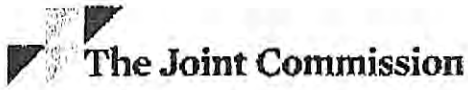

The Joint Commission

Broughton Hospital
1000 South Sterling Street
Morganton, NC 28655

Organization Identification Number: 1610

Date(s) of Survey: 12/11/2007 - 12/13/2007

PROGRAM(S)

Hospital Accreditation Program

SURVEYOR(S)

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Executive Summary

Based on the accreditation survey, your organization has met criteria that may result in Preliminary Denial of Accreditation. The survey findings will be reviewed in The Joint Commission's Central Office. If, as a result of this review, your organization continues to meet the criteria for Preliminary Denial of Accreditation, the survey findings will be posted to your secure extranet site and your organization will have 10 business days to submit clarifying Evidence of Standards Compliance (ESC), for any standards that you believe you were compliant with at the time of survey. Should the central office review of the clarifying ESC result in your organization continuing to meet the criteria for Preliminary Denial of Accreditation, the survey findings will be presented to the Accreditation Committee for a decision. Should the central office review of your Clarifying Evidence of Standards Compliance result in your organization no longer meeting criteria for Preliminary Denial of Accreditation, an on-site Clarification Validation Survey (CVS) will occur. This survey will be performed by a member of our Standards Interpretation staff within 5 days of the completion of our review of the clarifying ESC. Your Account Representative will contact you regarding this process.

The results of this accreditation activity do not affect any other Requirement(s) for Improvement that may exist on your current accreditation decision.

The Joint Commission

Accreditation Survey Findings

Requirement(s) for Improvement

Standard Text: Any use of restraint (to which these standards apply) is initiated pursuant to either an individual order (standard PC.11.50) or an approved protocol (standard PC.11.60), the use of which is authorized by an individual order.

Secondary Priority Focus Area(s): N/A

Element(s) of Performance

Scoring Category : A
7. Such renewal or new order is issued no less often than once each calendar day and is based on the licensed independent practitioner's examination of the patient.

Surveyor Findings

EP 7
Observed in Ward 14 Scroggs Building at Broughton Hospital site.
During tracer activities, observations were made that when a restraint was renewed, the physician signed and dated the renewal based on calendar day. There was no documentation to indicate that the patient had been examined by the physician each time the renewal was written. The patient had been placed in a posey vest restraint while in a geri chair since admission 12/28/06.

Standard: PC.12.50

Program: HAP

Standard Text: Non-physical techniques are the preferred intervention in behavior management.

Secondary Priority Focus Area(s): N/A

Element(s) of Performance

Scoring Category : A
1. Non-physical techniques are always the preferred intervention.*
* Such interventions may include redirecting the patient's focus or employing verbal de-escalation.

Surveyor Findings

EP 1
Observed in Ward 14 Scroggs Building at Broughton Hospital site.
During tracer activities, observations were made that a patient was placed in a manual restraint for 5 minutes. There was no documentation that non-physical techniques had been attempted prior to the manual restraint intervention.

Observed in Adult Psych Rehab at Broughton Hospital site.
During tracer activities, observations were made that nonphysical techniques were not always the preferred intervention. A patient spit in the face of a CNA. The immediate action was to initiate a manual restraint and place the patient in isolation time out. The patient did have a documented behavior plan available.

Observed in Adult Psych Rehab at Broughton Hospital site.
During tracer activities, observations were made that nonphysical techniques were not always the preferred intervention. A patient was slapped or hit by another patient. Instead of removing the patient away from the situation, a manual restraint was immediately initiated followed by seclusion and then a 4 point restraint. The patient did have a documented behavior plan available.

Standard: PC.12.160

Program: HAP

The Joint Commission

Accreditation Survey Findings

Requirement(s) for Improvement

EP 1
Observed in Ward 14 Scroggs Building at Broughton Hospital site.
During tracer activities, observations were made that the physician did not complete the "Suicide Risk Factors Supplement" that was required by organizational policy for safety precautions. The patient was admitted on 11/14/06 with suicide ideation and depression. The nursing assessment information at the time of admission listed only a check box for thoughts of suicide.

Observed in Adult Admissions 4 at Broughton Hospital site.
Several risk factors identified upon admission were not documented on a patient's suicide assessment checklist.

Observed in Male Admissions Crisis Stabilization at Broughton Hospital site.
Several risk factors identified upon admission were not documented on a patient's suicide assessment checklist.

These are the Requirements for Improvement related to the Primary Priority Focus Area:

Communication

Standard: NPSG Requirement 2E

Program: HAP

Standard Text: Implement a standardized approach to "hand-off" communications, including an opportunity to ask and respond to questions.

Secondary Priority Focus Area(s): N/A

Element(s) of Performance

Scoring Category : C
1. The organization's process for effective "hand off" communication includes: Interactive communications allowing for the opportunity for questioning between the giver and receiver of patient information.

Surveyor Findings

EP 1
Observed in Male Admissions at Broughton Hospital site.
The hospital did not have a standardized approach to hand-off communications between physicians to include the ability to ask and respond to questions. A patient's care was transferred from the admitting psychiatrist to another psychiatrist with no direct hand-off communication.

Observed in Adult Admissions 4 at Broughton Hospital site.
The hospital did not have a standardized approach to hand-off communications between physicians to include the ability to ask and respond to questions. A second patient's care was transferred from the admitting psychiatrist to another psychiatrist with no direct hand-off communication.

Observed in Male Admissions Crisis Stabilization at Broughton Hospital site.
The hospital did not have a standardized approach to hand-off communications between physicians to include the ability to ask and respond to questions. A third patient's care was transferred from the admitting psychiatrist to another psychiatrist with no direct hand-off communication.

The Joint Commission

Accreditation Survey Findings

Requirement(s) for Improvement

Standard: IC.1.10

Program: HAP

Standard Text: The risk of development of a health care-associated infection is minimized through an organizationwide infection control program.

Secondary Priority Focus Area(s): N/A

Element(s) of Performance

A description of the hospital's strategies to minimize, reduce, or eliminate the prioritized risks
A description of how the strategies will be evaluated

*Written plan A succinct, useful document, formulated beforehand, that identifies needs, lists strategies to meet those needs, and sets goals and objectives. The format of the "plan" may include narratives, policies and procedures, protocols, practice guidelines, clinical paths, care maps, or a combination of these.

Surveyor Findings

EP 4
Observed in Adult Admissions 4 at Broughton Hospital site.
Communication of information related to a patient with a methicillin resistant staphylococcus aureus wound on contact precautions was ineffective. He was permitted full access to the unit and the cafeteria, and was allowed by staff to have ungloved contact with this surveyor, with no warnings relayed before or after. Even 24 hours after this occurred, he continued to be allowed full access to the unit with no measures taken to preclude contact with other patients or staff while on contact precautions.

EP 9
Observed in infection control documents at Broughton Hospital site.
The infection control plan did not contained a description of the prioritized risks, statement of the goals of the program, description of the hospital's strategies to minimize, reduce, or eliminate the prioritized risk and a description of how the strategies would be evaluated.

Standard: IC.2.10

Program: HAP

Standard Text: The infection control program identifies risks for the acquisition and transmission of infectious agents on an ongoing basis.

Secondary Priority Focus Area(s): N/A

Element(s) of Performance

Scoring Category : B
1. The hospital identifies risks for the transmission and acquisition of infectious agents throughout the hospital based on the following factors:

The geographic location and community environment of the hospital, program/services provided, and the characteristics of the population served
The results of the analysis of the hospital's infection prevention and control data
The care, treatment, and services provided

Surveyor Findings

The Joint Commission

Accreditation Survey Findings

Requirement(s) for Improvement

These are the Requirements for Improvement related to the Primary Priority Focus Area:

Information Management

Standard: IM.6.10

Program: HAP

Standard Text: The hospital has a complete and accurate medical record for patients assessed, cared for, treated, or served.

Secondary Priority Focus Area(s): N/A

Element(s) of Performance

Scoring Category : B
11. The medical record delinquency rate averaged from the last four quarterly measurements is not greater than 50% of the average monthly discharge (AMD) rate and no quarterly measurement is greater than 50% of the AMD rate.

Note: The score for this Element of Performance will result from the condition described below.

The medical record delinquency rate averaged from the last four quarterly measurements is the following:

Not greater than 50% of the AMD rate and no single quarterly measurement are greater than 50% of the AMD rate-- the score is 2 -Compliance.

Not greater than 50% of the AMD rate but one or more quarterly measurements is greater than 50% of the AMD rate-- the score is 1 -Partial Compliance.

Greater than 50% of the AMD rate but less than twice (that is, 200%) the AMD rate-- the score is 0 – Insufficient Compliance.

Equal to or greater than twice (that is, 200%) the AMD rate-- the score is 0 – Insufficient Compliance and a decision of Conditional Accreditation: see DECISION RULE CON05.

Surveyor Findings

The average medical record delinquency rate for the last four quarters exceeded 50 percent. The hospital had identified this as an issue and recently had implemented policies to improve record completion, with some evidence of success.

Standard: IM.6.50

Program: HAP

Standard Text: Designated qualified staff accept and transcribe verbal or telephone orders from authorized individuals.

Secondary Priority Focus Area(s): N/A

Element(s) of Performance

Scoring Category : A
3. When required by law or regulation, verbal or telephone orders are authenticated within the specified time frame.

The Joint Commission

Accreditation Survey Findings

Requirement(s) for Improvement

These are the Requirements for Improvement related to the Primary Priority Focus Area:

Patient Safety

Standard: EC.1.10

Program: HAP

Standard Text: The hospital manages safety risks.

Secondary Priority Focus Area(s): N/A

Element(s) of Performance

Scoring Category : B
4. The hospital conducts comprehensive proactive risk assessments that evaluate the potential adverse impact of buildings, grounds, equipment, occupants, and internal physical systems on the safety and health of patients, staff, and other people coming to the hospital's facilities.

Scoring Category : C
5. The hospital uses the risks identified to select and implement procedures and controls to achieve the lowest potential for adverse impact on the safety and health of patients, staff, and other people coming to the hospital's facilities.

Surveyor Findings

EP 4
Observed in M103 at Broughton Hospital site.
During an environment of care tour and in discussions with staff, a number of new electric beds were introduced into patient care areas approximately six months ago. The electric beds contained at a minimum flexible 8 ft long cords and four side rails. The electric cords and side rails were a potential hazard for patients seeking to do self-harm. The Hospital did not do a risk assessment of the electric beds for patient hazard vulnerabilities before placing the beds into service. It should be noted that the Hospital began shortening and securing the electric cords during the survey.

EP 5
Observed in Room #3000 at Broughton Hospital site.
During the environment of care tour, room #3000 was used to store Oxygen cylinders, i.e., H cylinders and E cylinders. The cylinders were grouped together in their different size categories and supported by a metal chain to prevent tippage. At the time of the survey visit, the E cylinders were loosely contained by the chain and could easily tip over. This observation was validated by the Engineering Services Department staff.

Observed in M103 at Broughton Hospital site.
During the environment of care tour, in the medication room, there was a extension cord in use to accommodate several electrical plugs.

Standard: EC.5.40

Program: HAP

Standard Text: The hospital maintains fire-safety equipment and building features.

Secondary Priority Focus Area(s): N/A

Element(s) of Performance

The Joint Commission

Accreditation Survey Findings

Requirement(s) for Improvement

Secondary Priority Focus Area(s): N/A

Element(s) of Performance

Scoring Category : A
5. Facilities that have a generator providing emergency power for the services listed in Elements of Performance 5 through 17 of Standard EC.7.20: The hospital tests each emergency generator at least once every 36 months for a minimum of four continuous hours. This test shall be conducted under a load (dynamic or static) that is at least 30% of the nameplate rating of the generator.* ** Note 1: To be in initial compliance with this Element of Performance, organizations must have performed this test by July 1, 2007. Organizations that have successfully operated their generator(s) since July 1, 2004, according to the test criteria described above, will be considered to be in initial compliance with this Element of Performance and are required to retest before the three year anniversary date of such occurrence.Note 2: Hospitals that cannot achieve a minimum load of 30% of the emergency generator's nameplate rating, must assess the prime movers' exhaust gas temperature and meet the minimum temperature recommended by the manufacturer.

*This test may satisfy one of the tests required by Element of Performance 1.
**After the test, the fuel supply should be replenished. Any problems identified during the test shall be resolved promptly. For additional guidance, see NFPA 110 (2005 edition) Standard for Emergency & Standby Power Systems.

Surveyor Findings

EP 5
Observed in LSC Document Review at Broughton Hospital site.
There was no documentation of a four hour generator test every 36 months.

Observed in LSC Document Review at Broughton Hospital site.
small sample size

Observed in LSC Document Review at Broughton Hospital site.
small sample size

Standard: EC.7.50

Program: HAP

Standard Text: The hospital maintains, tests, and inspects its medical gas and vacuum systems.

Secondary Priority Focus Area(s): N/A

Element(s) of Performance

Scoring Category : A
1. The hospital inspects, tests, and maintains critical components of piped medical gas systems including master signal panels, area alarms, automatic pressure switches, shutoff valves, flexible connectors, and outlets.

Surveyor Findings

EP 1
Observed in LSC Document Review at Broughton Hospital site.
There was no documentation of master signal panel, area alarms, automatic pressure switch or shutoff valve testing.

The Joint Commission

Accreditation Survey Findings

Requirement(s) for Improvement

These are the Requirements for Improvement related to the Primary Priority Focus Area:

Physical Environment

Standard: EC.5.20

Program: HAP

Standard Text: Newly constructed and existing environments are designed and maintained to comply with the Life Safety Code®.

Secondary Priority Focus Area(s): N/A

Element(s) of Performance

Scoring Category : B
1. Each building in which patients are housed or receive care, treatment, and services complies with the LSC, NFPA 101® 2000; OREach building in which patients are housed or receive care, treatment, and services does not comply with the LSC, but the resolution of all deficiencies is evidenced through the following:

An equivalency approved by the Joint Commission Or

Continued progress in completing an acceptable Plan For Improvement (Statement of Conditions™, Part 4)

Surveyor Findings

See Life Safety Code Report

Standard: EC.8.10

Program: HAP

Standard Text: The hospital establishes and maintains an appropriate environment.

Secondary Priority Focus Area(s): N/A

Element(s) of Performance

Scoring Category : C
4. Areas used by the patients are safe, clean, functional, and comfortable.

Surveyor Findings

The Joint Commission

Accreditation Survey Findings

Requirement(s) for Improvement

hallway and presented a potential self-harm/hanging hazard for patients.
In discussions with staff and at the environment of care system tracer, staff stated that because of the type of patients (older medical) treated on M103, it was felt that the noted observations were not a hazard. However, staff had not considered that other patients (younger medical) from elsewhere in the Hospital could be transferred to M103 for a medical treatment (as is the Hospital's practice) requiring isolation and may be at risk to do self-harm. There was not evidence of a documented risk assessment having been completed for the concerns noted.

Observed in M103 at Broughton Hospital site.
Sinks located in patient rooms were noted to have exposed pipes underneath, presenting another safety/hazard potential for patients to commit self-harm.

The Joint Commission

Accreditation Survey Findings

Requirement(s) for Improvement

Standard: PC.11.20

Program: HAP

Standard Text: Performance improvement processes seek to identify opportunities to reduce the risks associated with restraint use through preventive strategies, innovative alternatives, and process improvements.

Secondary Priority Focus Area(s): N/A

Element(s) of Performance

1. The hospital measures and assesses its restraint use to identify opportunities to introduce preventive strategies, alternatives to use, and process improvements that reduce the risks associated with restraint use.

Surveyor Findings

EP 1
Observed in data use systems tracer at Broughton Hospital site.
The hospital collected data on restraint usage. However, there was no documentation where opportunities were identified to introduce preventive strategies, alternative to use, and process improvements that would reduce the risks associated with restraint use.

The Joint Commission

Accreditation Survey Findings

Requirement(s) for Improvement

EP 2
Observed in M103 at Broughton Hospital site.
During a tracer activity, an assessment written by a social worker stated that a legal guardianship was warranted for the patient. The patient had dementia and lacked capacity to make decisions about his care, whether to accept or refuse care, treatment and services. The Hospital has a process to initiate guardianship for a patient, however, had not done so for the patient of record. In discussions with staff, it was shared that the Hospital was without a clinical social worker until 10/07 to carry out the "guardianships" for patients. The patient's family members did not have the monies to pursue official guardianship. The patient has been in the Hospital for 18 months. At the time of the survey 12/11, guardianship had not been officially initiated.

Observed in M103 at Broughton Hospital site.
When reviewing the patient's care, it was noted in discussions with staff that the patient at the time of the survey, lacked capacity and was experiencing a psychotic episode and was not legally responsible to make decisions regarding the acceptance or refusal of care, treatment and services. There was no official surrogate appointed to act on the patient's behalf when the patient lacked capacity. There was three of four sons listed in the patient's record that the patient wanted notified as appropriate to her care.

Observed in Division A, Ward 3 at Broughton Hospital site.
During a tracer activity, nursing staff stated the patient was not competent to make decisions about her care. Staff stated that the patient's legal guardianship was held by the mother, however, there was no legal documentation within the record to demonstrate that the mother indeed held legal guardianship for the patient.

Standard: RI.2.40

Program: HAP

Standard Text: Informed consent is obtained.

Secondary Priority Focus Area(s): N/A

Element(s) of Performance

Scoring Category : C
2. Informed consent is obtained and documented in accordance with the hospital's policy.

Surveyor Findings

EP 2
Observed in Male Admissions Crisis Stabilization at Broughton Hospital site.
The record of a patient prescribed risperidone lacked consent for this medication as required by hospital policy.

Observed in Male Admissions Crisis Stabilization at Broughton Hospital site.
The record of a patient prescribed lorazepam lacked consent for this medication as required by hospital policy.

Observed in Adult Admissions 4 at Broughton Hospital site.
The record of a patient prescribed Thorazine lacked consent for this medication as required by hospital policy.

The Joint Commission

Accreditation Survey Findings

Requirement(s) for Improvement

EP 3

Observed in competence review at Broughton Hospital site.

The license of the physical therapist was renewed by 1/31/08. There was no documentation that primary source verification of the renewal had taken place at that time. Documentation indicated primary source verification took place on 4/18/07.

The Joint Commission

Accreditation Survey Findings

Life Safety Code

Inpatient Occupancy Existing Healthcare Occupancies; Section III - Compartments

Requirement: EC.A.3C.1

Phrase: Existing Health Care Occupancies Smoke barriers are: continuous from outside wall to outside wall. (EC.A.3C)(EC.A.3C.1)

Surveyor Findings:

A number of penetrations were noted in: Medical Imaging Dept, (3-4 inches in diameter) the piping and cableling for the airconditioner penetrated a wall into a wall duct; Room # 3000 outside of M103 unit, two horizontal penetrations into the wall inside the Oxygen room, one area around a pipe and a hole into what appears to be a duct within the wall.

Requirement: EC.A.3D.1

Phrase: Existing Health Care Occupancies Doors in smoke barriers are: fitted to prevent the spread of smoke. (EC.A.3D)(EC.A.3D.1)

Surveyor Findings:

The door in Scroggs ward 15 smoke partition was not smoke tight due to it's inability to close fully.

Requirement: EC.A.3F

Phrase: Existing Health Care Occupancies Duct penetrations of smoke barriers are protected by approved smoke dampers. (EC.A.3F)

Surveyor Findings:

There was no damper in the ductwork penetrating Room 227.

The Joint Commission

Accreditation Survey Findings

Supplemental Findings

These are the Supplemental Findings related to the Primary Priority Focus Area of:

Assessment and Care/Services

Standard: PC.3.10

Program: HAP

Standard Text: Patients who may be victims of abuse or neglect are assessed. (See standard RI.2.150.)

Secondary Priority Focus Area(s) N/A

Element(s) of Performance

Scoring Category : B
4. Victims of abuse or neglect are identified using the criteria developed or adopted by the hospital at entry into the system and on an ongoing basis.

Surveyor Findings

EP 4
Observed in Ward 14 Scroggs Building at Broughton Hospital site.
During tracer activities, observations were made that an assessment for abuse/neglect was not done at the time of admission using the criteria developed by the organization. Staff received education that listed examples of abuse, neglect and exploitation. A psychosocial assessment that addressed abuse/neglect for a patient admitted on 11/14/07 was not completed until 11/26/07, 12 days after admission to the hospital.

The Joint Commission

Accreditation Survey Findings

Supplemental Findings

These are the Supplemental Findings related to the Primary Priority Focus Area of:

Equipment Use

Standard: EC.3.10

Program: HAP

Standard Text: The hospital manages its hazardous materials and waste risks.

Secondary Priority Focus Area(s) N/A

Element(s) of Performance

Scoring Category : B
9. The hospital identifies and implements emergency procedures that include the specific precautions, procedures, and protective equipment used during hazardous materials and waste spills or exposures.

Surveyor Findings

EP 9
Observed in Morgue at Broughton Hospital site.
The morgue, which was reportedly occasionally used for autopsies, contained formalin. There was no eye wash station in or near the morgue for use in case of exposure to formalin or body fluids.

These are the Supplemental Findings related to the Primary Priority Focus Area of:

Infection Control

Standard: IC.4.10

Program: HAP

Standard Text: Once the hospital has prioritized its goals, strategies must be implemented to achieve those goals.

Secondary Priority Focus Area(s) N/A

Element(s) of Performance

Scoring Category : B
1. Interventions are designed to incorporate relevant guidelines* for infection prevention and control activities.

*Examples of guidelines include those offered by the CDC, Healthcare Infection Control Practices Advisory Committee (HICPAC), and National Quality Forum (NQF).

Surveyor Findings

EP 1
Observed in A Division, Ward 3 at Broughton Hospital site.
The mattress pad covers (located in the seclusion room # S208 and the restraint room # S206) integrity was compromised. There were tears/splits through to the foam foundation.

The Joint Commission

Accreditation Survey Findings

Supplemental Findings

These are the Supplemental Findings related to the Primary Priority Focus Area of:

Credentialed Practitioners

Standard: MS.4.15

Program: HAP

Standard Text: The decision to grant or deny a privilege(s), and/or to renew an existing privilege(s), is an objective, evidenced-based process.

Secondary Priority Focus Area(s) N/A

Element(s) of Performance

Scoring Category : B
1. The hospital, based on recommendations by the organized medical staff and approval by the governing body, establishes criteria that determine a practitioner's ability to provide patient care, treatment, and services within the scope of the privilege(s) requested. Evaluation of the following are included in the criteria:

Current licensure and/or certification, as appropriate, verified with the primary source.

The applicant's specific relevant training, verified with the primary source.

Evidence of physical ability to perform the requested privilege*.

Data from professional practice review by an organization(s) that currently privileges the applicant (if available).

Peer and/or faculty recommendation.

When renewing privileges, review of the practitioner's performance within the organization.

*Organizations should consider the applicability of the Americans with Disabilities Act (ADA) to their credentialing and privileging activities, and, if applicable, review their medical staff bylaws, policies, and procedures. Federal entities are required to comply with the Rehabilitation Act of 1974.

Surveyor Findings

EP 1
Observed in Credentials at Broughton Hospital site.
Psychiatrists were routinely granted privileges in "General Medicine", which included management of general medical problems and performance of physical examinations, without requiring evidence of current competence.

The Joint Commission

Accreditation Survey Findings

Life Safety Code

Inpatient Occupancy Existing Healthcare Occupancies; Section V - Exits

Requirement: EC.A.5I

Phrase: Existing Health Care Occupancies Doors to stairs or areas that are not conforming exits and are likely to be mistaken for exits are identified with signs reading "NO EXIT." (EC.A.5I)

Surveyor Findings:

Doors leading from stairwells E and F in Jones Building which led to non-exit floors, while marked with signs, could still have been mistaken for exits due to the relatively small print and complex verbiage on the signs. This was confirmed by having a randomly selected nurse attempt to exit from a stairwell; she attempted to exit through the first floor door rather than down one more flight of stairs to the unmarked exit.

Requirement: EC.A.5K.1

Phrase: Existing Health Care Occupancies Exit signs are: readily visible from any direction of access. (EC.A.5K)(EC.A.5K.1)

Surveyor Findings:

Exits leading out of stairwells F and E in the Jones building were not marked as such.

Inpatient Occupancy Existing Healthcare Occupancies; Section VI - Operating Features

Requirement: EC.A.6A

Phrase: Existing Health Care Occupancies Automatic transmission of the fire alarm signal is accomplished via: 1) an auxiliary protective signalling system, per NFPA 72,4-7 (direct connection to servicing fire department); or 2) a central station service, per NFPA 72,4-2) a proprietary supervising station system, per NFPA 72,4-3 or Joint Commission policy for a manual transmission system; or 4) a remote supervising station fire alarm system, per NFPA 72,4-4. (EC.A.6A)

Surveyor Findings:

There is no automatic transmission of fire alarm signals. The room housing the Command Center, which calls the fire department is not two hour rated construction.

The Joint Commission

Accreditation Survey Findings

Life Safety Code

Inpatient Occupancy Existing Healthcare Occupancies; Section I - Buildings

Requirement: EC.A.1A.4.b

Phrase: Existing Health Care Occupancies The following assemblies are constructed of materials with the minimum fire resistance rating based upon the type of construction: structural frame. (EC.A.1A)(EC.A.1A.4)(EC.A.1A.4.b)

Surveyor Findings:

The structural steel in the Scroggs ward 13 north exit was not coated with fire resistant material.

Requirement: EC.A.1B.2

Phrase: Existing Health Care Occupancies Where two-hour fire resistance rated separations are required: such separations extend from exterior wall to exterior wall. (EC.A.1B) (EC.A.1B.2)

Surveyor Findings:

There was an unsealed penetration in the 2 hour rated building separation in Scroggs ward 13 near room 116.

Requirement: EC.A.1E

Phrase: Existing Health Care Occupancies Duct penetrations in two-hour fire resistance rated separations are protected by dampers that have at least 1 1/2-hour fire resistance rated assemblies. (EC.A.1E)

Surveyor Findings:

The linen storage (patient belongings) room was lacking a damper in the ductwork.

Inpatient Occupancy Existing Healthcare Occupancies; Section II - Rooms

Requirement: EC.A.2I.4

Phrase: Existing Health Care Occupancies Corridor doors are: arranged to have not more than 3/4-inch undercuts. (EC.A.2I)(EC.A.2I.4)

Surveyor Findings:

The shower room door in Harper 20 was lacking a positive latch.

The Joint Commission

Accreditation Survey Findings

Requirement(s) for Improvement

These are the Requirements for Improvement related to the Primary Priority Focus Area:

Staffing

Standard: LD.2.20

Program: HAP

Standard Text: Each organizational program, service, site, or department has effective leadership.

Secondary Priority Focus Area(s): N/A

Element(s) of Performance

Scoring Category : B
2. Leaders hold staff accountable for their responsibilities.

Surveyor Findings

EP 2
Observed in Life Safety Code Tour at Broughton Hospital site.
The organization's process to alert the local fire authorities in case of fire was a delayed process that involved the security officer being dispatched to the location of the alarm when alerted by the command center. The officer would investigate the reason for the alarm, notify the command center and they in return would notify the local fire authorities. Upon the activation of any fire alarm the command center should call the local fire authorities immediately.

Standard: HR.1.20

Program: HAP

Standard Text: Staff qualifications are consistent with his or her job responsibilities.

Secondary Priority Focus Area(s): N/A

Element(s) of Performance

Scoring Category : A
3. When current licensure, certification, or registration are required by law or regulation to practice a profession*, the hospital verifies these credentials with the primary source at the time of hire and upon expiration of the credentials.Note: It is acceptable to verify current licensure, certification, or registration with the primary source via a secure electronic communication or by telephone, if this verification is documented. For additional information, see "primary source verification" in the Glossary.
Note: A primary source of information may designate another agency to communicate credentials information. The designated agency then can be used as a primary source.
Note: An external organization [for example, a credentials verification organization (CVO)] may be used to collect credentials information. A CVO must meet the CVO guidelines listed in the Glossary.
*Profession is a specialized work function within society, generally performed by a professional. It often refers specifically to fields that require extensive study and mastery of specialized knowledge and skills.

Surveyor Findings

The Joint Commission

Accreditation Survey Findings

Requirement(s) for Improvement

These are the Requirements for Improvement related to the Primary Priority Focus Area:

Rights & Ethics

Standard: LD.3.20

Program: HAP

Standard Text: Patients with comparable needs receive the same standard of care, treatment, and services throughout the hospital.

Secondary Priority Focus Area(s): N/A

Element(s) of Performance

Scoring Category : B
1. Patients with comparable needs receive the same standard of care, treatment, and services throughout the hospital.

Surveyor Findings

EP 1
Observed in Ward 14 Scroggs Building at Broughton Hospital site.
During tracer activities, observations were made that a patient seen by the dentist on 8/6/07 and identified as having a non-retentive upper denture and needing a permanent re-lining of the denture. Permission from the guardian/responsible party was obtained on 8/31/07. The patient had not as of the day of survey received the dental services. Staff indicated that there were other patients who had greater needs. The patient had been transferred to the medical building in August for an acute condition and returned back to the geripsych unit within a few days.

Standard: RI.2.70

Program: HAP

Standard Text: Patients have the right to refuse care, treatment, and services in accordance with law and regulation.

Secondary Priority Focus Area(s): N/A

Element(s) of Performance

Scoring Category : A
2. When the patient is not legally responsible, the surrogate decision maker, as allowed by law, has the right to refuse care, treatment, and services on the patient's behalf.

Surveyor Findings

The Joint Commission

Accreditation Survey Findings

Requirement(s) for Improvement

These are the Requirements for Improvement related to the Primary Priority Focus Area:

Quality Improvement Expertise/Activities

Standard: PI.2.10

Program: HAP

Standard Text: Data are systematically aggregated and analyzed.

Secondary Priority Focus Area(s): N/A

Element(s) of Performance

Scoring Category : B
1. Collected data are aggregated and analyzed.

Surveyor Findings

EP 1
Observed in Data system tracer at Broughton Hospital site.
The Hospital collects data from psychiatric debriefings after each restraint or seclusion episode. The data was not being aggregated and analyzed at the time of the survey visit.

Standard: PI.2.20

Program: HAP

Standard Text: Undesirable patterns or trends in performance are analyzed.

Secondary Priority Focus Area(s): N/A

Element(s) of Performance

Scoring Category : A
13. An analysis is performed for the following: ORYX core measure data that, over three or more consecutive quarters for the same measure, identify the organization as a negative outlier.

Surveyor Findings

EP 13
Observed in data systems tracer at Broughton Hospital site.
The organization had 2.5 years of ORYX core measure data identified as negative outliers. These negative outliers included client injury rate, percentage of clients restrained, percentage of clients secluded and restraint hours. The organization did not have documentation to indicate that an analysis had been completed to identify areas for improvement.

Standard: PC.11.20

Program: HAP

Standard Text: Performance improvement processes seek to identify opportunities to reduce the risks associated with restraint use through preventive strategies, innovative alternatives, and process improvements.

Secondary Priority Focus Area(s): N/A

Element(s) of Performance

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Requirement(s) for Improvement

EP 4

Observed in Ward 14 Scroggs Building at Broughton Hospital site.
During the environmental tour of the unit, an exposed door closer arm was observed in the bathroom/shower room as having the potential for self harm. Staff indicated observations are made every 15 minutes when a patient is in the bathroom/shower room.

Observed in Ward 15 Scroggs Building at Broughton Hospital site.
During the environmental tour of the unit, an exposed door closer arm in the patient bathroom/shower room was observed as having the potential for self harm. Staff indicated observations are made every 15 minutes when a patient is in the bathroom/shower room.

Observed in Ward 18 Youth Building at Broughton Hospital site.
During the environmental tour of the unit, observations were made that both shower stalls had open handrails that had the potential for self injury.

Observed in Ward 18 Youth Building at Broughton Hospital site.
During the environmental tour of the unit, observations were made that the telephone located at the end of the hallway had a long metal cord that could have the potential for self harm.

Observed in Adult Admissions 4 at Broughton Hospital site.
Interior door knobs in patient shower rooms could have been used in hanging attempts.

Observed in Adult Admissions 4 at Broughton Hospital site.
Shower mixer handles in patient shower rooms could have been used in hanging attempts.

Observed in Adult Admissions 4 at Broughton Hospital site.
Under sink plumbing fixtures in patient shower rooms could have been used in hanging attempts.

Observed in Adult Admissions 4 at Broughton Hospital site.
Sink faucet handles in patient shower rooms could have been used in hanging attempts.

Observed in Adolescent Ward 8 at Broughton Hospital site.
Undersink plumbing fixtures in patient restrooms could have been used in hanging attempts.

Observed in Adolescent Ward 8 at Broughton Hospital site.
Interior door handles in patient restrooms could have been used in hanging attempts.

Observed in Adolescent Ward 8 at Broughton Hospital site.
Commode stall wall supports in patient restrooms could have been used in hanging attempts.

Observed in Adult Admissions Triage at Broughton Hospital site.
A metal clad phone cord in the common hallway could have been used in a hanging attempt.

Observed in M103 at Broughton Hospital site.
During an environment of care tour, there were observations regarding safety of the area noted in a patient care isolation room, i.e., ante-room #3046 as part of room #3046A. In #3046A, the observations noted were: long television cord, at least 6 ft; B/P cuff mounted on the wall with a long coiled rubber cord, at least 6 ft; electric bed with side rails and an electric cord, at least 8 ft; non-breakaway curtain rod; and an electric coiled covered cable that ran from the wall into the ceiling, creating a 12-18 inch exposed loop.
In room #3046 (ante-room), there were approximately 4 ft of 2 inch diameter water pipes exposed just inside of and at the top of the door level. There was also a sink and counter-top that would allow climbing access to the pipes. The areas noted were not immediately observable by staff from the

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Requirement(s) for Improvement

Standard: NPSG Requirement 1A

Program: HAP

Standard Text: Use at least two patient Identifiers when providing care, treatment or services.

Secondary Priority Focus Area(s): N/A

Element(s) of Performance

Scoring Category : C

1. Two patient identifiers are used when administering medications or blood products

Surveyor Findings

EP 1

Observed in Ward 4 at Broughton Hospital site.
A patient stated that when administered medication, the nurse routinely addressed him by name and passed the medication without asking his name or other identification.

Observed in Ward 4 at Broughton Hospital site.
A second patient stated that when administered medication, the nurse routinely addressed him by name and passed the medication without asking his name or other identification.

Observed in Ward 4 at Broughton Hospital site.
A third patient stated that when administered medication, the nurse routinely addressed him by name and passed the medication without asking his name or other identification.

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Accreditation Survey Findings

Requirement(s) for Improvement

Standard: EC.5.40

Program: HAP

Standard Text: The hospital maintains fire-safety equipment and building features.

Secondary Priority Focus Area(s): N/A

Element(s) of Performance

2. Occupant alarm notification devices, including all audible devices, speakers, and visible devices, are tested at least annually.** For additional guidance, see NFPA 72-1999 edition (Table 7-3.2).

Scoring Category : C

8. For water-based automatic fire-extinguishing systems, all fire department connections are inspected quarterly.

Scoring Category : C

14. All fire and smoke dampers are operated at least every four years (with fusible links removed where applicable) to verify that they fully close.**For additional guidance, see NFPA 90A-1999 edition (section 3-4.7).

Surveyor Findings

EP 2

Observed in LSC Document Review at Broughton Hospital site.
There was no documentation of alarm notification device testing.

Observed in LSC Document Review at Broughton Hospital site.
small sample size

Observed in LSC Document Review at Broughton Hospital site.
small sample size

EP 8

Observed in LSC Document Review at Broughton Hospital site.
There was no documentation of first quarter fire department connection testing.

Observed in LSC Document Review at Broughton Hospital site.
There was no documentation of second quarter fire department connection testing.

Observed in LSC Document Review at Broughton Hospital site.
There was no documentation of third quarter fire department connection testing.

EP 14

Observed in LSC Document Review at Broughton Hospital site.
There was no documentation of fire and smoke damper testing.

Observed in LSC Document Review at Broughton Hospital site.
small sample size

Observed in LSC Document Review at Broughton Hospital site.
small sample size

Standard: EC.7.40

Program: HAP

Standard Text: The hospital maintains, tests, and inspects its emergency power systems.

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Accreditation Survey Findings

Requirement(s) for Improvement

Standard: IM.6.50

Program: HAP

Standard Text: Designated qualified staff accept and transcribe verbal or telephone orders from authorized individuals.

Secondary Priority Focus Area(s): N/A

Surveyor Findings

EP 3
Observed in Division A, Ward 3 at Broughton Hospital site.
During tracer activities, a telephone order written on 11/13/07 was not authenticated by the physician of record until 11/19/07. This authentication is outside the 48 hours requirement of CMS.

Observed in Division A, Ward 3 at Broughton Hospital site.
During a tracer activity, a telephone order written on 11/15/07, was not authenticated by the physician of reference until 11/19/07. The authentication was outside of the 48 hour requirement by CMS.

These are the Requirements for Improvement related to the Primary Priority Focus Area:

Organizational Structure

Standard: LD.4.10

Program: HAP

Standard Text: The leaders set expectations, plan, and manage processes to measure, assess, and improve the hospital's governance, management, clinical, and support activities.

Secondary Priority Focus Area(s): N/A

Element(s) of Performance

Scoring Category : B
2. The leaders develop plans for performance improvement.

Surveyor Findings

EP 2
Observed in leadership discussions at Broughton Hospital site.
The leaders had not developed a plan for performance improvement regarding the negative outliers for the core measure indicators at the time of survey. Outliers for 2.5 years consisted of client injury rates, percentage of clients restrained, percentage of clients secluded and restraint hours without evidence of a plan for improvement.

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Accreditation Survey Findings

Requirement(s) for Improvement

EP 1
Observed in Infection Control review at Broughton Hospital site.
The organization had not prepared a risk analysis for the transmission and acquisition of infectious agents throughout the hospital based on geographic location and community environment, program/services provided, and the characteristics of the population served, results of the analysis of the infection prevention and control data, and the care, treatment, and services provided.

Standard: IC.3.10

Program: HAP

Standard Text: Based on risks, the hospital establishes priorities and sets goals for preventing the development of health care-associated infections within the hospital.

Secondary Priority Focus Area(s): N/A

Element(s) of Performance

Scoring Category : B
1. Priorities are established and goals related to preventing the acquisition and transmission of potentially infectious agents are developed based on the risks identified.

Surveyor Findings

EP 1
Observed in infection control documents at Broughton Hospital site.
There were no goals and priorities established related to preventing the acquisition and transmission of potentially infectious agents developed since there was no risk analysis.

Standard: IC.7.10

Program: HAP

Standard Text: The infection control program is managed effectively.

Secondary Priority Focus Area(s): N/A

Element(s) of Performance

Scoring Category : B
4. This individual(s) facilitates ongoing monitoring of the effectiveness of prevention and/or control activities and interventions.

Surveyor Findings

EP 4
Observed in Adult Admissions 4 at Broughton Hospital site.
Monitoring of the effectiveness of prevention and control activities was not evident in that a patient with a methicillin resistant staphylococcus aureus wound, who had been placed on contact precautions, was allowed unrestricted activity on the unit and in the cafeteria with no warning provided to those who may have come into direct contact with him. While data on MRSA infected patients had been collected, there was no evidence of specific actions taken in the last year to reduce the risk of MRSA being spread to uninfected patients or staff.

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Accreditation Survey Findings

Requirement(s) for Improvement

These are the Requirements for Improvement related to the Primary Priority Focus Area:

Infection Control

Standard: EC.7.10

Program: HAP

Standard Text: The hospital manages its utility risks.

Secondary Priority Focus Area(s): N/A

Element(s) of Performance

Scoring Category : A
16. The hospital designs, installs, and maintains ventilation equipment to provide appropriate pressure relationships, air-exchange rates, and filtration efficiencies for ventilation systems serving areas specially designed,* to control air-borne contaminants (such as biological agents, gases, fumes, and dust).
*Areas specially designed include spaces such as operating rooms, special procedure rooms, delivery rooms for patients diagnosed or suspected of having airborne communicable diseases (for example, pulmonary or laryngeal tuberculosis), patients in "protective environment" rooms (for example, those receiving bone marrow transplants), laboratories, pharmacies, and sterile supply rooms.

Surveyor Findings

EP 16
Observed in M103 - Rm #3046A at Broughton Hospital site.
During an environment of care tour, the isolation room # 3046A contained an exhaust fan mounted into the wall to accommodate and create a negative pressure environment for patients with airborne communicable diseases. The fan exhausted horizontally and directly to the outside. There was no filter, i.e., Hepa type mounted within the exhaust system. In discussion with the Infection Control Nurse Coordinator, it was stated that there should be a Hepa type filter within the exhaust fan system. It was shared with the surveyor that there is a second isolation room and it does not contain any Hepa type filter within the exhaust fan system.

Standard: IC.1.10

Program: HAP

Standard Text: The risk of development of a health care-associated infection is minimized through an organizationwide infection control program.

Secondary Priority Focus Area(s): N/A

Element(s) of Performance

Scoring Category : B
4. Systems are in place to communicate with licensed independent practitioners, staff, students/trainees, volunteers, and as appropriate, visitors, patients, and families about infection prevention and control issues, including their responsibilities in preventing the spread of infection within the hospital.

Scoring Category : B
9. The hospital has a written IC plan* that includes the following:

A description of prioritized risks
A statement of the goals of the IC program

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Requirement(s) for Improvement

Standard Text: The patient and staff participate in a debriefing about the restraint or seclusion episode.

Secondary Priority Focus Area(s): N/A

Element(s) of Performance

Scoring Category : B
3. The debriefing is used to do the following:

Identify what led to the incident and what could have been handled differently
Ascertain that the patient's physical well-being, psychological comfort, and right to privacy were addressed
Counsel the patient for any trauma that may have resulted from the incident
When indicated, modify the patient's plan for care, treatment, and services

Scoring Category : B
4. Information obtained and documented from debriefings is used in performance improvement activities.

Surveyor Findings

EP 3
Observed in Division A, Ward 3 at Broughton Hospital site.
During a tracer activity, a patient who was manually restrained and secluded for less than five minutes refused to participate in a debriefing. From the documentation it appears only one attempt was made to debrief with the patient. The debriefing form used by the Hospital staff (ERI Progress Note) does not meet the elements of what the debriefing should be used for, i.e, what led to the episode; ascertain that the patient's well-being, psychological comfort and right to privacy were met; counsel the patient for any trauma from the episode; and modify the plan for care/treatment/services.

EP 4
Observed in Data system tracer at Broughton Hospital site.
During the data system tracer, the Hospital collects and documents information from debriefings, however, the Hospital was not utilizing the information collected in performance improvement activities.

Standard: NPSG Requirement 15A

Program: HAP

Standard Text: The organization identifies patients at risk for suicide.
Note: This requirement only applies to psychiatric hospitals and patients being treated for emotional or behavioral disorders in general hospitals.

Secondary Priority Focus Area(s): N/A

Element(s) of Performance

Scoring Category : C
1. The risk assessment includes identification of specific factors and features that may increase or decrease risk for suicide.

Surveyor Findings