM, revealed bruising on back of calves and at 3 PM bruising "inside groin and at front". November 15, 2024 at 8 PM, revealed bruising in groin bilaterally, sides of abdomen and left wrist. November 16, 2024 at 11 AM and 8 PM, revealed "large" bruising to bilateral groin. November 17, 2024 at 8 AM and 8 PM, revealed bruising bilateral groin, "bigger on right side". November 18, 2024 at 8 AM and 8 PM, revealed bilateral groin and mid scalp bruising. November 22, 2024 at 8 AM, revealed bruising on left labia majora (the outer folds of skin of the external female genitalia) and nurses continued to document bruising on MR34's labia through December 9, 2024. Review of the medical record and facility documents revealed no documented evidence staff identified the cause of the injuries, reported the injuries through the event reporting system or investigated the injuries for potential indicators of abuse. Interview on January 17, 2025, at 10:39 AM, EMP91 indicated if an abnormal finding was discovered during a skin assessment, and did not have a clear explanation, it should be reported in the event reporting system. EMP91 further indicated it was difficult to determine what was appropriate to report or what category to use when reporting, and relied on leadership to provide guidance.			A 385	Monitoring: To ensure competency checklists are completed timely and accurately, the NICU Educator will audit the checklists for any staff that travel from another facility to ensure they are accurate and complete for three months with 100% remediation of outliers: Numerator = # of traveling staff that have a documented completed competency checklist Denominator = # of traveling staff/month Responsible Leader: CNO		3/24/25
				A397	SUBJECT OF DEFICIENCY: Facility failed to ensure that nurses from another hospital had onboarding training or competencies prior to performing their shifts in the NICU Corrective Actions: To ensure effective onboarding for staff traveling from another facility to the NICU, the NICU Director, CNO, and other nursing leaders, in collaboration with the NICU educator, have developed a new procedure for onboarding to include a comprehensive competency checklist. This checklist includes a validation of competencies for accessing unit resources, environment of care, safety processes and procedures, workflow and unit processes, and equipment function and location. In addition, the traveling staff will also receive education on fall prevention, wound care		3/24/25

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A 145	Continued From page 25 Interview on January 21, 2025, at 9:50 AM, EMP5 indicated if the bruise was from a known cause, such as a medical procedure, the nurse should document the cause. EMP5 indicated routine procedures in the NICU, such as milking the leg (a method of gently massaging the leg to encourage blood flow) when performing a heel stick (method of taking a blood sample in the NICU), should not cause bruising. EMP5 further indicated if a nurse discovered bruising, they were expected to report the bruising to the charge nurse, notify the physician, and complete an event report. On January 9, 2025, the facility received a report indicating that MR44 sustained fractures of unknown origin in 2022. Review of MR44 revealed from July 19, 2022, through July 31, 2022, nurses documented "bruising" with no additional details or location noted. On August 2, 2022, nursing noted "scattered bruising to trunk and extremities." On August 3, 2022, nursing documented the provider was made aware of the bruising. On August 29, 2022, it was discovered MR44 had a fractured right humerus and on August 30, 2022, "healing fracture proximal third left humerus. " Interview on January 22, 2025, at 3:20 PM, EMP80 indicated that the event involving MR44 was not investigated or reported in 2022. EMP1 indicated that they notified CPS and performed an "initial medical record review" and EMP4 indicated that they looked through "some of the chart." EMP80 indicated that their legal counsel advised them to "pause" their investigation while the organization's leadership investigates.		A 397 orders, safe handling, the rapid debrief process, and the process for handling formula. The completion of this competency checklist will occur prior to or during the staff member's first shift on the unit. In addition to the competency checklist, the Director has created a NICU resource sheet that contains unit-specific practices and other critical information. This resource is provided to all staff members who work in the NICU. Monitoring: To ensure competency checklists are completed timely and accurately, the NICU Educator will audit the checklists for any staff that travel from another facility to ensure they are accurate and complete for three months with 100% remediation of outliers: Numerator = # of traveling staff that have a documented completed competency checklist Denominator = # of traveling staff/month Responsible Leader: CNO	4/15/25	

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A 145	Continued From page 26 On January 24, 2025, at 10:14 AM, EMP80 indicated that this case will be reviewed through the "Provider Practice Evaluation Committee" and will make a recommendation for referral to an external radiologist to review this case. EMP80 indicated that the facility is not treating nor investigating this case as suspicion for abuse, but indicated that their external counsel, OTH63, notified CPS because it had to do with fractures of unknown origin. EMP4 indicated that if an event results in harm that they will review the patient's medical record. Review of MR2's "Rad Chest 1 Portable View" (chest x-ray), dated November 21, 2024, revealed a displaced (broken ends of bones are not aligned with each other) right humerus fracture. Review of the facility event report, dated November 22, 2024, revealed classification "injury-not otherwise specified" and "harm-intervention required." There was no documented evidence the injury was investigated for potential indicators of abuse. Interview on January 23, 2025 at 2:05 PM, EMP80 indicated if a fracture was clinically significant, the physician should be notified and an event report should be completed. Interview on January 23, 2025 at 3:05 PM, OTH51 indicated radiologists are trained to identify potential indications of abuse, including noting fractures of different ages (fractures in which healing suggests the fractures occurred at different times). OTH51 further indicated fractures in NICU babies are uncommon. EMP80 indicated an event report was created for MR2's	A 398	SUBJECT OF DEFICIENCY: Facility failed to ensure nursing staff: adhered to hospital policy related to fall prevention, safe handling practices, and nasal suctioning; accurately documented skin assessments and notified the physician of abnormal assessment findings obtained a physician's order for wound care; completed daily checks for the NICU code cart (cart carrying medicine and equipment for use in emergency resuscitation) and defibrillator (device that applies an electric charge or current to the heart to restore a normal heartbeat); and removed expired dietary supplements and powdered formula from formula preparation rooms. Corrective Actions: Education Education was provided to currently working eligible/targeted staff and/or providers using multiple mechanisms. These mechanisms included email, HealthStream modules, huddles, one on one education, skills fairs, and/or huddle cards used by department leaders with the assistance of the NICU educator. Competency is validated prior to or on start of first shift for all staff, including float staff. Staff who have not completed the required education, on paid time off (PTO), and leave of absence will complete education prior to and/or during their first shift returning back to work. Education has been incorporated into new hire and contract staff education.	4/15/25	

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A 145	Continued From page 27 fracture. The facility did not provide documented evidence the event was investigated for potential indicators for abuse. Review of MR12 revealed on December 23, 2024, it was discovered MR12 had fractured rib. There was no documented evidence the fracture was investigated for potential indicators of abuse. Interview on January 24, 2025, at 10:33 AM, EMP4 indicated that when they receive an event report, if the incident reaches the level of "harm" the facility will start an investigation. EMP4 indicated that the facility reports incidents to CPS to "guarantee the safety of the people involved". EMP4 indicated that they were not trained to investigate abuse, they were trained to investigate process issues and what the facility could do to prevent harm. EMP28 indicated that "suspicion of abuse goes outside the safety realm", and a suspicion of abuse investigation might be done by security and human resources. EMP28 indicated that there is no formal algorithm for investigating suspicion of abuse and neglect, the clinical team makes the determination of suspicion of abuse and neglect then they notify leadership. EMP28 indicated that not every concern for abuse will lead to the same pathway of investigation. The facility did not provide documentation of investigation of injuries of unknown origin for suspicions of or potential indicators of abuse for MR1, MR2, MR 11, MR12, MR34, or MR44. Interview on December 27, 2024, at 2:18 PM, EMP1 indicated that EMP11 was identified by the facility as having cared for all four NICU babies with fractures in 2023 and placed on	A 398	Education will be provided to 100% of the clinical staff (regardless of prior education or background) that provide care to the NICU population initially as well as annually to include: • Safe handling of fragile babies • NICU Fragile Bone Protocol • Patient safety during lab draws and other procedures • Best practices for avoiding unnecessary trauma and injury • Fall prevention including crib safety • Oral and nasopharyngeal suctioning of neonates (nursing and respiratory therapists only) • Abuse and neglect • Rapid debrief process • NICU infant security policy (includes visitor validation) • Obtaining orders for wound care • Documentation of skin assessments • Hand Hygiene • Donning and Doffing of proper PPE and proper isolation precaution • Travelers "float staff" or staff who work in the NICU will receive this education during their first shift <i>Safe care, fall prevention and Suctioning</i> An observer program was established to ensure safe and proper handling during care provided for the neonates. The observer program remained in place until retrospective video review was completed and external stakeholders agreed that the observer program could be safely halted.	12/18/24	

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A 145	Continued From page 28 administrative leave on September 10, 2023. EMP1 indicated in addition, EMP50 was identified by CPS as having contact with all four babies with fractures in 2023, and was placed on administrative leave on October 5, 2023. Both EMP11 and EMP50 were allowed to return to work on September 17, 2024. Interview on January 2, 2025, at 2:16 PM, EMP3 indicated that the two nurses were approved to return to work because CPS concluded their investigation. The two nurses had to complete abuse and neglect training, safe handling and heel stick education with the nurse educator. EMP 3 indicated that upon return to work, EMP11 completed three days with a preceptor and the facility had no concerns with EMP11's care during that time. Review of the schedule from September 2024 revealed that EMP11 was scheduled to work with EMP79 on September 20, 21, 23, and 24, but was marked as "sick" on September 21, 2024. There was no other documentation of EMP11's preceptorship with EMP79. EMP50 did not have to complete a preceptorship upon return. Interview on January 3, 2025, at 2:31 PM, EMP2 indicated that there were no stipulations, restrictions, or conditions for the nurses to return to work, they just had to complete the education, and it was only discussed verbally. There was no documented plan in place to ensure and monitor the nurses' provision of safe care upon returning to work at the facility in September and October 2024. Interview on January 23, 2025, EMP4 indicated the annual abuse training for all employees is	A 398	A process was established following the reopening of the NICU to admissions. During the first 30 days of admissions, nurses and physicians rounded together on each NICU baby to ensure consistency in the documentation of assessments. This allowed for the immediate escalation of any abnormal findings. This process took place from February 5, 2025, to March 7, 2025. To maintain the accuracy of skin assessment documentation, nursing leadership will conduct ongoing reviews. Leaders will evaluate these assessments to ensure they are individualized and timely. Any inaccuracies will be addressed with the involved staff and corrected promptly. Code cart checks A new process was established to ensure daily code cart checks. The evening shift will validate that the check was performed by the day shift. If the check is incomplete, the team will finish it before the end of the day. To maintain ongoing nursing leadership oversight of code cart checks, the nursing leader or their designee will review code cart checks weekly and sign the bottom of the code cart sheet to confirm compliance. To maintain oversight, the Quality team will complete a weekly check to confirm nurse leader signature. Any variances will be reported to the CNO.	3/7/25 2/1/25 3/1am/25 2/1/25	

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A 145	Continued From page 29 titled "SQ Rights and Responsibilities Basics, Patient-Facing". Review of personnel files for seven employees (EMP1, EMP3, EMP4, EMP5, EMP22, EMP30, and EMP64) revealed there was no documented evidence they had completed the annual abuse training in 2024. In addition, there was no evidence of abuse and neglect training being completed by EMP1 from 2016 through 2023; EMP4, EMP5, and EMP11 from 2020 through 2023; EMP30 from 2021 through 2023; or EMP3 from 2022 through 2023. In 2023, there were four patients in the facility's NICU identified with fractures of unknown origin. In response, the facility installed security cameras in all the patient rooms in NICU. In addition, the facility implemented daily "muscular-skeletal head-to-toe assessments" of all patients in the NICU which was to be lead and reviewed by the neonatologist to look for any "suspected signs of abuse." The action plan indicated that " ... If any suspected signs of abuse are identified, the neonatologist calls the CMO [Chief Medical Officer] immediately to make [them] aware." Review of the facility's "Abuse and Neglect Education" revealed that two Neonatologists (NEO56 and NEO59) had no abuse trainings on file and the other Neonatologists received trainings on: NEO13- December 4, 2024, NEO52- September 19, 2024, NEO53- December 4, 2024, NEO55- September 25, 2024, NEO57- November 23, 2024, and NEO58- December 4, 2024. Interview with EMP1 on January 24, 2025, indicated that the facility is not responsible for training the Neonatologists on abuse as they are contract staff (this means that they provide services on behalf of the facility at the facility under an	A 398	<i>Expired formula</i> To ensure that expired formula is disposed of promptly and not used past its expiration date, a new process was established by which the secretary or charge nurse will conduct daily rounds in the formula rooms and discard expired formula. These rounds were added to the charge nurse shift checklist. Monitoring: <i>Safe care and fall prevention</i> To ensure that neonates are receiving appropriate safe care, concurrent video review will be completed on 40 encounters per month with a focus on: • Safe handling • Crib safety and fall prevention • Prevention of abuse, injuries and neglect Video review audits will be completed monthly for three months and then as needed for event analysis and investigation with 100% remediation of any outliers. Remediation will consist of immediate escalation to the director with coaching and education to occur as soon as possible. Numerator = # of encounters observed in which appropriate safe handling was observed Denominator = 40/month	4/1/25	12/20/24

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A 263	Continued From page 31 improvement program. The hospital's governing body must ensure that the program reflects the complexity of the hospital's organization and services; involves all hospital departments and services (including those services furnished under contract or arrangement); and focuses on indicators related to improved health outcomes and the prevention and reduction of medical errors. The hospital must maintain and demonstrate evidence of its QAPI program for review by CMS. This CONDITION is not met as evidenced by: Based on review of medical records (MR), review of documents and interview with staff (EMP) it was determined the facility failed to: document significant findings, actions or steps taken to improve performance, effectiveness of actions/steps, or goals in the NICU or measure, analyze, and track quality indicators related to a MRSA outbreak in the NICU (A0283); complete a thorough analysis of events to determine the cause of an injury so that appropriate preventive actions could be implemented to prevent reoccurrence, failed to track and investigate injuries of unknown origin, failed to analyze or document the progress of an the analysis of NICU patients with multiple fractures of unknown origin, failed to train staff to identify potential indicators of abuse and neglect, failed to perform investigations to rule out abuse and neglect, and failed to analyze patient deaths (A0286). Cross reference: §482.21(b)(2)(ii), 482.21(c)(1) & 482.21 (c)(3):	A 398	Numerator= # of charts reviewed that have wound care documented and a physician order present in the chart. Denominator = 30/month <i>Code cart checks</i> Nursing leadership on the unit will be responsible for reviewing the completed code cart checks each day to ensure they are being done correctly and at the appropriate times for three months with 100% remediation of outliers: Numerator = # of checks completed each month Denominator = days/month <i>Expired formula</i> NICU leaders will perform a weekly review to confirm that expired formula is discarded appropriately. This team will carry out weekly inspections for three months with 100% remediation of outliers. Numerator = # compliant inspections each week Denominator = 4/month Responsible Leader: CNO		2/1/25
		A 438	<u>SUBJECT OF DEFICIENCY:</u> Failed to maintain accurate and complete medical records. In addition, the hospital failed to maintain a system for medical records that ensured each medical record was easily assessable and readily available when needed.		4/1/25

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A 283	Continued From page 33 effectiveness of actions/steps, or goals in the NICU or measure, analyze, and track quality indicators related to a MRSA outbreak in the NICU. Findings: Review of facility policy, titled "Performance Improvement and Patient Safety Plan - 2024," revised June 2024, revealed "... e. Hospital Departments and Committees. All hospital departments and Committees shall be responsible for gathering data on their respective performances, which addresses the needs, expectations and responses of patients, staff and others. Department directors are responsible for continuously analyzing and improving their respective department's performance and maintain appropriate quality control programs. It is the responsibility of the department directors to ensure follow-up relevant to all quality control data collection in their department ... Evidence, which indicates departments/services are collecting this data, will be found in: i. PI Projects/Dashboard; ii. Quality reports and dashboards; iii. Documentation of activities directed to strategies/plans to improve performance and patient outcomes; iv. Patient Satisfaction Survey data; v. Review of comments (including patient complaints) from patients, families and/or others; vi. Employee Survey data; vii. Physician Survey data; viii. Employees and visitor's suggestions for change/improvements; ix. Departmental communication documents; and x. Review of personnel performance evaluations with opportunities for improvement. ..." On January 15, 2025, a request was made to the	A 438	Monitoring: To ensure timely and accurate documentation of assessments by both physicians and nursing, NICU leadership and Quality will conduct 30 assessment documentation audits a month for three months with 100% remediation of outliers Numerator = # of nursing or provider assessments are documented timely and accurate into the medical record Denominator = 30 assessments/month (20 nursing and 10 provider) Responsible Leader: CNO <u>SUBJECT OF DEFICIENCY:</u> Facility failed to implement an active hospital-wide program for the surveillance, prevention, and control of hospital associated infections (HAIs)		3/17/25
		A 747	Corrective Actions The hospital acknowledges that the Infection Control Committee is responsible for implementing strategies to prevent the transmission and control the spread of infections. This includes monitoring and tracking infection prevention activities to address the MRSA outbreak in the NICU. In February 2025, the team created a scorecard to monitor all actions taken to reduce the spread of MRSA in the NICU. This plan effectively tracks all infection prevention activities, implementation strategies, and progress toward process improvements and includes:		2/26/25

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A 283	Continued From page 35 surveyors. Review of facility policy, titled "Infection Prevention and Control Plan", effective June 2024, revealed "...the functions of the Infection Prevention and Control Committee are to review and analyze factors which affect the healthcare associated infection rates in an effort to prevent and control healthcare associated infections ... Is responsible for the monitoring of findings from patient care quality assessment activities that relate to infection prevention and control, and reviews pertinent findings from other hospital committees.....Permanent records of activities relating the infection prevention and control shall be maintained ... The Infection Preventionists (IP) carry out approved activities of the infection prevention and control program including coordinating surveillance activities, observation, identification, intervention, evaluation, education and consultationSurveillance PlanProvision of meaningful data regarding the levels of healthcare associated infection within the hospital to allow for continuous improvement in the quality of care of the patientAnnually and as needed, identification of risks for the acquisition and transmission of infectious agents are analyzed based on the scope of the program and surveillance data....Based on risks, priorities and goals of prevention of healthcare associated infections are determined .. Strategies are implemented to achieve these goals.... " Review of facility document, titled "NICU Quality Performance Report Q3 2024", undated, revealed there were no NICU Performance Improvement Projects or data related to the MRSA outbreak in the NICU.	A 747	- Denominator every other week improvements. Responsible Leader: CMO <u>SUBJECT OF DEFICIENCY:</u> A 749 Failed to consistently implement methods for preventing and controlling the transmission of infections within the hospital. Education Education was provided to currently working eligible/targeted staff and/or providers using multiple mechanisms. These mechanisms included email, HealthStream modules, huddles, one on one education, skills fairs, and/or huddle cards used by department leaders with the assistance of the NICU educator. Competency is validated prior to or on start of first shift for all staff, including float staff. Staff who have not completed the required education, on paid time off (PTO), and leave of absence will complete education prior to and/or during their first shift returning back to work. All Education has been incorporated into new hire and contract staff education. Education will be provided to 100% of the clinical staff (regardless of prior education or background) that provide care to the NICU population initially as well as annually to include: • Safe handling of fragile babies • NICU Fragile Bone Protocol • Patient safety during lab draws and other procedures		4/15/25

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A 283	Continued From page 36 Review of the facility document, titled "Infection Prevention & Control Risk and Hazard Vulnerability Assessment", undated, revealed neonates were at high risk for the likelihood of possible death or injury related to device related infections, resistant microbes, surgical site infections, and extrinsic infections (sources of infection such as transmission from healthcare workers, foodborne illness, contaminated surfaces, and equipment). The assessment did not include implementation of infection prevention or control activities to mitigate risk other than screening NICU patients for MRSA. Review of facility document, titled "Quality Construct", dated November 15, 2024, revealed a Metric/Group labeled MRSA, with action "End MRSA outbreak in NICU" with no additional detail related to how this would be accomplished. Clinical risk points included the unit had been terminally cleaned and there had been five new infections. There was no further information related to tracking, trending or analyzing data related to the continued outbreak of MRSA in the NICU or implementation of interventions. Interview on January 23, 2025 at 1:33 PM, EMP22 indicated there had been a MRSA outbreak in the NICU for over three years, and the facility had not determined the cause. EMP 22 further indicated they lead the IP Committee, but did not work on quality improvement projects related to the MRSA outbreak in the NICU. No new strategies had been implemented to mitigate the MRSA outbreak in the NICU in over a year, and they had not measured, analyzed or tracked quality indicators related to the NICU MRSA		• Best practices for avoiding unnecessary trauma and injury • Fall prevention including crib safety • Oral and nasopharyngeal suctioning of neonates (nursing and respiratory therapists only) • Abuse and neglect • Rapid debrief process • NICU infant security policy (includes visitor validation) • Obtaining orders for wound care • Documentation of skin assessments • Hand Hygiene • Donning and Doffing of proper PPE and proper isolation precaution • Travelers "float staff" or staff who work in the NICU will receive this education during their first shift Corrective Actions: To ensure that the hospital consistently employs effective methods for preventing and controlling infections in the NICU, the team collaborated with infection prevention specialists, nursing leadership, and executive leadership implemented the following measures: • Increased audits of hand hygiene and personal protective equipment (PPE) usage when a neonate is placed in isolation. • Updated signage for proper hand hygiene procedures at the NICU entrance.	4/15/25 2/25/25	

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A 283	Continued From page 37 outbreak.		Installed new hand hygiene timers at the entrances of the NICU	1/25/25	
	Interview on January 24, 2025 at approximately 1 PM, with EMP 80 indicated there were no QAPI performance improvement activities being tracked, analyzed or measured related to the MRSA outbreak in the NICU.		Provided equipment techs with an in-service training on isolette cleaning procedures	1/17/25	
A 286	PATIENT SAFETY CFR(s): 482.21(a), (c)(2), (e)(3)		Implemented a cleaning competency assessment for isolette equipment	2/17/25	
	(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.		Installed OneSource on the computer in the cleaning room (OneSource is an online resource for instruction manuals)	3/24/25	
	(2) The hospital must measure, analyze, and track ...adverse patient events ...		Updated the room cleaning responsibilities checklist for both EVS and Nursing	3/24/25	
	(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.		Completed EVS staff validations for room cleanings	1/31/25	
	(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: ...		Conducted supervisor validations of room cleaning logs to ensure oversight.	1/31/25	
	(3) That clear expectations for safety are established.		Provided ongoing education for EVS staff	1/31/25	
	This STANDARD is not met as evidenced by: Based on review of medical records (MR), review of facility policies and documents and		Monitoring: <i>Hand Hygiene and isolation precautions</i> Observations of hand hygiene will be done throughout the NICU with 100% remediation of deviation from practice Numerator = # of hand hygiene observations done correctly Denominator = 50/month		

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A 286	Continued From page 38 interview with staff (EMP), it was determined that the hospital failed to have an effective and on-going Quality Assurance and Performance Improvement (QAPI) program that adequately tracked and analyzed events, including injuries of unknown origin, to identify patterns and causes so that appropriate measures could be implemented to reduce reoccurrence and improve quality of services and patient safety. In addition, the hospital failed to monitor and ensure the consistent implementation, and adherence to, preventative actions to mitigate the risk of events resulting in harm to patients. Findings include: On January 15, 2025, a request was made to the facility for a list of all incidents, to include Adverse Events, Serious Events, and any other reported occurrences in the facility's Neonatal Intensive Care Unit (NICU) from May 1, 2024, to January 15, 2025. Later that day, upon receipt of the report, EMP4 indicated that this was the entire list of adverse events and that there were no "Serious Events" reported during the requested timeframe. Review of facility policy, "Facility Event and Close Call Reporting," origination January 1997, revised April 2017 and last reviewed August 2024, revealed " ... PURPOSE: This policy is intended to ensure the mitigation of risk and improve the quality of services by outlining the processes in which events and close calls are reported and factual and investigative information is preserved. POLICY: ... Facility managers to whom the notification is referred have 15 business days to complete and document their	A749	Isolation rounds will be conducted regularly to ensure that caregivers of neonates in isolation are monitored for the appropriate use of isolation PPE. Audit will be conducted for three months with 100% remediation of deviation from practice. Numerator =number of rounds in which PPE was appropriate. The denominator = 3 isolation rounds/week. <i>Isolette Cleaning</i> In addition to the competencies that have been developed and the education provided, the team will monitor the cleaning of isolettes through ATP testing, with the oversight of the Infection Prevention team. This testing will occur once the isolettes have been cleaned and are ready for use. 100% of ATP testing will pass with remediation of any failed tests. -Numerator: Number of ATP tests on isolettes that have passed -Denominator: 20 ATP tests/month <i>Room Cleaning Logs</i> To ensure validation of room cleaning logs, an audit of 30 cleaning logs will be performed monthly for three months with 100% remediation of outliers	2/26/25 3/1/25 4/1/25	

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A 286	Continued From page 40 code selected is accurate. 3. The manager will confirm that appropriate review/investigation has been conducted and has resulted in accurate primary cause and specific cause selection. 4. The manager will confirm appropriate disposition based on notification type, and federal, state, and local reporting requirements. 5. Patient events that have been declared as PSWP will be handled pursuant to the Hospital PSO Policy and Procedure. IV. Process for Investigation and Analysis of Incident Trends A. Standard summary reports are available to aggregate data and analyze trends and patterns. Each of the reports utilize generic search criteria screen and can be used with any of the notification types. ... B. These reports are utilized for risk identification, performance improvement, and committee reporting as appropriate. C. Data should be utilized to assist with the development of facility educational and improvement initiatives. ... VIII. Educational Requirements for Appropriate Reporting 1. Education should include that the event itself shall be factually and accurately documented in the patient's medical record; ... DEFINITIONS: Event: A discrete, auditable and clearly defined occurrence (NQF) Adverse Event: Any deviation from usual medical care that causes an injury to the patient or poses a risk of harm. Events include errors, preventable adverse events, and hazards. An incident in which a patient is harmed (WHO). An injury or the risk thereof caused by medical management rather than the underlying disease. An untoward, undesirable, and usually unanticipated occurrence. An act of commission or omission arising during clinical care which causes physical or psychological injury to a patient regardless of severity.....Error: Failure of a planned action to	A750	ATP testing of rooms after patient discharge non-compliance immediately addressed Monitoring: <i>Track quality indicators related to MRSA</i> The NICU MRSA task force will review the measures every two weeks to assess ongoing compliance and progress toward the goals outlined in the NICU Infection Prevention scorecard including compliance with hand hygiene, bare below the elbows and ATP testing of equipment with 100% immediate remediation of non-compliance. If the team identifies ineffective actions or an increase in MRSA-positive patients, they will conduct a thorough analysis to determine the root cause and implement additional action items or necessary corrections. The NICU Infection Prevention scorecard will be reviewed monthly by the Quality Council/Patient Safety team and quarterly by Infection Prevention to monitor compliance with process improvements. - Numerator: Number of scorecards reviewed every two weeks that show compliance with the three key performance indicators - Denominator every other week Responsible Leader: CNO	2/26/25	

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A 286	Continued From page 41 be completed as intended or use of wrong plan to achieve an aim; accumulation of errors result in accidents. Errors can include problems in practice, products, procedures, and systems. Close Call: Events or situations that could have resulted in an adverse event (accident, injury, or illness), but did not ... Occurrence: The action, fact, or instance of something that happens synonymous with an event Incident: Synonymous with occurrence or event. ... Notification: Notification is the act of or the method of informing those who need to know about an occurrence or event. It is the act of officially communicating or documenting the occurrence or event..... Harm: Impairment of structure or function of the body and/or deleterious effects arising there from. Harm includes disease, injury, suffering, disability, and death. Harm can be temporary or permanent impairment requiring intervention. Sentinel event: a sentinel event is a patient safety event (not primarily related to the natural course of the patient's illness or underlying condition) that reaches the patient and results in any of the following: Death, Permanent harm, Severe temporary harm Review of facility policy, "Serious Safety Events (SSE) (CSG.SSE.001)," origination January 2018, revised April 2024, revealed "SCOPE: This Policy applies to all Company affiliated facilities including, but not limited to, hospitals Specifically, this Policy is applicable to wherever patient care services are provided. MISSION: Above all else, we are committed to care and improvement of human life. PURPOSE: This Policy details a patient-focused approach to Serious Safety Events (SSE) that emphasizes			A770	<u>SUBJECT OF DEFICIENCY:</u> Governing body failed to ensure the infection prevention activities included monitoring and tracking of strategies implemented to control the spread of MRSA in the NICU. <u>Corrective Actions:</u> The highly engaged governing body will provide active and continual oversight by reviewing the infection prevention audit scorecard to have complete visibility to infection prevention activities and monitoring improvements <u>Monitoring</u> All ongoing actions, monitoring activities and results will be reported monthly to the Quality Council/Patient Safety and all other appropriate committees and the MEC/BOT. If the team identifies significant variations in the POC the MEC/BOT will be informed as soon as possible and will create an appropriate course of action. This reporting structure will be maintained for four months and continue as indicated to maintain compliance. <u>Responsible Leader:</u> CMO		4/15/25

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A 286	Continued From page 42 early identification, timely disclosure, and/or apology to the patient and/or Patient's Representative/Family and/or Support Person, and transparent communication across the HCA enterprise to assure learnings and care improvement are shared. Specifically, the Policy exists: To establish guidelines for response to patient harm events in a timely, thorough, fair and impartial manner through consistent investigation of events To support full event disclosure, through prompt, transparent and compassionate communication with the patient and/or Patient's Representative/Family and/or Support person because it is the right thing to do. To focus attention of the local Facility and the entire enterprise on understanding of the factors that have contributed to the SSE and, when necessary, on improving and changing culture, systems and/or processes to reduce the probability of such event being repeated in the future. To increase enterprise knowledge about patient safety events, contributing factors and strategies for prevention through identification and trending of local events and utilizing the learning across the enterprise to improve patient safety. To maintain confidence among clinicians and staff that above all else the Facility is committed to the care and improvement of human life and that patient safety is a priority of the Facility in all situations. To support process alignment with patient safety organizations (PSOs), regulatory agencies, including by not limited to ... CMS, TJC.....and state agencies, related to the identification, investigation and improvement activities conducted in furtherance of SSE prevention. POLICY:..... The Facility's board of trustees/governing body (or its equivalent) is ultimately responsible for the				

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A 286	Continued From page 43 quality and safety of the Facility. The Facility CEO or Administrator is responsible to the board of trustees/governing body for the Facility's response to a SSE..... The Patient Focus First Response Team will be activated to investigate and report events.....This process will be triggered in a timely manner even when a cause for the event is not yet known..... A thorough serious event analysis (SEA) will occur in response to all SSEs..... The Team will see the event through conclusion and implementation of the action plan. Ideally, the individuals selected to participate in the Patient Focus First Response Team will have advanced education in the management of SSEs..... Patient Safety Event: An event, incident, or condition that could have resulted or did result in harm to the patient. ... Sentinel Event: A Patient Safety Event (not primarily related to the natural course of the patient's illness or underlying condition) that reaches a patient and results in death, permanent harm, or severe harm..... Serious Safety Event or SSE: A Patient Safety Event (not primarily related to the natural course of the patient's illness or underlying condition) that reaches the patient and may result in any of the following: Death, Permanent harm Severe temporary harm, or risk thereof, Severe temporary harm is critical, potentially life-threatening harm lasting for a limited time with no permanent residual, but requires transfer to higher level of care/monitoring for a prolonged period of time, transfer to a higher level of care for a life-threatening condition, or additional major surgery, procedure, or treatment to resolve the condition. PROCEDURE: SSEs will be identified, evaluated and addressed as follows: F- FOCUS- FIRST ON CARE OF THE PATIENT				

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A 286	Continued From page 44 I- IDENTIFY SERIOUS SAFETY EVENTS R- RESPOND ACTIVATE THE PATIENT FIRST RESPONSE TEAM S- SHARE EVENT INFORMATION THROUGH DISCLOSURE T- TRANSFORM THROUGH EVENT ANALYSIS AND SHARED LEARNING ...In consultation with the Patient Focus First Response Team, the Department Manager (where the event occurred) should ensure that the initial event report in the occurrence reporting system by the end of the shift that the event was identified or no later than 24 hours after the event was identified. ... TRANSFORM THROUGH EVENT ALAYSIS AND SHARED LEARNING: A comprehensive systematic analysis into the event should be initiated as soon as possible.....This process should result in the identification of the causal and contributory factors and underlying variation in performance that may have contributed to the event. An effective Serious Event Analysis or (SEA) should provide a rich source of information about improving patient safety, allowing the Facility to learn from the event. From the event analysis, an action plan is formulated. Whenever possible the action plan will be developed based on evidence-based clinical processes with timelines for implementation. Indicators to measure evidence of success will be identified. ... Ideally the improvement process over time will move the Facility from short-term, isolated performance improvements to sustained, reliable, Facility-wide, and evidence-based improvements in patient care. Accountability for monitoring implementation and outcomes of the action plan will be assigned along with identified committee oversight and a committee reporting schedule. Within 45 business days of identification of the event the finalized action plan is to be submitted				

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A 286	Continued From page 45 to the DVPQ (Division Vice President- President of Quality or the PSG- Vice President of Quality) and may be submitted voluntarily to the Patient Safety Organization (PSO) by provider members. If the DVPQ is concerned that an effective action plan has not been formulated, discussion with the Facility leadership and their division leaders will occur. The processes identified above are intended to result in immediate improvement in response to a Serious Safety Event and result in short- and long-term improvements in the monitoring and reporting of events..... Although SSEs are very unfortunate, each event provides the occasion for intensive investigation and the opportunity to improve process involved in the event..... The goal of an effective SSE Policy is to stimulate clinicians and facilities to develop clear informed and effective processes for managing, and preventing where possible, patient harm events.". Review of facility document, "NICU Occurrence Report," from May 1, 2024, to January 15, 2025, revealed that there were 135 events reported in the NICU. The document did not contain or annotate any events as abuse or under investigation to rule out abuse. There was limited and incomplete documentation describing the events, actions taken by the facility related to the event, as well as the facility's "Investigative Methods" into the events. Six reports of the 135 reported events involved reports of fractures and identified areas of swelling on five patients (MR1, MR2, MR11, MR12, MR44). They were categorized under "Provision of Care" with a category sub-type of "Injury- Not Otherwise Specified" but four of the six reported events did not contain the "Level of Harm", whereas two of				

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A 286	Continued From page 46 the reported events were categorized as "Harm-Required Intervention." In addition, the report indicated that one patient (MR46) had a "burn", and it was noted to be "sizeable abrasions to both lower legs" "on the back of the calf area", "Harm- required intervention" and the actions taken by the facility "Supply Evaluation Purchase" and "Investigative Methods" were blank. Interview on January 15, 2025, at 3:20 PM, with EMP4 indicated that the facility was unable to provide information regarding their investigation into these reportable events because the events are reported to the PSO (Patient Safety Organization) and are considered Patient Safety Work Product (PSWP). EMP4 indicated that the facility has its' own PSO and that it is owned by the entity that owns the facility. Review of an email provided by EMP4, from the Assistant Vice President, HCA Healthcare Patient Safety Organization, dated January 15, 2024, at 4:45 PM, revealed "Any and all events reported into [name of reporting platform], the standard patient safety event reporting platform for all HCA Healthcare hospitals, are automatically reported to HCA Healthcare Patient Safety Organization (PSO) in real time. The HCA Healthcare PSO team is actively involved in reviewing reported events and collaborating with and providing feedback to hospitals to address reported events." EMP4 indicated that all events since June 1, 2022, were automatically reported to the PSO and are considered PSWP. On January 16, 2025, the facility was asked to provide evidence to demonstrate that the facility				

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A 286	Continued From page 47 analyzed these adverse patient events and developed and implemented appropriate preventive actions to prevent reoccurrence. At 2:40 PM, with EMP80, EMP80 displayed a revised "NICU Occurrence Report" on their computer. The revised report still contained limited information regarding the facility's analysis to determine the cause of the events and actions taken by the facility to prevent reoccurrence. Often "Coaching" was documented as the "Action Taken" without any other details. EMP80 indicated that sometimes staff will clarify the specific "Coaching" actions but other times it is not defined or clarified. EMP80 confirmed that when it is not clarified then it is unknown as to what specific actions were initiated or discussed to mitigate reoccurrence of the event and if those actions are appropriate to mitigate reoccurrence of the event. Interview on January 17, 2025, at 9:04 AM, with EMP4, indicated that the facility performs Root Cause Analysis (RCA) for events categorized as a Serious Safety Events (SSEs) but other events outside this category will not have an RCA. EMP4 was asked again if there were any Serious Events reported in the NICU during the requested timeframe and EMP4 again indicated that the facility did not have any Serious Events in the NICU from May 2024 to Present and that their corporate office reviewed the "NICU Occurrence Report" to check for any "misclassifications." Interview on January 17, 2025, at 10:55 AM, with EMP4, revealed that in November 2024, date unknown, the facility's PSO informed EMP4 that "Coaching" needed to be further clarified when it is utilized as a facility				

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A 286	Continued From page 48 action to prevent reoccurrence in response to an event. EMP4 indicated that their reporting system was updated with a free text box where additional comments could be added to document the specific actions as it relates to "Coaching". The facility has been working with the PSO since 2022. On January 17, 2025, EMP80, provided another revised "NICU Occurrence Report" for review. This report contained additional information but there appeared to still be inconsistent and/or incomplete documentation demonstrating thorough analysis of each event to determine the cause and prevention actions. Further review of the report revealed that an occurrence report was completed related to a patient sustaining a burn due to a warming mattress. It was indicated that the facility removed the mattress. On January 21, 2025, at 2:21 PM, EMP5 indicated that an occurrence report was submitted for MR46 after the patient was found with an excoriated area to the back of their legs. EMP5 indicated that it was hard to tell what could have caused it, but it was thought that it was from the thermal mattress. As a result, EMP5 indicated that they submitted a report to the FDA (U.S. Food and Drug Administration) to report an injury due to the mattress. Review of MR46 revealed that on October 10, 2024, a physician documented "suspect contact burn/irritation from uncovered chemical warming mattress edge at admission as likely cause." On October 13, 2024, a physician documented "irritation also may possibly be due to chaffing from rubbing legs across the soft fabric				

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A 286	Continued From page 49 positioner." Interview on January 21, 2025, with EMP14 indicated that it was initially thought the wounds were from the thermal mattress, but the patient was only on the mattress for a few minutes and the wounds did not appear until several days after contact with the mattress. It was later noted that the patient kicks their legs frequently against the positioning device, so it was determined that friction from the patient kicking their legs against the positioning was likely the cause of the wounds, and not a burn from the mattress. On January 22, 2025, at 2:00 PM, a meeting was held with EMP1, EMP3, EMP4, EMP5 and EMP80 to discuss their Quality Assurance and Performance Improvement (QAPI) Program. Selected events from the facility's "NICU Occurrence Report" were reviewed during the meeting to discuss how the facility is classifying/categorizing, trending, analyzing and investigating events, and developing appropriate prevention measures to prevent reoccurrences. Review of the event involving MR46 revealed that the facility, through their analysis, classified the injury as a "burn" attributing the injury to a warming mattress. However, during the survey, interview with facility staff working in the NICU and review of the patient's medical record, revealed that the injury was attributable to friction caused by the patient kicking their legs against the positioning device. The evidence provided from the facility of their analysis into the cause of the injury did not include friction as a possible cause of the injury, even though it was documented as a possible cause in the patient's medical record. This information was provided to the facility during the meeting. After the meeting				

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A 286	Continued From page 50 and discussion of this finding with the facility, EMP4 provided a report on January 24, 2025, that contained the investigation status (ex. "closed", "under review", "action plan underway", etc.) for each of the reported events contained on the "NICU Occurrence Report". Under the "Next Steps" section of the report it indicated that the event report for MR46 was "closed", and "Next Steps" stated "identified as friction abrasion from review. Eliminated other causes." EMP1 and EMP80 was asked to provided clarification as to when did the facility determine that the injury was caused by friction and not the warming mattress, as it appeared that this information was added as a cause after it was brought to the facility's attention during the meeting on January 22, 2025. No response was provided. The facility failed to complete a thorough analysis into this event to determine the true cause of the injury so that appropriate preventive actions could be implemented to prevent reoccurrence. Further review of the facility's reporting system revealed an inability to categorize events as abuse or suspicion of abuse. In addition, the facility does not track injuries of unknown origin. In 2023 there were four patients, in the facility's NICU, identified with fractures of unknown origin. In response, the facility installed security cameras in all the patient rooms in NICU. In addition, the facility implemented daily "muscular-skeletal head-to-toe assessments" of all patients in the NICU which was to be lead and reviewed by the neonatologist to look for any "suspected signs of abuse." The action plan indicated that " ... If any suspected signs of abuse are identified, the neonatologist calls the				

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A 286	Continued From page 51 CMO [Chief Medical Officer] immediately to make [them] aware." Review of the facility's "Abuse and Neglect Education" revealed that two Neonatologists (NEO56 and NEO59) had no abuse trainings on file and the other Neonatologists received trainings on: NEO13- December 4, 2024, NEO52- September 19, 2024, NEO53- December 4, 2024, NEO55- September 25, 2024, NEO57- November 23, 2024, and NEO58- December 4, 2024. Interview with EMP1 on January 24, 2025, indicated that the facility is not responsible for training the Neonatologists on abuse as they are contract staff (this means that they provide services on behalf of the facility, at the facility, under an agreement with the facility) and are not considered facility employees. However, as per the facility's plan to prevent reoccurrence of abuse to the patients of the NICU, the Neontologist were responsible for performing assessments to identify signs of abuse. On November 21, 2024, an x-ray revealed a fractured humerus (long bone in upper arm) on MR2. On November 22, 2024, MR1 was found to have swelling in the left thigh and a subsequent x-ray revealed a "impacted distal left femoral metaphyseal fracture [broken bone in the lower part of the thigh- caused when one broken end of the bone is driven into the other bone] with some evidence of healing." On November 25, 2024, at 10:57 AM, EMP1 indicated that they "reinstated weekly muscular-skeletal head-to-toe assessments", on November 22, 2024- after finding fractures on MR1 and MR2. Previously, in response to the fractures of unknown origin in 2023, the facility implemented "muscular-skeletal head-to-toe assessments" to be completed						

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A 286	Continued From page 52 "daily." EMP1 indicated that the "muscular-skeletal head-to-toe assessments" stopped sometime in "late July or early August 2024." Review of "Board of Trustees" meeting minutes, dated November 26, 2024, indicated that the facility's "external counsel" began an investigation. Further review of the meeting minutes indicated that the facility reported the events to Child Protective Services (CPS) and that CPS instructed the facility to review video footage of MR1 and to preserve the footage. In addition, it was indicated that CPS instructed the facility to suspend two nurses, who were previously suspended in response to CPS's instruction and investigation of the fractures of unknown origin in 2023. Mandated reporters are required to report events of abuse- including neglect, or events that are suspicious for abuse- including neglect to Child Protective Services. During a meeting on January 7, 2025, at 1:00 PM, OTH63, "external counsel", indicated that their investigations are focused on legal responsibilities, risks and reporting and EMP18 indicated that the hospital was performing an internal investigation to determine the cause of the injuries, but the facility may not be able to share information as the investigation is contained under Patient Safety Work Product. Review of MR1 revealed that the patient was admitted to the hospital's NICU in June 2024, for prematurity and respiratory distress. Review of MR1's "Nursing Flow Sheet Skin Assessment," dated July 21, 2024, at 3 AM, revealed bruising to the patient's shin on their right leg. Review of MR1's "NICU Shift Assessment," dated July 21,				

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A 286	Continued From page 53 2024, at 9 AM, revealed right lower extremity bruising on two sites on the shin and left lower extremity bruising, the length of the shin and back of calf. Review of the facility's "NICU Occurrence Report" revealed that this event was not reported nor was their documented evidence that injury of unknown origin was reported or investigated to determine the cause, including ruling out or identifying possible abuse and or neglect. In addition, review of MR1's "OT [Occupational Therapy] Treatment Notes" from November 11, 2024, through November 25, 2024, revealed that the patient received treatment from various occupational therapists (EMP31, EMP32, EMP33 and EMP37). Occupational Therapists documented the following: "Infant unfortunately with state & autonomic stress on entry, crying & with grunting followed by multiple episodes of emesis, swaddle bath held today due to significant distress on entry"; "Movement/tone-generalized hypertonicity w/ resistance to gentle ROM [range of motion] ... Infant arousing w/ painful GI pain from flatulence so performing abdominal massage and LE [lower extremity]" . On November 14, 2024, EMP37 documented "increased sensitivity noted w/ diapering/ BLE AAROM/PROM [bilateral lower extremities active assistance range of motion/passive range of motion] throughout undressing/diapering. 10 min for therapeutic holding and support for developmental flexion/posterior pelvic tilting w/ supported" . After November 14, 2024, "Treatment Notes" indicated that the patient was "very irritable during cares and noted to be sweaty"; "inconsolable crying during cares; transition to				

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A 286	Continued From page 54 crib to complete diaper change, become poorly consolable.....Gas noted intermittently during session, always accompanied by arching & crying. ... Soothed with changes in position ... Infant with variable tolerance throughout session, appearing to be quite uncomfortable"; "infant crying vigorously during caregiving.improved state regulation w/ pacifier and warmth of swaddle bath. Performed several abdominal massage strokes and gentle LE ROM [lower extremity range of motion]..... Movement/tone - abnormal benefits from frequent LE ROM ex. to improve GI mobility Infant experiencing GI discomfort related to flatulence w/ painful crying". On November 21, 2024, EMP31 documented "infant crying vigorously during caregiving." On November 25, 2024, EMP32 documented "infant found to have closed torus fx of distal end of L femur [an incomplete fracture of the lower part of the thigh bone] and closed fx of R tibia/fibula [fracture of the bones in the lower leg below the knee] both healing est [estimated occurrence of fractures] 2-6 weeks". The facility failed to provide evidence demonstrating that they analyzed the cause of this event, to include reviewing the patient's medical record which contained OT notes documenting the patient's crying and increased sensitivity during care and diapering. In addition, bruising of unknown origin was found on the patient in July 2024 and there was no evidence of investigation into that injury. There were two nurses who were suspended previously in 2023, as a result of the fractures found on patients in 2023, but they did not return back to work at the facility until September 17, 2024, which is after July 21, 2024, when MR1 was initially found with				

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A 286	Continued From page 55 bruising of unknown origin. On December 16, 2024, MR11 was found to have multiple fractures with a "concern for nonaccidental trauma." On December 18, 2024, EMP18 indicated that CPS instructed the facility to implement an "observer program" which required two staff be present when with a patient in the NICU. On December 23, 2024, MR12 was found with fractures after receiving a skeletal x-ray. It was noted that EMP4 did not report these events through the facility's event reporting system until January 8, 2025. No documented evidence was provided demonstrating that the facility conducted an analysis and there was no documented evidence regarding the progress of the investigation of the two fractures of unknown origin. On January 9, 2025, the facility received a report indicating that MR44 sustained fractures of unknown origin in 2022. Review of MR44 revealed that from July 19, 2022, through July 31, 2022, nursing documented that the patient had "bruising" with no additional details or location noted. On August 2, 2022, nursing noted "scattered bruising to trunk and extremities." On August 3, 2022, nursing documented that the provider was made aware of the bruising. On August 29, 2022, it was discovered MR44 had a fracture of the right humerus and on August 30, 2022, "healing fracture proximal third left humerus." Further review of MR44 revealed that one of the employees, suspended by the facility at the request of CPS in 2023 and again in 2024, had provided care to MR44 in 2022. Interview on January 22, 2025, at 3:20 PM,				

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A 286	Continued From page 56 EMP80 indicated that the event involving MR44 was not investigated or reported in 2022. EMP1 indicated that they notified CPS and performed an "initial medical record review" and EMP4 indicated that they looked through "some of the chart." EMP80 indicated that their legal counsel advised them to "pause" their investigation while the organization's leadership investigates. On January 24, 2025, at 10:14 AM, EMP80 indicated that this case will be reviewed through the "Provider Practice Evaluation Committee" and will make a recommendation for referral to an external radiologist to review this case. EMP80 indicated that the facility is not treating nor investigating this case as suspicion for abuse, but indicated that their external counsel, OTH63, notified CPS because it had to do with fractures of unknown origin. EMP4 indicated that if an event results in harm that they will review the patient's medical record. Interview on January 24, 2025, at 10:35 AM, with EMP1 and EMP4, EMP4 stated that they were not trained to perform investigations to rule out abuse- including neglect. They indicated that would be considered a "criminal" investigation which CPS and the police would handle. EMP4 indicated that suspicion of abuse goes outside "the patient safety realm" and that other people in the organization would "carry that suspicion of abuse investigation forward- security, HR [human resources], administration." The facility was asked to further explain their process for investigating- which would include analyzing reported injuries of unknown origin to determine the cause, including contributing factors. EMP4 indicated that they follow an "algorithm" to ensure				

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A 286	Continued From page 57 that notification is disseminated to the people who would "investigate." It starts with the leadership team and includes the medical staff. EMP80 indicated that it is a short time, "not days or weeks," to determine an event as suspicious for abuse. The hospital failed to provide evidence demonstrating daily assessments continued, as part of their ongoing action plan to prevent fractures of unknown origin, to identify suspected signs of abuse, so as that immediate measures could be initiated to protect patients from harm, nor was there any evidence that discontinuing this intervention was discussed or approved by the QAPI, Medical Executive Committee or the Board of Trustees. In addition, the facility did not use the cameras, installed as part of their ongoing action plan to address the fractures of unknown origin from 2023, to facilitate continued monitoring of the patients in the NICU to identify incidents of possible abuse occurring during care of the patient. As of January 24, 2025, a complete analysis had yet to be completed to determine the cause of the fractures. Further review of the "NICU Occurrence Report" revealed two reported patient deaths (MR13, MR30). The event for MR13 was documented as "Provision of Care" with a sub-type of "Unanticipated Change in Condition/Event" indicating that there was a "sudden infant code" and with "Death" identified as the "Level of Harm," and the event for MR30 was categorized under "Provision of Care" sub-type "Unexpected Death," indicating "infant death overnight bowel perforation" but the "Level of Harm" for this event was documented as "No Harm." EMP1				

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A 286	Continued From page 58 and EMP4 indicated that not all patient deaths are reviewed in the monthly "Mortality Committee" meeting. Deaths are first screened by the "Mortality Screening Committee" on a weekly basis to determine if they rise to the level for review during the monthly "Mortality Committee" meeting. Review of "Mortality" documents for MR13 and MR30 indicated that the "screening committee" categorized these patients' deaths as "Certainly not preventable." Interview on January 24, 2025, at 4:57 PM, with EMP1 confirmed that there was no documented evidence regarding the analysis of these two patient deaths nor how the facility arrived at the determination that the deaths were not preventable.				
A 385	NURSING SERVICES CFR(s): 482.23 The hospital must have an organized nursing service that provides 24-hour nursing services. The nursing services must be furnished or supervised by a registered nurse. This CONDITION is not met as evidenced by: Based on observations, review of videos, review of medical records (MR), review of documents and interviews with staff (EMP) it was determined the facility failed to implement a well-organized nursing service as evidence by: failure to ensure that nurses from another hospital had onboarding training or competencies prior to performing their shifts (A0397); failure to ensure nurses adhered to policies for fall prevention, wound care and expired formula, and failed to accurately document skin assessments and notify physician of abnormal assessments (A0398).				

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A 385	Continued From page 59 Cross Reference: §482.23(b)(5) Nursing Services: Patient Care Assignments §482.23(b)(6) Nursing Services: Supervision of Contract Staff				
A 397	PATIENT CARE ASSIGNMENTS CFR(s): 482.23(b)(5) A registered nurse must assign the nursing care of each patient to other nursing personnel in accordance with the patient's needs and the specialized qualifications and competence of the nursing staff available. This STANDARD is not met as evidenced by: Based on review of facility documents and interviews with staff (EMP), it was determined that the facility failed to ensure that nurses from another hospital had onboarding training or competencies prior to performing their shifts in the NICU (OTH69, OTH70, OTH71, OTH72, OTH73, OTH 74, OTH75, OTH76, and OTH77). Findings: A review of the nursing schedule for the NICU, dated September 2024 and November 2024, revealed that nine nurses (OTH69, OTH70, OTH71, OTH72, OTH73, OTH 74, OTH75, OTH76, and OTH77) employed at another hospital worked in the NICU during this time-period. Interview on December 26, 2024 at 4:00 PM, EMP1 indicated the hospital did not have a policy or procedure related to staff who were employed at another hospital working in the NICU.				

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A 397	Continued From page 60 On December 30, 2024, evidence of onboarding, orientation, and training for the nine nurses (OTH69, OTH70, OTH71, OTH72, OTH73, OTH74, OTH75, OTH76, and OTH77) was requested. EMP5 provided a document titled "Float Pool Cheat Sheet" on January 02, 2025, and indicated nurses from the other hospital were given this tip sheet to assist with care practices and documentation. EMP5 indicated there was no documentation of training, competencies, or onboarding to the NICU for the nurses prior to performing their shifts. EMP5 indicated that when the census is down at the other hospital, the NICU nurse manager at that hospital and EMP5 make the decision to float staff between hospitals. Interview on January 2, 2025, at 3:30 PM, EMP63 indicated the hospital had no documented evidence of orientation, onboarding, competencies, or training for OTH69, OTH70, OTH71, OTH72, OTH73, OTH74, OTH75, OTH76, or OTH77, prior to performing their shifts. Interview on January 2, 2025, at 4:30 PM, EMP2 indicated that nurses were floated between the organization's hospitals as needed and confirmed the hospital had no documented nursing competencies for these nurses (OTH69, OTH70, OTH71, OTH72, OTH73, OTH74, OTH75, OTH76, and OTH77) prior to performing their shifts.				
A 398	SUPERVISION OF CONTRACT STAFF CFR(s): 482.23(b)(6) All licensed nurses who provide services in the hospital must adhere to the policies and				

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A 398	Continued From page 61 procedures of the hospital. The director of nursing service must provide for the adequate supervision and evaluation of all nursing personnel which occur within the responsibility of the nursing service, regardless of the mechanism through which those personnel are providing services (that is, hospital employee, contract, lease, other agreement, or volunteer). This STANDARD is not met as evidenced by: Based on observations, review of medical records (MR), review of documents and interviews with staff (EMP), the facility failed to ensure nursing staff: adhered to hospital policy related to fall prevention, safe handling practices, and nasal suctioning (MR1); accurately documented skin assessments and notified the physician of abnormal assessment findings (MR1, MR28, MR34, MR46); obtained a physician's order for wound care (MR46); completed daily checks for the NICU code cart (cart carrying medicine and equipment for use in emergency resuscitation) and defibrillator (device that applies an electric charge or current to the heart to restore a normal heartbeat); and removed expired dietary supplements and powdered formula from formula preparation rooms. Findings: Review of the facility document, titled "ICU Fragile Bone Protocol," dated July 3, 2024, indicated: "...Picking up and holding. Option 1: Holding at shoulder - Caregiver bends over supine [lying on back] lying infant so that caregiver's shoulder touches infant. Caregiver slides one open hand under infant's back and head and the other under infant's bottom.				

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A 398	Continued From page 62 Caregiver lifts the infant onto shoulder while straightening into upright position. Option 2: Cradling in arms. Caregiver places one hand with fingers wide apart under infant's head and body. Caregiver places other hand with fingers wide apart under infant's buttocks and back. Caregiver uses forearms to support the infant's limbs so limbs do not dangle. Caregiver leans close to infant and gently lifts infant to caregiver's chest. Do not lift infant from under arms. ..." Review of facility policy, titled "Newborn Fall Prevention Protocol," revised June 2023, revealed: ". All newborns are considered at risk for falls/drops and the following precautions are to implemented: 1. Keep warmer/crib rails raised unless directly providing care. ..." Review of facility policy, titled, "Suctioning Neonate: Oral, Nasopharyngeal," revised May 2016, revealed: "...Guidelines ...For nasal suctioning, place bulb gently but snugly into the nostril after suction is created..." Video review with EMP5 on January 02, 2025, at 9:07 AM, of EMP11 providing care to MR1 on November 10, 2024 and November 13, 2024. Video on November 10, 2024, at 11:45 AM, revealed EMP11 carrying carrying the infant face down against EMP11's forearm. At 3:43 PM, EMP11 was observed holding the infant in one hand without providing support for the infant's head and neck. At 3:45 PM, EMP11 quickly twists the infant's head with one hand while the infant is lying on their back in the open crib. EMP5 indicated an infant's head and neck should be supported at all times and the quick twisting motion performed to the infant's neck was not				

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A 398	Continued From page 63 appropriate handling of an infant. At 5:47 PM, the infant was observed in an open crib while EMP11 left the crib rail down and walked away from the infant to throw away a diaper. EMP11 then picked the infant up with one hand and held the infant in the air away from their body to place them in an infant swing. EMP5 indicated that staff should not be picking up the infant with one outstretched arm. EMP11 was observed multiple times during the video review walking away from the crib without putting the crib rail up while the infant was in the crib. On November 13, 2024, at 2:38 PM, EMP11 was observed on video using a flexible suction catheter to suction the infant's nose. EMP11 forcefully inserted the suction catheter into the infant's nostril and advanced the catheter deeply into the nostril. EMP5 indicated that EMP11 was using the incorrect type of suction device for the nose. EMP5 stated the type of suction device EMP11 was using was to be used on an intubated infant to clear secretions in the back of the throat and the infant was not intubated. EMP5 further indicated a "mushroom" type suction device (device with a special tip) should be used for nasal suction to prevent the suction catheter from being inserted too far into the infant's nose. At approximately 3:50 PM, EMP11 was observed using a positioning device to hold a pacifier in place in the infant's mouth in a way that the infant would be unable to remove the pacifier. EMP5 indicated no device should be used to keep a pacifier in an infant's mouth. Review of facility policy, titled "Assessment and Reassessment of Patients," revised January 2021, revealed that the physician should be made aware of abnormal assessment findings.				

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A 398	Continued From page 64 Review of facility document, titled "Skin Assessment and Care: Neonates and Infants," revised August 2024, revealed "Purpose Statement: To provide safe, consistent, effective and individualized skin care assessment and management in accordance with current research and evidence based protocols." The policy did not provide guidance on nursing assessment or documentation of abnormal skin assessments, bruising or abrasions. Review of facility nursing education document, titled "Newborn Assessment," undated, revealed "...Proper assessment leads to the early identification of actual or potential problems. Early identification of potential risk factors guides priority setting for the continued assessment and care. In turn this leads to better treatment and potentially a better outcome...." The section titled "Skin" included descriptions of common newborn skin conditions, however the education did not provide guidance on documentation of abnormal skin assessments, bruising or abrasions. Review of facility nursing education document, titled "Newborn Assessment," dated February 11, 2024, revealed ". Skin. Inspect- color, normal vs abnormal, transient, short term or long term...." The education did not provide guidance on documentation of abnormal skin assessments, bruising or abrasions. The facility did not provide documentation of education provided to nurses related to documentation of abnormal skin assessment findings, bruising or abrasions. Interview on January 17, 2024, at 10:39 AM, EMP91 indicated if a bruise is noted on a NICU baby, nurses should document the location, size,				

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A 398	Continued From page 65 and color, and notify the physician. EMP91 indicated subsequent documentation of bruising should include color, size, location and any changes. Interview on January 21, 2024, at 9:50 AM, EMP5 indicated if a NICU baby is found with bruising or other skin issues, the nurses should document the location, color, and size and notify the physician. Interview on January 21, 2025, at 2:12 PM, EMP8 indicated they teach NICU nurses skin assessment in a live class and also in an online module for skin care assessment. EMP5 indicated they would expect nurses to note the location of the skin issue, what it looked like, color, and size of the injury and document notification to the physician and any interventions done. EMP5 further indicated they would expect the nurses to notify the physician immediately upon discovery. Review of MR1 "Nursing Flow Sheet Skin Assessment," dated July 21, 2024, at 3 AM, revealed bruising to the shin on the right leg. There was no documentation found which described the size or color of the bruising, or notification to the physician. Review of MR1 "NICU Shift Assessment," dated July 21, 2024, at 9 AM, revealed bruising of two sites on the right shin and bruising of the left lower extremity, the length of shin and back of calf. There was no documentation found which described the color of the bruising, the size of the bruising on the right shin, or notification to the physician.				

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A 398	Continued From page 66 Review of MR46 "Nursing Shift Assessment," dated October 9, 2024, at 8:00 PM, revealed nursing documentation of an abrasion noted on the posterior left leg/calf. The medical record contained no documentation that the physician was notified of the new abrasion until October 10, 2024 at 12 PM. Review of MR34 nursing documentation, dated November 6, 2024, revealed abrasions and bruising on the lower extremities with no documentation of origin. There was no documentation of notification of the abrasions and bruising to the physician on November 6, 2024. Review of MR34 "NICU Shift Assessment," dated November 9, 2024, at 9 AM, revealed bruising to right shin and left elbow, and at 3 PM revealed bruises on right foot, left thigh and back. There was no documentation of color, size of bruising, or notification to the physician. Review of MR34 "NICU Shift Assessment," dated November 10, 2024, at 9 AM, and 9PM, revealed bruising to right shin, right ankle, left thigh, left elbow and back. There was no documentation of color, size of bruising or notification to the physician. Review of MR34 "NICU Shift Assessment," dated November 11, 2024, at 9AM, revealed bruising to right shin, left thigh and left arm, "bruising/abrasion" to right foot and ankle and left foot. There was no documentation of color, size of bruising or notification to the physician.				

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A 398	Continued From page 67 Review of MR34 "NICU Shift Assessment," dated November 12, 2024, at 9AM, revealed bruising on right shin, left thigh, left wrist, back and feet. There was no documentation of color, size of bruising or notification to the physician. Review of MR34 "NICU Shift Assessment," dated November 13, 2024, at 9 AM, revealed bruising on back of calves and at 3 PM bruising "inside groin and at front". There was no documentation of color or size of bruising or notification to the physician. Review of MR34 "NICU Shift Assessment," dated November 15, 2024, at 8 PM, revealed bruising in groin bilaterally, sides of abdomen and left wrist. There was no documentation of color, size of bruising or notification to the physician. Review of MR34 "NICU Shift Assessment," dated November 16, 2024, at 11 AM and 8 PM, revealed "large" bruising to bilateral groin. There was no documentation of color, size of bruising or notification to the physician. Review of MR34 "NICU Shift Assessment," dated November 17, 2024, at 8 AM and 8 PM, revealed bilateral bruising of the groin, "bigger on right side". There was no documentation of color, size of bruising or notification to the physician. Review of MR34 "NICU Shift Assessment," dated November 18, 2024, at 8 AM and 8 PM, revealed bilateral groin and mid scalp bruising. There was no documentation of color, size of bruising or notification to the physician. Review of MR34 "NICU Shift Assessment," dated				

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A 398	Continued From page 68 November 22, 2024, at 8 AM, revealed bruising on left labia majora. Nurses continued to document bruising on labia through December 9, 2024. There was no documentation of color, size of bruising or notification to the physician. An interview was requested with a NICU physician to determine expectations for nurse reporting abnormal skin assessments to physicians. On January 24, 2025, at 2:18 PM, EMP80 indicated the attorney representing the NICU physicians (neonatologists) refused to permit the surveyors to interview any NICU physician. Review of facility policy, titled "Golden Hour Protocol and Small Baby Bundle for Infants < (less than) 32 weeks and/or < 1500 grams," revised June 2020 revealed "... D. Thermoregulation. 1. Maintain isolette humidity per thermoregulation policy 4. Keep ports and doors of isolette closed. ... " Review of facility policy titled "Thermoregulation: Neonatal," revised September 2024, revealed "...Definitions: Neutral Thermal Environment (NTE) - The temperature which maintains the infant axillary temperatures between: 36.5 C (Celsius) - 37.5 C / 97.7 F (Fahrenheit) - 99.5 F for all infants ... Policy StatementsD. Regardless of heat source provided, efforts are made to maintain infant's temperature as close to 98.6 F (36.9 C) as possible. (Note: The normal axillary temperature for any one infant can range from 36.5 C - 37.5 C / 97.7 F - 99.5 F) F. Re-warming a Cold Infant: 1. Notify MD of all temperatures not within range... "				

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A 398	Continued From page 69 Review of MR28 "Neonatal Nurses Notes," dated November 4, 2024, at 8:00 AM, revealed that upon entry to the room the isolette portholes were open from the previous shift, the patient was "cold" with an axillary temperature of 97.5 degrees Fahrenheit and the feeding started closer to 8:45 AM due to the patient's low axillary temperature. Interview on January 16, 2025, at 1:01 PM, EMP14 indicated that the patient's axillary temperature should be between 97.7 to 99.5 degrees Fahrenheit, and a low temperature could cause decreased perfusion to the gut (reduced blood flow to the gut can lead to tissue damage, inflammation, and potential bacterial overgrowth), so the provider will hold the patient's feeding. EMP14 indicated that the portholes left open should be documented as an occurrence report. Review of MR46 nursing documentation, dated October 10, 2024, revealed the nurse applied a silicone dressing (a soft, flexible, non-stick dressing used to cover wounds) to bilateral calf wounds. Further review of nursing documentation revealed the dressings remained in place until October 23, 2024, 13 days. There was no evidence of a physician's order for wound care, type of dressing to be applied, or the frequency of dressing changes. There was no documented evidence the dressings were changed for 13 days, from October 10, 2024 to October 23, 2024. Interview on January 21, 2025, EMP46 indicated the silicone dressings should be changed every three days, but then later stated the dressings could be left in place for 14 days. EMP46 indicated a physician's order was not needed for the wound dressing and further information could be found in the hospital's skin				

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A 398	Continued From page 70 care protocol. On January 22, 2025, EMP3 indicated the hospital did not have a skin care protocol for the use of silicone dressings and there should be a physician's order documented in the chart dictating the type of dressing used and the frequency for changes. EMP3 confirmed there was no documentation of a physician's order for a silicone dressing in MR46's medical record. Review of facility policy, titled "Resuscitation Services - [brand name] Pediatric Code Cart," last revised January 2019, revealed "... Procedure: C. Code Cart and Defibrillator Checks. Code cart integrity checks will be performed every 24 hours by qualified staff. The staff member performing the check will document the checks on the Code Cart and Defibrillator Check Sheet ... The prior month's checklist is signed by the unit Director and stored on that unit. Department Leaders will review and sign the Code Cart and Defibrillator checks weekly for their areas to ensure all checks are being done... " Review of the facility documents titled "The [brand name] Adult/Pediatric Defibrillator Check," for defibrillator number 601587128, dated October 2024, November 2024, December 2024, and January 2025, revealed there was no documentation that the defibrillator was checked on December 8, 14, and 22, 2024, or on January 1 and 8, 2025. A statement on the bottom of each form revealed "Completed logs should be maintained in the Department and reviewed weekly by the Department Director." There was no documented evidence that the forms were reviewed by the department director weekly for				

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A 398	Continued From page 71 October 2024, November 2024, December 2024, and January 2025. Review of the facility documents, titled "The [brand name] Adult/Pediatric Defibrillator Check sheet," for defibrillator number 601587129, dated October 2024, November 2024, December 2024, and January 2025 revealed there was no documented evidence that the forms were reviewed by the department director weekly for October 2024, November 2024, December 2024, and January 2025. In addition, there was no documented evidence that the defibrillator was checked on December 8 and 14, 2024, and on January 1, 2025. Review of the facility documents, titled "Neonatal Code Cart Check Sheet," dated October 2024, November 2024, December 2024, and January 2025, revealed instructions "Code Cart check sheets will be reviewed by the Department Director weekly and signed below." There was no documented evidence that the forms were reviewed by the department director weekly for October 2024, November 2024, December 2024, and January 2025. There was no documentation that the code cart was checked on October 26 and 29, 2024, December 8 and 14, 2024, and January 1, 2025, for two code carts. One Neonatal Code Cart Check Sheet was dated with the month and year as October 2025. One Defibrillator Check sheet was dated with the month and year as October 2025 and contained no defibrillator identification number. One Defibrillator Check sheet revealed no documentation of the Unit, Month, Year, or defibrillator identification number.				

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A 398	Continued From page 72 Interview on January 17, 2025, at 12:51 PM, EMP91 indicated that there are two code carts on the unit that are specific to the NICU. EMP91 indicated the night shift staff are responsible for checking the code cart daily and reporting any issues to the pharmacist. EMP91 indicated the staff are to document the checks in the logbook attached to the code cart. EMP61 indicated that the nursing staff on the unit check the code cart daily and EMP61 checks the code cart monthly. Review of facility policy, titled "Feeding Preparation in the Neonatal Intensive Care Unit (NICU)," effective December 2022, revealed "...check the expiration date on the container ... Can is good for 30 days once opened ... Close powder container and make sure to label with patient name and date/time opened..." Observation on January 15, 2025, at 10:51 AM, of the front formula preparation room located in the NICU with EMP15 revealed a bottle of MCT oil (a dietary supplement made from medium-chain triglycerides) with an expiration date of December 12, 2025. EMP15 verified the expiration date of the MCT oil and indicated it should have been removed from the formula preparation room. Observation on January 15, 2025, at 11:04 AM, of the back preparation room located in the NICU EMP15 indicated that the date written on the top of the powdered formula lid is the "open date" and the formula expires one month after opening. Three open containers of powdered formula were observed with open dates written on the lids: Similac Advanced, open date September 30, 2024, Enfamil, open date October 29, 2024, and				

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A 398	Continued From page 73 Similac Sensitive, open date November 14, 2024. EMP15 indicated all three open powdered formula containers were past the one-month open date and should have been discarded. Interview on January 23, 2025, at 10:47 AM EMP94 indicated that they are responsible for ordering formula and stocking the formula preparation rooms but were not checking for open-dates or expired formula.				
A 438	FORM AND RETENTION OF RECORDS CFR(s): 482.24(b) The hospital must maintain a medical record for each inpatient and outpatient. Medical records must be accurately written, promptly completed, properly filed and retained, and accessible. The hospital must use a system of author identification and record maintenance that ensures the integrity of the authentication and protects the security of all record entries. This STANDARD is not met as evidenced by: Based on review of medical records (MR), review of documents and interview with staff (EMP) it was determined the hospital failed to maintain accurate and complete medical records (MR1 and MR47). In addition, the hospital failed to maintain a system for medical records that ensured each medical record was easily assessable and readily available when needed. Findings: Review of facility policy, titled "Clinical Nursing Documentation," last revised November 2024, revealed "...Recall functionality [an option to auto-populate fields based on previous				

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A 438	Continued From page 74 documentation] is not used for patient assessment documentation... " Review of MR1 "NICU Shift Assessment" dated July 21, 2024, at 9:00 AM, revealed "Skin Other: Lower extremity bruising, 2 sites at shin. L [left] lower Extremity bruising [sic], length of shin and back of calf. MD [medical doctor] aware and assessed. Xray to be completed." An x-ray was obtained on July 21, 2024, at 11:10 AM. Additional review revealed identical documentation "Skin Other: Lower extremity bruising, 2 sites at shin. L lower Extremity bruising [sic], length of shin and back of calf. MD aware and assessed. Xray to be completed" on the following dates and times: July 21, 2024, at 9:00 AM and 8:00 PM, July 22, 2024, at 8:00 AM and 8:00 PM, July 23, 2024, at 9:00 AM, and July 24, 2024, at 3:00 AM. Interview on January 17, 2025, at 10:39 AM, EMP91 indicated that on the nursing flowsheets, the patient's previous assessment data is automatically prepopulated into the current flowsheet, however the full documentation located within each box was not visible, nurses could only see a small portion. EMP91 indicated if a nurse wanted to change the documentation, they would need to remove the checkmark from the box, and add documentation. EMP91 indicated nurses were trained by their preceptor to use these prepopulated, carried over fields as a way to "save time" when documenting and that utilizing the recall functionality was an acceptable practice in the NICU . EMP91 indicated they have had concerns with inaccurate documentation when nurses have used the former assessment findings and not modified				

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A 438	Continued From page 75 them with current assessment data. EMP91 further indicated they relied on verbal shift report handoffs when documentation in the medical record was questionable or unreliable. Review of MR47 document, titled "History and Physical," dated May 31, 2024, and signed electronically by NEO52, revealed within the document body there was an additional electronic signature from OTH103, dated May 29, 2024, two days prior to the date of the History and Physical. The documentation did not attribute what portions were authored by which physician or what portion of the note was applicable to assessment findings on May 29, 2024, or May 31, 2024. It was unclear from the document whether or not NEO52 authored any of the note or assessed the patient despite signing the document on May 31, 2024, at 10:39 AM. Interview on January 23, 2025 at 11 AM, EMP104 indicated it appeared OTH103's entire note was copied and pasted into NEO52's History and Physical note and NEO52 had not authored any of the note, but had signed it. EMP104 indicated that physicians have the ability to copy and paste other provider's notes into their documentation. An interview was requested with NEO52. Interview on January 24, 2025, at 2:18 PM, EMP80 indicated the attorney representing all of the NICU physicians refused to permit the surveyors to interview NEO52. Interview on January 17, 2025, at 10:27 AM, with EMP91 indicated the nursing staff documents in multiple electronic systems for each medical record. EMP91 indicated central lines (a long,				

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A 438	Continued From page 76 flexible tube inserted into a vein in the neck, chest, arm or groin, used for administering medications and fluids) are documented by nursing in two systems, the main nursing documentation system (EHR1) and also documented in an additional system (EHR2) because EHR1 data does not show up into the EHR2 data system. Physician documentation is in EHR2, but the majority of nursing NICU care is documented in EHR1. EMP91 stated that Newborn Nursery Unit care is also documented in EHR1. EMP91 indicated if a baby is transferred from the Newborn Nursery unit to the NICU, NICU staff have trouble viewing the Newborn Nursery unit documentation in EHR1. EMP91 further indicated the some of the Newborn Nursery data does not show on the NICU Flowsheets in EHR1, they have to exit the NICU flowsheet screen and enter into the screens for the Newborn Nursery in order to view it. EMP91 stated they have had trouble in the past with the medical record "locking up" and having difficulty accessing needed information. Interview on January 23, 2025, at 11 AM, EMP104 indicated they were not aware of all the electronic documentation systems that are used to document in the medical record, but later provided a list of ten electronic documentation systems that are used to document in the medical record. The list indicated that five of the systems interfaced directly with the medical record and the other five were comprised of systems in which records are printed out and scanned into the medical record in full or in part. EMP104 indicated that EHR1 had some information that interfaced with the legal record (the legal record is created after a patient is				

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A 438	Continued From page 77 discharged and records are scanned or automatically transferred into a different system) and some information that is not within the legal record.				
A 747	INFECTION PREVENTION CONTROL ABX STEWARDSHIP CFR(s): 482.42 The hospital must have active hospital-wide programs for the surveillance, prevention, and control of HAIs and other infectious diseases, and for the optimization of antibiotic use through stewardship. The programs must demonstrate adherence to nationally recognized infection prevention and control guidelines, as well as to best practices for improving antibiotic use where applicable, and for reducing the development and transmission of HAIs and antibiotic resistant organisms. Infection prevention and control problems and antibiotic use issues identified in the programs must be addressed in collaboration with the hospital-wide quality assessment and performance improvement (QAPI) program. This CONDITION is not met as evidenced by: Based on observations, review of medical records (MR), review of facility documents and interviews with staff (EMP) it was determined the facility failed to implement an active hospital-wide program for the surveillance, prevention, and control of hospital associated infections (HAIs) as evidenced by: failure to employ methods to prevent transmission and control the spread of infections (A0749); failure to monitor and track infection prevention and control activities or implement strategies to mitigate the MRSA outbreak in the NICU (A0750); and failure of the governing body to ensure the infection prevention activities included monitoring and tracking of				

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A 747	Continued From page 78 strategies implemented to control the spread of MRSA in the NICU (A0770, A0043). Cross Reference: §482.42(a)(2) Infection Prevention: Infection Control Program §482.42(a)(3) Infection Prevention: Infection Control Surveillance, Prevention §482.42(c)(1) Infection Prevention: Leadership Responsibilities §482.12 Condition of Participation: Governing Body				
A 749	INFECTION CONTROL PROGRAM CFR(s): 482.42(a)(2) The hospital infection prevention and control program, as documented in its policies and procedures, employs methods for preventing and controlling the transmission of infections within the hospital and between the hospital and other institutions and settings; This STANDARD is not met as evidenced by: Based on observations, review of medical records (MR), review of facility documents and interviews with staff (EMP), it was determined the hospital failed to consistently implement methods for preventing and controlling the transmission of infections within the hospital. Specifically, the facility failed to implement infection control practices for a patient on isolation precautions (MR12); failed to implement a consistent method of hand hygiene upon entering the NICU and staff failed to perform hand hygiene; failed to clean and disinfect an isolette (a small bed enclosed by plastic to control the temperature and humidity) per manufacturer's instructions for use (IFU) or implement training and competencies for cleaning medical equipment				

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A 749	Continued From page 79 used in the NICU; and failed to ensure consistent documentation of NICU patient room cleaning logs to verify rooms were cleaned daily. Findings: Review of facility policy, titled "Infection Prevention in Neonatal Intensive Care Unit (NICU)," dated April 2024, revealed "... Initial Scrub: When entering the NICU for the beginning of each shift, and prior to performing any sterile/surgical procedure staff/visitors will: 1. Wipe down personal or shared cellular device with cleaning wipes prior to washing hands. 2. Remove all jewelry below the elbows and push sleeves to above the elbow. 3. Begin 3 minute timer. 4. Wet hands and scrub with soap. Scrub will include up to the elbow. Please be sure to pay careful attention to nails, cuticles, fingertips, between the fingers and the thumb. 5. Once timer is complete, rinse from the forearm down and dry with a paper towel. 6. Apply three pumps of [brand name of hand antiseptic that is used by healthcare professionals to disinfect hands before surgery or to care for high-risk patients] to hands and forearms, rub in, and allow to air dry. a. Families/ancillary staff members apply 1 pump of [brand name of hand antiseptic] to hands and forearms, rub in, and allow to air dry ...When to perform hand hygiene/hand sanitizing 1. Before and after all patient contact3. Between body sites 4. Before applying gloves 5. After removal of gloves 6. Before and After touching equipment" Review of facility policy, titled "Hand Hygiene," revised November 2024, revealed: "...Decontaminate hands - a. Before having direct				

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A 749	Continued From page 80 contact with patients ... d. After contact with patient's intact skin (e.g., when taking a pulse or blood pressure). e. After contact with body fluids or excretions, mucous membranes, non-intact skin, and wound dressings if hands are not visibly soiled. f. If moving from a contaminated-body site to a clean-body site during patient care. g. After contact with inanimate objects (including medical equipment) in the immediate vicinity of the patient. h. After removing gloves. ..." Observation on December 20, 2024, at 11:45 AM, in the NICU revealed MR12 had signage posted on the door indicating the infant was on droplet and contact precautions (droplet precautions are implemented if a patient is known or suspected to have respiratory pathogens; contact precautions are implemented to prevent transmission of known or suspected pathogens via touch). Interview with EMP107 revealed the infant had MRSA and had been exposed to Respiratory Syncytial Virus (RSV-virus that can cause infections of the lungs and respiratory tract) and that all staff and visitors should wear a gown, mask, and gloves when entering the patient's room. EMP4 was observed entering the infant's room wearing gloves, a mask, and a gown that was untied and partially falling off the their body. EMP108 was observed entering the infant's room wearing no personal protective equipment (PPE). EMP108 left the room without performing hand hygiene and entered another infant's room. Inside MR12's room the trash can was observed overflowing with trash and soiled gowns were hanging over the side of the trash can and on the floor.				

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A 749	Continued From page 81 Review of video on November 26, 2024, at 9:28 AM, of MR1's room in the NICU on October 11, 2024, at 6:01 AM, revealed EMP110 performed a diaper change and then administered intravenous medications without changing gloves or performing hand hygiene. At 11:51 AM, OT109 did not perform a glove change or hand hygiene after a diaper change. At 11:57 AM, OT109 removed gloves after disposing of the diaper, did not perform hand hygiene then put on new gloves. Observation on January 03, 2025, at 4:45 PM, revealed EMP5 entered a room which had a sign on the door indicating the infant was on contact precautions. EMP5 was not wearing PPE. EMP5 then exited the room and was observed putting the gown on as they were walking back into the room. EMP1 was also observed in the infant's room with no PPE. Interview on January 06, 2024, at 2:00 PM, EMP22 confirmed that PPE should be put on before entering the room and that hand hygiene should be performed after diaper changes, patient care, and between patient interactions. Observation of the sinks at the first NICU entrance on January 15, 2024, at 10:04 AM, there were timers on the wall above the sink. EMP14 indicated the timers would measure one minute and staff would need to continue to reach their hand up to get timer to start again, so instead staff use their phones to time handwashing for three minutes. EMP83 was observed washing their hands, was not using a timer, and indicated they would say the alphabet twice, and that would equal three minutes. In				

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A 749	Continued From page 82 addition, above the sink there was conflicting signage that revealed "Handwashing Guidelines: ...Clean under your nails with the [brand] nail cleaner provided in the scrub-in area...Wash your hands/arms up to your elbows with soap and water for three minutes...Apply three pumps of [brand] Hand Antiseptic..." and a second sign which revealed "Hand Hygiene for Visitors - Wash hands and forearms with soap and water for 30 seconds...Apply 1 pump of [hand antiseptic] ..." Observation of sinks at the second entrance to the NICU, signage was posted which revealed instructions that were different than the signage at the first entrance sinks, and instructed visitors to wash hands and forearms with soap and water for three minutes and to apply three pumps of [hand antiseptic] to hands. EMP14 indicated that visitors' hands should be washed for three minutes upon entering the NICU while EMP62 indicated that visitors should wash their hands for thirty seconds. Interview on January 21, 2025, at 10:20 AM, EMP5 indicated gloves should be worn anytime staff risk contact with bodily fluids, and with infants this small [NICU infants] contact with bodily fluids is common. Review of video on January 21, 2025, at 2:30 PM, of EMP64 providing care to MR9 in the NICU on January 18, 2025, from approximately 7:18 AM until 9:12 AM. At 7:18 AM and 8:37 AM, EMP64 was observed with their hands in the isolette touching the patient and items within the isolette and was not wearing gloves. At 8:41 AM, EMP64 removed their left hand from the isolette, touched the screen of a machine, put their hand back into the isolette and proceeded to touch and				

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A 749	Continued From page 83 pick up the infant without performing hand hygiene between tasks. At 8:43 AM, EMP64 was observed applying gloves and placed their hands back into the isolette. At 8:44 AM, wearing the same gloves, EMP64 removed their hands from the isolette, retrieved a supply, returned to the isolette, and placed their gloved hands back inside the isolette. EMP64 then removed their left arm out of the isolette and wiped their face with their gloved wrist. No hand hygiene was performed. At 9:08 AM, EMP64 retrieved a disinfectant wipe and wiped one side of the isolette. EMP64 then opened a drawer and retrieved a supply. EMP64 then put their hands in the isolette, touched the infant's head and adjusted the pacifier in the infant's mouth. No hand hygiene was performed before touching the infant. From 9:11 AM to 9:12 AM, EMP64 wiped the top and side of the isolette with a disinfecting wipe, threw the wipe away and then put their hands back into the isolette without wearing gloves and without performing hand hygiene. During the same video review, NEO55 was observed providing care to MR9. At 8:32 AM, NEO55 applied gloves then touched the video monitoring device. Without performing hand hygiene or changing gloves NEO55 examined and touched the infant. At 8:36 AM, wearing the same gloves, NEO55 touched medical equipment then scratched their face then touched the monitor with their gloved hands. Review of video on January 21, 2025 of EMP67 providing care to MR34 on January 17, 2025, from approximately 8:57 PM to 9:05 PM, in the NICU. EMP67 was observed applying a pair of gloves, touching equipment, and then touching the infant. At 9:01 PM, EMP67 walked away from				

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A 749	Continued From page 84 the crib wearing the same gloves and upon return, touches the infant again. At 9:04 PM, EMP67 applied a new pair of gloves, touched the communication device they were wearing and then touched MR34. Interview on January 22, 2025, at 1:00 PM, EMP22 indicated that the NICU infection control policy had been revised about three weeks ago to allow for any visitor or staff not touching the infants to do an initial hand wash for 30 seconds and to use one pump of hand antiseptic. EMP22 indicated any staff member who has direct contact with the infants would perform a three-minute handwash followed by three pumps of hand antiseptic. EMP22 indicated that the change was communicated to NICU and ancillary department leadership via email and then disseminated to employees. The facility did not provide the updated policy prior to the end of the survey. Review of the IFU for maintenance, cleaning, and disinfection of an isolette revealed bleach should not be used to clean the LCD touch panel or the bedside panels and " ...Cleaning and disinfecting the humidifier water reservoir and lid. The humidifier water reservoir and its lid must be cleaned then must be disinfected either chemically or through steam sterilization. Clean. 1. Soak the parts fully in cleaning solution for 1 minute. Note: Make sure all sides of each part soak for 1 minute by turning the parts in the clean solution. 2. Dip the parts in cleaning solution 3 times to fully flush out soiling. 3. Visually inspect the parts. Note: If not visibly clean, remove remaining soil with swab saturated with cleaning solution. Disinfect with chemical. 1. Soak the				

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A 749	Continued From page 85 parts fully in disinfectant for 3 minutes. Note: Make sure all sides of each part soak for 3 minutes by turning the parts in the disinfectant. 2. Dry accessible areas of the parts with a dry soft lint-free cloth. 3. Allow the remaining areas of the parts to air dry ...Cleaning and disinfecting air circulation fan, tubing management grommets, porthole gaskets ... Clean: 1. Wipe the parts with a soft lint-free cloth saturated with cleaning solution until all accessible surfaces are visibly clean. 2. Soak the parts in cleaning solution for 1 minutes to fully flush out soiling. 3. Dip the parts in the cleaning solution 3 times. 4 .Visually inspect the parts and if not visibly clean remove soil with swabs saturated with cleaning solution. Disinfect 1. Soak the parts in disinfectant for 6 minutes...Remove chemicals1. For porthole gaskets; rinse the gasket with water 2 times. Dry all parts with a soft lint-free cloth to remove chemical. The air filter should be cleaned quarterly or following bed use with an infectious patient ... " Observation on January 22, 2025, at 1:09 PM, of EMP101 cleaning and disinfecting an isolette. EMP101 was observed disassembling the isolette, then proceeded to disinfect all parts of the isolette with bleach wipes to include the LCD touch panel and the bedside panels. EMP101 was then observed wiping the isolette from top to bottom near the wheel area and then moving back to the top of the isolette and continued to wipe the isolette with the same cloth. EMP101 wiped the water reservoir with a bleach cloth, but did not soak the water reservoir in cleaning solution or disinfectant as indicated in the IFU. EMP101 was observed plugging a sink and filling it with water and an unmeasured amount of				

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A 749	Continued From page 86 solution from a white bottle. EMP101 indicated the bottle contained a detergent and measuring the detergent and/or detergent to water ratio was not required. The bottle was labeled, [Brand name] Shampoo and Body Wash. EMP101 and EMP102 confirmed that the shampoo/body wash product was being used to clean the isolette gaskets and not a detergent. EMP101 soaked the gaskets in the solution while they disinfected other portions of the isolette and then moved the gaskets to a towel to dry. EMP101 did not disinfect the gaskets. Upon completion of cleaning and disinfecting the isolette, EMP101 did not use a cloth to remove the chemicals from the isolette as described in the IFU. EMP101 further indicated the isolette air filter is changed monthly or when a patient has MRSA. EMP101 indicated that the NICU staff would place a sign on the bed if the patient using the bed was diagnosed with MRSA. Interview on January 23, 2025, at 11:30 AM, at EMP102 indicated there was no mechanism in place to track what bed a MRSA positive NICU baby had been in to determine that the filter had been changed after cleaning and disinfecting. Review of facility policy, titled "Hospital Approved Disinfectants," revised August 2023, did not list [Brand name] shampoo and body wash as an approved disinfectant. Interview on January 23, 2025, at 11:30 AM, EMP102 indicated the Supply Chain department worked with the infection prevention team to ensure they were cleaning moveable medical equipment, which included intravenous pumps and isolettes, properly. EMP102 indicated there				

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A 749	Continued From page 87 were no written competencies for cleaning any moveable medical equipment. EMP102 indicated that they learned to clean the isolette from a prior supervisor and staff teaches new employees to clean it per the IFU. EMP102 denied receiving infection control training since being employed in the facility and had no written record of receiving infection control education. EMP102 was unsure when gloves should be changed when cleaning and disinfecting the isolette, was not familiar with the order of cleaning (ie; cleanest to dirtiest areas), and had not been trained on methods of MRSA transmission. Review of facility documents, titled "NICU Patient Room Cleaning Logs," dated January 2025, reviewed on January 15, 2025, revealed instructions "'Sign initials to verify completion of each task." The cleaning logs for NICU rooms 1 through 21 contained multiple dates with a line drawn down through each task instead of initials as per the form's instructions. The Supervisor Inspection row on the log for rooms 4 and 5 were initialed but the Day Shift tasks rows were not initialed as completed. The Evening Shift tasks for room 1 were not initialed as completed on January 14, 2025. The Day Shift tasks for rooms 3, 10, 11, 12, 13, 14, 15, 16, 18, 19, 20, 22, 24, 30, 31, 32, and 33, were not initialed as completed on January 11, 2025, and January 12, 2025. Interview on January 15, 2025, at 3:14 PM, EMP87 indicated that the staff drew a line through the boxes because those rooms were not occupied, and the staff does not clean rooms on days the rooms are unoccupied. The supervisor checks to ensure that nothing has				

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A 749	Continued From page 88 come into the room and then signs the form. EMP87 indicated that there is guidance directing staff how to complete the NICU Patient Room Cleaning Log. Interview on January 16, 2025, at 10:42 AM, EMP87 indicated that the NICU Patient Room Cleaning Log is exclusive to the NICU and there are designated NICU cleaning staff that complete training in the facility's electronic training program. EMP87 confirmed that there is no policy to indicate how to complete the log, but staff were taught how to use the log during orientation and the supervisor is to verify the room is cleaned daily. EMP87 indicated they review the logs at the end of each month and spot checks them during rounds on the unit. EMP87 indicated that the line drawn down the through the tasks indicates the room was vacant and the documentation is inconsistent.				
A 750	INFECTION CONTROL SURVEILLANCE, PREVENTION CFR(s): 482.42(a)(3) The infection prevention and control program includes surveillance, prevention, and control of HAIs, including maintaining a clean and sanitary environment to avoid sources and transmission of infection, and addresses any infection control issues identified by public health authorities; and This STANDARD is not met as evidenced by: Based on review of facility documents and interviews with staff (EMP) it was determined the facility failed to monitor and track infection prevention and control activities or implement strategies to mitigate the MRSA outbreak in the NICU.				

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A 750	Continued From page 89 Findings: Review of facility policy, titled "Infection Prevention and Control Plan," effective June 2024, revealed the Director of Infection Prevention is responsible for the coordination of the Infection Prevention and Control Program and "...The goal of the Infection Prevention Plan is to identify and minimize, reduce, and eliminate the risk of endemic and epidemic healthcare associated infections in patients and healthcare workers by utilizing surveillance activities, preventative measures and control of infections. A practical system is used for reporting, evaluating and maintaining records of infections among patients and personnel. The Infection Preventionists are responsible for the ongoing collection and analytic review of the data as well as required follow-up action. Ongoing reviews and evaluation of ...disinfection techniques employed by the hospital, preventative, surveillance and control procedures relating to inanimate hospital environment including storage, cleaning, sterilization and disinfection practices, central service, housekeeping should be evaluated and revised as necessary. This includes a periodic review of cleaning procedures, agents and schedules in use throughout the hospital, and consultation relative to any change in cleaning products or techniques. During review, it will be determined that they are used in accordance with manufacturer's instructions to avoid harming patients ... The Infection Preventionists carry out approved activities of the infection prevention and control program including coordinating surveillance activities, observation, identification, intervention, evaluation, education and				

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A 750	Continued From page 90 consultationSurveillance PlanProvision of meaningful data regarding the levels of healthcare associated infection within the hospital to allow for continuous improvement in the quality of care of the patientAnnually and as needed, identification of risks for the acquisition and transmission of infectious agents are analyzed based on the scope of the program and surveillance dataBased on risks, priorities and goals of prevention of healthcare associated infections are determined .. Strategies are implemented to achieve these goals.... " Review of facility document, "Weekly NICU Touchpoint," dated November 6, 2024, revealed a list of ongoing activities which included universal decolonization of babies (a treatment that uses topical agents to reduce or eliminate the presence of MRSA), decolonization offered to parents, CHG (an atiseptic skin cleanser) for parents prior to skin to skin contact, hand hygiene audits, ATP testing (detection of ATP indicates that organic material -microbial or biologic- is present on an object or surface after cleaning) and Glo Germ (product used for training hand hygiene and surface cleaning- glows under blacklight when cleaning is not completed properly), terminal cleaning of rooms (disinfection process when a patient has been discharged), and staff testing. Interview January 23, 2025, at 1:33 PM, EMP22 indicated there has been a MRSA outbreak in the NICU for over three years. EMP22 indicated there was no national infection prevention guidance followed for NICU, just a "playbook" provided by the corporation that provided best practices. EMP22 indicated if changes are made				

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A 750	Continued From page 91 to the playbook guidance, they would wait for corporate to update their book before implementing anything new. EMP22 indicated other than tracking the number of babies with MRSA, there was no tracking of strategies implemented to mitigate the MRSA outbreak, no documentation of revisions made to those strategies or documentation of outcomes related to strategies implemented. EMP22 further stated there had been no new strategies implemented in over a year "Certainly not things that can be tracked numerically and no data analysis." EMP22 indicated the Infection Preventionist (IP) will spot check if EVS is performing cleaning of patient environments by checking if Environmental Services (EVS) had signed off on logs, but the IPs did not document the spot checks, education provided or track for improvement. EMP22 indicated EVS sprays a room with a disinfectant after a baby is discharged to reduce MRSA transmission in the NICU, but this is not tracked by IP to ensure completion or need for improvement because it was difficult. EMP22 indicated there is a paper binder on the NICU to notify EVS when a baby is discharged and the room needs spraying, however there is no notification to the IPs when there is a discharge and the IPs do not have access to the NICU admission, transfer or discharge census. Review of facility email, titled "EOC [environment of care] Rounds," dated January 20, 2025, revealed equipment in the NICU had failed ATP testing. EMP22 indicated the hospital used a data collection web-based system to monitor ATP testing in the NICU. EMP22 indicated if an item				

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A 750	Continued From page 92 fails ATP testing, and it is the responsibility of EVS to clean that item, they are expected to clean it. EMP22 indicated if it is certain medical equipment such as a scale for weighing the babies, nursing is responsible to clean it. EMP22 indicated if an item fails, there is no way to collect data in the web-based system about what was done, such as was the item recleaned and retested, was education provided to staff or how the IP managed the issue. EMP22 indicated within the web-based system, the labels for collecting data were not specific to items in the NICU. EMP22 indicated an item designated as "bed drawers" was probably a NICU isolette, however it was not clear if it was and the item names could not be edited to clearly label what was tested. The December 2024, web-based report revealed bed drawers in the NICU failed ATP testing four times, however there was no information regarding what the item was, or actions taken to improve the process. EMP22 further indicated they no longer tracked which babies were in contact with the equipment used in NICU to track potential MRSA transmission, the only thing tracked was the number of babies with MRSA. EMP22 indicated Supply Chain cleaned isolettes and other equipment from the NICU and the IP did not oversee Supply Chain infection prevention procedures, policies or cleaning products used because the area did not fall under their purview. Interview on January 24, 2025, at 11:31 AM, EMP102 indicated Supply Chain sanitized moveable medical equipment from the NICU including mobile IV Pumps and isolettes. EMP102 indicated they had been aware of a MRSA outbreak in the NICU, but had not been				

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A 750	Continued From page 93 involved in tracking equipment, improvements to cleaning process, or educating staff cleaning equipment in Supply Chain on infection prevention. EMP102 indicated they did not know how MRSA transmitted in healthcare and had not had education in infection prevention techniques. EMP102 indicated they had not been aware that staff were using body wash and shampoo to wash the isolette gaskets until an observation with surveyors on January 22, 2024. EMP22 indicated after the observation, they purchased dish soap to use instead and they were not aware if there was a list of hospital approved cleaning agents. EMP22 indicated IP had come down occasionally to "spot check" if an isolette had been cleaned however EMP22 had not instructed staff to follow IFUs for cleaning and had not been aware staff were not cleaning the isolettes per manufacturer's instructions. EMP22 indicated cleaning audits performed in the department were "spot checks," did not audit if the cleaning process followed the IFUs, and audits were not documented. Interview on January 24, 2025, at 2:58 PM, EMP3 indicated the NICU tracked what isolettes babies were in during 2024, for four months, and compared to MRSA results of the infants, however the NICU did not keep the documentation and were unable to provide evidence this had been done.				
A 770	LEADERSHIP RESPONSIBILITIES CFR(s): 482.42(c)(1)(i) Standard: Leadership responsibilities (1) The governing body must ensure all of the following:				

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A 770	Continued From page 94 (i) Systems are in place and operational for the tracking of all infection surveillance, prevention, and control, and antibiotic use activities, in order to demonstrate the implementation, success, and sustainability of such activities. This STANDARD is not met as evidenced by: Based on review of facility documents and interviews with staff (EMP), it was determined the governing body failed to ensure the infection prevention activities included monitoring and tracking of strategies implemented to control the spread of MRSA in the NICU. Findings: Review of facility document, titled "Board of Trustees Bylaws," revised October 2022, revealed ". 7.7 Quality Assessment and Performance Improvement 7.7.1 The board is ultimately responsible for the quality of patient care and services provided by the Hospital by providing oversight of the Hospital ... The Board shall ensure that the program reflects the complexity of the Hospital's organization and services; involves all Hospital departments and services....and focuses on indicators related to improved health outcomes ...7.7.2.2.... That the hospital-wide quality assessment and performance improvement efforts address priorities for improved quality of care and patient safety, and that all improvement actions are evaluated. .." Review of facility document, titled "Infection Prevention & Control Risk and Hazard Vulnerability Assessment," undated, revealed neonates were at high risk for the likelihood of				

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A 770	Continued From page 95 possible death or injury related to device related infections, resistant microbes (a very small living organism, including bacteria, viruses, fungi, and protozoa, that are typically too small to be seen without a microscope), surgical site infections, and extrinsic infections (sources of infection such as transmission from healthcare workers, foodborne illness, contaminated surfaces, and equipment). The assessment did not include implementation of infection prevention or control activities to mitigate risk other than screening NICU patients for MRSA. Review of facility document, titled "Weekly NICU Touchpoint," dated November 6, 2024, revealed 94 NICU patients had contracted MRSA, and 43 had become recolonized (MRSA bacteria are present on the skin or mucous membranes after previously testing negative for the infection). The last new positive MRSA result was on November 4, 2024, and four babies were in isolation (the purpose of isolation is to prevent the transmission of microorganisms from infected or colonized patients to others) for MRSA. Review of facility document, titled "NICU Quality Performance Report Q3 2024," undated, revealed there were no NICU Performance Improvement Projects or data related to the MRSA outbreak in the NICU. Review of facility document, titled "Quality Construct," dated November 15, 2024, revealed a Metric/Group labeled MRSA, with action "End MRSA outbreak in NICU" and there was no additional detail related to how this would be accomplished. Clinical risk points included the unit had been terminally cleaned and there had				

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A 770	Continued From page 96 been five new infections. There was no further information related to tracking, trending or analyzing data related to the continued outbreak of MRSA in the NICU or implementation of interventions. Interview January 23, 2025, at 1:33 PM, EMP22 indicated there has been a MRSA outbreak in the NICU for over three years. EMP22 indicated other than tracking the number of babies with MRSA, there are no other tracking of strategies implemented to mitigate the MRSA outbreak, documentation of revisions made to those strategies or documentation or analysis of outcomes related to strategies implemented. EMP22 further indicated there had been no new strategies implemented in over a year, and "Certainly not things that can be tracked numerically and no data analysis." Interview on January 24, 2025, at 2:58 PM, EMP3 indicated the NICU tracked what isolettes babies were in for four months and compared that to NICU MRSA screening results, however the NICU did not keep the documentation.				