An onsite, unannounced recertification survey was conducted to determine the facility's compliance with the federal requirements set forth in the Medicare Conditions of Participation at 42 CFR Part 482. An entrance conference was conducted on August 12, 2019, at 8:45 am, in an 8th floor meeting room with the facility's Administrative Staff. A brief introduction and explanation of the survey process was provided with an opportunity for questions and discussion.

An exit conference was conducted on August 23, 2019, at 10:00 am, with hospital leadership and staff in the facility Auditorium. The preliminary findings were explained and an opportunity was given for questions and discussion. The next steps in the survey process were explained. An opportunity was given for the facility to provide evidence of compliance with those requirements for which non-compliance had been found during

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.
Deficient practices of the following Conditions of Participation were determined to pose an Immediate Jeopardy to patient health and safety and placed all patients in the facility at risk for the likelihood of harm, serious injury, and possibly subsequently death.

482.13 Patient Rights
482.42 Infection Control
482.51 Surgical Services

Patient Rights - Care in a Safe Setting:

On August 20, 2019, it was determined that patients were receiving Ketamine (a Schedule III controlled substance approved by the FDA as an anesthetic agent) by infusion in the Pain Management Outpatient Center. There was no policy in place for Ketamine infusions to be administered in the outpatient setting. Nurses were not monitoring the patients before, during, or after infusion. Nurses had not been trained to administer or monitor patients while receiving this medication. The facility's executive leadership team was informed of the findings of Immediate Jeopardy and were offered the opportunity to provide a plan of removal that would abate the likelihood of harm identified.

On August 21, 2019, the Executive Leadership Team provided an acceptable plan of removal to abate the Immediate Jeopardy. The plan was as follows:

<table>
<thead>
<tr>
<th>ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
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<tr>
<td>A 000</td>
<td>Continued From page 1 the survey. No further evidence was provided.</td>
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<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
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### Summary Statement of Deficiencies

1. The facility immediately ceased administering Ketamine via infusion in the outpatient clinics.

2. All administration of Ketamine via infusion will be done in the Non-OR PACU (Non-Operating Room Post Anesthesia Care Unit). Nursing staff in the PACU have the education and competencies to monitor patients receiving Ketamine by infusion.

3. Policies will be written for provision of the administration of Ketamine via infusion in the Outpatient Pain Management Unit.

4. Nursing staff in the outpatient unit will be trained on the administration of Ketamine via infusion and competencies will be required to provide care to patients in the Outpatient Pain Management Unit for the administration of Ketamine via infusion.

5. Physicians and Mid-level Practitioners will be educated on the nurses role in the administration and monitoring of Ketamine via infusion in the outpatient setting.

#### Infection Control:

Based upon observations, interviews, and record review, the facility failed to:

1. Ensure that clean linens were not contaminated by soiled linens, soiled equipment, and/or soiled staff uniforms.

2. Ensure that sterile surgical linens were handled and stored to prevent contamination by dust, soiled linens, soiled equipment, and/or soiled staff uniforms.
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**A. BUILDING**

**B. WING**

**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**NAME OF PROVIDER OR SUPPLIER**

**UNIVERSITY OF TEXAS M D ANDERSON CANCER CENTER, THE**

**STREET ADDRESS, CITY, STATE, ZIP CODE**

**UNIVERSITY OF TEXAS M D ANDERSON CANCER CENTER, THE**

1515 HOLCOMBE BLVD
HOUSTON, TX  77030

**SUMMARY STATEMENT OF DEFICIENCIES**

(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

1. Uniforms.

2. Ensure that durable medical equipment, which was removed from isolation rooms, was sanitized using the appropriate disinfectant for the organism being isolated and stored under appropriately clean conditions after disinfection.

3. Ensure that durable medical equipment, which was removed from isolation rooms, was sanitized using the appropriate disinfectant for the organism being isolated and stored under appropriately clean conditions after disinfection.

4. Ensure that nursing staff were educated in and used the appropriate disinfectant for the organism being isolated when disinfecting equipment coming out of patient isolation rooms.

5. Ensure that patient transportation staff cleaned and disinfected wheelchairs and stretchers between patient uses, as well as stored said equipment under appropriately clean conditions.

6. Ensure Environmental Services/Housekeeping maintained isolation precautions to prevent cross contamination while conducting housekeeping services.

**PROVIDER'S PLAN OF CORRECTION**

(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

**COMPLETION DATE**

A 000

Continued From page 3

uniforms.

3. Ensure that durable medical equipment, which was removed from isolation rooms, was sanitized using the appropriate disinfectant for the organism being isolated and stored under appropriately clean conditions after disinfection.

4. Ensure that nursing staff were educated in and used the appropriate disinfectant for the organism being isolated when disinfecting equipment coming out of patient isolation rooms.

5. Ensure that patient transportation staff cleaned and disinfected wheelchairs and stretchers between patient uses, as well as stored said equipment under appropriately clean conditions.

6. Ensure Environmental Services/Housekeeping maintained isolation precautions to prevent cross contamination while conducting housekeeping services.

On August 15, 2019, surveyors and survey leaders determined that these deficient practices posed an Immediate Jeopardy to the health and safety of all patients. The facility's Executive Leadership Team was informed of the Immediate Jeopardy and were offered the opportunity to provide a plan of removal that would abate the likelihood of harm identified.

On August 20, 2019, the facility's Infection Control Director, Material's Management Director, the Surgical Director, and the Executive Leadership Team provided an acceptable plan of removal to abate the Immediate Jeopardy. The
Continued From page 4

1. TMC laundry leadership was notified Monday, August 19, 2019, that all delivery trucks and clean linen will be inspected by Materials Management staff upon arrival confirming requirements for cleanliness are met. There is to be no dust, dirt, tape residue, or torn plastic, and that adequate shrink-wrapping and use of plastic covers to protect product from environment is required. TMC Laundry is to contact Materials Management 30 minutes prior to any delivery or pickup. The product will not be unloaded from truck until Materials Management personnel are present to inspect and complete a checklist to confirm cleanliness of the vehicle and of the product arriving. Materials Management staff will reject any carts or vehicle loads that do not meet delivery and/or transport requirements for clean transport.

2. A wall was constructed with a door opening to provide adequate separation between clean and dirty linen areas. Rooms to be terminally cleaned and air tested within 5 days prior to occupants moving back to space. Confirmation has been provided for correct airflow in newly constructed rooms.

3. Complete conversion to sterile disposable gowns, drapes, towels in both OR locations within next business day of the finding. Resolved 8-18. All reusable gowns, towels, and drapes have been removed from Main and Mays OR within next business day of the finding. Resolved 8-19. On-site support for the transition for both faculty and staff. Mitigation: mediation was rapid and intended to be permanent plan for the ORs. Scrub attire not protected, exposed to elements.
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<td>A 000</td>
<td>Continued From page 5 on the docks. Scrub attire arrived on Clean carts that were shrink wrapped on 8-17. Mitigation was immediate effective Friday. 8/17/19 and permanent.</td>
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<td>4.</td>
<td>Infection Preventionist presented Infection Control education to Materials Management staff on Friday 8/16 at 2:30 PM and 11 PM. Objectives on the education included, hand hygiene, PPE (donning and doffing), Transmission based precautions (types of isolation with PPE requirements), Soiled linen transport and Equipment cleaning. Staff were educated to use bleach wipes for cleaning and disinfection of all equipment coming to this area. To address the lack of staff knowledge of organisms and appropriate disinfectant it was decided to use bleach for all equipment in this area. Bleach covers the highest risk organisms including Clostridium Difficile. Any equipment surface damage will be assessed and addressed. Staff education with competencies will occur annually or as needed.</td>
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<td>5.</td>
<td>Due to cleanliness issues in the dock area, a full time Housekeeper assigned to dock. Increased frequency of power washing the dock to weekly. Increased utilization of other MD Anderson docks on North Campus in order to mitigate traffic on main docks. Wall to be placed to separate mobility related to kitchen services from rest of dock area.</td>
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Surgical Services:

Based upon observation, record review and interview, the facility failed to:
### UNIVERSITY OF TEXAS M D ANDERSON CANCER CENTER, THE

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<th>COMPLETION DATE</th>
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| A 000 |        |     | Continued From page 6  
1. ensure sterile surgical linen packs that contained surgical gowns, drapes, and towels were sterilized according to manufacturer recommendations.  
2. ensure sterile surgical linen packs that contained surgical gowns, drapes, and towels were transported in a manner that would protect the sterile items from moisture, excessive humidity, and condensation caused by temperature extremes.  
3. ensure there was a process in place to monitor the sterilization and transport of sterile linen packs from an outside contracted vendor to the surgery department.  

On August 15, 2019, surveyors and survey leaders determined that these deficient practices posed an Immediate Jeopardy to the health and safety of all patients. The facility’s Executive Leadership Team was informed of the Immediate Jeopardy and were offered the opportunity to provide a plan of removal that would abate the likelihood of harm identified.  

On August 20, 2019, the facility’s Infection Control Director, Material’s Management Director, the Surgical Director, and the Executive Leadership Team provided an acceptable plan of removal to abate the Immediate Jeopardy. The plan was as follows:  

1. Complete conversion to sterile disposable gowns, drapes, towels in both OR locations within next business day of the finding. Resolved 8-18.
A. BUILDING ____________________________

(X1) PROVIDER/SUPPLIER/CLA IDENTIFICATION NUMBER:

450076

(X2) MULTIPLE CONSTRUCTION
A. BUILDING ____________________________
B. WING ____________________________

(X3) DATE SURVEY COMPLETED

08/23/2019

NAME OF PROVIDER OR SUPPLIER

UNIVERSITY OF TEXAS M D ANDERSON CANCER CENTER, THE

STREET ADDRESS, CITY, STATE, ZIP CODE

1515 HOLCOMBE BLVD
HOUSTON, TX  77030

(X4) ID PREFIX TAG

SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

ID PREFIX TAG

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PROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

(X5) COMPLETION DATE

On August 20, 2019, additional information was provided to the Executive Leadership Team of findings in the Surgery Department that posed the likelihood of harm to the health and safety of patients receiving surgery in the facility. The facility failed to:

1. ensure that surgical instruments were transported to an offsite surgery center in a manner that would protect the sterile instruments from moisture, excessive humidity, and condensation caused by temperature extremes.

2. ensure that an instrument loaner set that contained surgical implants (Zimmer/Biomet Plates) was sterilized according to the manufacturer recommendations.

On August 22, 2019, the surgical leadership and Executive Leadership Team presented an acceptable plan of removal to abate the immediate jeopardy. The plan was as follows:

1. On 8/22/19, ceased utilizing One Tray Sealed
A 000 Continued From page 8

Sterilization Containers for any purpose and will comply with nationally recognized infection prevention and control guidelines and professionally acceptable standards of practice related to sterilization of instruments.

2. SPD day-shift staff have already been educated, remaining staff will be educated by end-of-day.

3. Reminding vendors of our policy that implant delivery must allow for proper sterilization. These reminders began on 8/22/19 and will be completed as soon as possible. It is being reinforced with all perioperative staff that patients will not go to the OR unless the necessary implants are ready for use. Faculty have also been notified of these vendor and staff requirements.

4. The guidelines and policies governing vendor-provided instrumentation and sterile implants will be reviewed and revised as necessary to ensure compliance with nationally recognized infection prevention and control guidelines and professionally acceptable standards of practice related to sterilization of instruments.

5. The facility is now transporting sterile instruments in van. Monitoring of the temperature and humidity in the van while instruments are transported to the off site surgical center. Temperature and humidity logs will be kept to ensure temperature and humidity is kept within appropriate range.

The following Conditions of Participation were
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| A 000 | Continued From page 9 | A 000 | found to be out of compliance:  
 CFR 482.12 Governing Body  
 CFR 482.13 Patient Rights  
 CFR 482.21 QAPI  
 CFR 482.23 Nursing Services  
 CFR 482.25 Pharmacy Services  
 CFR 482.28 Food and Dietetic Services  
 CFR 482.42 Infection Control  
 CFR 482.51 Surgical Services  
 CFR 482.54 Outpatient Services  

Glossary:  
Computed Tomography (CT)- A scan that combines a series of X-ray images uses computer processing to create cross-sectional images of the bones, blood vessels and soft tissues inside your body.  
Dialysate: Dialysate is a solution used in renal dialysis which is needed when normal kidney function fails.  
EHR- electronic health record  
E. coli (Escherichia coli): is one of several types of bacteria that normally inhabit the intestine of humans and animals (commensal organism). Some strains of E. coli are capable of causing disease under certain conditions when the...
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<td>A 000</td>
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<td>immune system is compromised or disease may result from an environmental exposure</td>
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<td></td>
<td>Hemodialysis: hemodialysis is a method that is used to remove waste products such as creatinine and urea and free water from the blood when the kidneys are in a state of renal failure.</td>
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<td>Midodrine: medication used to treat low blood pressure (hypotension) that causes severe dizziness or a light-headed feeling, like you might pass out.</td>
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<td>NPO- Nothing by mouth. To withhold food and fluids.</td>
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<td>PEG tube: (percutaneous endoscopic gastrostomy)</td>
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<td>Purposeful rounding- A nurse driven practice to anticipate patient needs to promote optimal outcome. The assessment consist of the &quot;5 P's&quot;: pain, potty, position, periphery and pump. Assessing pain, bathroom needs, turn and position pain for comfort, moving items within reach and checking the IV pump.</td>
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<td>STAT- immediately</td>
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<td>A 043</td>
<td>VRE: Vancomycin-resistant enterococci (VRE) is a form of bacteria that is resistant to Vancomycin, GOVERNING BODY</td>
<td>CFR(s): 482.12</td>
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<td>10/26/19</td>
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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 documents and interviews, this hospital failed to ensure that it has an effective Governing Body to oversee the total operation of the hospital. This hospital is a State government entity that falls under the University of Texas System, as such subject to the Texas Education Code (TEC). This hospital is focused on research of causes, treatments, and prevention of cancer, as well as a degree granting institution of the University of Texas System.

Findings:

Review of the TEC, Chapter 65, Section 65.11 shows that, "The government of the university system is vested in a board of nine regents appointed by the governor with the advice and consent of the senate. The board may provide for the administration, organization, and names of the institutions and entities in The University of Texas System in such a way as will achieve the maximum operating efficiency of such institutions and entities, provided, however, that no institution or entity of The University of Texas System not authorized by specific legislative act to offer a four-year undergraduate program as of the effective date of this Act shall offer any such four-year undergraduate program without prior recommendation and approval by a two-thirds vote of the Texas Higher Education Coordinating Board and a specific act of the Legislature."

Section Sec. 65.31, shows that, "(a) The board is
Continued From page 12

authorized and directed to govern, operate, support, and maintain each of the component institutions that are now or may hereafter be included in a part of The University of Texas System... (g) The board by rule may delegate a power or duty of the board to a committee, officer, employee, or other agent of the board."

Section 73.103 shows that, "The board of regents shall appoint a president of the institution..."

Section 52.352 shows that, "(d) In addition to powers and duties specifically granted by this code or other law, each governing board shall: ... (3) appoint the president or other chief executive officer of each institution under the boards control and management and evaluate the chief executive officer of each component institution and assist the officer in the achievement of performance goals..."

Review of the "Governing Body Charter for The University of Texas MD Anderson Cancer Center" dated June 18, 2019, showed that it was approved by the President of the hospital and not by the Board of Regents. The Charter showed that "In accordance with Texas education code and consistent with the authority of the Board of Regents, the President of The University of Texas MD Anderson Cancer Center serves as the Governing Body of the Hospital..." There was no Board of Regents signatory in the Charter to indicate the appointment of the President as the Governing Body for the hospital. There was no Board of Regents meeting minutes to show such appointment.
Further, review of documents presented for review during the survey failed to show clear indication that the Governing Body was discharging its oversight responsibilities on the total operation of the hospital in that the meeting minutes since June 20, 2019, showed commingling of functions of the Executive Leadership Team and the Governing Body. The June 20, 2019 meeting was called to order by the Chief Medical Officer. The minutes showed approval of revisions to the Medical Staff Bylaws, Fair Hearing Manual, Organizational Manual, Rules and Regulation, and policy changes. The President was not present during the meeting.

Interview with the President, Chief Operating Officer, and Chief Medical Executive confirmed the above findings.

Based on record review and interview, the Governing Body failed to effectively discharge its oversight responsibilities in the total operation of the hospital.

Findings:

1. Failed to ensure that medical staff privileges are only granted by the Governing Body. Cross refer to Tag A0046

2. Failed to ensure that Medical Staff are accountable to the Governing Body for the quality of care provided to patients. Cross refer to Tag A0049

3. Failed to ensure the quality of services
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provided under contract and services provided allows the hospital to meet all applicable Conditions of Participation. Cross refer to Tag A0084.

4. A. ensure patient’s safety before, during, and after receiving Ketamine (a Schedule III controlled substance approved by the FDA as an anesthetic agent) Infusions in the Pain Management Outpatient Clinic located on the 4th floor at 1515 Holcombe Boulevard in 4 (Patient #250, #251, #252, and #262) of 5 patient records reviewed.

B. ensure that a policy was in place that was approved by the Medical Staff for outpatient Ketamine infusions in the outpatient setting.

C. ensure patients were monitored and assessed by a Registered Nurse (RN) before, during, and after receiving Ketamine Infusions in the outpatient clinic.

D. ensure the RN’s were educated and trained to monitor patients who received Ketamine infusions.

E. ensure the RN’s were competent and trained in administering and monitoring patients that received conscious sedation.

F. ensure patients were monitored and assessed by a RN before, during, and after receiving conscious sedation.

G. ensure hemodialysis machines in use for hemodialysis treatment of patients were calibrated as to the dialysate concentrate prescribed by the physician in 1 of 1 observation.
### SUMMARY STATEMENT OF DEFICIENCIES

<table>
<thead>
<tr>
<th>ID PREFIX TAG</th>
<th>DESCRIPTION</th>
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<tbody>
<tr>
<td>H. A 043</td>
<td>Hemodialysis machine #5. Patient #36. H. administer enteral feeding and post feed flushes as prescribed by patient's physician. Patient #36. I. implement patient's physician's orders for pulmonary function test, VRE culture, and daily weight. Patient #212. J. ensure acid and bicarb (bicarbonate) wands were secured to the acid and bicarb jugs during dialysis. Also, 1 of 1 peritoneal dialysis patients did not have daily weights recorded as ordered by the physician. K. protect 1 of 1 patients and follow their own policy to contain and decontaminate a chemotherapy spill. Cross Refer to Tag A0144 L. ensure 7 of 20 patient visits reviewed revealed evidence of documentation of explanation of patient's rights. Cross Refer to Tag A0117 M. obtain adequate informed consent for anesthesia services provided during proton therapy (a type of radiation therapy) as only one anesthesia consent form was signed when proton therapy was initiated and anesthesia services were provided with a series of proton therapy treatments in 2 of 2 proton therapy patient records reviewed.</td>
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A. BUILDING ________________________

B. WING _____________________________

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 450076

(X2) MULTIPLE CONSTRUCTION A. BUILDING ________________________

B. WING _____________________________

(X3) DATE SURVEY COMPLETED 08/23/2019

(X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

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(A 043 Continued From page 16 Cross Refer to Tag A0131

N. provide privacy to its patients by monitoring patients in their surgical suites without fully disclosed consent, displaying electronic monitoring of surgical areas on monitors in the anesthesia work room in POD A and POD B of the surgical area.

Cross Refer to Tag A0143

O. ensure patient confidentiality. The facility failed to follow their own policies regarding safeguarding patient health information and controlling visibility of patient information on computer screens.

Cross Refer to Tag A0146

P. ensure restraints were implemented in accordance with safe and appropriate techniques as determined by hospital policy for 6 of 6 (#265, 266, 267, 269, 270, and 206) patients reviewed.

Cross Refer to Tag A0167

5. Failed to ensure that this hospital develop and maintain an effective and ongoing quality assessment and performance improvement (QAPI) program in 8 of 13 departments that were reviewed (Contracted services, Nursing, Dialysis, Lab, Surgical services, Nursing, Infection control and Outpatient services). Cross refer to Tags A0283 and A0286
A 043  Continued From page 17

6. Failed to:
A. provide patient care and treatment per facility policy, per physician orders, and/or notify physician of changes of condition for 29 patients of 29 patients reviewed (Patients # 18, 67, 171, 172, 177, 218, 225, 228, 230, 231, 233, 285, 286, 288, 290, 291, 293, 311, 312, 316, 317, 318, 319, 322, 323, 324, 325, 326, and 327).

   Cross Refer to Tag A0392

B. evaluate 1 (#307) of 1 patient's care needs and patient's health status by unnecessarily withholding clear liquids for six hours while waiting for a computed tomography (CT) scan. Per hospital protocol, the patient could have consumed a clear liquid diet for six of the nine hours the patient waited for completion of scan. This hospital failure placed the patient at risk for dehydration.

   Cross Refer to Tag A0395

C. ensure that nursing care plans include interventions regarding all patient diagnoses. Twenty four (24) (#13, #14, #17, #18, #20, #21, #24, #29, #45, #69, #70, #71, #76, #79, #109, #110, #111, #112, #225, #289, #313, #314, #315, and #326) of 44 medical records reviewed had incomplete plans of care.

   Cross Refer to Tag A0396

D. 1. administer medication as prescribed by the patient's physician in 1 of 7 sampled patients.
<table>
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<th>A 043 Continued From page 18 (Patient #48)</th>
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<td>2. follow the facility's policy for documentation of treatment and interventions in 6 ( #271, #39, #276, #277, #278, and #279) of 7 patients reviewed. Cross Refer to Tag A0405</td>
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7. Failed to:

A) 1) ensure 5 out of 5 contracted transportation couriers (Staff #304, #305, #367, #368, and #369) were transporting hazardous drugs (chemotherapy medications) in a safe manner. Courier staff were not trained on how to contain and clean a chemotherapy spill and did not possess the proper equipment for containing and cleaning of a chemotherapy spill during transport.

2) ensure safe disposal of medications. Drugs were being disposed of in sharps containers (plastic containers used for the disposal of used needles and glass) at two of the outpatient facilities (West Houston and Katy locations). Cross Refer to Tag A0491

B) develop accountability procedures to ensure controlled medications, such as narcotics, that were dispensed as a continuous intravenous (IV) infusion (medication delivered into a vein at a constant rate) were not diverted by unauthorized persons. Cross Refer to Tag A0494
### Provider/Supplier/CLIA Identification Number:

**Provider's Identification Number:** 450076

### Statement of Deficiencies and Plan of Correction

#### Statement of Deficiencies

8. Failed to provide dietary services in a sanitary manner to prevent the cross contamination of food products:

   **A.** The two portable freezer units and a multi-use food truck were located on the facility's loading dock adjacent to where construction debris and the facility's unsealed, contaminated linens were being off loaded and on loaded. The freezer unit's inside doors, floors, ceilings, and walls were noted with dark debris.

   **B.** Multiple kitchen equipment and counters were soiled with old dried food debris.

   **C.** Multiple staff were observed in the kitchen and handling food trays without the use of hair restraints.

   Cross refer to Tags A0618 and A0724

9. provide a sanitary environment to avoid sources and transmission of infectious and communicable diseases. The facility failed to:

   **A.** Ensure that clean linens were not contaminated by soiled linens, soiled equipment, and/or soiled staff uniforms.

   **B.** Ensure that sterile surgical linens were handled and stored appropriately to prevent contamination by dust, soiled linens, soiled equipment, and/or soiled staff uniforms.

   **C.** Ensure that durable medical equipment, which was removed from isolation rooms, was sanitized using the appropriate disinfectant for the
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<tr>
<td>A 043</td>
<td>Continued From page 20 organism being isolated and stored under appropriately clean conditions after disinfection.</td>
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<td>D.) Ensure that nursing staff were educated in and used the appropriate disinfectant for the organism being isolated when disinfecting equipment coming out of patient isolation rooms.</td>
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<td>E.) Ensure that patient transportation staff cleaned and disinfected wheelchairs and stretchers between patient use, as well as stored said equipment under appropriately clean conditions.</td>
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<td>F.) Ensure Environmental Services/Housekeeping maintained isolation precautions to prevent cross contamination while conducting housekeeping services.</td>
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<td>G.) Ensure policies were developed and implemented for the proper use of the Trophon High Level Disinfectant System for ultrasound probes.</td>
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<td>H.) Ensure staff were utilizing the required protective equipment when entering isolation rooms. The facility also failed to include the protective equipment required for isolation in the facility policy.</td>
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<td></td>
<td>I.) Ensure staff wash/sanitize hands between touching contaminated items and performing central venous catheter and vascular access care during initiation and termination of hemodialysis treatment on 2 of 2 patients observed. Patients #49 and 36.</td>
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<td>J.) Know the Hepatitis B antibody status or administer the immunization for 5 of 10</td>
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<td>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</td>
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<td>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</td>
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<td>A 043</td>
<td>Continued From page 21 non-immune surgical staff health records reviewed. (Staff #267, #272, #288, #289, and #291). The facility failed to follow the CDC guidelines and the facility policy on Hepatitis B monitoring and follow-up guidance.</td>
<td>A 043</td>
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<td>K.) To maintain a sanitary environment in 10 of 10 departments throughout the facility system. (Pain Management Clinic at 1515 Holcombe Blvd, MOHS and Dermasurgery Center, Main Campus Pharmacy, La Maistre Building, Mays Clinic Building, Main Campus, League City, West Houston, Sugar Land, and Diagnostic Imaging.)</td>
<td></td>
<td>Cross Refer to Tag A0749</td>
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<td>10. Failed to:</td>
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<td>A. ensure sterile surgical linen packs that contained surgical gowns, drapes, and towels were sterilized according to manufacturer recommendations.</td>
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<td>B. ensure sterile surgical linen packs that contained surgical gowns, drapes, and towels were transported in a manner that would protect the sterile items from moisture, excessive humidity, and condensation caused by temperature extremes.</td>
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<td>C. ensure there was a process in place to monitor the sterilization and transport of sterile linen packs from an outside contracted vendor to the surgery department.</td>
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<td>D. ensure that surgical instruments were transported to an offsite surgery center in a manner that would protect the sterile instruments</td>
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### SUMMARY STATEMENT OF DEFICIENCIES

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<td>A 043</td>
<td>Continued From page 22</td>
<td>from moisture, excessive humidity, and condensation caused by temperature extremes.</td>
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<td>E.</td>
<td>ensure that an instrument loaner set that contained surgical implants (Zimmer/Biomet Plates) was sterilized according to the manufacturer recommendations.</td>
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<td>Cross refer to Tag 0940</td>
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<tr>
<td>A 046</td>
<td>MEDICAL STAFF - APPOINTMENTS</td>
<td>CFR(s): 482.12(a)(2)</td>
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<tr>
<td>MEDICAL STAFF - APPOINTMENTS</td>
<td>[The governing body must] appoint members of the medical staff after considering the recommendations of the existing members of the medical staff.</td>
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<td>This STANDARD is not met as evidenced by: Based on record review and interview, the Governing Body failed to ensure that members of the hospital medical staff are appointed only by the Governing Body.</td>
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<td>Findings:</td>
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<td>Review of the Medical Staff Bylaws, Article IV, Section 4.3, shows, *Temporary Privileges. The Governing Body, the Chief Medical Executive, or the Chief Medical Officer, on written request of the appropriate Department Chair or Division Head, shall have the authority to grant temporary privileges to an appropriately licensed Practitioner</td>
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### STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

| ID | PREFIX | TAG
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#### PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

450076

#### STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

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<th>(X3) DATE SURVEY COMPLETED</th>
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#### MULTIPLE CONSTRUCTION

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#### UNIVERSITY OF TEXAS M D ANDERSON CANCER CENTER, THE

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#### PROVIDER'S PLAN OF CORRECTION

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#### A 046

**Continued From page 23**

with documented current clinical competence as set forth below and as detailed in written policy..." Further, it shows, "...Any grant of temporary privileges shall be reviewed by the CCMS at its next meeting. Temporary privileges may be terminated at anytime by the President, Chief Medical Executive, or Chief Medical Officer on recommendation of the CCMS, the ECMS, the Practitioner's Division Head, or the Department Chair responsible for supervision of the Practitioner..." Interviews with the Chief Medical Executive and the Chief Operating Officer confirmed that any of the individuals mentioned in the provision of the bylaws can grant or terminate temporary privileges which is contrary to the requirement of the regulation.

#### A 049 MEDICAL STAFF - ACCOUNTABILITY

**CFR(s): 482.12(a)(5)**

[The governing body must] ensure that the medical staff is accountable to the governing body for the quality of care provided to patients.

This **STANDARD** is not met as evidenced by:

Based on review of records, the Governing Body failed to ensure that the medical staff was accountable to the Governing Body for the quality of care provided to patients. The Governing Body was responsible for the conduct of the hospital which includes the quality of care provided to patients.

**Findings:**

Review of the Medical staff bylaws, Article II, Section 2.2, shows, "The Medical staff is
### Summary Statement of Deficiencies

#### A049 Continued From page 24

Accountable to the Governing Body through the Chief Medical Executive and Chief Medical Officer, for the fulfillment of its purposes and responsibilities and for assuring that all patient care activities are conducted consistent with accepted professional standards and legal and accreditation requirements." This finding is contrary to the requirement of the regulation.

Review of laboratory's policies, patient emergency release records for blood products, and in interview with staff, the laboratory failed to ensure signatures of the requesting physicians were obtained before or after emergency release of blood products [21 CFR 606.160(b)(3)(v)] for 7 of 10 patients in 2018 and 2019. Cross refer to CLIA Tag D5553.

Review of patient record DG_Blood1 revealed that patient was admitted on June 26, 2019, with diagnoses of hepatitis, rhabdomyolysis, chronic kidney disease, hip pain, and proximal muscle weakness. The patient was transfused with 5 units of PRBC on July 9, 2019, via rapid infusion. However, the medical record failed to show documentation of the need for the 5-units of PRBC. This was confirmed by a transfusion physician on 8/19/19 @ 11:00 AM.

Review of patient record DG_Blood2 revealed that patient received multiple units of platelets (2 units on 5/26/19, 3 units on 5/27/19, 1 unit on 5/28/19, and 2 units on 5/29/10). The patient was pronounced dead at 16:00 on 6/5/19. The ICU physician documented TRALI vs. TACO vs. PNA, however, there was no workup done. This was...
Review of patient DG_Blood3 revealed that patient received multiple units of blood products (on 6/26/19, 2 units of PRBC and 1 unit of platelet; on 6/27/19, 2 units of PRBC, 1 unit of platelet, 4 units of FFP; on 6/28/19, 1 unit of PRBC, 2 units of platelets; on 6/29/19, 2 units of PRBC and 1 unit of platelet). The patient condition deteriorated and pronounced dead at 12:57 on 6/30/19. There was no transfusion workup done. This was confirmed by a transfusion physician on 8/19/19 @ 11:00 AM.

Findings:

Review on 08/21/2019 of Contract Registered Nurse #118's personnel and training record revealed he was hired to the facility on 04/8/2019 as a contract registered nurse for hemodialysis.
A 084 Continued From page 26

Review of his personnel and training record revealed a color recognition test dated April 2014, which indicated the staff was color blind.

Review of a letter from an ophthalmologist dated May 23, 2019, revealed the following recommendation, "I would suggest testing MR #118 with water samples at work under various conditions to determine how well he is able to perform the tests. His past work performance related to water testing would be valuable."

Review of Contract Registered Nurse (#118's) training record revealed no documentation that the ophthalmologist's recommendation was followed.

Interview on 08/21/2019, at 9:30 a.m., with Contract Registered Nurse Manager (#157) revealed he had done the test but it was not documented.

Registered Nurse 65

Review of Contract Registered Nurse # 65's annual competency check list revealed she was hired to the facility on 12/10/2018 as a Registered Nurse providing hemodialysis treatment to patients at the hospital.

Review of a Dialysate Concentrate Adjustment Competency Assessment (Changing the concentrate value by adding electrolyte to the solution) dated 8/05/2019, revealed the competency was evaluated by verbalization only. There was no documentation that the staff was observed performing the task.
**A. BUILDING ____________________________**

**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**STATEMENT OF DEFICIENCIES**

**UNIVERSITY OF TEXAS M D ANDERSON CANCER CENTER, THE**

**STREET ADDRESS, CITY, STATE, ZIP CODE**

1515 HOLCOMBE BLVD
HOUSTON, TX  77030

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**SUMMARY STATEMENT OF DEFICIENCIES**

- **During an interview on 08/21/2019 at 10:00 a.m. with the Hospital Dialysis Nurse Manager revealed, the registered nurse changes the composition of the dialysate solution by adding electrolyte to the concentrate solution at times, but she did not observe staff performing the task.**

- Based on review of contracts and interview, the Governing Body failed to ensure that the services provided under contract were provided in a safe and effective manner.

**Findings:**

- Review of 8 contracts for patient care related services showed no metrics or indicators to evaluate the quality of services being provided. Example:

  1. The contract for laundry services with the Texas Medical Center Hospital Laundry Cooperative Association failed to ensure that linens delivered to the hospital were protected from environmental contaminants and failed to ensure that sterile linens/gowns were kept sterile during transport from the laundry facility to the hospital Operating Rooms.

  2. The contract with Brainlab for clinical consultation showed that the "onsite support facilitated by Brainlab engineer; stationed onsite for instant technical response in order to provide optimal technical support for surgical team..." Interview with the Director of Perioperative Services, Chief Operating Officer, Chief Medical
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<td>450076</td>
<td>UNIVERSITY OF TEXAS M D ANDERSON CANCER CENTER, THE HOUSTON, TX 77030</td>
<td>A 084</td>
<td>Continued From page 28 Executive, and the Associate Vice President of Supply Chain stated that there was no Brainlab engineer onsite but there are Brainlab Technicians onsite in the Operating Room during surgical procedures. Further, the contract shows that the onsite Brainlab engineer &quot;direct MR and radiology staff in performing necessary scans prior to surgery...&quot; An engineer is not a physician as defined in the Act and/or the regulations and therefore cannot direct what diagnostic tests are done on a patient in a Medicare participating hospital. Review of a list of contracted services revealed there was a total of 249 contracted services. Review of the list revealed some of the following missing information in relation to performance improvements Leica Bond RX service agreement used for auto-staining (lab testing) expired on 08/02/2019 (12 days prior to date of survey). &quot;According to documentation the performance indicators in the contract were insufficient. The corrective action was, Appropriate KPIs (key performance indicators) will be identified by Sourcing and contract stakeholder. KPIs will go through clinical review for insufficiency. Sourcing will incorporate KPIs into purchase orders until an amendment or new agreement is executed, if applicable. Scorecard will be developed by Sourcing and implemented for tracking KPIs. Contract stakeholder will track and collect supporting documentation.&quot;</td>
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### UNIVERSITY OF TEXAS M D ANDERSON CANCER CENTER, THE

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### SUMMARY STATEMENT OF DEFICIENCIES

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- **Best Care EMS (Emergency Medical service) - Ambulance Transport** which was the ambulance service for patient care. According to documentation the metrics for the contract was pending clinical review.

- **Cross Country Staffing** which was for temporary nurse staffing and allied services. According to documentation the metrics for the contract was pending clinical review.

- **Abbott f/k/a St Jude Medical/service** which was capital equipment service agreement. According to documentation the performance indicators in the contract were insufficient. The corrective action was, "Appropriate KPIs will be identified by Sourcing and contract stakeholder. KPIs will go through clinical review for insufficiency. Sourcing will incorporate KPIs into purchase orders until an amendment or new agreement is executed, if applicable. Scorecard will be developed by Sourcing and implemented for tracking KPIs. Contract stakeholder will track and collect supporting documentation."

- **Belimed OR Single Sterilizer Full Service Agreement** revealed the performance indicators were insufficient and not tracked. The corrective action was, "Appropriate KPIs will be identified by Sourcing and contract stakeholder. KPIs will go through clinical review for insufficiency. Sourcing will incorporate KPIs into purchase orders until an amendment or new agreement is executed, if applicable. Scorecard will be developed by Sourcing and implemented for tracking KPIs."
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<td>Contract stakeholder will track and collect supporting documentation.&quot;</td>
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Gulf Coast Testing was used for blood testing services for infectious disease prior to uploading into the National Marrow Donor Program registry revealed the performance indicators were insufficient and not tracked. " Appropriate KPIs will be identified by Sourcing and contract stakeholder. KPIs will go through clinical review for insufficiency. Sourcing will incorporate KPIs into purchase orders until an amendment or new agreement is executed, if applicable. Scorecard will be developed by Sourcing and implemented for tracking KPIs. Contract stakeholder will track and collect supporting documentation."

National Children's Hospital Laboratory Services Contract used for laboratory service agreement for targeted B-ALL Fusion Analysis in pediatric patients. Documentation revealed the performance indicators were insufficient. " Appropriate KPIs will be identified by Sourcing and contract stakeholder. KPIs will go through clinical review for insufficiency. Sourcing will incorporate KPIs into purchase orders until an amendment or new agreement is executed, if applicable. Scorecard will be developed by Sourcing and implemented for tracking KPIs. Contract stakeholder will track and collect supporting documentation."  

Viracor-IBT / Eurofins Clinical Diagnostic used for clinical laboratory services revealed the performance indicators were insufficient. " Appropriate KPIs will be identified by Sourcing
### Statement of Deficiencies and Plan of Correction

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<td>Continued From page 31 and contract stakeholder. KPIs will go through clinical review for insufficiency. Sourcing will incorporate KPIs into purchase orders until an amendment or new agreement is executed, if applicable. Scorecard will be developed by Sourcing and implemented for tracking KPIs. Contract stakeholder will track and collect supporting documentation.</td>
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<tr>
<td>A 094</td>
<td>OFF-CAMPUS EMERGENCY POLICIES AND PROCEDURES</td>
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- Castle Bioscience-Molecular Genetics Test used for Molecular Genetic Testing Services revealed the performance indicators were insufficient. "Appropriate KPIs will be identified by Sourcing and contract stakeholder. KPIs will go through clinical review for insufficiency. Sourcing will incorporate KPIs into purchase orders until an amendment or new agreement is executed, if applicable. Scorecard will be developed by Sourcing and implemented for tracking KPIs. Contract stakeholder will track and collect supporting documentation."

- Carefusion -support and maintenance agreement for Pyxis Equipment revealed the performance indicators were insufficient. "Appropriate KPIs will be identified by Sourcing and contract stakeholder. KPIs will go through clinical review for insufficiency. Sourcing will incorporate KPIs into purchase orders until an amendment or new agreement is executed, if applicable. Scorecard will be developed by Sourcing and implemented for tracking KPIs. Contract stakeholder will track and collect supporting documentation."
### Continued From page 32

**CFR(s): 482.12(f)(3)**

If emergency services are provided at the hospital but are not provided at one or more off-campus departments of the hospital, the governing body of the hospital must assure that the medical staff has written policies and procedures in effect with respect to the off-campus department(s) for appraisal of emergencies and referral when appropriate.

This STANDARD is not met as evidenced by:

Based on observation, review of documentation and interview, it was determined that the hospital failed to ensure that there were emergency supplies (crash carts) in 14 of 14 off campus outpatient locations available for emergency medical situations involving staff, patients and visitors at these hospital outpatient locations.

Findings were:

The hospital failed to ensure that there were emergency supplies (crash carts) in 14 of 14 off campus outpatient locations available for emergency medical situations involving staff, patients and visitors at hospital off campus outpatient locations.

During onsite observations at off campus hospital outpatient locations (which are departments of the hospital) on the week of 8/12/2019 to 8/16/2019 and 8/19/2019 to 8/22/2019, as well as interviews with senior hospital outpatient administrative staff, it was determined that there were off campus outpatient locations with no crash cart.

In an interview on 8/14/2019 with staff member#26, the survey team was told that the...
hospital outpatient sites were "911 facilities" and although there were AEDs (automatic external defibrillator) at these sites there were not crash carts or code blue teams at all these locations. In the event of an emergency, 911 would be called. Staff member #26 commented that it was a JCAHO (Joint Commission on Accreditation for Healthcare Organizations) recommendation not to have crash carts at the outpatient site locations.

In an interview on the morning of 8/19/2019 with senior hospital outpatient administrative staff members #1, #26, #261 (and #285, #286 who attended telephonically) the survey team was informed that the only outpatient location that has a crash cart onsite is the MD Anderson West Houston location at 13900 Katy Freeway, Houston, Texas, 77079.

Review of document provided to survey team stated: "Response to Request for removal of Crash Carts from HALs (Houston Area Locations)" stated: "Unable to location any other documentation notating recommendation from Joint Commission to remove Crash Carts from HALs other than what was provided in the CPR sub-committee meeting minutes."

Review of hospital document provided to team listing hospital outpatient locations included:

1.) MD Anderson Holly Hall Blood Donor Center located at 2555 Holly Hall Street, Houston, Texas, 77054, (approximately 2 miles from the main hospital location).

2.) MD Anderson Diagnostic Imaging - Bellaire located at: 6602 Mapleridge, Houston, Texas,
A 094 Continued From page 34

77081, (approximately 4.9 miles from main hospital location).

3.) MD Anderson Diagnostic Imaging - West Houston located at: 15021 Katy Freeway, Suite 100, Houston, Texas, 77094, (approximately 23 miles from the main hospital location).

4.) MD Anderson Diagnostic Imaging - West Houston located at 15021 Katy Fwy, Suite 100, Houston, Texas (approximately 19.7 miles from the main hospital location). Note: onsite survey team visit found this location had a crash cart.

5.) MD Anderson League City site located at: 2280 Gulf Freeway South, League City, Tx, 77573, (approximately 19.7 miles from the main hospital location).

6.) MD Anderson Memorial City located at: 925 Gessner Road, Medical Plaza 4, Houston, Texas, 77024, (approximately 15 miles from the main hospital location).

7.) MD Anderson Sugar Land site located at: 1327 Lake Pointe Parkway, Sugar Land, Tx, 77478, (approximately 17.3 miles from the main hospital location).

8.) MD Anderson The Center for Advanced Biomedical Imaging located at 1881 East Road, Houston, Texas, 77054, (approximately 2 miles from main hospital).

9.) MD Anderson The Woodlands MAC I site located at 17198 St. Luke’s Way, The Woodlands, Texas, 77384, (approximately 37.7 miles from the main hospital location).
### PROVIDER'S PLAN OF CORRECTION

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<td>11.)</td>
<td>MD Anderson Woman’s Hospital located at 1700 Fannin, Houston, TX, 77054, (approximately 1 mile from the main hospital location). Note: this location is for consultation only and physician practice.</td>
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<tr>
<td>12.)</td>
<td>Mohs and Dermasurgery Center located at 6655 Travis, Houston, Texas, 77030, (approximately 1 mile from the main hospital location). Note: onsite survey team visit found this location had a crash cart.</td>
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<td>13.)</td>
<td>Radiology Outpatient Clinic located at 1700 Holcombe Blvd, Houston, Texas, 77030, (approximately 0.2 miles from the main hospital location).</td>
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<td>14.)</td>
<td>The Proton Therapy Center located at 1840 Old Spanish Trail, Houston, Texas, 77054, (approximately 1 mile from the main hospital location). Note: onsite survey team found this location had a crash cart.</td>
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</table>

On the late morning of 8/16/2019 staff member #26 provided the survey team with a document listing the date and location of 911 calls to hospital outpatient sites in response to an emergency medical situation.

### Statement of Deficiencies and Plan of Correction

**UNIVERSITY OF TEXAS M D ANDERSON CANCER CENTER, THE**

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**SUMMARY STATEMENT OF DEFICIENCIES**

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<th>ID</th>
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<tbody>
<tr>
<td>A 094</td>
<td>Continued From page 36</td>
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</table>

The West Houston location had contacted EMS on 5/1/2019 and 7/29/2019.

Twelve (12) activations for medical 911 emergencies.

Review of hospital policy CLN0506, entitled: "Cardiopulmonary Resuscitation (CPR) Services & Emergency Medical Response (Code Blue) Policy" stated under the purpose section: "This policy outlines the processes for the provision of cardiopulmonary resuscitation (CPR) services and emergency medical response at The University of Texas MD Anderson Cancer Center (MD Anderson)."

The policy statement stated: "It is the policy of MD Anderson to provide emergency medical care to patients, visitors and other workforce members as appropriate."

The scope section of the policy stated: "Compliance with this policy is the responsibility of all faculty, trainees/students, and other members of MD Anderson’s workforce."

The definitions section of the policy stated: "Code Blue Team: Staff who immediately respond when a Code Blue is called and provide advanced cardiopulmonary life support."

Also listed under the definitions section was: "Houston Area Locations (HALS): MD Anderson facilities in the community that provide outpatients services to MD Anderson patients." (Note these "HAL" locations are the outpatient locations referred to above).
Continued From page 37

The general procedure portion stated: "1.2 The Code Blue Team should be activated by any workforce member for medical emergencies, including cardiopulmonary arrest, that involves an individual (including a patient, visitor, volunteer, or workforce member) experiencing any of the following conditions: A. Unresponsiveness, B. Not breathing, C. No pulse, D. Is in apparent physical distress, E. Requests help for difficulty breathing."

"1.3 For applicable medical emergencies that occur on the Main Campus (including the immediate grounds of these locations), activate the Code Blue Team by calling 713-792-7099 (see MD Anderson Code Blue Map)."

"1.4 For medical emergencies in all other locations, including MOHS Clinic, parking garages, Proton Therapy Center, Radiation Oncology Center (ROC), South Campus Research Buildings 1MC, the Zayed Building, and Holly Hall Blood Center, call 911."

In the 4.0 Code Blue Responsibilities section: "4.2 As expansion occurs in the Houston Area Locations (HALS), there may be an indication for internal Code Blue Teams. Determination of need will occur on the type of services being offered at that location and should be reviewed and approved by the CPR Subcommittee of the Medical Staff."

Review of hospital document: "CPR Subcommittee April 18, 2019" meeting minutes revealed comments concerning "Code Blue Operations Update." These comments included: "The HALS emergency plan comes through Code Blue Ops and CPR Subcommittee. Issue is how to manage medical emergencies, 911 response..."
A 094 Continued From page 38

area, until EMS arrives or anesthesia for procedures.” The follow up column listed a N/A.

Review of document entitled: “Houston Area Location League City Emergency Response” stated: “The first responder should delegate additional respondents to call 911.”


Review of document entitled: "West Houston HAL Departmental Emergency Operations Plan" for 13900 Katy Freeway, Houston, TX, 77079, stated on page 24: Medical Emergencies. "Call Code Blue Team for all clinical locations at the Main Campus and Mays Clinic. "Call 9-1-1 for all other locations."

Review of document entitled: "MD Anderson Cancer Center Sugar Land Departmental Emergency Operations Plan 2019" for 1327 Lake Pointe Parkway Sugar Land, TX, 77478 Suite 100, Suite 200, Suite 201, Suite 400", stated on page 22: Medical Emergencies. "Call Code Blue Team for all clinical locations at the Main Campus and Mays Clinic. "Call 9-1-1 for all other locations."

A. BUILDING _____________________________

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 450076

(X2) MULTIPLE CONSTRUCTION

A. BUILDING _____________________________

B. WING _____________________________

(X3) DATE SURVEY COMPLETED

NAME OF PROVIDER OR SUPPLIER

UNIVERSITY OF TEXAS M D ANDERSON CANCER CENTER, THE

STREET ADDRESS, CITY, STATE, ZIP CODE

1515 HOLCOMBE BLVD HOUSTON, TX 77030

(X4) ID PREFIX TAG

SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

ID PREFIX TAG

PROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

(X5) COMPLETION DATE

A 094 Continued From page 39

all clinical locations at the Main Campus and Mays Clinic. "Call 9-1-1 for all other locations."

The hospital could provide no documented evidence, that the Medical Staff had assessed the need, at each off campus outpatient service location, for an emergency response protocol, other than dialing 9-1-1. The Medical Staff had not assessed staff training or supplies that might be required to maintain a patient in an emergency situation, until Emergency Medical Staff could arrive and take over the care of the patient.

A 115 PATIENT RIGHTS

CFR(s): 482.13

A hospital must protect and promote each patient's rights.

This CONDITION is not met as evidenced by:

Based upon observation, record review, and interview, the facility failed to

A. ensure patient's safety before, during, and after receiving Ketamine (a Schedule III controlled substance approved by the FDA as an anesthetic agent) Infusions in the Pain Management Outpatient Clinic located on the 4th floor at 1515 Holcombe Boulevard in 4 (Patient #250, #251, #252, and #262) of 5 patient records reviewed.

B. ensure that a policy was in place that was approved by the Medical Staff for outpatient Ketamine infusions in the outpatient setting.

C. ensure patients were monitored and assessed by a Registered Nurse (RN) before, during, and
### A. BUILDING ________________________
(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 450076

### B. WING _____________________________

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<th>ID</th>
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<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
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<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>(X5) COMPLETION DATE</th>
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<tbody>
<tr>
<td>A 115</td>
<td>Continued From page 40 after receiving Ketamine Infusions in the outpatient clinic.</td>
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<td>D. ensure the RN's were educated and trained to monitor patients who received Ketamine infusions.</td>
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<tr>
<td>E. ensure the RN's were competent and trained in administering and monitoring patients that received conscious sedation.</td>
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<tr>
<td>F. ensure patients were monitored and assessed by a RN before, during, and after receiving conscious sedation.</td>
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<td>It was determined that these deficient practices posed an Immediate Jeopardy to patient health and safety, and placed all patients at risk for the likelihood of harm, serious injury, impairment, and/or subsequent death.</td>
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<td>G. ensure hemodialysis machines in use for hemodialysis treatment of patients were calibrated as to the dialysate concentrate prescribed by the physician in 1 of 1 observation. Hemodialysis machine #5.</td>
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<tr>
<td>H. administer enteral feeding and post feed flushes as prescribed by patient's physician. Patient #36.</td>
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<tr>
<td>I. implement patient's physician's orders for pulmonary function test, VRE culture, and daily weight. Patient #212.</td>
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<tr>
<td>J. ensure acid and bicarb (bicarbonate) wands were secured to the acid and bicarb jugs during dialysis. Also, 1 of 1 peritoneal dialysis patients</td>
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</table>
### Summary Statement of Deficiencies

<table>
<thead>
<tr>
<th>Tag</th>
<th>ID</th>
<th>Prefix</th>
<th>Description</th>
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<tbody>
<tr>
<td>A 115</td>
<td>Continued From page 41</td>
<td>did not have daily weights recorded as ordered by the physician.</td>
<td>K. protect 1 of 1 patients and follow their own policy to contain and decontaminate a chemotherapy spill. Cross Refer to Tag A0144</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>L. ensure 7 of 20 patient visits reviewed revealed evidence of documentation of explanation of patient's rights. Cross Refer to Tag A0117</td>
</tr>
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<td></td>
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<td></td>
<td>M. obtain adequate informed consent for anesthesia services provided during proton therapy (a type of radiation therapy) as only one anesthesia consent form was signed when proton therapy was initiated and anesthesia services were provided with a series of proton therapy treatments in 2 of 2 proton therapy patient records reviewed. Cross Refer to Tag A0131</td>
</tr>
<tr>
<td></td>
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<td></td>
<td>N. provide privacy to its patients by monitoring patients in their surgical suites without fully disclosed consent, displaying electronic monitoring of surgical areas on monitors in the anesthesia work room in POD A and POD B of the surgical area. Cross Refer to Tag A0143</td>
</tr>
</tbody>
</table>

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**Statement of Deficiencies and Plan of Correction**

**Name of Provider or Supplier:**

UNIVERSITY OF TEXAS M D ANDERSON CANCER CENTER, THE

**Street Address, City, State, Zip Code:**

1515 HOLCOMBE BLVD
HOUSTON, TX 77030

---

**Summary Statement of Deficiencies (Each Deficiency Must Be Preceded by Full Regulatory or LSC Identifying Information):**

A 115 Continued From page 41 did not have daily weights recorded as ordered by the physician.

K. protect 1 of 1 patients and follow their own policy to contain and decontaminate a chemotherapy spill.

Cross Refer to Tag A0144

L. ensure 7 of 20 patient visits reviewed revealed evidence of documentation of explanation of patient's rights.

Cross Refer to Tag A0117

M. obtain adequate informed consent for anesthesia services provided during proton therapy (a type of radiation therapy) as only one anesthesia consent form was signed when proton therapy was initiated and anesthesia services were provided with a series of proton therapy treatments in 2 of 2 proton therapy patient records reviewed.

Cross Refer to Tag A0131

N. provide privacy to its patients by monitoring patients in their surgical suites without fully disclosed consent, displaying electronic monitoring of surgical areas on monitors in the anesthesia work room in POD A and POD B of the surgical area.

Cross Refer to Tag A0143
### PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

450076

### STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

**DATE SURVEY COMPLETED:** 08/23/2019

**STREET ADDRESS, CITY, STATE, ZIP CODE:**
1515 HOLCOMBE BLVD
HOUSTON, TX 77030

**NAME OF PROVIDER OR SUPPLIER:**
UNIVERSITY OF TEXAS M D ANDERSON CANCER CENTER, THE

**DEPARTMENT OF HEALTH AND HUMAN SERVICES**

**CENTERS FOR MEDICARE & MEDICAID SERVICES**

**OMB NO. 0938-0391**

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<td>A 115</td>
<td>Continued From page 42</td>
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</table>

- **O.** ensure patient confidentiality. The facility failed to follow their own policies regarding safeguarding patient health information and controlling visibility of patient information on computer screens.

  Cross Refer to Tag A0146

- **P.** ensure restraints were implemented in accordance with safe and appropriate techniques as determined by hospital policy for 6 of 6 (#265, 266, 267, 269, 270, and 206) patients reviewed.

  Cross Refer to Tag A0167

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<tr>
<td>A 117</td>
<td>PATIENT RIGHTS: NOTICE OF RIGHTS</td>
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- **CFR(s): 482.13(a)(1)**

  A hospital must inform each patient, or when appropriate, the patient's representative (as allowed under State law), of the patient's rights, in advance of furnishing or discontinuing patient care whenever possible.

  **This STANDARD** is not met as evidenced by:

  Based on review of medical records and interview, it was determined that there was not always documented evidence of the teaching of patient's rights being provided to every patient with each visit. 7 of 20 patient visits (Patients # 148 thru 153 and patient # 162) reviewed revealed no evidence of documentation of explanation of patient's rights.

  **Findings:**

  Patient Education document entitled "Patient Rights and Responsibilities" stated in part "At the
A. BUILDING _________________________

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:
450076

(X2) MULTIPLE CONSTRUCTION
A. BUILDING _________________________
B. WING _____________________________

(X3) DATE SURVEY COMPLETED
08/23/2019

NAME OF PROVIDER OR SUPPLIER
UNIVERSITY OF TEXAS M D ANDERSON CANCER CENTER,THE

STREET ADDRESS, CITY, STATE, ZIP CODE
1515 HOLCOMBE BLVD
HOUSTON, TX  77030

FORM CMS-2567(02-99) Previous Versions Obsolete

(A.117) Continued From page 43

University of Texas MD Anderson Cancer Center, we respect you as an individual with unique health care needs. We want you to know about your rights as a patient, as well as what your responsibilities are to yourself, your health care team and to other patients."

Review of medical records during the week of 8/12/19 revealed 7 of 20 records (Patients # 148 thru 153 and patient # 162) lacked documented evidence that patient rights had been discussed with patients during each admission.

These findings were confirmed by Representative for Patient Advocacy on 8/16/19. Further on 8/15/19, the Manager of Business Services from the West Houston location admitted that 3 staff members there had not been trained to document teaching of patient rights at each admission.

(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 documentation and interviews with facility staff, the facility failed to obtain adequate informed consent for anesthesia.
services provided during proton therapy (a type of radiation therapy) as only one anesthesia consent form was signed when proton therapy was initiated and anesthesia services were provided with a series of proton therapy treatments in 2 of 2 proton therapy patient records reviewed. The anesthesia services were provided by different anesthesia providers from the provider who obtained informed consent in 2 of 2 proton therapy patient records reviewed. The anesthesia consent form did not specify that the consent was for any other dates of service other than the date the consent was executed. This resulted in a potential lack of informed consent for anesthesia services as the proton therapy progressed over a period of time. The facility policies did not specify that a single anesthesia consent could be used for multiple episodes of anesthesia services.

Findings:

The electronic medical record of patient #293 was reviewed on 8/20/19 with the assistance of RN staff #295. The record reflected patient #293 was a 3 year and 10-month old boy with high risk neuroblastoma who was receiving "consolidative radiation to the primary site of disease, 21.6 Gy in 12 fx...Start 8/12/19 ...The patient's last scheduled treatment is Tuesday, August 27, 2019."

The record contained a "Disclosure and Consent Anesthesia and/or Perioperative/Peri-procedure Pain Management (Analgesia)" dated 7/31/19. The form reflected in part "You have the right, as a patient, to be informed about your condition and the recommended anesthesia/analgesia to be used so that you may make the decision whether
### Statement of Deficiencies and Plan of Correction

**A. BUILDING**

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**(X3) DATE SURVEY COMPLETED**

08/23/2019

**NAME OF PROVIDER OR SUPPLIER**

UNIVERSITY OF TEXAS M D ANDERSON CANCER CENTER, THE

**STREET ADDRESS, CITY, STATE, ZIP CODE**

1515 HOLCOMBE BLVD
HOUSTON, TX  77030

**(X4) ID PREFIX TAG**

**SUMMARY STATEMENT OF DEFICIENCIES**

(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

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<td>(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</td>
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<td>(X5) COMPLETION DATE</td>
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**A 131 Continued From page 45**

or not to receive the anesthesia/analgesia after knowing the risks and hazards involved. This disclosure is not meant to scare or alarm you; it is simply an effort to make you better informed so you may give or withhold your consent to the anesthesia/analgesia."

"I (we) voluntarily request that anesthesia and/or perioperative pain management care (analgesia) as indicated below be administered to me (the patient). I (we) understand it will be administered by an anesthesia provider and/or the operating practitioner, and such other health care providers as necessary. Perioperative means the period shortly before, during and shortly after the procedure."

"I (we) understand that anesthesia/analgesia involves additional risks and hazards but I (we) request the use of anesthetics/analgesia for the relief and protection from pain or anxiety during the planned and additional procedures. I (we) realize the type of anesthesia/analgesic may have to be changed possibly without explanation to me (us)."

"I (we) understand that serious, but rare, complications can occur with all anesthetic/analgesic methods. Some of these risks are breathing and heart problems, drug reactions, nerve damage, cardiac arrest, brain damage, paralysis, or death."

"I (we) also understand that other complications may occur. Those complications include but are not limited to: GENERAL ANESTHESIA - injury to vocal cords, teeth, lips, eyes; awareness during the procedure; memory dysfunction/memory loss; permanent organ damage; brain damage."
A 131 Continued From page 46

The consent form was signed by the patient's mother on 7/31/19 0940 and by anesthesiologist staff #350 on 7/31/19 at 0940. The consent form did not indicate that the patient's authorized representative gave consent for anesthesia services on any other date than 7/31/19.

The record reflected that patient #293 received anesthesia services as follows:


**SUMMARY STATEMENT OF DEFICIENCIES**

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<td>A 131</td>
<td>Continued From page 47</td>
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#349, CRNA, staff #304 .


RN, staff #295 was asked if the record of patient #293 contained any other anesthesia consent forms for the period from 7/31/19 to 8/20/19 and after checking, staff #295 stated there were no other anesthesia consent forms other than the one dated 7/31/19.

The electronic medical record of patient #294 was reviewed on 8/21/19 with the assistance of RN staff #295. The record reflected patient #294 was a 2 year and 11 month old boy diagnosed with group III, stage 3 fusion negative parameningeal rhabomyosarcoma of the left infratemporal region with likely bilateral upper neck lymph node involvement. The record reflected "plan for definitive concurrent chemoradiation, L skull base b. neck 1800 cGy, start 7/30/19, last 8/12/19; L skull base neck 2 Proton cGyRBE start 8/13/19. The patient's last scheduled treatment is Friday, September 6, 2019."

The "Disclosure and Consent Anesthesia and/or Perioperative/Peri-procedure Pain Management (Analgesia)" form as outlined above was signed by patient #294's father on 7/17/19.
Continued From page 48
anesthesiologist, staff #344 on 7/17/19 1038. The consent form did not indicate that the patient's authorized representative gave consent for anesthesia services on any other date than 7/17/19.

The record reflected that patient #294 received anesthesia services as follows.


7/30/19. Procedure: XRT IMRT TX Delivery Complex. Anesthesia Type: TIVA. Anesthesiologist, staff #345, CRNA, staff #307.

7/31/19. Procedure: XRT IMRT TX Delivery Complex. Anesthesia Type: TIVA. Anesthesiologist, staff #350, CRNA, staff #305.


8/2/19. Procedure: XRT IMRT TX Delivery Complex. Anesthesia Type: TIVA. Anesthesiologist, staff #346, CRNA, staff #309.

8/5/19. Procedure: XRT IMRT TX Delivery Complex. Anesthesia Type: TIVA. Anesthesiologist, staff #347, CRNA, staff #310.

8/6/19. Procedure: XRT IMRT TX Delivery Complex. Anesthesia Type: TIVA. Anesthesiologist, staff #347, CRNA, staff #310.
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<tbody>
<tr>
<td>A 131</td>
<td>Continued From page 49</td>
<td></td>
<td>8/7/19. Procedure: XRT IMRT TX Delivery Complex. Anesthesia Type: TIVA. Anesthesiologist, staff #347, CRNA, staff #310.</td>
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<td></td>
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<td></td>
<td>8/8/19. Procedure: XRT IMRT TX Delivery Complex. Anesthesia Type: TIVA. Anesthesiologist, staff #347, CRNA, staff #311.</td>
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<td></td>
<td>8/9/19. Procedure: XRT IMRT TX Delivery Complex. Anesthesia Type: TIVA. Anesthesiologist, staff #347, CRNA, staff #309.</td>
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<td>8/12/19. Procedure: XRT IMRT TX Delivery Complex. Anesthesia Type: TIVA. Anesthesiologist, staff #345, CRNA, staff #312.</td>
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<td>8/14/19. Procedure: PTC - Proton TX Intermediate. Anesthesia Type: General - Spontaneous Breathing. Anesthesiologist, staff #352, CRNA, staff #312.</td>
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<td>8/16/19. Procedure: PTC - Proton TX Intermediate. Anesthesia Type: TIVA. Anesthesiologist, staff #349, CRNA, staff #304.</td>
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:
450076

(X2) MULTIPLE CONSTRUCTION
A. BUILDING _____________________________
B. WING _____________________________

(X3) DATE SURVEY COMPLETED
08/23/2019

NAME OF PROVIDER OR SUPPLIER
UNIVERSITY OF TEXAS M D ANDERSON CANCER CENTER, THE

STREET ADDRESS, CITY, STATE, ZIP CODE
1515 HOLCOMBE BLVD
HOUSTON, TX  77030

(X4) ID PREFIX TAG
A 131

(X5) COMPLETION DATE
A 131

SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

ID PREFIX TAG
A 131

PROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

A 131

Continued From page 50


RN, staff #295 was asked if the record of patient #294 contained any other anesthesia consent forms for the period from 7/17/19 to 8/20/19 and after checking, staff #295 stated there were no other anesthesia consent forms other than the one dated 7/17/19.

The facility policy # CLN0547 titled "Informed Consent Policy" dated 1/18/19 stated in part, "1.0 Patient Consent: Consent Required

1.1 Informed Consent should be obtained by the Attending Physician or Physician Designee for all applicable care, treatment, services, medications, interventions, or procedures, including major and minor surgeries, anesthesia, radiation therapy, chemotherapy, and bioimmunotherapy, before proceeding with such care, treatment, services, medications, interventions, or procedures ...

1.2 The Informed Consent process should include all applicable aspects of the Elements of Informed Consent ... for the duration of the treatment plan and should be documented in accordance with this policy.

1.3 Disclosure of information related to Informed Consent should be provided by appropriate members of the health care team and should involve an opportunity for the patient or Patient Representative to ask questions of the clinician.
ultimately responsible for the care, treatment, services, medications, interventions, or procedures being consented to (typically, a Physician or a Physician Designee).

...1.6 A separate Informed Consent for intravenous sedation, anesthesia and/or perioperative/peri-procedure pain management should be obtained before proceeding with such services.

...9.0 Multiphasic Intervention, Treatment, or Procedure

9.1 Treatments, interventions, or procedures that are multiphasic, or those that involve several known steps and are performed at subsequent intervals may be included into a single Informed Consent process.

9.2 Documentation in the Informed Consent form and the Physician or Physician's Designee's note should include what has been discussed with the patient or the Patient Representative.

10.0 Re-Consenting

10.1 Following a patient reassessment, the Informed Consent process should be repeated and a new Informed Consent form signed if any of the following circumstances occurs:

A. The patient's condition has changed since the Informed Consent was received such that the likely risks, hazards, limitations, side effects, or benefits may have changed significantly ...

B. The patient or Patient Representative has additional questions that may substantially affect
A 131 Continued From page 52
decisions about the proposed treatment, care, services, intervention, or procedure.

C. Any outstanding indications that the patient or Patient Representative does not understand the care, treatment, services, medications, interventions, or procedure for which Informed Consent was previously provided.

D. Information regarding new significant risks, hazards, limitations, side effects, or benefits relating to all the applicable treatment, care, services, intervention, or procedure becomes available after the Informed Consent was received.

E. Information regarding new alternatives to the applicable care, treatment, services, intervention, or procedure becomes available after Informed Consent was received, which may substantially affect decisions about the proposed treatment, care, services, intervention, or procedure.

F. The patient was consented as a Minor and has now reached adulthood ...

G. There is an error in the previously signed consent form ...

10.2 Re-consenting may not be required for the following circumstances:

A. Treatments with pre-planned, sequential procedures that have been discussed with, and consented by, the patient or Patient Representative during the Informed Consent process for the procedure, and none of the indications listed above in 10.1 have occurred.
### UNIVERSITY OF TEXAS M D ANDERSON CANCER CENTER, THE

#### SUMMARY STATEMENT OF DEFICIENCIES

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<th>ID</th>
<th>PREFIX</th>
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<th>PROVIDER'S PLAN OF CORRECTION</th>
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<tr>
<td>A 131</td>
<td>Continued From page 53</td>
<td>Refer to Re-Consenting for Treatment or Procedure for examples.</td>
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</table>

B. A change in the person(s) who is identified on the Informed Consent form as the person who will conduct the care, treatment, services, medications, interventions, or procedures, or who will administer any anesthesia.

The newly identified provider should have a discussion with the patient or Patient Representative, about the change in the previously identified provider on the Informed Consent form, and document this discussion and the agreement, or lack of agreement, with this change in the patient's medical record."

Facility-based policy attachment # ATT1920 titled "Re-consenting for Treatment or Procedure" dated 1/9/15 stated in part, "1.0 Treatments or Procedures Not Requiring Re-consenting

Re-consenting may not be required for certain pre-planned repeated treatments or procedures that are discussed with, and consented by, the patient or Patient Representative during the original consenting process. Examples of pre-planned repeated treatments or procedures include, but are not limited to, the following:

1.1 Radiation therapy.

1.2 Chemotherapy administration by either intravenous, intrathecal, intra-arterial or other routes.

1.3 Interventional Radiology procedures.
A 131 Continued From page 54

1.4 Endoscopy procedures that require sequential therapeutic interventions.

1.5 Blood transfusions.

1.6 Sedation/anesthesia administration or perioperative or peri-procedural drug administration for pain management.

1.7 Bone marrow aspiration."

In an interview with the Chief Nurse Anesthetist, staff #313 on 8/22/19 at approximately 10:00 am in the 11th floor consultation room, the above findings were reviewed with staff #313. Staff #313 acknowledged that there was a single anesthesia consent for patient #293 and #294 who both had multiple episodes of anesthesia services provided by various anesthesia providers.

A 143 PATIENT RIGHTS: PERSONAL PRIVACY

CFR(s): 482.13(c)(1)

The patient has the right to personal privacy.

This STANDARD is not met as evidenced by:
Based on observation and interview, it was determined that the facility failed to provide privacy to its patients by monitoring patients in their surgical suites without fully disclosed consent, displaying electronic monitoring of surgical areas on monitors in the anesthesia work room in POD A and POD B of the surgical area.

Findings:
A tour of the operating rooms on 8/20/2019 revealed cameras and video equipment in each of the operating rooms. During the tour upon entering the anesthesia work room for POD A and POD B, the computer screens were displaying live video of patients and was visible to anyone who had access to the room to view the patients in the operating rooms. Also, during the tour, surveyor entered the anesthesia work room and observed that the door had no locking mechanism, and anyone had access to view the patient in the operating room.

During an interview with Staff #366 on 8/19/2019, at 10:41 AM, she was asked what the process for privacy was for the computers that were displaying pictures of the patients in operating rooms. Staff #366 stated, "We are supposed to minimize the screen when we leave." Surveyor stated, "So, if someone unauthorized entered the room like housekeeping or materials management they could click the mouse and pictures would appear." Staff #366 stated, "Yes".

A review of the hospital's record titled, "Patient Rights and Responsibilities" revealed no consent about cameras and videos being used for monitoring in the operating room and the patient giving permission.

A review of the hospital's record titled, "Informed Consent Policy" revealed no consent about cameras and videos being used for monitoring in the operating rooms and the patient giving permission.

A review of the hospital's record titled, "Disclosure and Consent Anesthesia and/or
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<td>A 144</td>
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<tr>
<td>Perioperative/Perioperative -procedure Pain Management (Analgesia)* revealed no consent about cameras and videos being used for monitoring in the operating rooms and the patient giving permission.</td>
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<td>The patient has the right to receive care in a safe setting.</td>
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<td>A review of the hospital's record titled, &quot;Consent to Diagnosis &amp; Treatment&quot; revealed no consent about cameras and videos being used for monitoring in the operating rooms and the patient giving permission.</td>
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<td>This STANDARD is not met as evidenced by:</td>
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<td>A review of the hospital's record titled, &quot;Disclosure and Consent Medical &amp; Surgical procedures&quot; revealed no consent about cameras and videos being used for monitoring in the operating rooms and the patient giving permission.</td>
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<td>Based on observation, document review, and interview, the facility failed to:</td>
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<td>A review of the hospital's record titled, &quot;Acceptance of financial Responsibility and Assignment of Benefits&quot; revealed no consent about cameras and videos being used for monitoring in the operating rooms and the patient giving permission.</td>
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<td>A. ensure patient's safety before, during, and after receiving Ketamine (a Schedule III</td>
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<td>An interview with Staff #11 on the afternoon of 8/19/2019 confirmed the above findings.</td>
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<td>PATIENT RIGHTS: CARE IN SAFE SETTING CFR(s): 482.13(c)(2)</td>
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## Statement of Deficiencies and Plan of Correction

### Name of Provider or Supplier

UNIVERSITY OF TEXAS M D ANDERSON CANCER CENTER, THE

### Street Address, City, State, Zip Code

1515 HOLCOMBE BLVD
HOUSTON, TX 77030

### Summary Statement of Deficiencies

(Each Deficiency Must Be Preceded by Full Regulatory or LSC Identifying Information)

<table>
<thead>
<tr>
<th>ID</th>
<th>Prefix</th>
<th>Tag</th>
<th>Provider's Plan of Correction (Each Corrective Action Should Be Cross-Referenced to the Appropriate Deficiency)</th>
</tr>
</thead>
<tbody>
<tr>
<td>A 144</td>
<td>Continued From page 57</td>
<td>Infusions in the Pain Management Outpatient Clinic located on the 4th floor at 1515 Holcombe Boulevard in 4 (Patient #250, #251, #252, and #262) of 5 patient records reviewed.</td>
<td></td>
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</tbody>
</table>

| B. | ensure that a policy was in place that was approved by the Medical Staff for outpatient Ketamine infusions in the outpatient setting. | | |
| C. | ensure patients were monitored and assessed by a Registered Nurse (RN) before, during, and after receiving Ketamine Infusions in the outpatient clinic. | | |
| D. | ensure the RN's were educated and trained to monitor patients who received Ketamine infusions. | | |
| E. | ensure the RN's were competent and trained in administering and monitoring patients that received conscious sedation. | | |
| F. | ensure patients were monitored and assessed by a RN before, during, and after receiving conscious sedation. | | |
| G. | ensure hemodialysis machines in use for hemodialysis treatment of patients were calibrated as to the dialysate concentrate prescribed by the physician in 1 of 1 observation. | | |

It was determined that these deficient practices posed an Immediate Jeopardy to patient health and safety, and placed all patients at risk for the likelihood of harm, serious injury, impairment, and/or subsequent death.
A. BUILDING _____________________________
B. WING _____________________________

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

450076

DATE SURVEY COMPLETED

08/23/2019

NAME OF PROVIDER OR SUPPLIER
UNIVERSITY OF TEXAS M D ANDERSON CANCER CENTER, THE

STREET ADDRESS, CITY, STATE, ZIP CODE
1515 HOLCOMBE BLVD
HOUSTON, TX 77030

ID PREFIX TAG

SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL
REGULATORY OR LSC IDENTIFYING INFORMATION)

ID PREFIX TAG

PROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

A 144 Continued From page 58
Hemodialysis machine #5.

H. administer enteral feeding and post feed
flushes as prescribed by patient's physician.
Patient #36.

I. implement patient's physician's orders for
pulmonary function test, VRE culture, and daily
weight. Patient #212.

J. ensure acid and bicarb (bicarbonate) wands
were secured to the acid and bicarb jugs during
dialysis. Also, 1 of 1 peritoneal dialysis patients
did not have daily weights recorded as ordered by
the physician.

K. protect 1 of 1 patients and follow their own
policy to contain and decontaminate a
chemotherapy spill.

Findings:

PATIENT #250

Patient #250 was admitted for an outpatient
Ketamine Infusion on 7/18/2019. Review of the
Physician medication order revealed, "Ketamine
25 mg in 100 ml sodium chloride once over 1
hour." The Ketamine Infusion was started at 2:47
PM and completed at 3:58 PM per documentation
by Staff #262. The last vital sign was taken at
4:19 PM. Physician #375's documentation
revealed patient received 2 mg Versed IV (a
sedative medication used to help patients feel
relaxed before a procedure given Intravenous)
before the start of the infusion. No physician
order, documentation of time given, or who
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<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
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<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
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<tr>
<td>A 144</td>
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<td>Continued From page 59 administered the medication could be located within the medical record. No pre or post infusion assessment by a Registered Nurse was documented in the medical record. Physician #375's documentation revealed patient's disposition was &quot;Home&quot;. There was no documentation of what time the patient left the facility. No further documentation was located throughout the medical record regarding a responsible driver or to whom discharge instructions were given to.</td>
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**PATIENT #251**

Patient #251 was admitted for an outpatient Ketamine Infusion on 8/12/2019. Review of the Physician medication order revealed, "Ketamine 50 mg in 100 ml sodium chloride once over 1 hour." The Ketamine Infusion was started at 2:42 PM and completed at 3:42 PM per documentation by Staff #263. The last vital sign taken was at 3:10 PM. This was 32 minutes prior to the completion of the Ketamine infusion. Physician #374's documentation revealed patient received 2 mg of Versed IV prior to the start of the infusion. No physician order, documentation of time given, or who administered the medication could be located within the medical record. No pre or post infusion assessment by a Registered Nurse was documented in the medical record. No documentation of vital signs or monitoring post infusion could be located within the record. There was no documentation of what time the patient left the facility. Physician #374's documentation revealed patient's disposition was "Home". No further documentation could be located throughout the medical record regarding a responsible driver or to whom discharge instructions were given to.
**PATIENT #252**

Patient #252 was admitted for an outpatient Ketamine Infusion on 8/8/2019. Review of the Physician medication order revealed, "Ketamine 50 mg in 100 ml sodium chloride once over 1 hour." The Ketamine Infusion was started at 11:32 AM and completed at 12:45 PM per documentation by Staff #263. The last vital sign taken was at 12:45 PM. A pre infusion-pain score was documented at "8" (a numeric pain scale used to indicate a patient's pain level, 1-10 with 10 being the worse pain.) and no documentation of post infusion assessment was noted in the record. Physician #373 documented Patient #252 "...was monitored for approximately 30 minutes afterward in the post procedure area. The patient was discharged home as per protocol..." No pre-assessment or post assessment was documented by the Registered Nurse. No documentation of the discharge time or if the patient was accompanied by a responsible adult. A Review of the "AFTER VISIT SUMMARY" revealed, Versed was administered at 11:31 AM. No dose was documented. Further review of the medical record did not reveal an order was written by the provider or who administered the medication.

Staff #188 confirmed the above findings.

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**PATIENT #262**

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<td>Continued From page 60 instructions were given to.</td>
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<td>Staff #188 confirmed the above findings.</td>
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A 144 Continued From page 61

Patient #262 was admitted for an outpatient Ketamine Infusion on 8/7/2019. Review of the Physician medication order revealed, "Ketamine 70 mg in 100 ml sodium chloride once over 2 hours." The Ketamine Infusion was started at 11:25 AM and completed at 3:00 PM per documentation by Staff #264. The last vital sign was recorded at 1:00 PM and the infusion was completed at 3:00 PM. Physician #374 documentation revealed, patient received 2 mg of Versed IV prior to the start of infusion. No physician order, documentation of time given, or who administered the medication could be located within the medical record. No documentation of a nursing assessment prior to the start of the infusion was in the medical record. There was a post infusion progress note documented by Staff #264 dated 8/7/2019 at 8:51 AM and read, "...Procedure completed. Patient re-evaluated by fellow and/or attending physician and discharged in stable condition..." This progress note documented by Staff #264 was timed 2 hours and 34 minutes before the start of the infusion. There was no documentation of what time the patient left the facility and if they were released with a responsible adult.

Staff #188 and #295 confirmed the above findings.

PATIENT #262 (Date of Service 7/24/2019)

Patient #262 was admitted for an outpatient Ketamine Infusion on 7/24/2019. Review of the Physician medication order revealed, "Ketamine 50 mg in 100 ml sodium chloride once over 1 hour." The Ketamine Infusion was started at 11:44 AM and completed at 1:20 PM per
A. BUILDING ____________________________
B. WING ____________________________

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

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<tr>
<td>A 144</td>
<td>Continued From page 62 documentation by Staff #263. Physician #374 documented patient received 2 mg of Versed IV prior to the start of infusion and an additional 2 doses of 1 mg Versed was given for anxiety. No physician order, documentation of time given, or who administered the medication could be located within the medical record. No documentation of a nursing assessment prior to the start of the infusion was in the medical record. There was a post infusion progress note documented by Staff #263 dated 7/24/2019 at 10:00 AM and read, &quot;...Procedure completed. Patient re-evaluated by fellow and/or attending physician and discharged in stable condition...&quot; The progress note documented by Staff #263 was timed 1 hour and 44 minutes before the start of the infusion. There was no documentation of what time the patient left the facility and if they were released with a responsible adult. Staff #188 and #295 confirmed the above findings.</td>
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A review of the document titled, "LOW DOSE KETAMINE (INTRAVENOUS) ADMINISTRATION FOR PAIN MANAGEMENT IN THE HOSPITALIZED ADULT PATIENT" revealed the policy was written and approved for inpatients only. No further documentation, policy, or protocol was provided for review.

A Review of the drug information for Ketamine (Ketalar) on the FDA.com website, Reference ID: 4089409 revealed the following:

"...Emergence reactions have occurred in approximately 12 percent of patients."
### STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

<table>
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<tr>
<th>(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:</th>
<th>(X2) MULTIPLE CONSTRUCTION A. BUILDING ___________________________</th>
<th>(X3) DATE SURVEY COMPLETED 08/23/2019</th>
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**NAME OF PROVIDER OR SUPPLIER**

UNIVERSITY OF TEXAS M D ANDERSON CANCER CENTER, THE

**STREET ADDRESS, CITY, STATE, ZIP CODE**

1515 HOLCOMBE BLVD
HOUSTON, TX 77030

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<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>(X5) COMPLETION DATE</th>
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| A 144             | Continued From page 63

The physiological manifestations vary in severity between pleasant dream-like states, vivid imagery, hallucinations, and emergence delirium. In some cases, these states have been accompanied with confusion, delirium, excitement, and irrational behavior.

When Ketalar is used on an outpatient basis, the patient should not be released until recovery from anesthesia is completed and then should be accompanied by a responsible adult.

**Warnings**

Cardiac function should be continually monitored. Respiratory depression may occur with over dosage or too rapid a rate of administration of Ketalar, in which case supportive ventilation should be employed. Mechanical support of respiration is preferred to administration of analeptics.

**Risk of Drowsiness**

The patients should be cautioned that driving an automobile, operating hazardous machinery, or engaging in hazardous activities should not be undertaken for 24 hours or more (depending upon the dosage of Ketalar and consideration of other drugs employed) after anesthesia ...

Ketalar (Ketamine) is a CIII non-barbiturate general anesthetic.

A review of Policy # CLN0596 titled, "Sedation/Analgesia for Procedures Policy (Policy
A. BUILDING _____________________________

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

450076

(X2) MULTIPLE CONSTRUCTION

A. BUILDING _____________________________
B. WING _____________________________

(X3) DATE SURVEY COMPLETED

08/23/2019

450076

STREET ADDRESS, CITY, STATE, ZIP CODE

1515 HOLCOMBE BLVD
HOUSTON, TX  77030

NAME OF PROVIDER OR SUPPLIER

UNIVERSITY OF TEXAS M D ANDERSON CANCER CENTER, THE

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(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

(X5) COMPLETION DATE

A 144 Continued From page 64
Related to Universal Protocol)" revealed the following:

"...2.0 Medication Administration

2.4 RN's assisting in administration of Sedation/Analgesia are responsible for documenting the drug, dose, route, site, time, and effects all medications including oxygen therapy on the institutionally approved Sedation Record.

2.5 All drugs administered for the Sedation/Analgesia shall have dose and time of administration documented in the patient's medical record.

6.0 Patient/Caregiver Teaching & Discharge Planning

6.2 Outpatients must have a responsible adult who will be available to provide transportation arrangements prior to the procedure. Before discharge, the patient and/or the accompanying adult must verbalize an understanding of the above instructions and will verify the he/she has received a written copy of the instructions by signing the appropriate discharge instructions.

7.0 Equipment and Plan of Care

7.1. During the procedure, a minimum of two available licensed Personnel will be required:

A. Physician Operator, who must order the sedative medication and Supervise its administration, including additional doses and titration.
A 144 Continued From page 65

B. RN Monitor, who has the primary duty to:

Continuously monitor the appropriate physiologic variables from the time of the administration of the sedative medication until discharge criteria are met; or until the patient is discharged ..."

Further review of this policy did not reveal any specific training or competencies that were required for a Registered Nurse to safely administer and/or monitor a patient receiving conscious sedation.

On 8/20/2019 after 1:00 PM, a review of employee files for Staff #263 and #187 was conducted with the Human Resources Department. Staff #263 and #187 did not have documentation of competencies or training to give or monitor patients receiving conscious/moderate sedation in their files. This was verified by the Human Resources Representative.

An interview was conducted on 8/16/2019 at 8:50 AM with Staff #187 and Staff #188. Staff #187 was asked which patients received Versed (a medication that helps patients relax or feel sleepy before a medical procedure) prior to procedures. Staff #187 stated, the only patients that receive Versed are the Ketamine infusions and that is based on the patients’ needs at the time of their visit. Staff #188 stated, also stated if any of the other pain procedures require Versed they are taken to the Main Operating Room.
An interview with Physician #372 was conducted on 8/16/2019 after 9:30 AM. Physician #372 was asked if patients receiving Ketamine infusions were given any type of sedation prior to the start of the infusion. Physician #372 stated, "All Ketamine Infusions are pre-medicated with Versed."

An interview was conducted on 8/20/2019 at 9:20 AM with Staff #263. Staff #263 was asked if any sedation medication was given to patients that were given Ketamine infusions for their chronic or acute pain. Staff #263 stated, "Yes, they usually do get Versed before the infusion starts and the nurse gives it and we stay with the patient. If they have a family member they stay in the room also." Staff #263 was asked if she had education and training on giving and monitoring a patient receiving Conscious Sedation. Staff #263 stated, "No." Staff #263 was asked if the provider stayed in the room during the infusion. Staff #263 stated, they don't always stay in the room but they never leave the clinic. Staff #263 was asked if she knew the maximum dose of Ketamine a patient could receive safely before it became anesthetic dose. Staff #263 replied, "No but we never give over 50 mg or less than 25 mg." Staff #263 was then asked how long the patient was monitored before they could be released from the clinic. Staff #263 said, "We will monitor them in the post procedure room, next to the nurse's station for about 45 minutes."

An interview was conducted on 8/20/2019 at 9:20 AM with Staff #187. Staff #187 was asked if any sedation medication was given to out patients that were receiving Ketamine infusions for their
A 144 Continued From page 67

chronic or acute pain. Staff #187 stated, "Yes, they usually get Versed before the infusion starts and the nurse gives it IV push (intravenously pushed through IV tubing) and we stay with the patient. If they have a family member they stay in the room too." Staff #187 was asked if she had any education or training on giving and monitoring a patient receiving Conscious Sedation. Staff #187 stated, "No." Staff #187 was asked if the provider stayed in the room during the infusion. Staff #187 stated, they don't always stay in the room. Staff #187 was asked if she knew the maximum dose of Ketamine a patient could receive safely before it became an anesthetic dose. Staff #187 replied, "No." Staff #187 was then asked how long the patient was monitored before they could be released from the clinic. Staff #187 said, "We will monitor them for 45 minutes after the infusion is completed."

An interview was conducted with Physician #320 on 8/20/2019 at 10:05 AM. Physician #320 was asked how the patients were monitored during a ketamine infusion. Physician #320 stated the nurse stays with the patient and monitors the vital signs during the infusion and then they are kept post infusion for 1 hour for monitoring and they are always released with a responsible person.

Staff #188 confirmed the above findings.

Review of the Operators Manual, Page 44, for 2008 K hemodialysis machine directs staff as follows: "Verify that the concentrate type displayed near the top of the screen correctly matches the prescribed concentrate type, and
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<td>A 144</td>
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<td>that the acid bicarbonate or acetate concentrates connected to the machine match the type selected. If an incorrect concentrate type is displayed, the correct concentrate must be entered.</td>
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On 08/12/2019, at 10:32 a.m., Patient # 36 was observed on the hemodialysis unit in room #1979. The Patient was receiving hemodialysis treatment at a blood flow rate of 300 mls/minute and a dialysate flow rate of 600 mls/minute. The Patient was utilizing a Fresenius 2008K hemodialysis machine #5.

Observation of the setting on the hemodialysis machine revealed, the hemodialysis machine was set to mix a dialysate concentrate of 2.5 potassium and 2.5 calcium.

Review of the Patient's prescription revealed a Physician's order dated 08/12/2019 for a dialysate concentrate of "2.5 mEq/L potassium and 1.5 mEq/L calcium first 2 hours and calcium 2.00 mEq/L remaining two hours."

Review of the setting on the hemodialysis machine revealed the hemodialysis machine was not calibrated to mix the dialysate concentrate of calcium 1.5 mEq/liter.

The Surveyor immediately notified hemodialysis Unit Manager #62 that the hemodialysis machine was not calibrated to mix the prescribed dialysate concentrate for the Patient's hemodialysis treatment.

The Facility's Hemodialysis Unit Manager said, there were 9 hemodialysis machines in use in the
### A 144

**Summary Statement of Deficiencies**

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**Facility and that they were not calibrated to mix dialysate concentrate of calcium 1.5 mEq.**

**Patient #36**

On 08/14/2019 at 9:15 a.m. Patient #36 was observed on the hemodialysis unit in room 1979. The Patient had a PEG tube (percutaneous endoscopic gastrostomy) in place with a bag and tubing attached. The bag was empty, and feeding was observed partially in the tubing. The tube was not flushed after administration of the feeding.

The Surveyor notified the hemodialysis nurse of her observation of feeding partially in the tubing while the bag is empty.

Review on 08/14/2019 of the Patient's clinical record revealed a physician's order dated (8/10/2019 for Novasource Renal (renal dialysis TF low electrolyte content) half can X 4 feeding. Water flush before each feed 60 and water flush after each feeding 120.

Review of the patient's clinical record revealed a physician order dated 08/12/2019 for Novasource Renal (renal dialysis TF low electrolyte content) I can X 4 feeding. Water flush before each feed 60 and water flush after each feeding 120.

Review of the Patient's clinical record for the following dates revealed no documentation that the Patient's (PEG) was flushed after administration of the Patient's nutritional feed and that the required amount of formula (4 cans daily) was administered to the Patient on the following days:
### Statement of Deficiencies and Plan of Correction

**Name of Provider or Supplier**

UNIVERSITY OF TEXAS M D ANDERSON CANCER CENTER, THE

**Street Address, City, State, Zip Code**

1515 HOLCOMBE BLVD
HOUSTON, TX 77030

**Form CMS-2567(02-99) Previous Versions Obsolete F7QU11**

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<td>A 144</td>
<td>Continued From page 70 08/11/2019: Feed administered at 18:00 and discontinued at 22:00. review of the record revealed Post flush water was not administered to the patient. 08/14/2019: Feed administered at 20:00. review of the record revealed Post flush water was not administered to the Patient. Documentation indicated prescribed formula was administered at the following times: 0900, 1800 and 2000. Review of the Patient's clinical record revealed the Patient was administered 3 cans of feed on 08/14/2019 instead of the prescribed 4 cans. 08/15/2019: PEG tube feed administered at 20:30. Review of the record revealed post flush water was not administered to the Patient. Documentation indicated prescribed formula was administered on the following times: 0959, 1635 and 2030. Review of the Patient's clinical record revealed the Patient was administered 3 cans of feed on 08/15/2019 instead of prescribed 4 cans. Review of the Patient's laboratory results dated 08/16/2019 revealed an albumin level of 2.5 L gm/dl (facility's reference range 5.5 -5.2 gm/dl), sodium 133 L MEq/L (facility's reference range 136-145), and Chloride 93 L MEq/L (facility's reference range 98-107). Review of a Registered Dietician's progress notes dated 08/13/2019 revealed the following entry &quot;Severe Protein Calorie Malnutrition.&quot;</td>
<td>A 144</td>
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Patient # 212

On 08/20/2019 at 11:07 a.m. Patient #212 was observed in the intensive care unit at room # 723. The Patient was receiving oxygen via a nasal cannula at 2 liters/per minutes.

Review on 08/20/2019 of the Patient's clinical record located in the electronic medical record, revealed a physician's order dated 08/06/2019 for PFT (pulmonary function test).

Review of the Patient's medical record revealed there was no indication in the record that the test was performed.


Interview on 08/20/2019 at 2:30 p.m. with Informatic Clinical Analysis staff who reviewed the record with the Surveyor revealed, "the order is still active". She further stated, she could not find the result that the test was done."

Review of the Patient's clinical record revealed no indication that the VRE culture was done on Sunday 8/11/2019.

A 144
Continued From page 72
and 08/10/2019 for daily weight.

Review of the Patient's clinical record located in
the electronic Medical Record revealed no
indication that daily weight was done as ordered
by the physician on 08/11/2019, 08/12/2019,
08/13/2019, 08/14/2019, 08/15/2019, and
08/16/2019.

During a tour of the inpatient dialysis area on
8/13/2019, at 9:35 AM, observed the acid and
bicarb wands not secured to the acid and bicarb
jugs during the dialysis treatment. The wands
were hanging from the jugs making them
susceptible to being knocked out of the jugs and
for contaminates to enter the jugs. This could
also allow for acid or bicarb spills if the jug was
knocked over due to the wands not being secured
on the jugs.

An interview with Staff #57 on 8/13/2019, at 9:45
AM, confirmed the acid and bicarb wands do not
fit securely on any of the acid and bicarb jugs in
the dialysis unit.

Patient 281

A review of the medical records for peritoneal
dialysis patient #281 revealed, daily weights were
not completed as ordered.

Peritoneal dialysis was ordered on 8/17/2019 to
run nightly for 6 exchanges.

Daily weights were ordered by the physician on
admission 8/16/2019 at 10:46 PM.
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<td>In review of the medical record for patient #281 weights were documented as follows:</td>
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8/16/19 - 67 kg
8/17/19 - 67.9 kg
8/18/19 - 69 kg
8/19/19 - no weight documented
8/20/19 - 69 kg

An interview with Staff #57 on 8/22/2019 at 9:30 AM confirmed weights should have been done daily before peritoneal dialysis and there was no weight documented on 8/20/2019.

Facility policy entitled "Chemotherapy Spills and Surface Contamination Policy" stated under 'Small Spills (500cc or Less): ...

7.2 Spills on Non-Carpeted Surface with Chemotherapy Spill Kit:

If spill is on a non-carpeted surface, locate a Chemotherapy Spill Kit available in the area, locate additional supplies (e.g., soap, water, a 10% bleach solution such as Dispatch, and absorbent material), and follow the steps below:

A. Take out contents of the Chemotherapy Spill Kit. Display the sign that warns others about the spill. Don the PPE following the procedure outlined in Section 3.1.

B. Contain spill by laying the Chemosorb pads over the spill. The pads will absorb the liquid and transform it into a gel to assist with disposal.
A. Caution: Chemosorb gel is extremely slippery when wet. Avoid skin and eye contact, and do not inhale.

B. Cuff both yellow biohazard bags and place on the floor adjacent to spill site.

C. Detach scoop from scraper and use both to pick up the Chemosorb gel, being careful not to contaminate gloves. Place the gel in one of the waste bags. If there is any broken glass, use the scoop to place it in a sharps container.

D. Use absorbent pad, soap, and water to pick up any remaining gel. Place the absorbent pad in the same bag.

E. During cleanup, use only one hand to directly clean the spill area and exposed surfaces.

F. Use the other hand to touch non-contaminated areas and supplies.

G. Using the contaminated hand, wipe the area with soap-dampened absorbent pad using an inward, circular motion, cleaning from least contaminated to the most contaminated areas. Use water-dampened absorbent pad to rinse the area.

H. Repeat the process three times.

I. Spray a 10% bleach solution (such as Dispatch) on absorbent pad and, using the same inward, circular motion, use it to clean area. Discard contaminated absorbent pad in yellow bag.
A 144 Continued From page 75

L. Allow the area to air dry for fifteen minutes.

M. Seal the yellow bag, place it inside the second yellow bag, and seal it.

N. Place sealed bags in a biohazard receptacle for disposal.

O. Following cleanup for all spills, remove PPE following the procedure in Section 3.2.

P. Coordinate final cleaning with Environmental Services.

7.3 Spills on Non-Carpeted Surface without Chemotherapy Spill Kit:

If Chemotherapy Spill Kits are not available in the immediate area, follow the steps below to clean up the spill:

A. Don PPE following procedure outlined in Section 3.1.

B. Place blue absorbent pads over the spill area to absorb the bulk of the spill and place the used pads in a biohazard container.

C. Dampen absorbent pad with warm water and small amounts of soap. Wipe down the contaminated area starting from the outer area of the spill, then working inward to the center of the spill. The used absorbent pad should be placed into a biohazard container. Used water dampened absorbent pad to rinse the area.

D. Repeat this process three times.

E. Spray a 10% bleach solution (such as...
### STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

**NAME OF PROVIDER OR SUPPLIER:**

UNIVERSITY OF TEXAS M D ANDERSON CANCER CENTER

**STREET ADDRESS, CITY, STATE, ZIP CODE:**

1515 HOLCOMBE BLVD
HOUSTON, TX 77030

**STATEMENT OF DEFICIENCIES**

(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

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- **Dispatch** on absorbent pad and wipe the spill area. Discard the contaminated pads in a biohazard container.

- **F.** Allow the area to air dry for fifteen minutes.

- **G.** Place spill debris in a biohazard receptacle for disposal.

- **H.** Follow the clean-up for all spills, remove PPE following the procedure in Section 3.2.

- **I.** Coordinate final cleaning with Environmental Services, if required.

Patient Grievance dated 6/4/19 stated "On June 2nd, the patient's chemo was hung and started at midnight. Around 0330, the patient woke up wet and called the RN. The patient's clothing and bedding were wet and there was a large spill on the floor along with some blood. The RN cleaned the floor with bath towels, changed the bed linens, and changed the patient. The towels, linens and patient's personal clothing were all thrown in the regular trash. The patient showered.

The RN advised his Charge Nurse that the spill was less than 100cc and he cleaned it up. The next night, the patient and the spouse told the assigned RN and the CN that the spill was almost to the door and they were concerned about exposure. They stated that they asked several people about it throughout the day, but nobody addressed it. Additionally, they are concerned that the patient did not receive his full dose (or potentially any of the dose) of chemo.

Review of facility self-investigation revealed incorrect attachment of tubing and
**A 144** Continued From page 77

Chemotherapeutic medications at the IV infusion pump which caused the leak. Apparently, the nurse only evaluated the fluid on the floor and not on the patient's linens and clothing so incorrect spillage was calculated. The spill was not cleaned according to policy nor documented in the patient medical record. Further, the remaining chemotherapeutic medication was not returned to the pharmacy for evaluation. Because of the lack of documentation and reporting, Environmental Services did not complete terminal cleaning of the room for 20 hours.

In an interview with the Representative for Patient Advocacy on 8/19/19, it was acknowledged that they incorrectly cleaned and reported chemotherapeutic spill that caused staff and patients exposure to toxic materials.

**A 146** PATIENT RIGHTS: CONFIDENTIALITY OF RECORDS

CFR(s): 482.13(d)

Patient Rights: Confidentiality of Records

This STANDARD is not met as evidenced by:

Based on observation and interview, the facility failed to ensure patient confidentiality.

Findings:

Facility policy entitled: "Patient Privacy: Safeguarding Paper PHI Policy" stated in part, "It is the policy of The University of Texas MD Anderson Cancer (MD Anderson) to comply with state and federal laws governing the protection and confidentiality of PHI." "The Health Insurance Portability and Accountability Act of 1996 (HIPPA) requires that certain protections be
A. **BUILDING**

**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:** 450076

**(X2) MULTIPLE CONSTRUCTION**

A. **BUILDING**

**B. WING**

**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**(X3) DATE SURVEY COMPLETED**

08/23/2019

**NAME OF PROVIDER OR SUPPLIER**

UNIVERSITY OF TEXAS M D ANDERSON CANCER CENTER, THE

**STREET ADDRESS, CITY, STATE, ZIP CODE**

1515 HOLCOMBE BLVD
HOUSTON, TX  77030

**FORM APPROVED**

OBT NO. 0938-0391

**450076**

**08/23/2019**

**SUMMARY STATEMENT OF DEFICIENCIES**

(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

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**PROVIDER'S PLAN OF CORRECTION**

(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

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applied to PHI, including PHI contained in paper form. It is MD Anderson's policy to comply with HIPPA and other applicable guidance by implementing appropriate safeguards for the use, storage, transport, transmission and disposal of paper PHI.

Page 2 of 6 stated: "Paper PHI should not be left unattended on photocopiers, printers, fax machines, or in other common areas (such as conference rooms)."

Page 4 of 6 stated: "5.1 In General: Paper PHI should be stored in secure locations (e.g., locked file cabinets or access-controlled rooms or areas)."

Tour of patient floor G10NW on 8/14/19 revealed a specimen collection container on a counter accessible to patients and visitors. Next to the collection container was a book where nursing staff wrote the patient name and specimen type. The unsecured patient information was confirmed during the tour on the same day by the Associate Director of the Department of Nursing.

Portions of medical records as well as identifying patient information were found unsecured and thus potentially accessible by unauthorized individuals in various outpatient clinics:

During a tour on 8/12/19 of the Fifth floor of the Mays Clinic Reconstructive Surgery Unit, room 5.2408 (note: this area had no door and thus there was no way to secure the area from unauthorized individuals who may have chosen to enter), the surveyors found that there were
portions of medical records which were unsecured on top of a wooden shelving unit and thus, potentially accessible by unauthorized individuals. When the surveyors entered this area, there were no staff observed to be working in the room. The survey team found a hard copy 2-page discharge summary and a hard copy 3-page pre-operative note for Patient # 37. Also found was a hard copy 2-page operative note for Patient # 184.

In addition, the surveyors observed a printed hard copy listing of the clinic schedule for 8/12/2019, which listed 6 patients including the two referenced above.

In interviews with the RN Nurse Manager and the RN, Executive Director on the afternoon of 8/12/2019, it was confirmed that portions of medical records were found unsecured.

During a tour of the 6th floor Mays building Gynecologic Oncology Center on the afternoon of 8/12/2019, the surveyors found that the door to the "Camellia Room" was not lockable and inside this room in an unlocked wall-mounted cabinet there were what appeared to be daily patient schedules, listing the names of patients who were to be seen on that particular day. These sheets ranged in date from 2016 to 2018. When the surveyors entered this area, there were no staff observed to be working in the room. The surveyors asked the RN Clinical Director to estimate approximately how many of these patient schedule sheets there were. She responded that there were approximately 400 of the daily schedule sheets.
A 146 Continued From page 80

During a tour on 8/14/19 of the LaMaistre building 11th floor Bone Marrow Aspiration clinic, the following was found: on the lobby/registration area counter there was black plastic bin found which contained 2 Bone Marrow Aspiration Clinic Patient Arrival Forms. These forms were for patient # 188. This form contained patient medical record numbers that contained a patient name. The form was lying face down in the plastic tray and beside the plastic tray was an 'out to lunch' sign, which prompted patients to place their arrival forms in the bin. When the surveyors initially approached the registration desk area, there was no staff member observed in the area. In an interview in the early afternoon of 8/14/2019 with staff members # 301 and #26, it was confirmed that these forms containing patient information were found unsecured.

In the unlocked Specimen room there was an unlocked wall mounted cabinet containing a binder as well as loose sheets which were labeled "Specimen Log In Sheets". There were approximately 200 of these sheets. Each of the sheets contained six separate lines where specimens could be logged-in, as well as a patient name, medical record number, and diagnosis. The area where the patient name was recorded contained a sticker, listing the patient name. During an interview in the early afternoon of 8/14/2019 with the RN Nurse Manager it was confirmed the specimen log book and loose specimen sheets were not secured.

During a tour of the LaMaistre building 10th floor, the surveyors turned the door handle to the
A. BUILDING ____________________________

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

450076

(X2) MULTIPLE CONSTRUCTION

A. BUILDING ______________________________________

B. WING ______________________________________

(X3) DATE SURVEY COMPLETED

08/23/2019

NAME OF PROVIDER OR SUPPLIER

UNIVERSITY OF TEXAS M D ANDERSON CANCER CENTER, THE

STREET ADDRESS, CITY, STATE, ZIP CODE

1515 HOLCOMBE BLVD

HOUSTON, TX  77030

(X4) ID PREFIX TAG

SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

ID PREFIX TAG

PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

(X5) COMPLETION DATE

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<td>Continued From page 81 Audiologists office and it was found to be unlocked; no staff were inside. (note: this office is immediately adjacent to a patient lobby/waiting area). As the surveyors stepped inside the office they observed that one of the large desk mounted computer monitors was on, and a closer examination of the monitor revealed that there was what appeared to be a patient schedule, listing the names of individual patients. Also observed in the office were hard copies of unsecured patient schedule sheets with names of individual patients, and there were also unsecured file folders on the desk for what appeared to be hearing aid orders which again, contained the names of patients. In an interview on the early afternoon of 8/14/2019 with the Nurse Manager, it was confirmed the door to the audiologist office was not locked and that the patient information inside the office, to include the computer screen as well as the hard copies on the desk, were not secured.</td>
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During a tour on 8/14/19 of the LaMaistre building 10th floor Head and Neck Center workroom, it was observed that there was no door or physical barrier preventing people from entering this area. When the surveyors entered the room, there were no staff present. Inside the room there was an unlocked small filing cabinet and inside this cabinet were portions of 6 patient records to include radiation treatment records. Some of these documents were dated from 2013. In an interview on the early afternoon of 8/14/2019 with the Nurse Manager it was confirmed the patient medical record documents found in the workroom were unsecured.

During a tour of building G floor 22 on 8/21/2019,
### Statement of Deficiencies and Plan of Correction

**Name of Provider or Supplier:**

UNIVERSITY OF TEXAS M D ANDERSON CANCER CENTER, THE

**Street Address, City, State, Zip Code:**

1515 HOLCOMBE BLVD
HOUSTON, TX 77030

**Form Approved OMB No. 0938-0391**

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**Event ID:** F7QU11  
**Facility ID:** 810041  
**Printed:** 10/09/2019  
**OMB NO:** 0938-0391

### Summary Statement of Deficiencies

Each deficiency must be preceded by full regulatory or LSC identifying information.

**A 146** Continued From page 82

the following observation was made.

A tech, identified as Staff #381, was near the nurses station and the surveyor requested to speak with a nurse. Staff #381 exited the area of nurses station and left to locate a nurse. The computer screen was visible and did not time out. The surveyor walked into the nurses station and viewed 48 patients by first and last name, date of admission, room number and physician.

Staff #66, the Registered Nurse returned, after a short discussion she left the nurses station. She entering the hallway, then returned and disabled the viewing of the patient list on the computer screen.

**A 167** PATIENT RIGHTS: RESTRAINT OR SECLUSION

CFR(s): 482.13(e)(4)(ii)

[The use of restraint or seclusion must be--]

(ii) implemented in accordance with safe and appropriate restraint and seclusion techniques as determined by hospital policy in accordance with State law.

This STANDARD is not met as evidenced by:

Based on review of facility policy, review of medical records and interview, the facility failed to ensure restraints were implemented in accordance with safe and appropriate techniques as determined by hospital policy for 6 of 6 (#265, 266, 267, 269, 270, 206) patients reviewed.

Findings:

Facility policy entitled "Restraint Policy" stated in part, "It is the policy of The University of Texas
A. If Non-Violent Restraint(s) is applied, a telephone or written order must be obtained either during the emergency application of the Restraint(s) or immediately (within 30 minutes) after application of Restraint(s). A Physician must evaluate the patient in person within 24 hours of initiating the Restraint(s) and authenticate the telephone order, if applicable.

B. If Violent or Self-Destructive Behavior Restraint(s) are applied, a telephone or written order must be obtained either during the emergency application of the Restraint(s) or immediately (within 30 minutes) after the application of the Restraint(s). A Physician must evaluate the patient in person within one hour of initiating the Restraint(s) and authenticate the telephone order, if applicable.

Patient # 265 had an order for "Violent/Self-Destructive" restraint at 0450 on
A 167 Continued From page 84

5/24/19. There was no documented evidence of the restraint or Q15 minute checks of the patient. The reason for the restraint was "Imminent danger to others." The order was discontinued at 0654 and a new order was written for "Non-Violent" 2-point restraint.

Patient # 266 was put into 2-point "Violent" restraint on 7/5/19 at 1820. The physician did not complete a face to face assessment until 2113.

Patient # 267 had an order for "Violent/Self-Destructive" restraint at 0451 on 5/24/19. There was no documented evidence of the restraint or Q15 minute checks of the patient. The reason for the restraint was "Imminent danger to others." The order was discontinued at 0652 and a new order was written for "Non-Violent" 2-point restraint.

Patient # 206 was put into 2-point restraint at 7/26/19 at 0012. The order for restraint was not entered until 10:59 am. The order was discontinued at 0457 on 7/27/19. On 8/6/19, this same patient was put into a 2-point "Violent" restraint at 2153. No face to face was completed within one hour by a physician. The patient received emergency medications Haldol and Ativan. There was no nursing documentation to evaluate the effectiveness of the medications.

Patient # 269 was transferred from the ED on 5/12/19 at 0511 in restraints. No order for restraint was made until an order for a "Violent" restraint was entered on 5/12/19 at 1332. There
### Statement of Deficiencies and Plan of Correction

**University of Texas M D Anderson Cancer Center, The**

<table>
<thead>
<tr>
<th>ID</th>
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<th>Tag</th>
<th>Name of Provider or Supplier</th>
<th>Street Address, City, State, Zip Code</th>
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<tbody>
<tr>
<td>450076</td>
<td>UNIVERSITY OF TEXAS M D ANDERSON CANCER CENTER,THE</td>
<td>1515 HOLCOMBE BLVD, HOUSTON, TX 77030</td>
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**Summary Statement of Deficiencies**

(Each Deficiency Must Be Preceded By Full Regulatory Or LSC Identifying Information)

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were no documented Q15 minute checks for this order. At 1424, there is documentation that bilateral wrist restraints were applied, and a new order was written for "non-violent" restraint.

On 7/12/19 at 1940, Patient # 270 received Thorazine 25 mg IVPB for "agitation." There was no documented re-evaluation of the medication's effectiveness. On that same day at 2054, patient was put into bilateral "non-violent/medical" restraint. The nurse's note prior to restraint stated that patient was unable to receive his radiation treatment due to agitation. He also tried to kick and hit his sitter and the nurse. Patient was restrained until 7/13/19 at 1130. This restraint was ordered as a non-violent restraint when it is apparent that the restraint was "Violent." A violent restraint required a one-hour assessment by a physician and should have lasted no longer than 4 hours.

The above restraint errors were confirmed by the unit Psychiatrist, the Director of Psychiatry, the Director of Specialty and the Representative for Patient Advocacy during chart review on 8/22/19.

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<td>A 263</td>
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<td>QAPI CFR(s): 482.21</td>
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The hospital must develop, implement and maintain an effective, ongoing, hospital-wide, data-driven quality assessment and performance improvement program.

The hospital's governing body must ensure that the program reflects the complexity of the hospital's organization and services; involves all
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| A 263         | Continued From page 86 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 observation, interview, and record review, the facility failed to develop and maintain an effective and ongoing quality assessment and performance improvement program in 7 of 13 departments that were reviewed (Contracted services, Nursing, Dialysis, Lab, Surgical services, Infection control, and Outpatient services). The facility failed to: A. ensure they identified opportunities for improvement with data that was being collected. The facility failed to ensure contracted services were assessed and quality improvement projects were developed. B. to set performance improvement activities that affected health outcomes, patient safety, and quality of care. The facility failed to provide documentation of performance improvement projects that were implemented as a result of incidents involving harm to patients. The facility failed to provide documentation of performance improvement projects being implemented after incidents involving quality of care on patients. C. to measures it's success and track performance to ensure that improvements were
**A. BUILDING**

**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**1515 HOLCOMBE BLVD**

**UNIVERSITY OF TEXAS M D ANDERSON CANCER CENTER, THE**

**STREET ADDRESS, CITY, STATE, ZIP CODE**

**1515 HOLCOMBE BLVD**

**HOUSTON, TX  77030**

**NAME OF PROVIDER OR SUPPLIER**

**UNIVERSITY OF TEXAS M D ANDERSON CANCER CENTER, THE**

**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**ID**

**PREFIX**

**TAG**

**SUMMARY STATEMENT OF DEFICIENCIES**

**ID**

**PREFIX**

**TAG**

**PROVIDER'S PLAN OF CORRECTION**

**ID**

**PREFIX**

**TAG**

**COMPLETION DATE**

**A 263** Continued From page 87

sustained. The facility failed to provide documentation of tracking of performance improvement projects that were implemented as a result of incidents involving harm to patients.

D. to ensure Quality improvement projects being escalated to the Quality Council, Executive leadership team and Governing body (local and institutional).

Refer to A tag 0283 for additional information.

E. ensure the facility's Governing Body and Medical Staff provided clear expectations for safety program on escalation of sentinel events through Quality. They failed to ensure a clear process was established for reporting serious sentinel events, and monitoring restraints and seclusions.

Refer to A tag 0286 for additional information.

**A 283 QUALITY IMPROVEMENT ACTIVITIES**

**CFR(s): 482.21(b)(2)(ii), (c)(1), (c)(3)**

(b) Program Data

(2) [The hospital must use the data collected to - .....]  

(ii) Identify opportunities for improvement and changes that will lead to improvement.

(c) Program Activities

(1) The hospital must set priorities for its performance improvement activities that--

(i) Focus on high-risk, high-volume, or problem-prone areas;

(ii) Consider the incidence, prevalence, and severity of problems in those areas; and

10/26/19
A. BUILDING _____________________________

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

450076

(X2) MULTIPLE CONSTRUCTION

A. BUILDING _____________________________

B. WING _____________________________

(X3) DATE SURVEY COMPLETED

08/23/2019

(X4) ID PREFIX TAG

SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

(X5) COMPLETION DATE

ID PREFIX TAG

PROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

A.283 Continued From page 88

(iii) Affect health outcomes, patient safety, and quality of care.

(3) The hospital must take actions aimed at performance improvement and, after implementing those actions, the hospital must measure its success, and track performance to ensure that improvements are sustained.

This STANDARD is not met as evidenced by:

Based on observation, interview, and record review, the facility failed to:

A. ensure they identified opportunities for improvement with data that was being collected. The facility failed to ensure contracted services were assessed and quality improvement projects were developed.

B. to set performance improvement activities that affected health outcomes, patient safety, and quality of care. The facility failed to provide documentation of performance improvement projects that were implemented as a result of incidents involving harm to patients. The facility failed to provide documentation of performance improvement projects being implemented after incidents involving quality of care on patients.

C. to measures it's success and track performance to ensure that improvements were sustained. The facility failed to provide documentation of tracking of performance improvement projects that were implemented as a result of incidents involving harm to patients.

D. to ensure Quality improvement projects being
### Summary Statement of Deficiencies

*(Each deficiency must be preceded by full regulatory or LSC identifying information)*

#### Contracted Services

Review of a list of contracted services revealed there was a total of 249 contracted services. Review of the list revealed some of the following missing information in relation to performance improvements:

- Leica Bond RX service agreement used for auto-staining (lab testing) expired on 08/02/2019 (12 days prior to date of survey).

"According to documentation the performance indicators in the contract were insufficient. The corrective action was, Appropriate KPIs (key performance indicators) will be identified by Sourcing and contract stakeholder. KPIs will go through clinical review for insufficiency. Sourcing will incorporate KPIs into purchase orders until an amendment or new agreement is executed, if applicable. Scorecard will be developed by Sourcing and implemented for tracking KPIs. Contract stakeholder will track and collect supporting documentation."

---

#### Table: Provider's Plan of Correction

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**Excerpt from A 283:**

- Escalated to the Quality Council, Executive leadership team and Governing body (local and institutional).

This deficient practice was found in 7 of 13 departments that were reviewed (Contracted services, Nursing, Dialysis, Lab, Surgical services, Infection control and Outpatient services).

**Findings:**

- CONTRACTED SERVICES

Review of a list of contracted services revealed there was a total of 249 contracted services. Review of the list revealed some of the following missing information in relation to performance improvements:

- Leica Bond RX service agreement used for auto-staining (lab testing) expired on 08/02/2019 (12 days prior to date of survey).

"According to documentation the performance indicators in the contract were insufficient. The corrective action was, Appropriate KPIs (key performance indicators) will be identified by Sourcing and contract stakeholder. KPIs will go through clinical review for insufficiency. Sourcing will incorporate KPIs into purchase orders until an amendment or new agreement is executed, if applicable. Scorecard will be developed by Sourcing and implemented for tracking KPIs. Contract stakeholder will track and collect supporting documentation."
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<tr>
<td>A283</td>
<td>Continued From page 90</td>
<td>A283</td>
<td>Best Care EMS (Emergency Medical service) - Ambulance Transport which was the ambulance service for patient care. According to documentation the metrics for the contract was pending clinical review.</td>
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<td>Cross Country Staffing which was for temporary nurse staffing and allied services. According to documentation the metrics for the contract was pending clinical review.</td>
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<td>Abbott f/k/a St Jude Medical/service which was capital equipment service agreement. According to documentation the performance indicators in the contract were insufficient. The corrective action was, &quot;Appropriate KPIs will be identified by Sourcing and contract stakeholder. KPIs will go through clinical review for insufficiency. Sourcing will incorporate KPIs into purchase orders until an amendment or new agreement is executed, if applicable. Scorecard will be developed by Sourcing and implemented for tracking KPIs. Contract stakeholder will track and collect supporting documentation.&quot;</td>
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<td>Belimed OR Single Sterilizer Full Service Agreement revealed the performance indicators were insufficient and not tracked. The corrective action was, &quot;Appropriate KPIs will be identified by Sourcing and contract stakeholder. KPIs will go through clinical review for insufficiency. Sourcing will incorporate KPIs into purchase orders until an amendment or new agreement is executed, if applicable. Scorecard will be developed by</td>
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A. BUILDING ________________________
B. WING _____________________________

**UNIVERSITY OF TEXAS M D ANDERSON CANCER CENTER, THE**

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<td>A 283</td>
<td>Continued From page 91</td>
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Sourcing and implemented for tracking KPIs. Contract stakeholder will track and collect supporting documentation."

Gulf Coast Testing was used for blood testing services for infectious disease prior to uploading into the National Marrow Donor Program registry revealed the performance indicators were insufficient and not tracked. "Appropriate KPIs will be identified by Sourcing and contract stakeholder. KPIs will go through clinical review for insufficiency. Sourcing will incorporate KPIs into purchase orders until an amendment or new agreement is executed, if applicable. Scorecard will be developed by Sourcing and implemented for tracking KPIs. Contract stakeholder will track and collect supporting documentation."

National Children's Hospital Laboratory Services Contract used for laboratory service agreement for targeted B-ALL Fusion Analysis in pediatric patients. Documentation revealed the performance indicators were insufficient. "Appropriate KPIs will be identified by Sourcing and contract stakeholder. KPIs will go through clinical review for insufficiency. Sourcing will incorporate KPIs into purchase orders until an amendment or new agreement is executed, if applicable. Scorecard will be developed by Sourcing and implemented for tracking KPIs. Contract stakeholder will track and collect supporting documentation."

Viracor-IBT / Eurofins Clinical Diagnostic used for clinical laboratory services revealed the performance indicators were insufficient. "

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| A 283 | | |}

Event ID: F7QU11 Facility ID: 810041
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<th>(X5) COMPLETION DATE</th>
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<tbody>
<tr>
<td>A 283</td>
<td>Continued From page 92 Appropriate KPIs will be identified by Sourcing and contract stakeholder. KPIs will go through clinical review for insufficiency. Sourcing will incorporate KPIs into purchase orders until an amendment or new agreement is executed, if applicable. Scorecard will be developed by Sourcing and implemented for tracking KPIs. Contract stakeholder will track and collect supporting documentation.&quot; Castle Bioscience-Molecular Genetics Test used for Molecular Genetic Testing Services revealed the performance indicators were insufficient. &quot; Appropriate KPIs will be identified by Sourcing and contract stakeholder. KPIs will go through clinical review for insufficiency. Sourcing will incorporate KPIs into purchase orders until an amendment or new agreement is executed, if applicable. Scorecard will be developed by Sourcing and implemented for tracking KPIs. Contract stakeholder will track and collect supporting documentation.&quot; Carefusion-support and maintenance agreement for Pyxis Equipment revealed the performance indicators were insufficient. &quot; Appropriate KPIs will be identified by Sourcing and contract stakeholder. KPIs will go through clinical review for insufficiency. Sourcing will incorporate KPIs into purchase orders until an amendment or new agreement is executed, if applicable. Scorecard will be developed by Sourcing and implemented for tracking KPIs. Contract stakeholder will track and collect supporting documentation.&quot;</td>
<td>A 283</td>
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</tbody>
</table>
### Statement of Deficiencies and Plan of Correction

**A. Building:**

**NAME OF PROVIDER OR SUPPLIER:**

UNIVERSITY OF TEXAS M D ANDERSON CANCER CENTER, THE

**STREET ADDRESS, CITY, STATE, ZIP CODE:**

1515 HOLCOMBE BLVD
HOUSTON, TX 77030

**DATE SURVEY COMPLETED:**

08/23/2019

### Summary Statement of Deficiencies

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<th>COMPLETION DATE</th>
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<tr>
<td>A. 283</td>
<td>Continued From page 93</td>
<td>TMC Hospital Laundry Coop Association which was used for Hospital Laundry and Linen Services revealed that the metrics were pending review.</td>
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<td>During an interview on 08/14/2019, after 8:30 a.m., Staff #’s 121 and 122 said that the servicers were responsible for keeping their own metrics. A dashboard was being created and they are trying to create a committee. They were bringing in a company to help categorize their contacts.</td>
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<td>Staff #61 said the program was being designed right now for contracted services and it will feed into the main quality dashboard.</td>
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<td>Staff #’s 61, 121 and 122 confirmed contracted services had not been evaluated, metrics identified or monitored.</td>
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<td><strong>NURSING</strong></td>
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<td>During an observation on 08/13/2019, after 1:00 p.m., Quality improvement project boards were observed on G12. The board listed current projects for the unit.</td>
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<td>During an interview on 08/13/2019, after 1:00 p.m., RN #55 showed the surveyor a list of improvement projects that they were currently working on for the unit. The list was more extensive than the projects listed on the board. RN #55 explained that some of the projects were completed and some were still in process.</td>
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<td>During an interview on 08/13/2019, after 2:20 p.m., RN #’s 50 and 56, said that some of the</td>
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A 283 Continued From page 94

Project improvements that they were working on were K-card rounding, enhanced recovery, femoral catheters, stem cell, medication purpose/side effects, and sleep experience. A request was made to see a list of the current improvement projects for nursing with the information that was analyzed.

RN #50 provided 13 studies that they were working on under the umbrella of nursing.

There was no documentation of when some were started and the goals for how long they were going to continue before reevaluation.

Review of the Quality Assessment and Improvement Programs for 2019 and 2020 did not outline all of the local and institutional projects.

RN #s 50 and 51 said that some of the metrics that staff had on a local level were not being reported up to Quality and Governing Body. If there was a policy change that affected the entire institution the improvement project would be sent to the Quality council, Executive leadership, and Governing body.

SURGERY

Review of Patient Safety Committee Minutes dated 05/28/2019 revealed the following:

*Patient Death While on Heparin: 54 year old female with secondary malignant neoplasm of the brain with a scheduled placement of stereotactic head frame for gamma knife radiosurgery. Patient
A 283 Continued From page 95

had an untoward reaction to Bupivacaine and Lidocaine injection into scalp frame pin sites due to overdosages."

Underneath action items the following was listed:

"Conduct a medication use evaluation of 0.75 % Bupivacaine usage at MDA and determine if it is being used according to FDA approved indications. Post evaluation, determine if P& T Committee intervention is warranted.

Provide education to EC, Neurosurgery, and Gamma Knife staff on the s/s of Bupivacaine toxicity and use of intralipids in treatment.

Develop a process for areas that use Bupivacaine without anesthesia service support and EC to have access to intralipids for possible Bupivacaine toxicity.

Review the ordering tool to evaluate the oral agents used for pain control and present case study to in neurosurgery staff meeting."

All were due by 05/17/2019 and follow-up action planning meeting scheduled.

Review of the root cause analysis information revealed a new "Surgical Safety Checklist" which was dated 06/27/2019.

There was documentation of future changes in order sets for the Bupivacaine starting in August 2019

Review of Quality Assessment and Performance Improvement and Executive Leadership meeting
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<td>A 283</td>
<td>Continued From page 96</td>
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<td>minutes that were provided for the timeframe of June - August 2019 made no mention of the improvement projects that had been implemented in relation to this root cause analysis.</td>
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<td>During an interview on 08/19/2019, after 8:40 a.m., Physician #79 said that the incident occurred because of an overdose of Bupivacaine. To correct the problem an order set was developed to adjust the medication based on weights. Training was provided to surgeons. The timeout procedure was changed.</td>
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<td>Review of Quality Assurance Performance Improvement (QAPI) documentation revealed the following events from May - June 2019:</td>
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<td>May Safety Intelligence Reports</td>
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<td>Harm Score 5 (meaning moderate temporary harm)</td>
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<td>Early termination due to chest pain</td>
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<td>Harm Score 4 (meaning severe temporary harm)</td>
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<td>Catheter Malfunction</td>
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<td>Wrong dose of Zosyn prescribed, patient was on CRRT (continuous renal replacement therapy) medication was prescribed after initiating CRRT, because of that BPA (bisphenol-A) didn’t fire</td>
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<td>June Safety Intelligence Reports</td>
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<td>Harm Score 5</td>
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<td>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</td>
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<td>A 283</td>
<td>Continued From page 97</td>
<td>Early termination due to hypertension and chest pain</td>
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<td>Acute change during IHD (in-center hemodialysis)- Muscle cramps and tachycardia</td>
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<td>Harm Score 4</td>
<td>Catheter access issue -no blood return</td>
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<td>Delay in transportation</td>
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<td>Review of quality minutes dated 07/15/2019 revealed that &quot;Nursing Dialysis Metrics - deferred to the next meetings.&quot;</td>
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<td>Review of Patient Safety minutes dated 07/23/2019 revealed there were two root cause analysis in May and two in June 2019. There was no mention of the events from dialysis.</td>
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<td>Review of quality minutes dated 07/29/2019 revealed the dialysis department gave a presentation, but there was no documentation of the events that were listed for dialysis.</td>
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<td>Review of the quality minutes agenda dated 08/12/2019 revealed no mention of dialysis.</td>
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<td>During an interview on 08/16/2019 after 11:12 a.m., RN #63 said, all the evidence for the safety events were in the information provided to the surveyors. RN #63 said they implemented new procedures because of the problems with the catheters. The problem with transportation of the patients had been identified, but the problems with late medications were not addressed.</td>
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| | During an interview on 08/20/2019 after 2:00 p.m., Staff #’s 61, 62 and 64 confirmed that not all quality improvement projects were taken to the
A. BUILDING ____________________________  
B. WING _____________________________

450076  

STATEMENT OF DEFICIENCIES  
AND PLAN OF CORRECTION  

STREET ADDRESS, CITY, STATE, ZIP CODE  
1515 HOLCOMBE BLVD  
HOUSTON, TX  77030

SUMMARY STATEMENT OF DEFICIENCIES  
(EACH DEFICIENCY MUST BE PRECEDED BY FULL  
REGULATORY OR LSC IDENTIFYING INFORMATION)

ID  
PREFIX  
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A 283 Continued From page 98  
Quality council.

Review of Patient #48's clinical record revealed a physician's order dated 07/31/2019 for "Midodrine 10 mgs via gastrostomy tube three times daily before meal. Hold if SBP greater than 150 mm/Hg in addition, Monday, Wednesday, and Friday when he receives dialysis. Please give a dose 30 minutes BEFORE dialysis (not additional dose but mid-day dose). Avoid administering after the evening meal, or within 4 hours of bedtime."

Review of the Patient's medication administration record and hemodialysis treatment record for the following days revealed, Medication Midodrine 10 mgs was not administered 30 minutes prior to hemodialysis treatment as prescribed:

08/09/2019: Medication Midodrine 10 mgs administered at 8:43 a.m. and hemodialysis treatment initiated at 10:00 a.m.

08/07/2019: Medication Midodrine 10 mgs administered at 8:01 a.m. and hemodialysis treatment initiated at 11:00 a.m.

08/05/2019: Medication Midodrine 10 mgs administered at 9:29 a.m. and hemodialysis treatment initiated at 10:20 a.m.

08/02/2019: Medication Midodrine 10 mgs administered at 9:10 a.m. and hemodialysis treatment initiated at 10:00 a.m.

The Surveyor reviewed the Patient's clinical record with the Unit's Manager who confirmed that the medication was not administered as
**SUMMARY STATEMENT OF DEFICIENCIES**

(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

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<th>ID PREFIX TAG</th>
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<th>COMPLETION DATE</th>
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<td>A 283</td>
<td></td>
<td>Continued From page 99 prescribed because at times transportation is late in transferring the Patient to hemodialysis for hemodialysis treatment.</td>
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</table>

Review of the Dialysis Quality Assessment Performance Improvement Meeting Minutes for July 2019 revealed documentation which indicated there was a problem transporting patients to the hemodialysis unit.

Interview on 08/19/2019 at 9:35 a.m. with the Facility's Dialysis Nursing Director revealed, she had identified that patients were not transported timely to the hemodialysis unit, but she had not done a root cause analysis or a plan implemented to address the transportation problem with patients. She said, she met with personnel from transportation and spoke with the contract staff manager they would to use the contract nurses to pick up their patients but this was not implemented.

Outpatient Services:

The hospital failed to ensure that:

1.) There was documentation of results related to specific quality assurance process improvement initiatives for the endoscopy center.

2.) There was documentation of a performance initiative for the melanoma skin center.

3.) There was corrective action when monthly metrics were not met for West HAL (Houston Area Location).

The surveyors were presented with a 4-page document entitled: "Ambulatory Operations +
A 283 Continued From page 100
Access Quality Assurance Process Improvement Initiatives (6/18-8/19)." Staff member #1 informed the surveyor that this document was compiled in response to surveyor request for examples of PI initiatives.

Review of this document listed 32 separate hospital centers and improvement initiatives for each of the centers. At the bottom of each page was the statement: "Blue = attendee lists, agendas and minutes available". Of the 139 improvement initiatives listed 47 were blue.

Specific examples included:

1.) The Endoscopy Center. Among the improvement initiatives for the Endoscopy Center were: Revision of HLD (high level disinfection) process. In interviews with staff member #26 on 8/20/2019 and 8/21/2019, it was confirmed that there was no documentation available for the Revision of HLD process improvement initiative.

2.) Performance initiative for The Melanoma/Skin Center was listed as: "Review and streamlining of instruments." The survey team was presented with an undated document entitled: "Quality Improvement Initiatives". This document contained a section entitled: "Review and streamlining of instruments." The comments for this section stated: "Problem: Providers feedback that the instruments in trays are not appropriate and are not used and have to open individual packs. Also, out dated." "Intervention: Created a team with faculty (derm), MA and AA to go through all trays, visually check, discard, create a new tray, order and bundle new trays for procedures. From 11 instruments down to 7
| A 283 | Continued From page 101 instruments per tray. Decreased use of individual packs and replacements, saving not only dollars but increased efficient by not running out of room while procedure is ongoing to grab additional or appropriate individual instruments. |

No documentation was found by or provided to the surveyor regarding the outcome or status of this performance initiative. In an interview with staff members #1 and #26 on 8/20/2019 it was confirmed that there was no documentation available for this performance initiative.

3.) Review of document for West Houston HAL (Houston Area Location) regarding "Nursing Audit Tool: Standardize reporting of monthly metrics." This document stated: "Improve and maintain patient education documentation rates above 95% for new patients and consults." A corresponding document showing monthly percentages achieved for this metric revealed that "Education Documentation: New" the percentages for Apr-19 were: 93%, for May-19: 91%, for Jun-19: 89% and for Jul-19: 92%.

When the surveyor asked for documentation as to what the West Houston HAL was doing in regard to not meeting the identified metric of 95% an email was provided by staff member #18 for review. This email which was dated August 20, 2019 from staff #286 stated: For the four months (April ‘19-July ‘19) that were below 95% target, the corrective action plan will be as follows."

Among the actions listed was: "1. Identify the instances where the documentation is lacking." The email concluded by stating: "The concentration of these errors was mainly due to a lot of newer staff getting used to the process."
A. BUILDING _____________________________

PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 450076

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

A. BUILDING _____________________________

STATEMENT OF DEFICIENCIES

B. WING _____________________________

DATE SURVEY COMPLETED: 08/23/2019

STREET ADDRESS, CITY, STATE, ZIP CODE: 1515 HOLCOMBE BLVD

UNIVERSITY OF TEXAS M D ANDERSON CANCER CENTER

PROVIDER'S PLAN OF CORRECTION

(A) ID PREFIX TAG

SUMMARY STATEMENT OF DEFICIENCIES

(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

B. WING _____________________________

ID PREFIX TAG

COMPLETION DATE: 

ID PREFIX TAG

COMPLETION DATE: 

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: F7QU11 Facility ID: 810041 If continuation sheet Page 103 of 268

A 283 Continued From page 102

Growing pains.” No other documentation was found by or provided to the surveyor addressing that the metric was not met for four consecutive months.

LABORATORY

Review of the "Division of Pathology and Laboratory Medicine CLIA Laboratory Quality Plan" date 8/9/19 revealed an algorithm for reporting Quality Assessment Performance Improvement (QAPI). All divisions will report to the Quality Executive Council then to Division Head and ultimately Quality Assurance Performance Improvement Council. Review of the Pathology and Laboratory Medicine Quality Council Report for the second quarter of 2019 revealed data was collected. The laboratory had comments on the data sheet concerning actions taken on an issue or goals but there was no defined approach to the continuous study and improvement of the processes of providing healthcare services to meet the needs of patients.

Review of the Executive Leadership Team Meeting Minutes for 7/2/19 and 7/9/19 revealed there was no documentation found concerning the Laboratory data, findings, actions, or process improvements.

INFECTION CONTROL

Review of the Infection Control Quality initiatives revealed an Annual Infection Program Risk Assessment and Analysis. The program assessment and analysis had an Infection Control Risk Assessment Plan attached for 2019. The
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<td>A 283</td>
<td>Continued From page 103</td>
<td>plan included the following:</td>
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<td>Emergency Mgmt Plan</td>
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<td>ICU Associated Infection</td>
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<td>Disinfection/Sterilization/Low level Clean- Patient Care Equipment</td>
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<td>Clostridium difficile</td>
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<td>CRBSI/CLABSI</td>
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<td>Respiratory Viruses</td>
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<td>Leukemia</td>
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<td>Antimicrobial Stewardship (AMS)</td>
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<td>Use of Isolation Precautions</td>
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<td>Surgical Site Infections</td>
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<td>Temperature and Humidity (OR and SPD areas)</td>
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<td>PICU (PICS)</td>
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<td>Duodenoscopy Re-processing</td>
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<td>Legionella/Waterborne</td>
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<td>Fungal</td>
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A 283 Continued From page 104

Invasive Procedures Outside the OR

CAUTI

Multi-resistant Organisms

Blood Borne pathogens

Pharmacy-compounding

Food and Nutrition Services

IR Pavilion

Patient Care Supply Storage

Communicable Diseases

Mycobacterium tuberculosis

Construction/Renovation

An interview was conducted on 8/14/19, at 11:00AM, with Staff #40, #137, and #138. Staff #40 spoke to infection control and the QAPI projects they are looking at. Staff #137 reported they are focusing on c-diff and the high rate of infection in CA patients. They had purchased UV lights to use in surgery and in patient's rooms to help eliminate infections. Staff #138 stated, they were not sure where they will fall in reporting to quality at this time. Staff #138 was asked how they are reporting regularly to QAPI and medical staff? Staff #138 stated, they are having meetings and following issues on the infection control committee level and will be taking up the information when it is their time to report. Staff #138 was not sure of the date.
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Isolation was discussed. Staff #40 reported that the facility has an isolation module for the nurses to follow and environmental care rounding was performed every day. Staff #40 reported that they are focusing on CLABSI/CAUTI and reporting that information monthly to the Infection Control Committee. Staff #40 and #137 stated they would bring documentation of the QAPI for Infection Control. Staff #40, 137, and 138 did not have any evidence to provide the surveyors with at that time. The only information provided to the surveyors after multiple request was a Outcomes Report on "Decreasing CLABSI with Daily CHG Bathing." There was no other information provided.

Review of the QAPI Council Meeting minutes for 7/29/19 revealed that Infection Control had not participated or reported to QAPI.

Review of the Medical Quality Planning Committee revealed the committee was canceled for June and July.

Review of the minutes of the ELT on 7/30/19, 8/1/19, 8/8/19 revealed there was no infection control information discussed or presented to the ELT.

Review of the minutes of the Governing Board Executive Leadership Team Meeting Minutes for 7/2/19 and 8/1/19 revealed there was no infection control information discussed or presented.
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

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<td>A 283</td>
<td>Continued From page 106</td>
<td>A 283</td>
<td>An interview with Staff #61 and #62 was conducted on 8/19/19. Staff #62 reported that the departments would be reporting to QAPI, GB, ELT, and would be put on a schedule on when they will be reporting their information and data. Staff #62 stated that he was working with the teams on how to present. At this time there was no further data, analysis, monitoring or implementation of Infection Control provided.</td>
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| A 286 | PATIENT SAFETY | A 286 | CFR(s): 482.21(a), (c)(2), (e)(3)  
(a) Standard: Program Scope  
(1) The program must include, but not be limited to, an ongoing program that shows measurable improvement in indicators for which there is evidence that it will ... identify and reduce medical errors.  
(2) The hospital must measure, analyze, and track ...adverse patient events ...  
(c) Program Activities .....  
(2) Performance improvement activities must track medical errors and adverse patient events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the hospital.  
(e) Executive Responsibilities, The hospital's governing body (or organized group or individual who assumes full legal authority and responsibility for operations of the hospital), medical staff, and administrative officials are responsible and accountable for ensuring the following: ...  
(3) That clear expectations for safety are established. | | | | |
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<td>A286</td>
<td>Continued From page 107</td>
<td>This STANDARD is not met as evidenced by: Based on record review and interview, the facility's Governing Body and Medical Staff failed to ensure that clear expectations for safety were established by implementing a clear process of reporting serious sentinel events, and monitoring restraints and seclusions. Review of the Patient Safety Committee Meeting minutes dated 7/23/19 revealed the committee met and discussed 2 Root Cause Analysis (RCA) cases. Harm and potential for harm occurred in the RCA and changes were implemented. The Patient Safety Committee minutes revealed the following: A change was made in the fall policy and procedure. Develop standards of practice guidelines, template, algorithms for CNS lymphoma patient with ICP and educate staff and explore the ability for One Connect to flag the Glasgow scores for providers who can’t see nursing documentation. Plans were discussed in how the committee was going to move forward in identifying events using the present consulting company's model. Three presentations were given on the Sentinel Event with the medication Bupivacaine, Patient Safety Skin presentation, the continuous Quality Assessment and Performance Improvement Program. Review of the Quality Assessment Performance Improvement (QAPI) meeting minutes for 7/29/19 revealed that Staff #79 had not presented any of</td>
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the RCA information. There was no written
evidence the patient safety committee presented
the changes made to the policy and procedures,
the development of guidelines, templates,
 algorithms, or staff education to be developed.

Review of the QAPI Medical Committee meeting
minutes revealed there was no meeting for June,
July, and August. Staff #61 confirmed the findings
on 8/20/19. Staff #61 stated, "They cancelled
their meetings so there would be no minutes."

Review of the Executive Committee of Medical
Staff (ECMS) meeting minutes on 7/30/19
revealed Patient Safety Report from 5/28/19 was
presented and Occupational Health. There was
no documentation of the RCAs or the outcomes.

Review of the Executive Leadership Team (ELT)
meeting minutes on 7/9/19 revealed no minutes
for patient safety. The meeting minutes for 7/2/19
revealed patient safety was addressed in
generality and discussions were made on the
metrics they would be following in the future.
There was no discussion noted on Patient Safety
Events/RCAs and outcomes to the ELT or
Governing Body. On 8/1/19 the Governing Body
Executive Leadership Team minutes describe
Staff #79 reporting SI events data and two RCAs
but no mention of which RCAs reported or
outcomes.

An interview was conducted with Staff #79 in the
morning of 8/19/19. Staff #79 reported about two
years ago the facility started daily patient safety
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<td>A 385</td>
<td>NURSING SERVICES</td>
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**A. BUILDING _____________________________**

**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**NAME OF PROVIDER OR SUPPLIER**

UNIVERSITY OF TEXAS M D ANDERSON CANCER CENTER, THE

**STREET ADDRESS, CITY, STATE, ZIP CODE**

1515 HOLCOMBE BLVD
HOUSTON, TX 77030

**FORM APPROVED**

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

**PRINTED:** 10/09/2019

**MULTIPLE CONSTRUCTION**

A. BUILDING _____________________________

**DATE SURVEY COMPLETED**

08/23/2019

**STREET ADDRESS, CITY, STATE, ZIP CODE**

1515 HOLCOMBE BLVD
HOUSTON, TX 77030

**EVENT ID:** F7QU11

**SUMMARY STATEMENT OF DEFICIENCIES**

Each deficiency must be preceded by full regulatory or LSC identifying information.

**NURSING SERVICES**

<table>
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<th>CFR(s): 482.23</th>
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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 upon observation, record review, and interview, the facility nursing staff failed to:

**PROVIDER'S PLAN OF CORRECTION**

Each corrective action should be cross-referenced to the appropriate deficiency.
A. PROVIDE patient care and treatment per facility policy, per physician orders, and/or notify physician of changes of condition for 29 of 29 patients reviewed (Patients #18, 67, 171, 172, 177, 218, 225, 228, 230, 231, 233, 285, 286, 288, 290, 291, 293, 311, 312, 316, 317, 318, 319, 322, 323, 324, 325, 326, and 327).

Cross Refer to Tag A392

B. EVALUATE 1 (#307) of 1 patient's care needs and patient's health status by unnecessarily withholding clear liquids for six hours while waiting for a computed tomography (CT) scan. Per hospital protocol, the patient could have consumed a clear liquid diet for six of the nine hours the patient waited for completion of scan. This hospital failure placed the patient at risk for dehydration.

Cross Refer to Tag A0395

C. ENSURE that nursing care plans include interventions regarding all patient diagnoses. Twenty four (24) (#13, #14, #17, #18, #20, #21, #24, #29, #45, #69, #70, #71, #76, #79, #109, #110, #111, #112, #225, #289, #313, #314, #315, and #326) of 44 medical records reviewed had incomplete plans of care.

Cross Refer to Tag A0396

D. 1. ADMINISTER medication as prescribed by the patient's physician in 1 of 7 sampled patients. (Patient #48)
A 385 Continued From page 111

2. follow the facility's policy for documentation of treatment and interventions in 6 (#271, #39, #276, #277, #278, and #279) of 7 patients reviewed.

Cross Refer to Tag A0405

A 392 STAFFING AND DELIVERY OF CARE
CFR(s): 482.23(b)

The nursing service must have adequate numbers of licensed registered nurses, licensed practical (vocational) nurses, and other personnel to provide nursing care to all patients as needed. There must be supervisory and staff personnel for each department or nursing unit to ensure, when needed, the immediate availability of a registered nurse for bedside care of any patient.

This STANDARD is not met as evidenced by:
Based on record review and interviews, the hospital failed to have adequate numbers of licensed registered nurses and other personnel to provide care to all patients to meet their needs. Lack of staffing resulted in inability to provide care that was ordered for the patient.

Nursing staff failed to provide patient care and treatment per facility policy, per physician orders, and/or notify physician of changes of condition for 29 patients of 29 patients reviewed (Patients # 18, 67, 171, 172, 177, 218, 225, 228, 230, 231, 233, 285, 286, 288, 290, 291, 293, 311, 312, 316, 317, 318, 319, 322, 323, 324, 325, 326, and 327).

Findings:
### Statement of Deficiencies and Plan of Correction

**Name of Provider or Supplier:**

UNIVERSITY OF TEXAS M D ANDERSON CANCER CENTER, THE

**Street Address, City, State, Zip Code:**

1515 HOLCOMBE BLVD  
HOUSTON, TX  77030

<table>
<thead>
<tr>
<th>ID</th>
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<th>Summary Statement of Deficiencies (Each Deficiency Must Be Preceded By Full Regulatory Or LSC Identifying Information)</th>
<th>Completion Date</th>
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<tbody>
<tr>
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<td>Continued From page 112</td>
<td>Review of incident reports documented the following:</td>
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1. Pt. #288 failed to receive "his immunotherapy Ipi/Nivo at the time requested because they are understaffed in the evening."

2. Pt #293 failed to receive "his chemotherapy (chemo) that was due at 10 AM. Pharmacy emphasized that the drug is short-stable and expensive and pharmacy would only prepare the dose close to the time it's due. Pharmacy delivered the drug at 9:55 and notified 2 nurses. At 11:21, the pharmacy received a message saying that the drug was expired. The pharmacy prepared the drug, but it will be later than 30 minutes due to the amount of time it takes to prepare the drug...They will bring the drug around 12:55 due to the limited number of staff the floor has on the weekend during lunch time."

3. Pt #317 failed to receive "the appropriate dose of chemotherapy due to the PCT not documenting a correct weight and overriding the EPIC alert...Not reported to the RN...The RN noticed on the third day that the weight was a discrepancy. The RN reported to the Pharmacy and the physician immediately and the dose was adjusted."

4. Pt. #318 failed to "...receive the amicar drip due to the pump being off. RN that was caring of the patient did not know. (IV pumps are suppose to be checked every two hours during "5 P rounding." (5 P rounding: Potty, Pumps, periphery, position and pain)."
### SUMMARY STATEMENT OF DEFICIENCIES

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5. Pt. #319 "...fell while going to the bathroom. There were three nurses assigned to the Pod and all 3 were involved with a Code in another room. The patient felt weak and lowered herself to the floor and did not sustain an injury."

6. "Nurses were float nurses to the floor. The patient care tech went to the other floor without notifying the nurses. No help answering the call lights...They had a confused patient who was jumping in and out of bed...Nurses were not able to go on break or supper because it was not safe for just one nurse left on the pod. The resource RN was also full load and said she did not have a lunch break either."

7. Pt.#321 "...was cleared for chemo at 1556 but chemo was not started on the day shift...When questioned about why chemo wasn't started the dayshift nurse stated that she wasn't able to do chemo and the charge nurse told her to admit the patient and the night shift could administer the chemo."

8. Pt. #316 "...Pt had chemo due at 2230. A change of assignment occurred at 2230 due to preceptor being sent to ED. Event occurred after preceptor left. Patient assignments were changed in the middle of the shift due to staffing and acuity considerations." (This is just a random sample of the numerous incidents that are all similar to those listed)
A confidential interview was conducted with an employee on 8/13/2019, documented "...the nursing staff feels that they are not adequately staffed. The staff feels that all the nurses feel the same way. Nurses learn how to do short cuts to take care of patients. Most of the time they are staffed at 4:1 but you cannot do a good job of patient care with that ratio. 3:1 patient to nurse ratio is what they are shooting for. This floor is very busy and if you have 'Q1 hour flap checks' on more than one patient you are too busy to make sure that everything is done on time. A few nurses have left the hospital due to staffing. When asked if the Charge Nurse or the Clinical Nurse Leaders take patients or help out, the staff stated that the Charge Nurse sometimes is assigned a patient. The Clinical Nurse Leaders (CNL) will come and try to help if you beg them or if you can find them, but they are not up on their education and keeping up with what is going on and they usually do not know what to do once they come to help you. Staff states that she goes home after her shift and wonders if she missed anything on her patient or if she did everything for her patient that was ordered. The staff states that it is stressful because our patients are so critical and have so much going on that you have to stay on top of things and double check that you have done everything for the patient. She states that the patients are the ones effected by the short staffing. They are not getting the care they deserve."

An interview with Personnel #328 on 8/13/2019, the surveyors asked about staffing. Personnel #328 stated that they staff via budget. On the floor, we were on the ratio is 4:1 (4 patients to 1 RN). This was an extremely busy floor and the...
nurses were busy with patient care. When asked if there was anyway they can get additional nurses to help when they have new surgeries for admit, blood administration, chemo administration, etc.. Personnel #328 stated, they do not consider acuity when staffing. Personnel #328 stated, "it really works out, the only floor that have a different nurse to patient ratio is ICU, Pedi ICU, and the Leukemia floor. They have a charge nurse, clinical nurse leaders, and the Associate Nurse Director who can lend a hand when they need extra help." The nurses were very busy and rushing around the unit working. It was approximately 2:00 PM and the charge nurse was asking nurses if they had received a lunch break. Personnel #328 stated "the nurses go to each other and offer breaks as they have time."

On 8/12/2019, Personnel #24 and Personnel #256 were asked to test the defibrillator. After fumbling around for a few minutes and trying to figure out how to do the testing of the defibrillator, Personnel #24 and Personnel #256 pulled out the instructions to the defibrillator and test fired the defibrillator.

Personnel #328 stated, "Personnel #24 and Personnel #256 are not the usual personnel that test the defibrillator." The surveyor asked if that is not a skill that all nurses should know how to perform and Personnel #328 stated, "yes." The surveyor asked if the nurses on the floors were not ACLS certified and Personnel #328 stated... "ACLS is not required except in ICU."

On 8/14/2019, Personnel #302, Personnel #42,
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and Personnel #291 were asked to test the
defibrillator. The personnel were having trouble
test firing the defibrillator. The Personnel fired
the defibrillator but got a message on the screen
that did not confirm the firing. The Personnel
were confused and stated they would call
Bio-Med department to come and check the
defibrillator.

Personnel #328 stated, "...Not sure if that is a
warning or if that comes up every time you fire
the defibrillator, but they will have it checked out."
The surveyor told Personnel #328 that it should
be a daily event on their unit and out of 3
Personnel that might have to use the defibrillator
at anytime, they are not sure the defibrillator is
working properly or not. What would the
Personnel do if they were in a code and did not
know for sure if the defibrillator was working
properly or not.

On 8/12/2019, interview with RN #332 revealed
"staffing is a rollercoaster", it can be difficult to
retain nurses on the unit and registered nurses
cannot be hired if there is no opening.

Interview with RN#331 was completed on
8/14/2019. The nurse stated concerns with
increase in patient falls possibly linked to not
enough nurses staffed on unit.

Patient #311 was hospitalized 8/11/2019 -
8/16/2019 at the facility with diagnoses of oral
cancer, urinary tract infection, and malnutrition.
### STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

#### (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

450076

#### (X2) MULTIPLE CONSTRUCTION

- A. BUILDING _____________________________
- B. WING _____________________________

#### (X3) DATE SURVEY COMPLETED

08/23/2019

#### NAME OF PROVIDER OR SUPPLIER

UNIVERSITY OF TEXAS M D ANDERSON CANCER CENTER, THE

#### STREET ADDRESS, CITY, STATE, ZIP CODE

1515 HOLCOMBE BLVD
HOUSTON, TX 77030

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On 8/21/2019 patient #311 EHR was reviewed. It was noted the purposeful rounding (5 P's) was documented only for the following dates/time:

- 8/16/2019- 2 PM, 12 PM, 8 AM, 2:00 AM, (patient was discharged 8/16/2019)
- 8/15/2019- 12 PM, 8 AM, 4:00 AM, 12:30 AM
- 8/14/2019- 7:00 PM, 5:00 AM
- 8/13/2019- 9:30 PM, 7 PM, 4 PM, 2 PM, 12 PM, 10 AM, 9 AM, 8 AM, 5 AM,
- 8/12/2019- 7 PM-7 AM, 6:30 AM.

Patient #312 was hospitalized 8/9/2019 - 8/13/2019 at the facility with a diagnosis of kidney cancer, hypertension, and kidney insufficiency.

On 8/21/2019 patient #312 EHR was reviewed. It was noted the purposeful rounding (5 P’s) was documented only for the following dates/time:

- 8/13/2019- 4 PM, 2 PM, 7:30 AM, 5 AM, 4 AM, 1 AM (patient was discharged 8/13/2019).
- 8/12/2019- 9 PM, 7 PM, 5 PM, 4:30 AM, 12 AM.
- 8/11/2019- 8:30 PM, 7 PM, 5 PM, 2 PM, 11 AM, 10 AM, 8 AM, 4 AM 12 AM
- 8/10/2019- 8 PM, 6 PM-7 AM, 4 AM,
- 8/9/2019- 11 PM, 10 PM, 5:30 PM | A 392 | | | |
A. BUILDING _____________________________

PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 450076

STATEDMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION
A. BUILDING
B. WING

(X3) DATE SURVEY COMPLETED
08/23/2019

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SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

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On 8/13/2019 RN#325 verbalized purposeful rounding is to be completed by nursing staff, every hour and every two hours at night for all patients

On 8/21/2019 RN#259 confirmed purposeful rounding is to be completed by nursing staff every hour and every two hours at night while the patient is hospitalized

The "Inpatient Nursing Documentation of Patient Care Policy" dated 7/18/2019 states the following: ...."4.0 Shift Documentation. 4.1 The following must be documented every shift or more frequently, if ordered or applicable: .... I. Purposeful Rounding." The policy contained a list of definitions that included the definition for purposeful rounding: "For the purpose of this policy, refers to intentional nursing staff rounding to ensure the key elements for patient safety are in place, including but not limited to the 5Ps (Pain, Position, Possession, Potty, and Pump) and visual safety checks. Purposeful rounding will occur hourly from 0700 - 2100 and every 2 hours from 2200 - 0600. Purposeful Rounding may be performed more frequently, as needed."

Nursing failed to implement physician orders for daily weights, incentive spirometry, sitz bath, TED (anti-embolism/compression) hose, and sequential compression devices (SCD).

Findings:

Review of facility policy titled "Inpatient Nursing Documentation of Patient Care Policy," dated
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7/18/19, showed that it was the policy of the facility for nursing to record patient interventions in the medical record in a timely, accurate, and complete manner.

Record review of eight (8) current & five (5) discharged patients' clinical records showed 12 patients had physician orders for the following nursing interventions:

I. Daily weights:

Patient #231: seven (7) weights missed
Patient #230: six (6) weights missed
Patient #225: six (6) weights missed
Patient #326: four (4) weights missed
Patient #324: three (3) weights missed
Patient #218: two (2) weights missed
Patient #233: two (2) weights missed
Patient #228: two (2) weights missed
Patient #325: two (2) weights missed
Patient #323: two (2) weights missed
Patient #327: two (2) weights missed
Patient #322: two (2) weights missed

II. TED Hose:
**Patient #230:** Physician order dated 08/08/19 for TED hose. There was no nursing documentation that TED hose were ever applied. The patient was discharged on 08/19/19.

Patient #233: Physician order dated 05/06/19 for TED hose. This was an active order for 15 days, only four (4) nursing entries related to TED hose during that time period.

Patient #322: Physician order dated 02/04/19 for TED hose. There was no nursing documentation that TED hose applied for nine days (02/4 through 02/13/19).

During an interview on 08/19/19, at 10:15 AM, with RN Navigator # 335, she stated that if TED hose were ordered by physician, nursing was required to document TED hose every shift as: "on, off, or patient refused, or other related comments."

**III. SCD:**

Patient #326: Physician order dated 08/10/19 for SCD. There was no nursing documentation that SCD was ever applied.

Patient #323: Physician order, dated 08/08/19 for SCD. There was no nursing documentation that SCD was ever applied.
### A. BUILDING 450076 PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

- **STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

- **(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:** 450076
- **(X2) MULTIPLE CONSTRUCTION A. BUILDING ____________________________**
- **(X3) DATE SURVEY COMPLETED:** 08/23/2019

#### NAME OF PROVIDER OR SUPPLIER

**UNIVERSITY OF TEXAS M D ANDERSON CANCER CENTER, THE**

- **STREET ADDRESS, CITY, STATE, ZIP CODE:** 1515 HOLCOMBE BLVD HOUSTON, TX 77030

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#### IV. Incentive Spirometry (IS):

- **Patient #322:** Physician order dated 02/04/19 for "Incentive Spirometry 10 x daily while awake." There was no documentation of incentive spirometry (IS) for 18 days, only two entries of IS were recorded for 26 days of the active order (Feb. 23 & 24, 2019).

- **Patient #327:** Physician order dated 01/30/10 for incentive spirometry. There were only 4 nursing entries related to IS, the order was active for twenty days. This patient was discharged 02/20/19.

- During an interview on 08/20/19, at 11:30 AM, with RN Navigator #335, she stated that respiratory therapy would often provide the initial IS patient education but nursing was responsible for recording the actual IS use by the patient.

#### V. Sitz bath:

- **Patient # 231:** Physician order dated 07/29/19 for "sitz bath three times a day." There was no nursing documentation sitz baths were ever provided.

- The medical records were reviewed on a series of dates between 8/13/19 and 08/22/19. All electronic records were reviewed each time with RN Navigator #335. RN Navigator #335 was unable to locate the documentation to verify the physician orders had been implemented for the 12 patients listed above.
### UNIVERSITY OF TEXAS M D ANDERSON CANCER CENTER, THE

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<td>A 392</td>
<td>Nursing failed to:</td>
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<td>A. Acquire physician's orders for the treatment of wounds present on admission.</td>
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<td>B. During a wound dressing change a nurse did not discard her dirty gloves, wash her hands and apply clean gloves before handling a clean gauze dressing.</td>
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<td>C. The nurses were inconsistent in following the wound care nurse's recommendations.</td>
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<td>D. The facility did not develop a policy for Dating and Labeling of wound dressing changes.</td>
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<td>Findings:</td>
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<td>Review of Patient #67's medical records reflected a 74-year-old-male, admitted on 8/8/19 with a left elbow surgical wound. The patient was seen by the wound care nurse on 8/9/19 when she made recommendation for the treatment of the patient's left elbow and left lateral knee wounds. The left elbow treatment recommendations included cleansing the wound and changing the dressing every other day and as needed for soilage [sic] or saturation, and to assess under foam dressing at least once per day. The left lateral knee treatment recommendations included cleansing the wound and changing the dressing every other day and as needed for soilage [sic] or saturation. The wound care nurse did not obtain a physician's order for the wound treatments.</td>
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<td>During an interview on the morning of 8/22/19, in the facility INR room, Staff #42 stated, &quot;It's up to</td>
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the provider to put the recommendations into an order ... Physicians should write an order to get a wound consult ... the recommendation is not a physician's order."

An observation on the morning of 8/16/19, in patient room G1243, with Staff #54 present revealed Patient #67 receiving wound care to a left lower leg wound. Staff #82 removed the old dressing, a small amount of blood was noted on the dressing. Staff #82 cleaned the wound with a saline soaked gauze, then dried the wound with a clean dry gauze, and applied a clean dressing over the wound. Staff #82 did not perform hand hygiene and change her gloves after removing the dirty dressing and prior to cleaning of the wound, possibly contaminating the wound, and did not document the date the dressing was changed on the dressing. Patient #67's left elbow dressing did not have a date to indicate when the dressing had been changed last.

Review of the facility provided document Skills: Dressing (undated) reflected,

"... 16. Remove the old dressing by slowly pulling back across the wound in the direction of hair growth ...

17. Dispose of the soiled dressing in the wastebasket or waterproof bag, following the organization's practice for infection control.

19. Prepare the dressing supplies using aseptic technique.

20. Pour sterile saline or the prescribed solution...
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08/23/2019

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over sterile 4 X 4-in gauze pads or use an
organization-approved spray wound cleanser.

21. Perform hand hygiene and don gloves. Don
sterile gloves if the practitioner orders sterile
dressing changes, such as for sharp debridement...

C.) Review of the Wound Care Nurse’s
assessment dated 8/8/19 reflected,

Recommend to discontinue [sic]the wound VAC
and change dressing recommendations to a
Collagen dressing to further aide in the healing
process. For the skin tears on the left lateral
knee, would recommend using a non-adherent
dressing such as Mepilex Lite or Xeroform.

Review of physician’s orders dated 8/16/19
reflected,

“For the left Elbow:

1. Cleanse wound using pressurized saline
(Lawson#10318- order from Materials
Management via fax), pat dry.

2. Cut and apply Hydrofera Blue Ready to cover
the wound bed (Lawson #9806)

3. Secure wound with Medipore or paper tape

4. Change dressing every other day and PRN if
soiled, displaced or saturated.

5. May assess under dressing at least once per
day”
A. BUILDING
B. WING

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 450076

DATE SURVEY COMPLETED: 08/23/2019

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SUMMARY STATEMENT OF DEFICIENCIES

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ID PREFIX TAG

A 392 Continued From page 125

Review of the Left Elbow daily assessments reflected no documented wound assessments on 8/10/19, 8/11/19, 8/12/19, and 8/17/19. The dressing changes were missed, per the wound care nurse's recommendations on 8/11/19, 8/15/19, and 8/18/19. The nurses had been treating the wounds without a physician's order for 8 days.

D. ) Review of the facility provided Skills:
Dressing document (Undated) reflected, "...27. Label the dressing per the organization's practice ...", The facility was unable to provide the organization's practice.

During an interview on the morning of 8/20/19, in an Administrative Conference room, Staff #314, stated, "...We do not have a policy on the labeling of dressing changes."

During an interview on the morning of 8/20/19, in an Administrative Conference room, Staff #290 stated, "Best practice is, the dressings should be dated when the dressing was changed."

Record review on 8/21/19, of Pt #172's medical records showed doctor's orders for a blood transfusion to be given on 5/10/19. Further review of orders stated for vital signs to be taken 15 minutes after initiation of transfusion, then every hour until finished.

Review of vital sign documentation showed the first vital sign was taken 20 minutes after initiation...
A 392 Continued From page 126
(5 minutes late) and there were no vital signs taken until two hours after initiation, completely missing the one-hour post initiation. In an interview on 8/21/19, at 11:00 AM, Staff #144 stated that the nurse giving the blood transfusion was late five minutes to obtain the first vital signs and the one-hour post initiation of transfusion vital signs were completely missed and should have been done per doctor's orders.

Record review on 8/21/19, of Patient #177’s medical records showed an order for a blood transfusion to be given on 8/15/19 with vital signs to be taken every 15 minutes for one hour, then every 30 minutes for one hour, then every hour until completed. Further review revealed the initiation of infusion started at 10:15 AM, and the vital signs were not taken at 12:15, nor again at 1:15. In an interview on 8/21/19, at 11:45 AM, Staff #141 stated that the two vital signs were not done per doctor's orders.

Record review on 8/21/19, of Patient #171’s medical records showed, he received an infusion of chemotherapy on 8/16/19. Doctor's orders stated to take vital signs prior to infusion. Further review revealed the infusion initiation was 10:23 AM, but there were no vital signs taken prior to this. In an interview on 8/21/19, at 12:00 PM, Staff #141 stated "...the nurse didn't do it [the vital signs prior to infusion]."

Record review of facility policy #CLN1115 titled "Blood Component Administration and Transfusion Reaction Policy" stated to obtain vital signs 30 minutes prior to starting a blood

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<td>Record review on 8/21/19, of Patient #177’s medical records showed an order for a blood transfusion to be given on 8/15/19 with vital signs to be taken every 15 minutes for one hour, then every 30 minutes for one hour, then every hour until completed. Further review revealed the initiation of infusion started at 10:15 AM, and the vital signs were not taken at 12:15, nor again at 1:15. In an interview on 8/21/19, at 11:45 AM, Staff #141 stated that the two vital signs were not done per doctor's orders.</td>
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transfusion, and also every hour after 15 minutes
after the initiation, then hourly from start of
transfusion through completion.

Review of medical records on 08/19/2019,
8/20/2019, and 08/21/2019 revealed the
following:

Patient #18 was admitted on 08/09/19, for
complications related to Adrenal Cancer to
include bilateral pulmonary embolisms, acute
kidney injury, diabetes, dehydration, and
Cushing's Syndrome.

The patient was ordered Thrombo-Embolic
Deterrent (TED) hose on 08/09/19 at 7:09 p.m.
There was no documentation in the patient's
medical record to show the patient ever received
the TED hose. There is no documentation to
show that the doctor was notified that the order
was not carried out by the nurses.

Further review of the record revealed there were
four incidents when the patient's vital signs were
out of the physician set parameters of "Notify
Team when O2 sat is less than 90, systolic blood
pressure (top number) greater than 150 and/or
diastolic blood pressure (bottom number) greater
than 90."

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A 392 Continued From page 128
08/13/19 1955 - Blood Pressure 176/91

An interview with staff # 330 on 08/20/19, at approximately 10:45 a.m., revealed that nursing staff should have followed all physician orders and should have notified the physician when doctors' orders are not followed. Staff # 330 confirmed the vital signs were outside of the physician set parameters. Staff # 330 stated the nurse should have notified the physician.

Patient #285 was admitted on 08/07/19, with a new diagnosis of lung cancer. On 8/08/19, at 2:30 p.m., the physician ordered for TED hose and Sequential Compression Device (SCD) to be placed on the patient. There was no documentation that this order was carried out or that the physician had been notified that the order had not been carried out. Documentation on 08/13/19, at 8:00 p.m., revealed the patient refused "Anti-Embolism Intervention." There was also no documentation that showed the nurse notified the physician.

An interview with staff # 330 on 08/20/19, at approximately 3:21 p.m., revealed that nursing staff should have followed all physician orders and should have notified the physician when doctors' orders are not followed. Staff # 330 confirmed documentation that the patient refused "Anti-Embolism Intervention" on 08/12/19 at 8:00 p.m., and there was no documentation to show the nurse notified the physician of the patient's refusal.
A. BUILDING _____________________________

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

450076

(X2) MULTIPLE CONSTRUCTION

A. BUILDING _____________________________

B. WING _____________________________

(X3) DATE SURVEY COMPLETED

08/23/2019

NAME OF PROVIDER OR SUPPLIER

UNIVERSITY OF TEXAS M D ANDERSON CANCER CENTER, THE

STREET ADDRESS, CITY, STATE, ZIP CODE

1515 HOLCOMBE BLVD
HOUSTON, TX 77030

(X4) ID PREFIX TAG

SUMMARY STATEMENT OF DEFICIENCIES

(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

ID PREFIX TAG

PROVIDER'S PLAN OF CORRECTION

(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

(X5) COMPLETION DATE

A 392 Continued From page 129

Patient #286 was admitted on 07/15/19, for chemotherapy. Review of medical record revealed on 7/15/19, the physician entered vital sign parameter orders on when the physician is to be notified if they vital signs fall above or below what the doctor had set. The physician ordered to be notified if patient's respiration rate is greater than 25 or less than 12, if the systolic blood pressure is greater than 150 or less than 90, and diastolic blood pressure is greater than 90 or less than 50. There were 6 instances when the nurse did not notify the physician of vital signs outside the set parameters.

08/12/19 1400 - respirations 28
08/12/19 1458 - respirations 28
08/12/19 1558 - respirations 26
08/12/19 1658 - respirations 26, blood pressure 152/74
08/12/19 2251 - blood pressure 154/77
08/13/19 0051 - blood pressure 154/75

Further review of the medical record, revealed, the patient became unresponsive on 08/16/19, at 10:44 p.m., per an entry written by a nurse practitioner. A nurse note dated 08/17/19, at 6:38 a.m., described an event when the patient became unresponsive around the above noted time. However, the note was not identified as a late entry. It is noted this patient expired on 08/16/19.

An interview on 08/20/19, at approximately 1:50
### Summary Statement of Deficiencies

**Patient #288** was admitted on 06/19/19, for a craniotomy due to brain cancer. On 06/19/19 at 7:43 p.m., the physician entered an order for hourly neurovascular checks. Review of the medical record revealed the following:

- **06/19/19 2000 - start**
- **06/19/19 2105 - 5 minutes late**
- **06/19/19 2305 - 5 minutes late**
- **06/20/19 - 0600 - No Glasgow Coma Scale Documented**
- **06/20/19 - 0700 - No neuro check documented**
- **06/20/19 - 0800 - No Glasgow Coma Scale Documented**
- **06/20/19 - 0900-1100 - No neuro check documented, and no documentation found to explain why the neuro checks were not completed for 3 hours.**
- **06/20/19 - 1130 - restarted**
- **06/20/19 - 1200 - no Glasgow Coma Scale**

---

**A 392 Continued From page 130**

- p.m., with staff # 330, confirmed the vital signs were outside physician ordered parameters and the nurse did not notify the physician. Staff # 330 stated nursing staff should have followed all physician orders and should have notified the physician regarding the vital signs outside of parameters. Staff # 330 also confirmed the entry from 08/17/19 should have been noted as a late entry.

Patient #288 was admitted on 06/19/19, for a craniotomy due to brain cancer. On 06/19/19 at 7:43 p.m., the physician entered an order for hourly neurovascular checks. Review of the medical record revealed the following:
### Statement of Deficiencies and Plan of Correction

**A. Building ___________________________**

**B. Wing _____________________________**

**Name of Provider or Supplier**

UNIVERSITY OF TEXAS M D ANDERSON CANCER CENTER, THE

**Street Address, City, State, Zip Code**

1515 HOLCOMBE BLVD HOUSTON, TX  77030

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### Summary Statement of Deficiencies

(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

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<th>ID</th>
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<td>A 392</td>
<td>Continued From page 131 Documented</td>
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<tr>
<td>06/20/19 - 1300</td>
<td>- No Glasgow Coma Scale Documented</td>
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<tr>
<td>06/20/19 - 1445</td>
<td>- 15 minutes late, no Glasgow Coma Scale Documented</td>
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<tr>
<td>06/21/19 - 0814</td>
<td>- Physician order entered to stop hourly neurovascular checks.</td>
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Further review revealed a physician's order for SCD's on 06/19/19, at 7:45 p.m., was not documented as being completed.

All findings were confirmed by staff # 330 on 08/20/19, at approximately 2:00 p.m.

Patient #290 was admitted on 8/19/19, at 7:41 p.m., for complications related to Leukemia. The patient received multiple blood transfusions beginning 08/20/19 at 12:43 a.m. Documentation revealed on 08/20/19, at 6:39 a.m., the patient had a critical Hemoglobin value of 6.4. There was no documentation to show the nurse notified the physician in a timely manner. Further review revealed a verbal order by a nurse on 08/20/19, at 8:51 a.m., an order was received to redraw the hemoglobin and on 08/20/19, at 9:10 a.m., a critical hemoglobin values of 6.5 was recorded in the medical record. There was no documentation found in the medical record that the nurse notified the physician of the critical laboratory value. Further review of the medical record revealed that the patient was not administered a medication as ordered by the physician. On 08/20/19, the 10:00 p.m., dose of Sodium-bicarb mouthwash was not documented.
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**A. BUILDING____________________**

**PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:** 450076

**B. WING _____________________________**

**DATE SURVEY COMPLETED ** 08/23/2019

**NAME OF PROVIDER OR SUPPLIER**

UNIVERSITY OF TEXAS M D ANDERSON CANCER CENTER, THE

**STREET ADDRESS, CITY, STATE, ZIP CODE**

1515 HOLCOMBE BLVD HOUSTON, TX 77030

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<tr>
<td>A 392</td>
<td>Continued From page 132 administered to the patient as ordered.</td>
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An interview was conducted with staff # 54 on 08/21/19, at 10:00 a.m. When asked what the procedure for addressing critical lab values were, she responded that the nurse is to notify the physician within 30 minutes of receipt of the lab. She also stated the nurse is supposed to document the notification and action in the medical record. Staff # 54 was also asked about medication documentation. She stated, the nurse is to scan the medication when it is given, and it is entered into the medical record. When asked what the nurse would do if the medication was not given, she stated there should be a comment entered and the physician should be notified. Staff # 54 confirmed the above findings.

Patient #291 was admitted on 08/03/19, with pain related to his cancer diagnosis. Review of the medical record revealed the patient's vital signs were outside of the following parameters (pulse >100, systolic blood pressure greater than 160 or less than 90, diastolic blood pressure greater than 90, or less than 40) 16 times between the 08/03/19 and 08/09/19. Further review revealed the physician did not set patient specific vital signs for this patient.

08/03/19 0009 - blood pressure 144/92
08/03/19 0410 - blood pressure 151/100
08/03/19 0939 - blood pressure 152/92
08/03/19 1514 - blood pressure 152/91
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<td>08/03/19 1852 - blood pressure 152/94</td>
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<td>08/03/19 2109 - blood pressure 147/93</td>
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<td>08/03/19 2228 - blood pressure 154/96</td>
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<td>08/04/19 1917 - blood pressure 160/88</td>
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<td>08/05/19 1519 - blood pressure 150/91</td>
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<td>08/06/19 1122 - blood pressure 146/91</td>
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<td>08/06/19 1532 - blood pressure 151/95</td>
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<td>08/06/19 1532 - pulse 125</td>
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<td>08/06/19 1945 - blood pressure 141/95</td>
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<td>08/08/19 1414 - blood pressure 151/90</td>
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<td>08/08/19 2044 - blood pressure 150/90</td>
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<td>08/09/19 1325 - blood pressure 137/93</td>
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There was no documentation to show the nursing staff ever notified the physician regarding the vital signs out of parameters. Further review revealed the patient refused vital signs 6 times:

- 08/04/19 0500 - patient refused to have vital signs taken
- 08/04/19 0730 - patient refused to have vital signs taken
- 08/04/19 0815 - patient refused to have vital signs taken

There was no documentation to show the nursing staff ever notified the physician regarding the vital signs out of parameters. Further review revealed the patient refused vital signs 6 times:

- 08/04/19 0500 - patient refused to have vital signs taken
- 08/04/19 0730 - patient refused to have vital signs taken
- 08/04/19 0815 - patient refused to have vital signs taken
A 392 Continued From page 134

08/09/19 0820 - patient refused to have vital signs taken

08/09/19 1301 - patient refused to have vital signs taken

08/11/19 1500 - patient refused to have vital signs taken

An interview was conducted with staff # 100 at the time of review. Staff # 100 was asked what the expectation of reporting abnormal vital signs when the physician has not set patient specific vital signs. Staff # 100 stated the nurse was to report abnormal vital signs based on parameters set by the charting system if the physician had not ordered patient specific parameters. Staff # 100 further stated the nurse should have notified the physician of the patient's refusal to have vital signs taken.

There was no documentation that the nursing staff notified the physician of the abnormal vital signs or the patient's refusal of vital signs. The above findings were confirmed on 08/12/19 by staff # 100 and # 101.

Review of the facility's policy CLN0647 titled "Inpatient Nursing Documentation of Patient Care" dated 07/18/2019, revealed the following:

Section 1.0 General Information and Collection of Information:

1.1 - The Registered Nurse (RN), in collaboration with other health care providers and the patient/caregiver, is responsible for reviewing the
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<td>RN SUPERVISION OF NURSING CARE</td>
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patient's Assessment data, formulating a plan of care and evaluating patient response and outcomes as well as identifying the learning needs and or barriers to learning.

The nursing staff failed to follow this policy by not reviewing the assessment data and physician orders were not followed on multiple occasions.

1.4 "When documenting a late entry, indicate 'Late Entry' with a comment of note in the patient's medical record.

The nurse failed to identify a late entry in a patient's medical record as a late entry after the patient had expired."

Section 4.0 Shift Documentation:

4.2 Document medication administration.

The nurse failed to document administration of a medication in the patient's medical record, or any reason for the medication not being administered as well as not documenting the provider was notified the medication was not given.

Section 9.0 Critical Results

9.1 - "Critical results will be communicated to the Physician or Advanced Practice Provider (APP) as soon as possible and documented with 60 minutes from the time the results are available."

The nurse failed to document the notification of the physician or APP in the medical record.
A registered nurse must supervise and evaluate the nursing care for each patient.

This STANDARD is not met as evidenced by:
Based on interviews and records review, the hospital failed to evaluate 1 (#307) of 1 patient's care needs and patient's health status by unnecessarily withholding clear liquids for six hours while waiting for a computed tomography (CT) scan. Per hospital protocol, the patient could have consumed a clear liquid diet for six of the nine hours the patient waited for completion of the scan. This hospital failure placed the patient at risk for dehydration.

Patient #307 was admitted 8/12/2019, with active diagnoses of leukemia, dehydration, and sepsis. Patient #307 care plan was reviewed on 8/20/2019. The patient care plan did not include the risk for dehydration.

On 8/18/2019, 1:47 PM, a CT scan of abdomen with contrast was ordered by Physician #380. The scan was not performed until 8/18/2019 at 11:29 PM. This test requires the patient to drink an oral contrast - for better imaging of the abdominal cavity. During an Electronic Health Record (EHR) review on 8/22/2019, the hospital order set for CT abdomen with contrast was noted. The following was included in the order set: "Diet: Clear liquids only, three hours prior to scheduled CT examination."

On 8/21/2019, an interview occurred with patient
A 395 Continued From page 137

#307 and next of kin. The interview revealed, the patient ate breakfast on 8/18/2019 and did not eat for the rest of the day due to pending CT scan on that day.

On 8/21/2019, at 11:25 AM, an interview was conducted with RN #380, who was assigned to patient on 8/18/2019 from approximately 6:45 AM-7:15 PM. The RN alleged that he called the CT department multiple times throughout the day to see when he could prepare for CT scan/have patient drink oral contrast prior to scan. According to the RN, he was not notified to start preparing for CT scan until 7:30 PM and the patient was scheduled for scan at 8:30 PM. RN #380 confirmed patient food and fluids by mouth was withheld (NPO) after CT ordered.

On 8/21/2019, at 2:15 PM, an interview with the Diagnostic Radiology Manager, Diagnostic Radiology Supervisor, Diagnostic Radiology Nursing Supervisor, and Diagnostic Radiology Nursing Assistant Supervisor was held. The interview revealed Patient #307 CT scan was ordered, the radiologist reviewed the patient's kidney function lab result and recommended giving intravenous fluids (IV fluids) before and after CT scan. An order was placed by provider to administer intravenous fluids for four hours before scan and six hours after scan. This staff stated it is the responsibility of the diagnostic radiology nurse and inpatient nurse to coordinate scan time. STAT and urgent scheduled orders and critical care patients have a high priority and may delay completing scans routine scheduled orders. If oral contrast is ordered the goal is to have patient scanned within two hours of drinking.
A. BUILDING _____________________________
(296x721)
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION
(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 450076
(X2) MULTIPLE CONSTRUCTION
A. BUILDING _____________________________
B. WING _____________________________
(X3) DATE SURVEY COMPLETED 08/23/2019
NAME OF PROVIDER OR SUPPLIER
UNIVERSITY OF TEXAS M D ANDERSON CANCER CENTER, THE
STREET ADDRESS, CITY, STATE, ZIP CODE
1515 HOLCOMBE BLVD
HOUSTON, TX  77030
(X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETION DATE
A 395 Continued From page 138 However, the patient still can be scanned if oral contrast was completed greater than two hours. The patient is allowed clear liquids up to three hours of scheduled scan, afterwards the patient should be NPO until scheduled scan. The staff was able to show documentation of diagnostic radiology nurse from 8/18/2019. The note stated the diagnostic radiology nurse and inpatient nurse coordinating the start time for oral contrast on 8/18/2019 at 7:30 PM and tentative scheduled CT scan at 8:30 PM.
EHR review of Patient #307 showed an order for IV fluids ”100 ml/hr for 4 hours prior to and 6 hours following CT”. This order was from Physician #380 on 8/18/2019 at 1:47 PM
On 8/18/2019, at 2:45 PM, intravenous fluids was started and completed 8/18/2019 at 6:45 PM by RN #326.
Records review of EHR showed Patient #307 drank the oral contrast on 8/18/2019, at approximately 7:16 PM. There were three routine CT scans performed prior to Patient #307 scan. One of the three CT scans was ordered after Patient #307 order date/time.
On 8/22/2019 RN #54 was interviewed. It was asked if it is standard for a patient to be NPO for a CT abdomen with contrast. RN #54 stated she was unsure.
Policy titled *Adult/Pediatric Oral Contrast
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**A 395 Continued From page 139**

Administration on Inpatient Units and the Emergency Center dated 1/5/2018 states the following: "...2.2 Radiology Nursing Staff Responsibility .... B. Confirmation that the oral contrast order set has been received by the inpatient RN. The inpatient nurse will coordinate the patient's appointment time, contrast administration times, initial report, and transportation needs. C. Coordination of the oral contrast administration time with the inpatient RN" Policy titled "Administration of Iodinated Contrast Material" dated February 2019 state the following: "2.9 Inpatient hydration should be addressed pre and post procedure by the floor nurse."

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**A 396 NURSING CARE PLAN**

CFR(s): 482.23(b)(4)

The hospital must ensure that the nursing staff develops, and keeps current, a nursing care plan for each patient. The nursing care plan may be part of an interdisciplinary care plan

This STANDARD is not met as evidenced by: Based on review of documentation and interview, it was determined that nursing care plans failed to include interventions regarding all patient diagnoses. Twenty-four (24) (#13, #14, #17, #18, #20, #21, #24, #29, #45, #69, #70, #71, #76, #79, #109, #110, #111, #112, #225, #289, #313, #314, #315, #326) of 44 medical records reviewed had incomplete plans of care.

**Findings:**

Facility policy entitled "Interdisciplinary Inpatient
A 396  Continued From page 140

Care Plan and Education Record Policy" stated in part, "The Care Plan process begins at the first point of contact upon inpatient admission and is ongoing throughout the hospital stay. Inpatients should have a plan of care initiated within 24 hours of admission and documented in the medical record. Appropriate clinical practice guidelines (CPG) should be added by the licensed health care provider (LHP) to each patient's Care Plan based on the patient's condition and/or needs. The CPG provides a list of topics that the LHP can select to individualize the Care Plan and provide education. The individualized Care Plan and Education Record are documented in the medical record."

Patient # 21 had no nursing plan of care initiated for Altered Mental Status.

Patient # 29 had no nursing plan of care initiated for Acute Kidney Injury or Hemoptysis.

Patient # 20 had no nursing plan of care initiated for Tachycardia or Fever and Chills.

Patient # 13 had no nursing plan of care initiated for Anticoagulation Therapy.

Patient # 17 had no nursing plan of care initiated for Prevention of DVTs (pt. had history).

Patient # 14 had no nursing plan of care initiated for Hearing Loss.

Patient # 69 had no nursing plan of care initiated for anticoagulation therapy or Anemia (Hgb 7.3-8.2).

Patient # 70 had no nursing plan of care initiated.
## SUMMARY STATEMENT OF DEFICIENCIES

### (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

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<th>ID</th>
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<td>A 396</td>
<td>Continued From page 141 for Pleural Effusion or Dyspnea.</td>
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<td>Patient # 71 had no nursing plan of care initiated for Acute Renal Failure Syndrome or Dehydration.</td>
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<td>Patient # 76 had no nursing plan of care initiated for Altered Nutrition for hypoalbuminemia (albumin was 2.8 and decreasing).</td>
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<td>10 of 15 medical records reviewed had incomplete plans of care. This was confirmed by nursing staff and the Representative for Patient Advocacy on 8/13 and 8/14/2019.</td>
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<td>Record review of the facility policy &quot;Inpatient Nursing Documentation of Patient Care Policy&quot;, dated 07/18/2019 stated: Shift documentation:</td>
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<td>The following must be documented every shift or more frequently, if ordered or applicable.</td>
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<td>Document individualized care plans, interventions and outcomes.</td>
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<td>Reassess learning needs as appropriate.</td>
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<td>Patient # 24 had no care plan initiated for addressing deep vein thrombus.</td>
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<td>Patient # 109 had no nursing care plan initiated to address the Whipple procedure.</td>
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<td>Patient # 110 had no nursing care plan initiated to address the an ileostomy.</td>
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<td>Patient # 111 had no nurse care plan initiated to address the ileostomy.</td>
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A 396 Continued From page 142

Patient # 112 had no nursing care plan initiated to address a total hysterectomy.

Interview on 08/13/2019 at 1100 with the clinical nurse leader who stated "I see what you mean".

Patient #326

Record review on 08/20/19, of the current patient census for Unit G-22 showed Patient #326 was admitted on 8/08/19 with a diagnosis of cancer of the rectum.

Interview on 08/20/19, at 10:30 AM, with his bedside nurse RN # 337, she stated Patient #326 had a pelvic abscess and a prior colostomy, and was admitted for increased weakness and pain. She said physical therapy staff ordered a trapeze bar yesterday to help with his markedly decreased mobility.

Review of Patient #326's electronic medical record failed to show "impaired mobility" and "colostomy" as topics addressed in his care plan.

Interview on 08/20/19, at 1:30 PM, with RN Navigator #335, she said both of these issues should have been updated in the care plan.

Patient # 225

Record review on 08/14/19, of the electronic medical record of Patient # 225 showed, she was admitted on 08/09/19, with history of metastatic bone cancer. Patient #225 was noted upon...
### A. BUILDING _______________________

**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**DATE SURVEY COMPLETED** 08/23/2019

**NAME OF PROVIDER OR SUPPLIER**

**UNIVERSITY OF TEXAS M D ANDERSON CANCER CENTER, THE**

**STREET ADDRESS, CITY, STATE, ZIP CODE**

1515 HOLCOMBE BLVD
HOUSTON, TX  77030

### PROVIDER’S PLAN OF CORRECTION

**EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY**

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### SUMMARY STATEMENT OF DEFICIENCIES

(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

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#### A. 396

Continued From page 143

Admission to have a Stage III pressure ulcer to her sacrum.

Review of Patient # 225's care plan failed to show wound care as a topic addressed in her care plan. Interview on 08/14/19 at 11:45 AM with RN Navigator #335, she said "wound care" should have been listed in the care plan.

Patient # 18 was admitted for complications related to adrenal cancer, dehydration, bilateral pulmonary embolisms, Cushing's syndrome, and acute kidney injury. The patient had no nursing plan of care initiated for bilateral pulmonary embolisms, Cushing's Syndrome, and acute kidney injury.

An interview was conducted with RN # 330 regarding the nurses' responsibility to initiate a patient specific care plan. The staff member stated the care plans should be specific to the patient. The staff member demonstrated how the nurse can add items to the care plan and how they can be changed to specifically meet the patients if it is not included in the preloaded database. RN # 330 confirmed the care plan for patient # 18 was not complete or patient specific.

Patient # 45 was admitted with a diagnosis of squamous cell cancer of the oral cavity and malignant neoplasm of overlapping sites of mouth. He lives in an assisted living center and he is walker dependent. The care plan did not address the problem with change in body image, problems with immobility, and knowledge deficit.

Patient #79 was admitted with with a diagnosis of rhabdomyosarcoma of prostate with low back...
### A. BUILDING

#### PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:
450076

#### MULTIPLE CONSTRUCTION

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<td>Pain, left leg pain and numbness. The care plan did not address the problem with activity change, appetite change and fatigue. New radiation therapy. Patient #289 was admitted with a diagnosis of osteoporosis, acquired absence of bilateral breasts and nipples, personal history of breast cancer, local recurrence of breast cancer, infiltrating duct carcinoma of female breast, pain due to neoplastic disease malignant neoplasm of chest wall, and generalized acute body pains. The care plan did not address the problem with change of body image, knowledge deficit, recurrence of cancer. Patient #313 was admitted for surgery for a malignant neoplasm of the right kidney, except renal pelvis. The care plan did not address the problem of knowledge deficit due to new cancer diagnosis with surgery, anxiety related to new diagnosis and change of appetite. Patient #314 was admitted with a diagnosis of Leukemia. The patient care plan did not address the problem of knowledge deficit due to new diagnosis, anxiety related to new diagnosis. Patient #315 was admitted with right extremity sarcoma, hemorrhage, and abdominal pain. The care plan did not address his recurrence of cancer, surgery with change of body image, change of appetite with abdominal pain.</td>
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#### STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

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#### DATE SURVEY COMPLETED
08/23/2019
### Statement of Deficiencies and Plan of Correction

**Name of Provider or Supplier:**

**University of Texas M D Anderson Cancer Center, The**

**Street Address, City, State, Zip Code:**

1515 Holcombe Blvd
Houston, TX 77030

<table>
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<tr>
<th>ID</th>
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<th>Summary Statement of Deficiencies (Each Deficiency Must Be Preceded by Full Regulatory or LSC Identifying Information)</th>
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<th>Provider's Plan of Correction (Each Corrective Action Should Be Cross-Referenced to the Appropriate Deficiency)</th>
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<td>An interview with Personnel #327 on 8/21/2019 confirmed that there were changes in the patients condition or needs and that they should have been addressed on the Care Plan. Facility policy entitled &quot;Interdisciplinary Inpatient Care Plan and Education Record Policy&quot; stated in part &quot;The Care Plan process begins at the first point of contact upon inpatient admission and is ongoing throughout the hospital stay. Inpatients should have a plan of care initiated within 24 hours of admission and documented in the medical record. Appropriate clinical practice guidelines (CPG) should be added by the licensed health care provider (LHP) to each patient's Care Plan based on the patient's condition and/or needs. The CPG provides a list of topics that the LHP can select to individualize the Care Plan and provide education. The individualized Care Plan and Education Record are documented in the medical record...4.2 The RN should evaluate the progress and achievement of the Care Plan goals and revise as appropriate prior to bedside shift report and permanent hand-off communication.&quot;</td>
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<td>A 405</td>
<td>Administration of Drugs</td>
<td>CFR(s): 482.23(c)(1), (c)(1)(i) &amp; (c)(2)</td>
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(1) Drugs and biologicals must be prepared and administered in accordance with Federal and State laws, the orders of the practitioner or practitioners responsible for the patient's care as specified under §482.12(c), and accepted standards of practice.

(i) Drugs and biologicals may be prepared and administered on the orders of other practitioners not specified under §482.12(c) only if such
A. BUILDING ______________________

(X1) PROVIDER/SUPPLIER/CLA
IDENTIFICATION NUMBER:

450076

(X2) MULTIPLE CONSTRUCTION
A. BUILDING ______________________
B. WING ______________________

(X3) DATE SURVEY COMPLETED

08/23/2019

NAME OF PROVIDER OR SUPPLIER

UNIVERSITY OF TEXAS M D ANDERSON CANCER CENTER, THE

STREET ADDRESS, CITY, STATE, ZIP CODE

1515 HOLCOMBE BLVD
HOUSTON, TX  77030

(X4) ID PREFIX TAG

SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL
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ID PREFIX TAG

PROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE
CROSS-REFERENCED TO THE APPROPRIATE
DEFICIENCY)

(X5) COMPLETION DATE

A. 405

Continued From page 146

practitioners are acting in accordance with State
law, including scope of practice laws, hospital
policies, and medical staff bylaws, rules, and
regulations.

(2) All drugs and biologicals must be
administered by, or under supervision of, nursing
or other personnel in accordance with Federal
and State laws and regulations, including
applicable licensing requirements, and in
accordance with the approved medical staff
policies and procedures.

This STANDARD is not met as evidenced by:
Based on observation, interview, and record
review, the facility's nursing staff failed to:

A.  administer medication as prescribed by the
patient's physician in 1 of 7 sampled patients.
(Patient #48)

B.  follow the facility's policy for documentation of
treatment and interventions in 6 (#271, #39,
#276, #277, #278, and #279) of 7 patients
reviewed.

Findings:

A.  Review of Patient #48's clinical record
revealed a physician's order dated 07/31/2019 for
"Midodrine 10 mg via gastrostomy tube three
times daily before meal. Hold if SBP greater
than 150 mm/Hg. In addition, Monday,
Wednesday, and Friday when he receives
dialysis. Please give a dose 30 minutes BEFORE
dialysis (not additional dose but mid-day-
dose). Avoid administering after the evening meal or
within 4 hours of bedtime."
**SUMMARY STATEMENT OF DEFICIENCIES**

(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

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Review of the Patient's medication administration record and hemodialysis treatment record for the following days revealed Medication Midodrine 10 mg was not administered 30 minutes prior to hemodialysis treatment as prescribed:

- **08/09/2019**: Medication Midodrine 10 mg administered at 8:43 a.m. and hemodialysis treatment initiated at 10:00 a.m.
- **08/07/2019**: Medication Midodrine 10 mg administered at 8:01 a.m. and hemodialysis treatment initiated at 11:00 a.m.
- **08/05/2019**: Medication Midodrine 10 mg administered at 9:29 a.m. and hemodialysis treatment initiated at 10:20 a.m.
- **08/02/2019**: Medication Midodrine 10 mg administered at 9:10 a.m. and hemodialysis treatment initiated at 10:00 a.m.

The surveyor reviewed the Patient's clinical record with the Unit's Manager who confirmed that the medication was not administered as prescribed because at times transportation is late in transferring the Patient to hemodialysis for hemodialysis treatment.

Facility policy titled "Medication Administration Record" stated in part "The following will be indicated on the electronic MAR: ...I. Indication for a medication."

Facility policy titled "Inpatient Nursing Documentation of Patient Care Policy" stated in part "It is the policy of The University of Texas MD..."
A 405 Continued From page 148

Anderson Cancer Center (MD Anderson) that:

"Documentation of assessment, interventions, evaluation, and patient/caregiver education in the inpatient setting (including the Emergency Center (EC), Clinical Decision Unit (CDU), and Transitional Post-Anesthesia Unit (TPACU) is recorded in the patient's medical record."

The policy continued under "Patient Assessment and Reassessment":

"Reassessment of a patient will be documented:

A. Prior to, during, and after a procedure or treatment, as indicated.

B. Within an appropriate timeframe, for the evaluation of effectiveness and patient's response to the intervention.

C. If clinically indicated (e.g., change in the patient's status/condition), ordered or applicable."

Review of the following medical records on 8/21/19 revealed the following:

Patient # 271 received Ativan 0.5 mg IM (indicated for anxiety) on 8/5/19 at 0450. There was no documentation by the nurse who administered the medication with rational for giving the medication nor evaluation for the medication's effectiveness.

Patient # 39 received Ativan 0.5 mg on 7/30/19 (indicated for nausea and vomiting). There is no nursing documentation to explain why the

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### A 405 Continued From page 149

Medication was given nor was there a documented evaluation of its effectiveness.

Patient # 276 received Ativan 1 mg on 5/22/19 STAT at 1357 and 1534. There was no indication on the order why the medication was ordered.

Patient # 277 received Ativan IV on 7/22/19 at 1539 and again on 7/24/19 at 0834. There is no indication for use on the MD order.

Patient # 278 received PRN Ativan and Haldol IV on 7/8/19. There was no indication why these medications were given by the nurse.

Patient # 279 received a onetime dose of Ativan and Dilaudid. The ordering MD had no indication for prescribing the medication.

In interviews with the unit Psychiatrist, the Director of Psychiatry, the Director of Specialty and the Representative for Patient Advocacy on 8/22/19, the above medication documentation errors were confirmed.

### A 489 Condition of Participation: Pharmaceutical Services

CFR(s): 482.25

§482.25 Condition of Participation: Pharmaceutical Services.

The hospital must have pharmaceutical services that meet the needs of the patients.

The institution must have a pharmacy directed by
A 489 Continued From page 150

A registered pharmacist or a drug storage area under competent supervision. The medical staff is responsible for developing policies and procedures that minimize drug errors. This function may be delegated to the hospital's organized pharmaceutical service. This CONDITION is not met as evidenced by:

Based on observation, review of records, and interview, the hospital failed to:

A)

1) ensure 5 out of 5 contracted transportation couriers (Staff #304, #305, #367, #368, and #369) were transporting hazardous drugs (chemotherapy medications) in a safe manner. Courier staff were not trained on how to contain and clean a chemotherapy spill and did not possess the proper equipment for containing and cleaning of a chemotherapy spill during transport. No evidence was provided to verify that courier staff were aware of the potential for occupational exposure to chemotherapy agents and risks associated with it. This unsafe condition placed staff, patients, and the public at risk of potential harm by unknowingly coming in contact with a hazardous drug that had not been properly contained and cleaned.

2) ensure safe disposal of medications. Drugs were being disposed of in sharps containers (plastic containers used for the disposal of used needles and glass) at two of the outpatient facilities (West Houston and Katy locations). This unsafe condition allowed for the possible unauthorized retrieval of medications (to include narcotics) by unauthorized persons.

Cross Refer to Tag A0491
### Statement of Deficiencies and Plan of Correction

**A. Building ____________________________**

**Provider/Supplier/CLIA Identification Number:** 450076

**Statement of Deficiencies and Plan of Correction**

**Date Survey Completed:** 08/23/2019

**Provider/Supplier:** UNIVERSITY OF TEXAS M D ANDERSON CANCER CENTER, THE

**Address:** 1515 HOLCOMBE BLVD

**City, State, Zip Code:** HOUSTON, TX 77030

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**Continued From page 151**

B) develop accountability procedures to ensure controlled medications, such as narcotics, that were dispensed as a continuous intravenous (IV) infusion (medication delivered into a vein at a constant rate) were not diverted by unauthorized persons. This unsafe condition placed patients at risk of not receiving the amount of prescribed medications and potentially being cared for by an impaired staff member who could have diverted medication intended for the patient.

Cross Refer to Tag A0494

**A 491** Continued From page 151

**Pharmacy Administration**

CFR(s): 482.25(a)

**[§482.25 Condition of Participation: Pharmaceutical Services

.....The medical staff is responsible for developing policies and procedures that minimize drug errors. This function may be delegated to the hospital's organized pharmaceutical service.]**

**§482.25(a) Standard: Pharmacy Management and Administration**

The pharmacy or drug storage area must be administered in accordance with accepted professional principles. This STANDARD is not met as evidenced by:

Based on observation, review of records, and interview, the hospital failed to ensure:

A. 5 out of 5 contracted transportation couriers (Staff #304, #305, #367, #368, and #369) were transporting hazardous drugs (chemotherapy medications) in a safe manner. Courier staff were...
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

---

**NAME OF PROVIDER OR SUPPLIER**

UNIVERSITY OF TEXAS M D ANDERSON CANCER CENTER, THE

**STREET ADDRESS, CITY, STATE, ZIP CODE**

1515 HOLCOMBE BLVD

HOUSTON, TX 77030

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**SUMMARY STATEMENT OF DEFICIENCIES**

(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

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**SUMMARY STATEMENT OF DEFICIENCIES**

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**A.** On the morning of 8-12-2019, a tour of the Inventory Control area of pharmacy was made with Staff #49, #50, #139, and #336 present. A shelf with the four off-site pharmacy locations (League City, Sugarland, Woodland, and Katy) was observed. When asked if chemotherapy agents were transported to the off-site pharmacies, Staff #139 advised that chemotherapy was transported to the off-site pharmacies for use at the infusion centers. Transportation was provided by contracted couriers.

Review of the contract between the hospital and

---

**B.** safe disposal of medications. Drugs were being disposed of in sharps containers (plastic containers used for the disposal of used needles and glass) at two of the outpatient facilities (West Houston and Katy locations). This unsafe condition allowed for the possible unauthorized retrieval of medications (to include narcotics) by unauthorized persons.

---

**Findings:**

**A.** not trained on how to contain and clean a chemotherapy spill and did not possess the proper equipment for containing and cleaning of a chemotherapy spill during transport. No evidence was provided to verify that courier staff were aware of the potential for occupational exposure to chemotherapy agents and risks associated with it. This unsafe condition placed staff, patients, and the public at risk of potential harm by unknowingly coming in contact with a hazardous drug that had not been properly contained and cleaned.

---

**B.** safe disposal of medications. Drugs were being disposed of in sharps containers (plastic containers used for the disposal of used needles and glass) at two of the outpatient facilities (West Houston and Katy locations). This unsafe condition allowed for the possible unauthorized retrieval of medications (to include narcotics) by unauthorized persons.

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**Exhibit:**

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**Review of the contract between the hospital and**
A. BUILDING ______________________

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 450076

(X2) MULTIPLE CONSTRUCTION
A. BUILDING ______________________
B. WING ______________________

(X3) DATE SURVEY COMPLETED 08/23/2019

NAME OF PROVIDER OR SUPPLIER

UNIVERSITY OF TEXAS MD ANDERSON CANCER CENTER, THE

STREET ADDRESS, CITY, STATE, ZIP CODE
1515 HOLCOMBE BLVD
HOUSTON, TX  77030

(X4) ID PREFIX TAG

SUMMARY STATEMENT OF DEFICIENCIES
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the courier service was made. A Statement of Work (SOW) between the Institution-Wide Courier Service and the hospital was included in the contract. Per the SOW, under item "2. Description of Requested Service" the following was noted:

*Dedicated Route Services

Contractor will be responsible for the timely pick-up and delivery of different items to/from various departments/locations within the TMC and other clinical research facilities in the Houston-metropolitan area.

Items to be transported may be, but not limited to: envelopes and documents (including time sensitive and confidential), supplies (medical, office patient nutrition, etc.) perishable supplies, blood products, bodily fluids, biohazards, laboratory and pathology samples, surgical instruments, computer equipment, monitors, printers, and miscellaneous items such as: medical graphics materials, posters, balloons for employee recognition events, etc. Some of the times will require proper storage at regulated temperature.

By Request Services

Contractor will be responsible for the timely pick-up/delivery of laboratory specimens, including but not limited to the following categories: anatomical/surgical pathology, chemistry, cytology, blood bank, coagulation, cytogenetics/molecular genetics, hematology, immunology (sic)/serology, immunocytology, microbiology, and virology; patient prescriptions; pharmaceutical supplies; and stock medication.
**A. BUILDING**

**X1 PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:**
450076

**X2 MULTIPLE CONSTRUCTION**

A. BUILDING _____________________________

B. WING _____________________________

**X3 DATE SURVEY COMPLETED**
08/23/2019

**NAME OF PROVIDER OR SUPPLIER**

UNIVERSITY OF TEXAS M D ANDERSON CANCER CENTER, THE

**STREET ADDRESS, CITY, STATE, ZIP CODE**
1515 HOLCOMBE BLVD
HOUSTON, TX  77030

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<td>A 491</td>
<td>Continued From page 154 Other items include reports, supplies and other materials (e.g., specimen containers, x-ray films, pre-packaged regimens, medical records, etc.) to and from designated locations within the scope of the contract. Contractors shall ensure the appropriate transport conditions to guarantee specimen integrity and the security and confidentiality of all documents, laboratory reports, medical records and comply with HIPPA (sic) regulations. ... 3. Minimum Contractor Specifications, Certifications, Experience and Requirements ... Contractors shall ensure that all drivers: 1) maintain an acceptable driving records. 2) have a valid Texas driver's license (not suspended or revoked). 3) are trained in bio-hazardous materials handling, blood borne pathogens exposure, spill cleanup in compliance with DOT, CDC Transportation regulations, and applicable State, federal, local agency regulations. 4) trained in applicable Health Insurance Portability and Accountability (HIPPA) (sic) regulations.”</td>
<td>A 491</td>
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While the SOW specified that drivers would be handling biohazardous materials and were at risk for blood borne pathogen exposure that required specialized training to include spill cleanup, no mention was found of couriers transporting chemotherapy agents that required specialized training and specialized equipment for spill containment and cleanup.

On 8-13-2019, training records for all contracted couriers were requested. Records were received for Staff #304, #305, #367, #368, and #369. Each...
A 491 Continued From page 155

courier had two certificates from "Integrity Medical Courier Training for the following:

"...satisfactory completion of required annual HIPAA Awareness Training for Medical Couriers in observance of the Health Insurance Portability and Accountability Action of 1996. (HIPAA)"

"...satisfactory completion of Automated Bloodborne Pathogen Awareness class on Bloodborne Pathogens, Exposure Control, Transportation & Specimen Integrity Best Practice Industry Standards (as based on OSHA 29 CFR 1910.1030)"

No records for training on the containment and cleanup of chemotherapy spills was alleged or provided.

On 8-15-2019 after 10:00 AM, in interview was conducted with Staff #303. Staff #303 demonstrated how the chemotherapy was packaged for transport. The containers used to transport chemotherapy did not contain markings on the outside of the container warning that hazardous drugs were inside. The packaging inventory sheet was placed on the inside of the container. The packaging labels placed on the inventory sheet for the drugs being transported contained the drug name and destination, but did not indicate that the drug was a hazardous drug. Staff #303 was asked why there were no markings as to the type of drug being placed in the transport container for the couriers to know they were transporting hazardous drugs (chemotherapy). Staff #303 explained that contents of the container were not listed so that couriers would not be tempted to take the drugs.
### Summary Statement of Deficiencies

#### A 491

**Staff #303 was asked how couriers were supposed to know that the package contained hazardous drugs that required special precautions, Staff #303 stated that "they signed contracts stating they know they are carrying hazardous drugs." No such contract was provided. The only contract that was provided was the contract reviewed above.

On 8-15-2019 at approximately 1:45 PM, couriers Staff #304 and Staff #305 were interviewed. Both couriers explained that they were certified in HIPAA and Blood Borne Pathogens. They both confirmed this was the only training required. They stated that they did not drive commercial courier vehicles. They drove their own private vehicles. They both verified that they did not have Commercial Driver's Licenses (CDL) that would have required additional training other than what had been provided already. Staff #305 had an Occupational Safety and Health Administration (OSHA) approved Blood Borne Pathogen spill kit in a cooler bag she used to transport biohazardous specimens. Staff #304 stated her spill kit was in her private automobile. Staff #304 was observed to remove a Blood Borne Pathogen spill kit from under the driver's seat of her private automobile. Staff #305 stated she had the same kit in her private automobile. When asked if she would use this kit to contain and clean up any liquids leaking from the blue container she had just picked up from the pharmacy, Staff #304 stated, "I sure would". Staff #305 agreed and stated she would use that kit also.

Blood Borne Pathogen spill kits and OSHA approved Chemotherapy spill kits and procedures are not interchangeable.
A 491 Continued From page 157

Review of MD Anderson Institutional Policy ADM0171, Chemotherapy Spills and Surface Contamination Policy, was made as follows:

*Purpose

The purpose of this policy is to ensure personal and environmental protection to faculty, trainees/students, and other members of The University of Texas MD Anderson Cancer Center's (MD Anderson's) workforce involved in handling cleanup operations for Chemotherapy agents. Faculty, trainees/students, and other members of the MD Anderson's workforce who are planning to have children or who are pregnant will also reduce their likelihood of Exposure to the lowest possible level by following all of the requirements contained in this policy.

... 2.0 Education

2.1 Faculty, trainees/students, and other members of MD Anderson's workforce will receive appropriate instructions on (1) the management of Chemotherapy agents, (2) overall protection of faculty, trainees/students, and other member of MD Anderson's workforce, and (3) care of the patient receiving Chemotherapy agents according to Position Description.

2.2 Strict adherence to the standard operating procedures and correct use of PPE within the intended purpose statement of this policy provides overall personal protection of faculty, trainees/students, and other members of MD Anderson's workforce.
### Statement of Deficiencies and Plan of Correction

<table>
<thead>
<tr>
<th>ID</th>
<th>Prefix</th>
<th>Tag</th>
<th>Summary Statement of Deficiencies (Each Deficiency Must Be Preceded by Full Regulatory or LSC Identifying Information)</th>
<th>ID</th>
<th>Prefix</th>
<th>Tag</th>
<th>Provider’s Plan of Correction (Each Corrective Action Should Be Cross-Referenced to the Appropriate Deficiency)</th>
<th>Completion Date</th>
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</thead>
<tbody>
<tr>
<td>A 491</td>
<td>Continued From page 158</td>
<td>2.3 Disclosure for the potential of occupational Exposure to Chemotherapy agents shall be made to all faculty, trainees/students, and other members of MD Anderson’s workforce and documented in personnel records.</td>
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<td>2.4 All private duty, temporary, and contract workforce members will be given information by their respective agency explaining the potential for occupational Exposure to Chemotherapy agents prior to working at MD Anderson.</td>
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<td>No evidence was alleged or provided that demonstrated the hospital verified requirement 2.4, listed above, was completed by the contracted agency prior to allowing contracted couriers to transport chemotherapy medications.</td>
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<td>B. During a tour of the West Houston outpatient facility on 8/14/2019, an interview was conducted with staff #123. The surveyor asked staff #123 about the drug disposal process at the facility. Staff #123 said the nurses dispose of medications in the sharps containers. The surveyor asked staff #122, how do you dispose of drugs? Staff #122 said, drugs are disposed of in the sharps containers.</td>
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<td>During a tour of the Katy outpatient facility on 8/15/2019 an interview was conducted with staff #171. The surveyor asked staff #171 how do you dispose of drugs? Staff #171 said drugs are disposed of in the sharps container. An interview was conducted with staff #166, staff #166 said drugs are disposed of in the sharps containers.</td>
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<td>A 491</td>
<td>Continued From page 159</td>
<td>A 491</td>
<td>During the interviews with staff #123, 122, 171 and 166 the findings were confirmed.</td>
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<td>A 494</td>
<td>PHARMACY DRUG RECORDS</td>
<td>A 494</td>
<td>CFR(s): 482.25(a)(3)</td>
<td></td>
<td></td>
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<td>Current and accurate records must be kept of the receipt and distribution of all scheduled drugs.</td>
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This STANDARD is not met as evidenced by:
Based on observation, review of record, and interview, the facility failed to develop accountability procedures to ensure controlled medications that were dispensed as a continuous intravenous (IV) infusion (medication delivered into a vein at a constant rate) were not diverted by unauthorized persons. This unsafe condition placed patients at risk of not receiving the actual amount of prescribed medications and potentially being cared for by an impaired staff member who could have diverted medication intended for the patient.

On 8-13-2019, after 1:00 PM, a tour of the ICU on G-7 was conducted with Registered Nurses (RN) #317, #318, and #319 present. In ICU room 24, a continuous intravenous infusion of Fentanyl, a narcotic drug, was observed to be running through a standard infusion pump that could be used for all types of medications. The IV bag of medication was not in a secured, locked box. The tubing used to connect the bag to the infusion pump and connect the infusion pump to the patient's IV site was observed to be standard IV tubing. This tubing was observed to have a port where a needle and syringe could be used to withdraw or add medications between the medication bag and the pump. It also had the
A. BUILDING ________________________  PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 450076

B. WING ____________________________

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

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<tr>
<td>A494</td>
<td>Continued From page 160</td>
<td>same type of access port on the tubing between the pump and the patient.</td>
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This unsecured set-up has the likelihood to allow for unauthorized persons to access and withdraw narcotics without detection. RN #317, #318, and #319 confirmed that the only time the medication was measured was when the bag was completed. The medication remaining in the bag and in the tubing was measured and recorded as waste by two RN's. RN #317 and #318 confirmed that the amount of drug wasted was not compared to the documented administration on the nursing flow sheet to verify that the total amount of Fentanyl in the bag was accounted for.

An interview was conducted with Staff #139 on 8-13-2019. Staff #139 stated that the Medication Diversion Committee had been aware that the bags of controlled medications were unsecure. Staff #139 stated, the committee was looking into different types of lock boxes for the bags but were still investigating the different types. Staff #139 stated, he was not aware of the problem with the tubing having port access above and below the pump. Staff #139 stated, there was an initiative being studied to replace the pump tubing and that the port-less tubing would be included in that initiative. Staff #139 stated that initiative would take approximately one year. Staff #139 stated that nursing documented the amount of Fentanyl given on the nursing flow sheet. Staff #139 stated that currently, pharmacy staff did not reconcile the amount of documented medication administration from the nursing flow sheet with the amount of wasted medication to ensure the documented amounts matched the dispensed medication amount.
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<td>A 494</td>
<td>Continued From page 161</td>
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<td>Records were reviewed for Patient #257 and #258 on 8-19-2019. Review of the flow sheets found that the documented milliliters of Fentanyl administered did not add up to the total amount dispensed for the patient.</td>
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<td>Patient #257 had received Fentanyl through continuous IV infusion between 6-10-2019 through 7-2-2019. IV tubing was required to be changed every 72 hours. The tubing change and medication bag change were not at the same time. Tubing changes were a set time, every 72 hours. Medication bag changes depended on the patient condition and how fast the rate of medication administration was set. This rate varied based on patient condition. Per interview with Staff #306, approximately 15 to 20 milliliters of fluid were required to fill the tubing. When the tubing was changed, no documentation of the waste of the medication that was left in the tubing at the time of tubing change was found. From the start of the IV infusion of Fentanyl for Patient #257, to the stop of the infusion, at least 7 tubing changes should have occurred with a potential for unaccounted waste of Fentanyl of approximately 105 to 140 milliliters.</td>
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<td>A 536</td>
<td>SAFETY FOR PATIENTS AND PERSONNEL CFR(s): 482.26(b)(1)</td>
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<td>On 8-20-2019, Staff #139 was again interviewed. Staff #139 confirmed that pharmacy staff were not able to reconcile Patient #257's record of medication dispensed with record of medication administered and/or wasted.</td>
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Proper safety precautions must be maintained against radiation hazards. This includes adequate shielding for patients, personnel, and facilities, as well as appropriate storage, use and disposal of radioactive materials. This STANDARD is not met as evidenced by:

Based on a tour, interview, and a review of documentation, the facility failed to ensure that proper safety precautions must be maintained against radiation hazards. This includes adequate shielding for patients, personnel, and facilities, as well as appropriate storage, use and disposal of radioactive materials.

Finding:

Facility policy ADM3264 entitled, "Radioactive Apparel" stated in part,

"4.0 Caring for Radioprotective Apparel ..."

4.2 Each department shall have procedure for care and cleaning of radioprotective apparel according to manufacturer's guidelines or accepted standards."

Per interview and observations, the facility mainly utilizes Sani-Wipes to clean all lead aprons. There were no department specific procedures to identify appropriate manufacturer guidelines for cleaning aprons indicating what products are approved for cleaning these aprons.

During a tour of the Main Campus Diagnostic Imaging area on 08/12/19, staff was asked what product was utilized to clean lead aprons. Staff member # 113 replied that the aprons were...
| ID | PREFIX | TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID | PREFIX | TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | COMPLETION DATE |
|---|---|---|---|---|---|---|---|---|---|
| A.536 | | | Continued From page 163 cleaned with Sani-Wipes. During a tour of the West Houston on 08/15/19 facility surveyors asked what product was utilized to clean lead aprons. The staff member interviewed replied Sani-Wipes. The staff member was asked what the manufacturer recommendations were for cleaning that brand of lead apron which was Universal Medical. On 08/16/19, the facility provided information from the Universal Medical website regarding cleaning of their aprons. The website stated in part, "Approved disinfectants for vinyl and weblon materials: Galahad, LPH, Amphy1, One-Stroke, Vespene II, Viro-Check, Alcide LD." In interview on 08/17/19 staff member # 105 stated that they were contacting Universal Medical to clarify if the use of Sani-Wipes is approved by the company. This staff member stated that facility was also in the process of contacting all vendors they had purchased aprons for to see if Sani-Wipes are acceptable to use on their lead aprons. As of 08/22/19 the facility provided this surveyor a list of lead apron vendors and their response to inquiries regarding if the use of Sani-Wipes is approved. The facility had over 20 vendors they utilize for lead aprons. 7 vendors indicated the use of Sani-Wipes or QAT wipes was approved for their products. 13 of the vendors had not responded and/or they could not locate contact information for the vendors. 1 vendor specified, "Use only warm water and mild detergent on our specially formulated Clorox apron cleaner." | A.536 | | | | | |
## A. BUILDING ______________________

**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**STATEMENT OF DEFICIENCIES**

**PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:** 450076

**DATE SURVEY COMPLETED:** 08/23/2019

**MULTIPLE CONSTRUCTION B. WING _____________________________**

**NAME OF PROVIDER OR SUPPLIER**

UNIVERSITY OF TEXAS M D ANDERSON CANCER CENTER, THE

**STREET ADDRESS, CITY, STATE, ZIP CODE**

1515 HOLCOMBE BLVD
HOUSTON, TX  77030

**FORM APPROVED OMB NO. 0938-0391**

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<td>A 536</td>
<td>Continued From page 164</td>
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<td>Based on the above findings there was no standardized procedure, approved cleaner, or system for cleaning the lead aprons. This was confirmed in an interview with staff members #40 and 105 on 08/22/19.</td>
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<td>A 547</td>
<td>QUALIFIED STAFF</td>
<td>A 547</td>
<td>10/26/19</td>
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<td>CFR(s): 482.26(c)(2)</td>
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<td>Only personnel designated as qualified by the medical staff may use the radiologic equipment and administer procedures. This STANDARD is not met as evidenced by: Based on review of facility documents, review of personnel files, and staff interview, the facility failed to ensure only personnel designated as qualified by the medical staff may use the radiologic equipment and administer procedures.</td>
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<td>Findings:</td>
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<td>Review of the facility 2017 Radiation Safety Manual stated in part, &quot;2.3 Radiation Safety Training</td>
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<td>...Training is required annually for:</td>
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<td><em>Personnel who care for patients ... that are being treated with unsealed radioactive material and that do not meet the requirements to be released immediately from radiation safety isolation.</em></td>
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<td>Review of the personnel file for staff # 228 on 8/21/19, a radiology technician, revealed radiation safety training was dated 3/22/18, 17 months overdue. This was verified by their direct</td>
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<td>A 547</td>
<td>Continued From page 165</td>
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<td>supervisor, during review. On 8/22/19, documentation was provided that staff # 228 completed the training on 8/21/19.</td>
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<tr>
<td>A 618</td>
<td>FOOD AND DIETETIC SERVICES</td>
<td>CFR(s): 482.28</td>
<td>The hospital must have organized dietary services that are directed and staffed by adequate qualified personnel. However, a hospital that has a contract with an outside food management company may be found to meet this Condition of Participation if the company has a dietitian who serves the hospital on a full-time, part-time, or consultant basis, and if the company maintains at least the minimum standards specified in this section and provides for constant liaison with the hospital medical staff for recommendations on dietetic policies affecting patient treatment.</td>
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### Contamination of Food Products

A. The two portable freezer units and a multi-use food truck were located on the facility's dock area adjacent to where construction debris and the facility's unsealed, contaminated linens were being off loaded and on loaded. The freezer unit's inside doors, floors, ceilings, and walls were noted with dark debris.

B. Multiple kitchen equipment and counters were soiled with old dried food debris.

C. Multiple staff were observed in the kitchen and handling food trays without the use of hair restraints.

**Findings:**

A.) An observation on morning of 8/15/19, on the facility's dock receiving area, revealed a large, open construction container with discarded construction debris inside, including fiberglass, dirty stained ceiling tiles, and wall board. The Sysco food delivery truck was making a food delivery and was sitting adjacent to the construction container.

An observation on the morning of 8/19/19, on the facility's dock receiving area revealed the facility's contracted linen service truck being loaded with large containers of soiled linens. The containers were uncovered and the linen was stacked over the top. The linen truck was parked adjacent to the Sysco delivery truck making a food delivery.

Review of the facility provided Isolation Policy MD Anderson Institutional Policy #CNN0432
A. BUILDING ______________________
(X1) PROVIDER/SUPPLIER/CLA
IDENTIFICATION NUMBER:
450076

STATEMENT OF DEFICIENCIES
AND PLAN OF CORRECTION

(X2) MULTIPLE CONSTRUCTION
A. BUILDING ______________________
B. WING ______________________

(X3) DATE SURVEY
COMPLETED
08/23/2019

NAME OF PROVIDER OR SUPPLIER
UNIVERSITY OF TEXAS M D ANDERSON CANCER CENTER,THE

STREET ADDRESS, CITY, STATE, ZIP CODE
1515 HOLCOMBE BLVD
HOUSTON, TX  77030

(X4) ID
PREFIX
TAG
SUMMARY STATEMENT OF DEFICIENCIES
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(X5) ID
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TAG
PROVIDER’S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE
CROSS-REFERENCED TO THE APPROPRIATE
DEFICIENCY)

COMPLETION
DATE

A 618 Continued From page 167
reflected, "...All Soiled linen should be treated the
same regardless of whether or not a patient is on
isolation ....

B.) Observations on the morning of 8/12/19 in
the facilities kitchen, accompanied by Staff #60,
RD, LD, Director of Nutritional Services, revealed
the following:

- Three plastic cutting boards with deep gouges
cut into the material leaving visible dried food
debris in the grooves.

- The facility’s soup dispensing machine had
multiple parts with dried-on food debris, with the
likelihood of debris falling back into the soup.

- The underside of shelving in the bakery was
dirty with dried food debris that could fall into the
food being prepared.

- The large round cooking kettle had visible food
residue and a piece of paper was noted sitting in
the bottom of the kettle’s inside drain.

Review of the facility policy Cleaning and
Sanitizing #7-08 Department of Dining Services
(last reviewed January 2018) reflected,
"Introduction To outline the procedures for
cleaning and sanitizing in order to prevent
contamination of food products ... Scheduled:
The areas occupied by Production, the cafeteria
and Catering will be kept clean and free of dust,
dirt and grease. These areas and all equipment
will be cleaned on a scheduled basis ...
Non-Food: All non-food contact surfaces of
equipment will be cleaned as often as necessary
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<td>A 618</td>
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<td>Continued From page 168 to keep the equipment free of dust, dirt, grease and food particles. Sanitized: Kitchenware, utensils, food preparation surfaces and food contact surfaces of equipment will be washed, rinsed and sanitized after each use or interruption of operation ...</td>
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<td>C.) Observations while being accompanied by Staff #314 on the morning of 8/13/19 revealed,</td>
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<td>- On the G11 inpatient unit revealed, Staff #58, room service staff with a beard, was not wearing a beard guard to cover the facial hair. Staff #58 stated, &quot;I should be covering my beard.&quot;</td>
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<td>- On the G11 inpatient unit revealed, Staff #146, room service staff with a beard and moustache, the beard was covered but not the moustache. Staff #146 stated, &quot;I don't have to cover the moustache.&quot;</td>
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<td>- In the facility's kitchen, revealed Staff #313, Refrigeration contractor, in the facility's food preparation area without a hair restraint and a beard guard for his beard. During an interview on the morning of 8/13/19, Staff #60, RD, LD, Director of Nutritional Services stated, &quot;They need to be wearing hairnets and the beard and moustache need to be covered ... Anyone coming into the kitchen needs to be wearing a hair restraint.&quot;</td>
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<td>A 701</td>
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<td>MAINTENANCE OF PHYSICAL PLANT CFR(s): 482.41(a)</td>
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<td>The condition of the physical plant and the overall</td>
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A 701 Continued From page 169

hospital environment must be developed and maintained in such a manner that the safety and well-being of patients are assured. This STANDARD is not met as evidenced by:

Based on observation, record review, and interview, the facility failed to ensure that the hospital environment was maintained in a safe manner.

Findings:

1. Emergency Communication in Restrooms in Corridors:

a. During tours throughout the facility (Lutheran and Alkek building as well as outpatient clinics Mays, League City and West Houston) it was observed that there was no standardized emergency pull cords in patient designated bathroom in corridors to inpatient units and throughout the facility. If a patient or a visitor who use these bathrooms in the corridors were to fall and could not get up there was no means of communication for calling staff for help. There was no standardization of signage identifying a patient bathroom from staff bathrooms throughout facility. Some areas had signage and locks preventing patients from entering staff bathroom, others did not have signage or means of preventing patients from entering staff designated bathrooms.

b. Observation: During tours of MD Anderson Diagnostic Imaging -West Houston which is an outpatient department, it was observed that on the Mammography imaging side of the suite bathroom had emergency stop buttons 4 - 5 feet from the floor. If pressed, a light would come on.
**NAME OF PROVIDER OR SUPPLIER**

UNIVERSITY OF TEXAS M D ANDERSON CANCER CENTER,THE

---

**STREET ADDRESS, CITY, STATE, ZIP CODE**

1515 HOLCOMBE BLVD
HOUSTON, TX 77030

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**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

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**A. BUILDING IDENTIFICATION NUMBER:**

450076

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**B. WING IDENTIFICATION NUMBER:**

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**DATE SURVEY COMPLETED:**

08/23/2019

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**PROVIDER'S PLAN OF CORRECTION**

(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

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</table>
| A 701     |     | Continued From page 170 outside of the bathroom. There were no audible alarms. No emergency pull cords that a patient could reach 6 inches from the floor to access for patients who could fall on the floor could not get up while in these bathrooms.

   c. Observation on 8/15/2019 at 1:30 PM at the Diagnostic Imaging West Houston Bone imaging area showed four (4) patient bathrooms. Two (2) of the bathrooms had a red call button about 2 ½ feet from the floor adjacent to the toilet and tissue dispenser. A red light on the ceiling outside the bathroom came on when the red call button was pushed in bathroom ECB1.3187. There was no audible alarm when the red button was pushed. No staff member came to bathroom ECB1.3187 when the red light came on in the hallway. In the other two (2) patient bathrooms, there was a red button and a white button. The red button was on the wall and the white button was on the tissue dispenser. The red button in bathroom EDB1.3135 controlled the red light outside the bathroom and the white button made a doorbell sound at the nurse's station when pushed by the surveyor. There was no signage in any of the bathrooms that identified the buttons as emergency call buttons.

d. Interviewed staff # 43 throughout the tours of the facility Aug 12 - 22, 2019 at various times who also witnessed, took pictures, and confirmed that patient/visitor bathrooms in the corridors to the inpatient units and the outpatient clinics visited did not have emergency pull cords or any form of emergency call system for patient or visitors who collapse on the floor. Staff #43 also observed there were no standardization of signage
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<td>A 701</td>
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<td>delineating staff restrooms from patient restroom. If a restroom in corridor had “staff use” signage there were no standardization of preventing patients from going into staff bathrooms.</td>
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<td>e.</td>
<td></td>
<td>In an interview with Staff 176 on 8/15/2019 at 1:30 PM at Diagnostic Imaging Bone Imaging suite, she stated that the bathrooms with just the red button do not alarm at the nurse's station, adding that if the red button was pushed, a staff member would need to be in the area to notice it. She also stated that there was no signage in any of the bathrooms that instructed patients to push the red or white emergency buttons (red or white) in case of an emergency</td>
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</table>
| f. | | Interview with nursing staff # 367 at G21 floor on 08/19/19 at 02:15 p.m. revealed, patient restroom G21.3605 in corridor outside of nursing unit an emergency pull cord alarm was not installed. She stated "we're using this unit temporarily."
| | | | | | | |
| g. | | Interview on 08/20/19 at 09:28 a.m. with staff #368 on G18 floor revealed that patients in therapy would use the restroom in corridor G18.3605. He confirmed the restroom had no emergency pull cord alarm in place. | | | | | |
| h. | | Review of National Fire Protection Association 99 which refers to healthcare facilities states "Under NFPA 99, each patient bed and bath is required to have a call station. Call stations in the bathroom must be accessible to someone lying on the floor ...." | | | | | |
A. BUILDING _______________________
 provid/or supplier identification number: 

B. WING _____________________________

NAME OF PROVIDER OR SUPPLIER

UNIVERSITY OF TEXAS M D ANDERSON CANCER CENTER, THE

STREET ADDRESS, CITY, STATE, ZIP CODE

1515 HOLCOMBE BLVD
HOUSTON, TX 77030

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i. American with Disability Act Requirement (ADA) states "The ADA mandates that an accessible element, such as a nurse call system, must be mounted no higher than 48 inches from the ground for spaces that only allow forward reach"


(a) Patient toilet and bathing facilities. A nurse emergency call system shall be provided at each inpatient toilet, bath, sitz bath, and shower room. A nurse emergency call shall be accessible to a collapsed patient lying on the floor. Inclusion of a pull cord will satisfy this standard.

(b) Outpatient and treatment areas. Provisions for emergency calls shall be provided in outpatient and treatment areas where patients may be subject to incapacitation."

2. Based on observation, interview, and record review, the facility failed to ensure the safety of patients and staff by maintaining the ceiling tiles in 2 of 2 areas: Janitor's Closet WTC2.10.10 and G7 hallway at room G7.3220C. Failure to maintain the complete membrane formed by the ceiling can compromise the operation of the sprinklers or detectors.

a. Observation on 8/14/2019, at 11:00 AM, of the Medical Arts Center in The Woodlands showed that a ceiling tile was cocked sideways in a
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<td>Janitor's Closet WTC2.10.10, located on the second floor. A sprinkler head had been installed in ceiling.</td>
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<td>b. Observation on 8/21/2019, at 11:30 AM, of a hallway in G7 showed that a ceiling tile just outside room G7.3220C was missing. The hallway had ceiling sprinkler heads.</td>
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<td>c. In an interview with Staff 43 on 8/21/2019 at 11:30 AM, he stated the ceiling tiles should be in place.</td>
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<td>d. Record review of Maintenance Infection Control Risk Assessment (not dated or timed) revealed: &quot;Table C - Description of Infection Control Precautions by Class ... Class II ... 5. Immediately replace ceiling tile(s) displaced for visual inspection.&quot;</td>
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<td>e. Observed on 8/21/19 at 8:45 am Baseboards in Alkek building 1st floor near elevator dinged and bent, floors dirty from heavy traffic in area near elevators</td>
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<td>A 724</td>
<td>FACILITIES, SUPPLIES, EQUIPMENT MAINTENANCE CFR(s): 482.41(d)(2)</td>
<td>Facilities, supplies, and equipment must be maintained to ensure an acceptable level of safety and quality. This STANDARD is not met as evidenced by: Based on observation, interview, and review of policy, the facility failed to:</td>
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<td>1. Ensure facility equipment was on a Preventive Maintenance Program and had stickers on equipment to show equipment they had been</td>
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<td>A 724</td>
<td>A 724</td>
<td>10/26/19</td>
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2. Maintain facilities and supplies to ensure an acceptable level of safety and quality as expired medical supplies were found in patient care areas available for use which potentially could have resulted in unsafe or ineffective medical supplies being used.

Finding:

1. During tour of facility equipment there were random equipment found in facility that was either not on a preventive maintenance program or did not have a safety Preventive maintenance sticker on the equipment

   a. During a tour of the hospital Acute Palliative Care Unit on 08/20/19 in the company of staff #97 revealed two Hoyer lifts had no inspection sticker indicating they had been inspected for safety. Interview with staff #97 during the tour, confirmed that the two Hoyer lifts had no inspection sticker.

   b. Interview with staff #366 on 08/21/19 at 09:35 a.m., revealed the hospital had not inspected the two Hoyer lifts. Staff #366 stated, "we're in the process of developing a PM (Preventive maintenance) procedures for the hospital Hoyer lifts."

   c. Observation of Mays Clinic at Cancer prevention unit on 08/13/19 at 09:25 a.m., revealed the specialized mammography assist chair used in the unit had not been inspected.
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<td>A 724</td>
<td>Continued From page 175</td>
<td>d. Interview with nursing staff # 39 on 08/13/19 at 09:26 a.m. at Mays clinic who confirmed the mammography chair had no inspection sticker. Personnel #1 stated &quot;I didn't know it was not inspected. It's supposed to have an inspection sticker.&quot;</td>
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<td>e.</td>
<td>Observed Preventive maintenance stickers missing from some of the equipment in random facilities toured example room P716 in Lutheran building automated vital sign monitor with no preventive maintenance stickers, Alkek Operation room suite missing preventive maintenance stickers on Storz CMAC Anesthesia monitor as evidence of preventive maintenance being done on equipment.</td>
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<td>f.</td>
<td>Interview with nursing staff #9 on August 21, 2019 at 10:23am during tour of main OR at the Alkek building, witnessed and confirmed Storz CMAC Anesthesia Monitor was missing PM stickers. Interviewed staff # 367 on August 13, 2019 at 11:15am am during tour of unit on floor P7 Lutheran building who witnessed and confirmed preventive maintenance sticker was missing and should have been on equipment.</td>
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<td>g.</td>
<td>Review of Instruction manual for both mammography, total lift chair and Hoyer lift. The Hoyer lift instruction manual state that &quot;daily checks, yearly service, inspections, and tests will ensure a lift is kept in optimum safety working condition. The Ultralift manual states &quot;daily, monthly and yearly inspections and adjustments</td>
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<td>are to be done by a qualified technician .... inspection should be recorded and include but not be limited to, date, model, serial number, findings, corrective measures ...&quot;</td>
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h. Review of facility policy titled "Medical Equipment Management Plan" with last revision date of 02/24/18, reflected the following purpose: "...involves the promotion of safe environment for patients and staff, which meet regulatory, operational and financial requirements."

2. a. A bottle of isopropyl alcohol found in the Holly Hall Blood Donor Center that had been transferred from the original container was not properly labeled which potentially caused it to be kept beyond the expiration date.

b. Emergency call cords in dressing rooms in the Radiology Outpatient Clinic were rendered inoperable by the cords being wrapped around plastic wall signs which potentially could cause a patient in distress not being able to get help readily.

c. During a tour of the Respiratory Department on the morning of 8/12/19 in the company of staff #34 the following expired supplies were found.

1. Found in the Dirty Equipment Room: Bleach Germicidal Wipes, 1 lb. 10 oz. container, expired 8/17; Hydrogen Peroxide spray, 2 oz. bottle, 6 expired 8/12 and a 4 oz. bottle expired 4/10.
2. Found in the MICU RT Storage Room in a bronchoscopy cart, Cytology Brush, expired 9/17.

d. In an interview with staff #34 during the tour on the morning of 8/12/19, staff #34 confirmed that the above listed supplies were expired.

e. During a tour of the Cardiopulmonary Center on the morning of 8/19/19 in the company of staff #296, PDI Sani-Cloth Bleach Wipes, package of 75, expired 6/19 were found in PFT Room #3. In an interview with staff #296 during the tour on the morning of 8/19/19, staff #296 confirmed that the Sani-Cloth Bleach Wipes were expired.

f. During a tour of the Thoracic and Orthopedic Treatment Center on the afternoon of 8/19/19 in the company of staff #299 the following expired supplies were found in the Cast Room: BD Eclipse Needle, 30 gauge x ½", 3 expired 9/17; BD Eclipse Needle, 27 gauge x ½", 30 expired 1/19; and Xeroform 5" x 9", 2 expired 3/19. In an interview with staff #299 during the tour on the afternoon of 8/19/19, staff #299 confirmed that the above listed supplies were expired.

g. During a tour of the Holly Hall Blood Donation Center located at 2555 Holly Hall St. Houston, TX 77054 on the morning of 8/20/19 in the company of staff #331, an approximately 4 oz. plastic bottle containing a clear solution was found in the refrigerator in the collection area lab. The bottle had a handwritten label which reflected "91% Isopropyl Alcohol 7/20/16." There was no
## Statement of Deficiencies and Plan of Correction

### NAME OF PROVIDER OR SUPPLIER

**UNIVERSITY OF TEXAS M D ANDERSON CANCER CENTER, THE**

### STREET ADDRESS, CITY, STATE, ZIP CODE

**1515 HOLCOMBE BLVD**

**HOUSTON, TX  77030**

### Summary Statement of Deficiencies

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Expiration date recorded on the label. In an interview with staff #331 during the tour on the morning of 8/20/19, staff #331 stated that the bottle should have been labeled with the expiration date.

h. The facility policy entitled "Beyond Use Dating and Labeling of Medications, Disinfectants and Antiseptics in Patient Care, Perioperative and Procedural Areas Policy" #CLN0438 dated 12/13/17 reflected in part "1.3 C. Disinfectants and Antiseptics should be discarded by the Expiration Date indicated by the manufacturer on the label."

i. The facility policy entitled "Reagents - Labeling, Preparation, and Storage" # DIV QIP 0613 dated 7/23/09 reflected in part "3.0 Reagents, calibrators, controls, stains, chemicals and solutions are properly labeled, as applicable and appropriate, with the following elements: Name, content quantity, concentration or titer; Storage requirements; Date prepared, filtered or reconstituted by laboratory; Expiration date or new expiration date if opening the container changes the expiration date, storage requirements, etc.; Lot number if applicable; Cautionary information, if applicable."

j. In a tour of the Radiology Outpatient Clinic located at 1700 Holcombe Blvd., Houston, TX 77030 on the morning of 8/15/19 in the company of staff #195, the emergency call cords in 2 of 4 dressing rooms were observed to be wrapped around a plastic sign mounted on the back wall of the room so if the cord was pulled, the
### PROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

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<td>k.</td>
<td>During observation of the Breast Center Outpatient Clinic on floor 5 in the late morning on 8/12/19, it was revealed that Treatment Room #3 contained 16 expired 6.0 sutures, the &quot;Chart Room&quot; contained 12 expired 7.0 sutures, and Room #10 contained an expired Mediplex Transfer Dressing. In an interview on 8/12/19 at the time of these findings with Staff #29 Nurse Manager, she stated the expired supplies should not have been in the rooms.</td>
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<td>l.</td>
<td>During observation of the Genitourinary Outpatient Center's Clean Utility Room on floor #7 on the morning of 8/13/19, it was revealed that the dermatology &quot;Padget&quot; machine contained 16 expired disposable blades (expired 9/07). In an interview on 8/13/19 at 10:00 AM with Staff #32-Nurse Manager, he stated the 16 expired disposable blades should have been discarded and not have been available for use.</td>
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<td>m.</td>
<td>During observation of the 11th floor Bone Marrow Aspiration outpatient clinic in the early afternoon on 8/14/19, there were expired &quot;Sanicloth&quot; wipes used for cleaning in rooms #13 (expiration 4/19) and #14 (expiration 6/19). In an interview on 8/14/19 at the time of these findings with Staff #185, he stated the expired Sanicloths</td>
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A 724 Continued From page 180
   should not have been in the rooms.

   n. During observation of the Head and Neck outpatient center workroom on the 10th floor in the late afternoon on 8/14/19, there was one full box of expired Hemoccult slides (expiration 7/18). In an interview with Staff #184 during the time of observation, she stated the Hemoccult slides should not have been available for patient use and promptly discarded the entire box.

   o. Review of hospital "employee notes" dated Friday, August 5, 2016 stated: "Here are seven ways to maintain the cleanliness of patient-care items in clean supply/storage rooms.: ...4. Discard expired supplies by regularly checking supplies ..."

   p. Review of hospital "Focus of the Week | July 1, 2019" stated: "Monitor expiration dates of supplies/medications". Among the areas listed was: "Crash cart medications and supplies (e.g., pads)." "Medical supplies, including disinfectants and antiseptics".

A 747 INFECTION CONTROL
   CFR(s): 482.42

   The hospital must provide a sanitary environment to avoid sources and transmission of infections and communicable diseases. There must be an active program for the prevention, control, and investigation of infections and communicable diseases.

   This CONDITION is not met as evidenced by:
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<tr>
<td>Based on observations, interviews, and records review, the facility failed to provide a sanitary environment to avoid sources and transmission of infectious and communicable diseases. The facility failed to:</td>
<td>Based on observations, interviews, and records review, the facility failed to provide a sanitary environment to avoid sources and transmission of infectious and communicable diseases. The facility failed to:</td>
</tr>
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<td>1.) Ensure that clean linens were not contaminated by soiled linens, soiled equipment and/or soiled staff uniforms.</td>
<td>1.) Ensure that clean linens were not contaminated by soiled linens, soiled equipment and/or soiled staff uniforms.</td>
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<td>2.) Ensure that sterile surgical linens were handled and stored to prevent contamination by dust, soiled linens, soiled equipment and/or soiled staff uniforms.</td>
<td>2.) Ensure that sterile surgical linens were handled and stored to prevent contamination by dust, soiled linens, soiled equipment and/or soiled staff uniforms.</td>
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<td>3.) Ensure that durable medical equipment which was removed from isolation rooms was sanitized using the appropriate disinfectant for the organism being isolated and stored under appropriately clean conditions after disinfection.</td>
<td>3.) Ensure that durable medical equipment which was removed from isolation rooms was sanitized using the appropriate disinfectant for the organism being isolated and stored under appropriately clean conditions after disinfection.</td>
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<td>4.) Ensure that nursing staff were educated in and used the appropriate disinfectant for the organism being isolated when disinfecting equipment coming out of patient isolation rooms.</td>
<td>4.) Ensure that nursing staff were educated in and used the appropriate disinfectant for the organism being isolated when disinfecting equipment coming out of patient isolation rooms.</td>
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<td>5.) Ensure that patient transportation staff cleaned and disinfected wheelchairs and stretchers between patient uses, as well as stored said equipment under appropriately clean conditions.</td>
<td>5.) Ensure that patient transportation staff cleaned and disinfected wheelchairs and stretchers between patient uses, as well as stored said equipment under appropriately clean conditions.</td>
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<td>6.) Ensure Environmental Services/Housekeeping maintained isolation precautions to prevent cross contamination while conducting housekeeping services.</td>
<td>6.) Ensure Environmental Services/Housekeeping maintained isolation precautions to prevent cross contamination while conducting housekeeping services.</td>
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<tr>
<td>It was determined that these deficient practices posed an Immediate Jeopardy to patient health</td>
<td>It was determined that these deficient practices posed an Immediate Jeopardy to patient health</td>
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A 747 Continued From page 182

and safety and placed all patients in the facility at risk for the likelihood of harm, serious injury, and possibly subsequently death.

7.) Ensure policies were developed and implemented for the proper use of the Trophon High Level Disinfectant System for ultrasound probes.

8.) Ensure staff were utilizing the required protective equipment when entering isolation rooms. The facility also failed to include the protective equipment required for isolation in the facility policy.

9.) Ensure staff wash/sanitize hands between touching contaminated items and performing enteral venous catheter and vascular access care during initiation and termination of hemodialysis treatment on 2 of 2 patients observed. Patients #49 and 36.

10.) Know the Hepatitis B antibody status or administer the immunization for 5 of 10 non-immune surgical staff health records reviewed. (Staff #267, #272, #288, #289, and #291). The facility failed to follow the CDC guidelines and the facility policy on Hepatitis B monitoring and follow-up guidance.

11.) To maintain a sanitary environment in 10 of 10 departments throughout the facility system. (Pain Management Clinic at 1515 Holcombe Blvd, MOHS and Dermasurgery Center, Main Campus Pharmacy, La Maistre Building, Mays Clinic Building, Main Campus, League City, West Houston, Sugar Land, and Diagnostic Imaging.)
SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

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Cross Refer to Tag A0749

A 749 INFECTION CONTROL PROGRAM
CFR(s): 482.42(a)(1)

The infection control officer or officers must develop a system for identifying, reporting, investigating, and controlling infections and communicable diseases of patients and personnel.

This STANDARD is not met as evidenced by:

Based on observations, interviews, and records review, the facility failed to provide a sanitary environment to avoid sources and transmission of infectious and communicable diseases. The facility failed to:

1.) Ensure that clean linens were not contaminated by soiled linens, soiled equipment, and/or soiled staff uniforms.

2.) Ensure that sterile surgical linens were handled and stored to prevent contamination by dust, soiled linens, soiled equipment, and/or soiled staff uniforms.

3.) Ensure that durable medical equipment, which was removed from isolation rooms, was sanitized using the appropriate disinfectant for the organism being isolated and stored under appropriately clean conditions after disinfection.

4.) Ensure that nursing staff were educated in and used the appropriate disinfectant for the organism being isolated when disinfecting equipment coming out of patient isolation rooms.
A 749 Continued From page 184

5.) Ensure that patient transportation staff cleaned and disinfected wheelchairs and stretchers between patient use, as well as stored said equipment under sanitary conditions.

6.) Ensure Environmental Services/Housekeeping maintained isolation precautions to prevent cross contamination while conducting housekeeping services.

It was determined that these deficient practices posed an Immediate Jeopardy to patient health and safety, and placed all patients in the facility at risk for the likelihood of harm, serious injury, and possibly subsequent death.

Findings:

1.) Observations conducted on 8/14/19, from 1:30 p.m. to 2:30 p.m., of the main laundry staging areas for the hospital revealed the following information:

-Soiled Linen area (the pit): Both sets of double doors leading into the soiled linen area were being maintained in an open fashion. At the back of the soiled linen room was another set of double doors which were partially pushed open. Clean linen could be viewed through the door. The surveyor asked the Director of Materials Management what area was behind the double doors located at the back of the soiled linen room. The director stated that it (the doors) lead directly into the clean linen area and that the door...
A 749 Continued From page 185

should remain shut. The director then closed the
doors. However, a crack remained between the
doors which was large enough to fully see the
clean linen.

-Clean Linen area: Observation of the clean linen
carts containing the operating room (OR) scrubs
revealed that they were being stored in directly in
front of the double doors which lead into the
soiled linen area. The surveyor could feel air flow
coming from the soiled linen area into the clean
linen carts which had a foul odor. The plastic
covering of the carts was ripped and torn and was
being blown by the air flowing through the door.
Continued observations revealed sterile surgical
linens were being stored on wire racks in the
same room with basic linens. The sterile linens
were not wrapped in a manner to ensure sterility
and the cart itself was only partially covered by a
torn plastic sheet. Dust and other debris were
observed on the sterile linens. On the other side
of the same room was located the employee's
personal lockers as well as lockers marked for
the deposit of employees soiled work clothing.
On the adjoining the wall where the work lockers
were located was another set of double doors
with a sign marked "soiled equipment."

In an interview conducted on 8/14/19 at the time
of observation, the Director of Materials
Management, stated that the sterile linen being
stored in the main linen area was back up for
surgery and that materials staff were just waiting
for the surgery staff to request the sterile linens
so it could be sent up. During continued interview,
the surveyor asked about the adjoining room
marked "soiled equipment". The director stated,
A. PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 450076

NAME OF PROVIDER OR SUPPLIER: UNIVERSITY OF TEXAS M D ANDERSON CANCER CENTER, THE

STREET ADDRESS, CITY, STATE, ZIP CODE: 1515 HOLCOMBE BLVD HOUSTON, TX 77030

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

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"no one is to be exiting with dirty equipment through that door."

During another interview conducted on 8/15/19, at 9:00 a.m., with the Director of Material Management regarding the sterile linen observed by the surveyors on 8/14/19, The director stated he had a conversation with the Operating Room (OR) supervisor prior to the surveyor's arrival the morning of 8/15/19. The OR supervisor informed him that the sterile linens observed the previous day should be sent back to the laundry due to dating/labeling concerns on the packaging. Prior to his conversation with the OR director, he was not aware that there was anything wrong with the sterile linens. He further revealed that he thought the packaging of the sterile linens looked appropriate. However, the sterile linens should have been sent to the dirty (soiled) laundry area for reprocessing.

2.) Continued observations conducted on 8/15/19, from 9:15 a.m. to 10:30 a.m., of the main clean linen storage area revealed the following:

-Two linen carts were observed to contain sterile surgical linens. The sterile surgical linens were not wrapped in a manner to ensure sterility and were soiled with dust and unidentified debris. These carts were being stored directly across from the staff lockers and the doors leading to the soiled equipment area. While the surveyors were observing the sterile surgical linens, hospital staff were observed to open the soiled equipment room doors and removed 2 equipment carts from the soiled area, wheeling them through the clean linen area.
A 749 Continued From page 187

In an interview conducted on 8/15/19 at the time of observation, the Director of Materials Management stated that he was not aware that the other 2 carts of sterile linens were down in the clean linen storage area.

In an interview conducted on 8/15/19, at 3:50 p.m., the director of Infection Control revealed that the main soiled linen storage area (the pit) was a "negative pressure" room.

In an interview conducted on 8/16/19, at 10:00 a.m., the Director of Operations and Maintenance and Heating Ventilation and Air Conditioning (HVAC) Technician #209 stated that prior to the evening of 8/15/19 the hospital's main soiled linen storage area was a "positive pressure" room. The HVAC technician also stated that the main clean linen room was supposed to be a "positive pressure" area, but the system was not functional. He further stated that he was not certain how long it had been broken.

Record review of the facility policy entitled: Infection Control for Patient Care Areas, dated 4/11/19, Version #46.0 revealed in part the following information:

Section 4.6) Patient care linen should be stored in a way as to assure cleanliness and to prevent contamination.

-M.) Package, transport, and store clean linens by methods that should ensure their cleanliness and
A 749 Continued From page 188

protect them from dust and soil during intra-facility and inter-facility loading, transport, and unloading.

Record review of the facility policy entitled: Isolation Policy, dated 3/31/16, Version# 49.0, revealed in part the following information:

Section 16.0) Soiled Linen
-All soiled linen should be treated the same regardless of whether or not a patient is on isolation.

Record review of the facility policy entitled: Instrument and Equipment: Cleaning, Disinfection & Sterilization, dated 7/31/19, Version# 50.0, revealed in part the following information:

4.8) Storage of Sterile Items:

E.) Factors that Compromise the Bacterial Barrier Efficiency of a Package Material:

- Airborne bacteria may be forced into the package by incorrect or excessive handling, poor storage facilities, or improper techniques.

- Dust may be forced into the package by incorrect or excessive handling, poor storage facilities, or improper techniques.

F.) Appropriate Storage Conditions for Sterile Packs: Per AAMI recommendations, including:

- Limited Access to storage area and/or closed cabinets.
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<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
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| A 749 | Continued From page 189 | A 749 | -Store soiled/dirty supplies separately from clean or sterile supplies.  
-Area must be clean, dry, and dust free.  
-Temperature and relative humidity per AAMI recommendations.  
-Controlled area signs posted.  
3.) Observation conducted on 8/15/19 at 10:10 a.m. of the facility Soiled Equipment room, located adjacent to the clean linen area, revealed the following information:  
-Areas marked "Clean" and "Dirty" were demarcated by a roughly taped red line on the floor.  
-Equipment carts located on the "clean" side of the room were observed to have peeling tape, dust, unidentified debris, and stains/spills on them.  
-Wire racks used to store clean equipment had debris and an unidentified dried brown substance on them.  
-Wooden shelves used to store clean equipment were observed to have large amounts of accumulated dust and unidentified debris on them.  
-Medical equipment identified as clean, and ready for patient use, were observed to have dust and debris on the surface of the machines.  
-An IV pump which was on the "clean" side of the |
A 749 Continued From page 190

room was noted to have a substance that resembled dry blood splatter on the side, with accumulated dust and debris on top of the machine.

In an interview conducted on 8/15/19, at the time of discovery, the director of Infection Control confirmed the above findings.

Record review of the facility policy entitled: Infection Control for Patient Care Areas, dated 4/11/19, Version# 46.0 revealed in part the following information: Section 4.14) Clean or sterile items should be separated from dirty equipment and dirty areas.

In an interview conducted on 8/15/19, at 10:20 a.m., Materials Management Staff #339 stated that equipment that comes from isolation rooms comes down to the soiled equipment room bagged. When asked by the surveyor if materials management staff are informed what type of organism was in the isolation room where the equipment was located, he stated, "no, they don't tell us. We just know it came from isolation because it is bagged." When asked what type of disinfectant is used to clean equipment from isolation rooms, the staff stated that materials management staff use Super Sani Wipes (Purple) (QUAT Type) to clean all equipment. Even equipment from isolation rooms.

In an interview conducted on 8/15/19, at 3:50 p.m., the Director of Infection Control revealed that the soiled equipment area, which is
### SUMMARY STATEMENT OF DEFICIENCIES

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**A 749 Continued From page 191**

Adjacent to the main clean linen storage, is used to store equipment from patient isolation rooms. She further stated that IV pumps, from isolation rooms, are disinfected twice. Once by materials management staff, then a second time by pharmacy staff.

In an interview conducted on 8/19/19, at 2:10 PM, the Assistant Manager of Pharmacy confirmed that pharmacy does a second wipe down of the IV pumps with Super Sani Wipes (QUAT) which come from the "clean" side of the equipment room in materials management. When asked by the surveyor why pharmacy staff felt it was necessary to perform a secondary cleaning of the pumps, the assistant manager stated, "for our own piece of mind." The surveyor then asked if pharmacy personnel were informed what type of organism was in the isolation room in which the IV pumps were removed. He stated, "no, we aren't told what type of isolation the patient is on."

Record review of the facility policy entitled: Isolation Policy, dated 3/31/19, Version# 49.0, revealed in part the following information:

15.0) Environmental Measures:
   15.3) Cleaning and disinfecting non-critical surfaces in patient care areas are part of standard precautions. In general, these procedures do not need to be changed for patients on isolation precautions, except for C. Difficile, cluster, or outbreak in which 1:10 dilution of sodium hypochlorite (bleach) may be used.

4.) Observations conducted on 8/13/19, at 11:25
A 749 Continued From page 192

am, of Room # G 1248 (patient 42) revealed there was an isolation cart located outside his room. A sign which stated the patient was on contact isolation was hung on the door. An open box containing individually wrapped Super Sani Wipes (QUAT type) was located on the cart. The package information located on the Sani wipe box stated that the box held 50 individually packaged wipes. The surveyor opened the top of the box and observed only 13 packages of wipes were left.

In an interview conducted on 8/13/19, at the time of observation, with Associate Director of the palliative care unit revealed that patient # 42 was on isolation precautions for C. Difficile (C-Diff) toxin. When asked what disinfectant was to be used for patients on isolation for C-Diff infection, the Associate Director stated that staff were supposed to be using bleach wipes for the disinfection of C-Diff isolation rooms.

In an interview conducted on 8/13/19, at 11:32 am, Registered Nurse (RN) #98 revealed that she was the primary nurse for patient #42. She further stated that the Super Sani Wipe Box, which was observed on the isolation cart, came with the cart and that she was the one that opened the box to use it (the wipes). When asked by the surveyor what she used the Super Sani wipes (QUAT) to disinfect, RN#98 would not tell the surveyor.

Observation conducted on 11:38 am of the garbage can outside of patient #42's isolation room revealed numerous open used packages of...
A 749 Continued From page 193
Super Sani wipes, which had been discarded in the garbage can.

Record review of the Physician's progress notes for Patient #42 revealed that he was a 70-year-old male, admitted on 8/04/19, with diagnosis of advanced metastatic pancreatic cancer. Further review of the clinical record revealed that the patient had a consult with the Infectious Diseases Physician due to Klebsiella pneumonia bacteremia and C. Difficile, for which the patient was placed on contact isolation.

Record review of the facility policy entitled: Isolation Policy, dated 3/31/19, Version# 49.0, revealed in part the following information:

15.0) Environmental Measures:

15.3) Cleaning and disinfecting non-critical surfaces in patient care areas are part of standard precautions. In general, these procedures do not need to be changed for patients on isolation precautions, except for C. Difficile, cluster, or outbreak in which 1:10 dilution of sodium hypochlorite (bleach) may be used.

5.) Observations conducted on 8/21/19 from 10:00 am to 11:08 am of the facility wheelchair storage areas revealed the following:

- The floors in the patient transportation storage rooms, where wheelchairs were stored, were observed to have dust, food wrappers, screws, unidentified debris, as well as a black substance throughout the floor.
A 749 Continued From page 194

- Base boards were falling off the walls.

- Large holes were observed in the sheetrock.

- Large bins of soiled linens were being stored in the same room with the wheelchairs. IV poles were being stored behind the soiled laundry bin. One IV pole had become entangled in the top of the bin and was stuck.

In an interview conducted on 8/21/19, at 10:32 am, the Associate Director of Patient Resources confirmed the above findings. She further stated that the wheelchair storage room was not on a routine housekeeping schedule, and that patient transportation staff were responsible for notifying housekeeping when the storage room needed cleaning.

During continued observations conducted on 8/21/19, at 10:55 am, patient escort staff #357 was observed to be cleaning a wheelchair for patient transport. As staff was getting ready to leave the storage area, the surveyor asked patient escort staff #357 if the wheelchair was now "clean" and ready for patient use. The staff stated "yes." Upon the surveyor's further observations, the "clean" wheelchair was noted to have a white splattered substance on the inside of the wheelchair arms, chewed bubble gum stuck between the top portion of the seat and arm rest, and human hair stuck to the connection where the foot rest attaches to the main body of the wheelchair.

Observations conducted on 8/21/19, from 11:15
A 749 Continued From page 195 a.m. to 11:45 a.m., of the patient transportation stretcher storage area revealed the following:

- The bottoms of the stretchers throughout the storage area were noted to be soiled with dust, unidentified debris, and a black substance.

- 3 stretchers were observed to have a dried brownish red substance on the wheels which resembled dried blood.

- 2 mortuary tables were observed to have candy wrappers shoved in the openings of the metal frames.

- 6 stretchers were observed to have used rubber gloves, candy wrappers, and other unidentified debris shoved down inside of the integrated oxygen tank holders.

- The stretchers throughout the storage area had a black substance located on the inside of the integrated oxygen tank holders.

- 4 stretchers had ripped/torn pads and were still in circulation for patient use.

During the above observations, staff were observed cleaning stretchers in preparation for patient use. The surveyors noted staff were only wiping down the top of the mattress pad and the siderails of the stretchers. At no time were staff observed to clean underneath the mattress pads, look inside the oxygen tank holders, or clean the bottom and wheels of the stretchers.

In an interview conducted on 8/21/19, at 11:35
A 749 Continued From page 196 am, patient escort staff #358 stated that staff only clean the top portion of the mattress pad and the siderails of the stretchers.

In an interview conducted on 8/21/19, at 11:39 am, the Director of Patient Transportation confirmed the above findings and revealed that staff only clean the areas of the stretcher that the patient is likely to touch.

Record review of the facility policy entitled: Instrument and Equipment: Cleaning, Disinfection & Sterilization, dated 7/31/19, Version# 50.0, revealed in part the following information:

Section 2.2) Steps for Cleaning Reusable Instruments, Equipment, and Items in the Environment:

-B.) Equipment:

-Remove any organic or inorganic debris by manually cleaning.

-C.) Environmental Items (e.g. door handles, phones, counters, nurse call devices, bedside tables, workstations on wheels, beds, stretchers, patient care furniture, keyboards and floors).

-Remove any organic or inorganic debris by manually cleaning.

-Patient care furniture, e.g. stretcher pads, mattresses, sleeper sofas, reclining chairs, should be free of tears, rips of damage that could prevent appropriate cleaning or disinfection.

-Remove any organic or inorganic debris by manually cleaning.
**A 749 Continued From page 197**

Based on observations, review of facility documents, and staff interview, the facility failed to develop and implement policies governing control of infections and communicable diseases.

**Findings:**

*Facility-based policy titled "Instrument and Equipment: Cleaning, Disinfection & Sterilization Policy" stated in part,

"3.5 High-Level Disinfection (Semi-Critical Items)

A. New Instrument and Equipment manufacturer requirements for High-Level Disinfection must be determined prior to purchase, and Infection Control, Environmental Health and Safety (EH&S) and Facilities should be notified to assure best practice guidelines for Disinfection can be met."

...J. Policies and procedures for High-Level Disinfection will be developed using the validated instructions provided by the medical device manufacturers, reviewed at regular intervals, revised as necessary, and readily available in the practice setting."

Observations of the Radiology Department in the main campus and West Houston Diagnostic Imaging throughout the survey (8/12/19 through 8/21/19) revealed staff were using a Trophon High-Level Disinfection system for ultrasound probes.

In an interview on 8/16/19 at 10:35 am, when asked for a policy regarding the system, staff #105 stated there was no policy regarding the
**SUMMARY STATEMENT OF DEFICIENCIES**

(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

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Continued From page 198 specific Trophon system.

*The waterbath manual in the CT simulator area of the Sugarland site stated in part, “Reprocessing: Warning: Users of this product have an obligation and responsibility to provide the highest degree of infection control to patients, co-workers and themselves. To avoid cross-contamination, follow infection control policies established by your facility. Note: Drain and clean waterbath periodically.”*

The facility "Civco Water Bath Cleaning Procedure" stated in part, "This procedure should be performed monthly."

Review of the facility water bath cleaning schedule for the Sugarland site on 8/15/19 revealed the following months were missing for the last two years: 10/17, 2/18, 5/18, 9/18 and 12/18.

The above was verified in an interview with staff # 105 on the morning of 8/22/19.

Based on observation, interview, and record review, the facility failed to provide care in a sanitary environment when staffs were going into isolation rooms without the required protective equipment and the facility's isolation policies did not include the protective equipment required for Protective isolation and the appropriate sanitizing product for C-Difficile.

Findings:
Review of the facility policy, Infection Control for Patient Care Areas Policy (Published Date: 4/11/2019) reflected, "The purpose of this policy is to minimize the risk of the transmission of infections from patient to patient and between patients and faculty, trainees/students, and other members of MD Anderson's workforce ....3.2 Once a patient has been identified as requiring isolation ... the isolation status should then appear in the patient medical record .... Once the isolation status of the patient is determined, appropriate action should be taken ...."

Review of the facility policy, Isolation Policy (Published Date: 3/31/2016) reflected, "The purpose of this policy is to prevent transmission of microorganisms from infected or Colonized patients to other patients, family members, visitors, ...

2.0 Protective Isolation
2.1 Protective isolation is the practice of protecting a susceptible patient from acquiring an infection from other sources, either directly or indirectly.

2.2 Although protective isolation is no longer recommended by the CDC, protective isolation may be instituted for patients on the Hematology Services and the Pediatric Service at the discretion of the Physician. The services utilizing protective isolation are responsible for providing education on this issue to the nursing units caring for their patients ...

5.0 Contact Isolation ... D. Clostridium Difficile
### Statement of Deficiencies and Plan of Correction

**Name of Provider or Supplier:** UNIVERSITY OF TEXAS M D ANDERSON CANCER CENTER, THE  
**Street Address, City, State, Zip Code:** 1515 HOLCOMBE BLVD HOUSTON, TX 77030

<table>
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<th>ID</th>
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<th>Summary Statement of Deficiencies (Each Deficiency Must Be Preceded by Full Regulatory or LSC Identifying Information)</th>
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<th>Provider's Plan of Correction (Each Corrective Action Should be Cross-Referenced to the Appropriate Deficiency)</th>
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| A 749 | Continued From page 200  
(wash hands with soap/water only) ... | A 749 | An observation on the morning of 8/12/19, on the G10 unit, revealed Staff #202 and Staff #47 go into room G10.70 without donning an isolation mask or gloves. The nurses turned off the IV machine that was beeping and lowered the bed. The sign on the patient’s door reflect the patient was on Contact Isolation Precautions.  
During an interview on the morning of 8/12/19, Staff #47 when asked if she was aware the patient was on Contact Isolation stated, "I didn't see the sign, this isn't my patient ..."  
During an interview on the morning of 8/12/19, Staff #47 stated, "The patient is on protective Isolation, gloves and masks need to be worn .... They put the wrong sign on the door."  
During an interview and observation on the morning of 8/13/19, Room G10.70 with a Contact Isolation sign on the door, when asked what she was on isolation for, Staff #47 stated, "C-diff ... it's the wrong sign. A 'Contact Isolation with soap and water' sign was placed on the door." |
### A 749

Continued From page 201

Review of the patient's medical records revealed Patient #187 was not at risk for contracting an infectious disease and did not require Protective Isolation.

During an interview on the morning of 8/14/19, in the facility conference room, Staff #40 confirmed the facility's Protective Isolation policy did not reflect the protective equipment needed or detail the exclusions for a person on Protective Isolation such as no fresh plants and that the wording 'may' to 'must' for the Section 15.3, related to use of beach with patient on C. Difficile Isolation, needed to be changed.

Based on observation, interview, and record review, the facility’s staff failed to maintain a sanitary environment by ensuring staff wash/sanitize hands between touching contaminated items and performing central venous catheter and vascular access care during initiation and termination of hemodialysis treatment on patients. Patient #s 49 and 36

Findings:

Patient #49

On 08/12/2019, at 12:04 p.m., contract
Registered Nurse #59 was observed on the 11th floor Hemodialysis suite. The Registered Nurse was observed terminating hemodialysis treatment on Patient #49 who had a right double lumen subclavian central venous catheter, by which he had received hemodialysis treatment.

<p>| Event ID: F7QU11 | Facility ID: 810041 | If continuation sheet Page 202 of 268 |</p>
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<td>Observation revealed the Registered Nurse created a clean field which she stored syringes with normal saline for flushing of the Patient's central venous catheter and swabs. The Registered Nurse donned a pair of clean gloves, picked up the garbage bin with her gloved hands then touched the clean field with her contaminated hand used to remove the garbage bin. The Registered Nurse did not wash/sanitize her contaminated hands after touching the contaminated garbage bin. Subsequent observation revealed the nurse was observed wearing a face shield with a mask attached. During rinse back of the Patient's blood and termination of the limbs of the central venous catheter from the external blood line revealed, the mask was observed under Registered Nurse #49's nostrils which created the potential for harmful pathogen from the nurses' nostrils contaminating the Patient's central venous catheter. On 08/12/2019, at 12:18 p.m., the surveyor notified Registered Nurse#49 of her observation of break in infection control technique while discontinuing the patient's hemodialysis treatment. Registered Nurse #49 stated &quot;ok.&quot; Patient #36 On 08/14/2019, at 9:15 a.m., Registered Nurse #118 was observed in the hemodialysis unit in room 1979. The Registered Nurse was initiating hemodialysis treatment on Patient #36. The Patient had a left arm vascular access via which</td>
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he receives hemodialysis treatment.

Observation revealed Registered Nurse (118) donned a pair of clean gloves, removed the soiled dressing from the patient's vascular access site, assessed the patient by checking the patient's blood pressure and feet, reset the cardiac monitor attached to the patient, picked up a face shield from the computer station and applied it to his face. After completing the various tasks, the Registered nurse cleaned the Patient's vascular access site and inserted the hemodialysis needles with his contaminated gloved hands.

Subsequent observation revealed the Registered Nurse washed his hands and applied a pair of clean gloves. He then flushed the patient's lines and attached the external blood lines to the needles he had inserted. After attaching the blood lines, Registered Nurse #118 applied alcohol jell to the contaminated gloves he was wearing then picked up the patient's prescription sheet from the computer station.

During an interview on 08/14/2019, at 9:45 a.m., in the presence of the Facility's Hemodialysis Nurse Manager and Registered Nurse #118, the surveyors notified Registered Nurse #118 that he had used the same gloves to examine the patient and touched various objects in the room and his face while applying the face shield, then used his contaminated gloved hands to cannulate the patient's vascular access. Registered Nurse #118 stated, "I thought I changed my gloves twice." The Surveyor then informed him that he had applied alcohol jell to the pair of gloves while
A 749 Continued From page 204

being worm by him. Registered Nurse (118) stated, "I was nervous."

Review on 08/14/2019 of Patient # 36’s Clinical record revealed a laboratory result dated 08/12/2019 which indicated the patient was positive for (Escherichia coli).

Review of the facility's contracted service current Policy and Procedure on Treatment Initiation Utilizing Dialysis Catheter:

Policy # A-TI-0090 directs staff as follows: "To avoid possible catheter contamination or undue injury to patient, the key is to properly access and de-access the dialysis catheter using aseptic technique."

Review of the facility's current policy and procedure on Hand Hygiene Published 3/22/2019 version #35 directs staff as follows:

"Standard precautions include: "Hand Hygiene -Perform hand hygiene:

(a) After touching blood, body fluids, secretions, excretions and contaminated items - weather or not gloves are worn.

(B) After removing gloves

(c) Between patient contacts

(d) Any time to avoid transfer of microorganisms to other patients or the environment.

(e) Between tasks and procedures on the same
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<th>A 749</th>
<th>Continued From page 205 patient to prevent cross contamination of different body sites.</th>
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<td>(5) Change gloves between tasks and procedures on the same patient after contact with material that may contain a high concentration of microorganisms.</td>
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<td>Based on observation, interview, and record review, the facility failed to ensure adherence to its policy regarding appropriate use of personal protective equipment (PPE) and hand hygiene.</td>
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<td>Two (2) of six (6) nurses observed providing direct patient care failed to change gloves and sanitize their hands per policy (registered nurse [RN] #98 &amp; #65).</td>
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<td>Findings:</td>
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<td>Review of facility policy titled &quot;Hand Hygiene Policy&quot;, dated 3/22/19,&quot; showed that when hand washing was not indicated, antiseptic hand rub could be used. Indications for antiseptic hand rub included: before donning and after removing sterile or non-sterile gloves; before handling medication; and after coming in contact with inanimate surfaces in the patient environment.</td>
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<td>RN #98</td>
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<td>Observation on 08/14/19, at 10:30 AM, showed RN #98 prepared to change the intravenous tubing (IV), change the IV &quot;manifold,&quot; and administer IV medications to Patient #215.</td>
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<td>RN #98 gathered the medication and equipment,</td>
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A 749 Continued From page 206

washed her hands, and donned appropriate PPE. She stated, she was going to administer IV Thorazine 50 milligrams (mg) in a 50 milliliter (ml) fluid "piggyback." She said, she was also going to give the patient some Robinul IV push.

During the changing of the IV tubing, RN # 98 dropped something on the floor and picked it up with her gloved hand, which touched the floor. While wearing the same contaminated glove, she returned to connecting the IV medication and programmed the IV pump.

After RN #98 finished hanging the IV Thorazine, she again dropped something on the floor and picked it up wearing the same gloves. She failed to change her gloves and sanitize her hands.

While wearing the same contaminated glove, RN # 98 administered Robinul IV push to a peripheral IV line in Patient # 215's lower left forearm.

During an interview immediately following the medication administration, RN # 98 stated that she should have changed her gloves and sanitized her hands both times she touched the glove to the floor. She verified it was an infection control issue.

RN # 265:

Observation on 08/15/19, at 10:10 A.M., showed RN # 265 prepared to change Patient # 227's dressing covering her peripherally inserted central
A 749 Continued From page 207 catheter (PICC). In addition, the RN was administering medication to this patient.

RN # 265 gathered the needed supplies, disinfected the overbed table, washed her hands, and donned appropriate PPE. She sanitized her hands after removing the old dressing to the PICC site and donned sterile gloves.

Following the PICC dressing change, RN # 265 removed her sterile gloves but failed to sanitize her hands between glove changes. She proceeded to administer Patient # 227’s medication.

Based on review of personnel files and interview, the facility failed to know the Hepatitis B antibody status or administer the immunization for non-immune staff for 5 (#267, #272, #288, #289, and #291) of 10 surgical staff health records reviewed. Also, the facility failed to follow the CDC guideline and the facility policy on Hepatitis B monitoring and follow-up guidance.

A review of Staff #267’s health record revealed Hepatitis B titer was not drawn. The declination was signed by Staff #267 and marked, “I do not need the Hepatitis B vaccination series; because already had it.” There was no evidence the staff member had taken the Hepatitis B series. The facility failed to offer the Hepatitis B vaccine series or draw a titer.

A review of Staff #272’s health record revealed Hepatitis B titer was not drawn. The declination
### Statement of Deficiencies and Plan of Correction

**Provider/Supplier/CLIA Identification Number:** 450076  
**Name of Provider or Supplier:** University of Texas M D Anderson Cancer Center, The 
**Street Address, City, State, Zip Code:** 1515 Holcombe Blvd, Houston, TX 77030

<table>
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<th>ID Prefix</th>
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<td>Continued From page 208 was signed by Staff #272 and marked, &quot;I do not wish to receive the Hepatitis B vaccine at this time.&quot; There was no evidence the staff member had taken the Hepatitis b series. The facility failed to offer the Hepatitis B vaccine series or draw a titer.</td>
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A review of Staff #288's health record revealed Hepatitis B titer was not drawn. The declination was signed by Staff #267 and marked, "I do not need the Hepatitis B vaccination series; because already took it." There was no evidence the staff member had taken the Hepatitis b series. The facility failed to offer the Hepatitis B vaccine series or draw a titer.

A review of Staff #289's health record revealed Hepatitis B titer was not drawn. The form titled, "Employee Health Record" had no form filled out for the Consent/Refusal for Hepatitis B vaccination. There was no evidence the staff member had taken the Hepatitis b series. The facility failed to offer the Hepatitis B vaccine series or draw a titer.

A review of Staff #291's health record revealed Hepatitis B titer was not drawn. The form titled, "Employee Health Record" had the documentation that the Hepatitis B 1st dose was given 3/8/2010 and the second dose was given 5/3/2012. The documentation showed the series was not given correctly according to the CDC guideline. There was no form filled out for the Consent/Refusal for Hepatitis B vaccination. There was no evidence the staff member had taken the Hepatitis b series. The facility failed to
A 749 Continued From page 209

offer the Hepatitis B vaccine series or draw a titer.

A review of the CDC guideline for Hepatitis B vaccine revealed the following:

"Hepatitis B vaccine is recommended for unvaccinated adults who are at risk for hepatitis B virus infection, including:

Health care and public safety workers at risk for exposure to blood or body fluids

Residents and staff of facilities for developmentally disabled persons

Anyone who wants to be protected from hepatitis B

Hepatitis B vaccine is made from parts of the hepatitis B virus. It cannot cause hepatitis B infection. The vaccine is usually given as 2, 3, or 4 shots over 1 to 6 months.

Not at risk, but want protection from hepatitis B (identification of risk factor not required): 2- or 3-dose series Hep B (2-dose series Hepatitis-B at least 4 weeks apart [2-dose series Hep B only applies when 2 doses of Hepatitis-B are used at least 4 weeks apart] or 3-dose series Engerix-B or Recombivax HB at 0, 1, 6 months [minimum intervals: 4 weeks between doses 1 and 2, 8 weeks between doses 2 and 3, 16 weeks between doses 1 and 3]) or 3-dose series HepA-HepB (Twinrix at 0, 1, 6 months [minimum intervals: 4 weeks between doses 1 and 2, 5 months between doses 2 and 3])."
### Statement of Deficiencies and Plan of Correction

**A. Building** [X1] Provider/Supplier/CLIA Identification Number: 450076

**B. Wing**

**Department of Health and Human Services**
**Centers for Medicare & Medicaid Services**

**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**Printed:** 10/09/2019

**Multiple Construction**

<table>
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<tr>
<th>ID</th>
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<th>Summary Statement of Deficiencies (Each Deficiency Must Be Preceded by Full Regulatory or LSC Identifying Information)</th>
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<th>Provider's Plan of Correction (Each Corrective Action Should Be Cross-Referenced to the Appropriate Deficiency)</th>
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<tr>
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<td>Continued From page 210</td>
<td>A 749</td>
<td>A review of the facility policy titled, &quot;HIV/HBV policy revealed the following: &quot;All HCW's (Healthcare Worker) providing direct patient care should have a complete series of hepatitis B vaccine prior to the start of direct care or should complete the series as readily as possible.&quot;</td>
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<td>An interview with Staff # 371 on 08/22/2019, at 9:00 AM, confirmed that Staff #267, #272, #288, #289, and #291 had not their Hepatitis B titer. Also, that the CDC guidelines for Hepatitis B and facility policy had not been followed.</td>
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<td>On 08/12/2019, at 10:30 am, an observation was made of Housekeeping #98. The housekeeper was observed as she came out of room G2272 (Patient #51). The patient's door had a sign indicating that the patient was in contact isolation. The housekeeper was observed as she took the sweeper out of the room and placed it in the isolation cart without disinfecting the pole.</td>
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<td>On 08/12/2019 at 10:40 am, Housekeeper #98 was interviewed. She stated that she attended training on how to clean isolation rooms.</td>
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**Name of Provider or Supplier:**

**UNIVERSITY OF TEXAS M D ANDERSON CANCER CENTER, THE**

**Street Address, City, State, Zip Code:**

1515 Holcombe Blvd
HOUSTON, TX 77030

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Event ID: F7QU11
Facility ID: 810041
If continuation sheet Page 211 of 268
**Statement of Deficiencies and Plan of Correction**

<table>
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3. Medical waste management for building service: 07/06/2015 and 10/05/2016

4. Personal Protective Equipment Training: 02/01/2017, 12/05/2017, 08/07/2019

5. Hand Hygiene and Personal Protective Equipment: 08/06/2019 and 08/16/2019

Surveyor: Doris Raymond

On 08/12/2019, at 11:30 am, an observation was made of Housekeeper #99. Room G1863 (Patient #6) had a sign on the door indicating that the patient was on contact/respiratory isolation. The Housekeeper was observed leaving the patient's room with her gloves on. She placed the sweep in the housekeeping cart without decontaminating the pole and in the process, contaminated the housekeeping card.

On 08/12/2019, at 11:45 am, an interview was conducted with Housekeeper #99. The Housekeeper stated she did not decontaminate the sweeper pole and forgot to do so.

Record review of the Housekeeper #99 Training indicated she completed:

1. Personal Protective Equipment Training: 11/22/2016, 03/15/2018 and 10/19/2018

2. Hazardous Communication and Blood borne Pathogens: 07/27/2017, 04/26/2018 and 10/18/2018
On 08/13/2019, at 11:10 am, an observation was made of a Housekeeper as she entered and departed an isolation room. Room G1244 (Patient #61) had a sign on the door indicating that the patient was on Contact Isolation. The Housekeeper #100 was observed as she came out of the room wearing her PPE. She went to her housekeeping cart and grabbed a plastic bucket containing pre-sanitized wet wipes. The housekeeper then went back into the patient's room. She came out of the room carrying a sweeper. She placed the sweeper in the housekeeping cart without sanitizing the pole. The housekeeper then went back into the patient's room carrying a toilet bucket and toilet brush. She then came back out and placed the toilet bucket and brush into the housekeeping cart without sanitizing the bucket or the brush.

On 08/13/2019, at 11:20 am, an interview was conducted with the Housekeeper. The housekeeper stated that she is new to the position. She indicated that she learned about isolation precautions in computer training.

On 08/20/2019, at 11:00 am, an interview was conducted with the hospital Environmental Service Manager (#376) and the Associate Vice President of Patient Care and Prevention Facilities (#377). During the interview, they stated that the Housekeeping Department has team leaders that are responsible for 3 to 5 floors. Those team leaders are responsible for providing assistance to the housekeepers for anything they may need. They are required to be
A 749 Continued From page 213

in the units 5 hours a day. The Managers indicated that the training in place for the new housekeepers is conducted on the computer where they learn about personal protective equipment and blood-pathogen. They confirmed that the computer program does not have a post test to evaluate how much the new employee housekeeper captures during the training. During the second week of the training, they receive instruction on uniform policy, time cards, and time schedules. During the third week, the new housekeeper works with the team leader and then they work on their own. The Managers stated that the PPE return training is performed when the new housekeeper goes to the floors with their team leader. The Environmental Service/Housekeeping does not have a skill laboratory to train and observe return demonstrations while they are observed by management.

On 08/15/2019, at 11:50 am, an observation was made of a Patient Care Assistant (#323) as she exited room G963 (Patient #145). The Patient's door had a sign indicating the patient is on Contact Isolation. Patient Care Assistant (#323) was observed as she came out of the room with gloves and face mask on while carrying a large bag with contaminated/soiled linen. The bag was in contact with her uniform and the floor. As the Patient Care Assistant came out of the room, she contaminated the door handle. It was observed that the Technician also touched her face with the contaminated gloves.

On 08/15/2019, at 12:00 PM, Assistant #323 was interviewed. She stated, she was distracted and
A 749 Continued From page 214

forgot to take her gloves and mask off before leaving the room. The Patient Care Assistant stated that the dirty laundry bag was too heavy to lift, stating "I dragged it". When asked if she knew what she had contaminated, the Assistant responded, "The floor, my face, and my uniform". The Patient Care Assistant did not recognize that she had also contaminated the patient's room door handle.

The review of MD Anderson Policy # CLN0436/Infection Control for Patient Care Areas Policy: 4.6 D. All linen should be "rolled or folded" to avoid unnecessary motion which may cause a dispersal of bacteria into the air. Dirty linen should be bagged at the site of generation and in a manner that minimizes agitation and prevents contamination of the environment and staff.

On 08/15/2019, at 12:05 PM, an interview was conducted with a Clinical Nurse Lead #291. The Clinical Nurse Lead stated that the Patient Care Assistants are well trained in isolation procedures and that they are Certified Nurses Aide.

Review of the MD Anderson Policy # CLN0436 revealed,

4.10 Disposable Equipment Supplies and/or PPE (personal Protective Equipment)

A. Disposable equipment, supplies and/or PPE not meeting the biohazardous definition should be discarded in a general trash container inside the patient's room/area. This includes disposable materials from isolation cases.
**A. BUILDING ________________________**

**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

450076

(X2) MULTIPLE CONSTRUCTION

A. BUILDING ________________________

B. WING _____________________________

(X3) DATE SURVEY COMPLETED

08/23/2019

(X4) ID PREFIX TAG

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On 08/16/2019, at 10:00 am, the MD Anderson Infection Control Director confirmed that the Protective Personal Equipment (PPE) observation made during the week of 08/12/2019-08/16/2019 were not as her expectations. The Director stated that she took notes on the areas and the staff that needed to be retrain on isolation precautions and PPE.

Based on observation and interviews, the facility failed to maintain a sanitary environment in 2 (Pain Management Clinic at 1515 Holcombe Blvd and the MOHS and Dermasurgery Center located at 6655 Travis Street) of 2 locations observed.

**Findings:**

**PAIN MANAGEMENT CLINIC**

An observation tour was conducted on 8/15/2019 and again on 8/19/2019, after 10:00 AM, in the Pain Management Outpatient Clinic at 1515 Holcombe Blvd. on the 4th floor with Staff #188, #204, and #262.

Clean Utility Room

Observed in the Clean Utility Room, R4.1039, on 8/15/2019, a portable ultrasound that was soiled with dust and dirt. Inside this room were patient supplies stored on metal shelves. On the metal shelves were yellow plastic bins storing patient supplies that were sterile and single use items. Multiple bins were noted to have dirt and debris on the inside. Sterile supplies were stored next to unsterile supplies on the same shelf. The
## Statement of Deficiencies and Plan of Correction

**University of Texas M D Anderson Cancer Center, The**

**Street Address, City, State, Zip Code:** 1515 Holcombe Blvd

**Date Survey Completed:** 08/23/2019

### Summary Statement of Deficiencies

Each deficiency must be preceded by full regulatory or LSC identifying information.

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### Exam Room 3

Observed on 8/15/2019, in Exam Room 3, on the patient exam table was a torn mattress exposing the surface under the vinyl covering. The exposed material could not be properly sanitized to prevent transmission of infectious diseases.

On the wall, located across from the exam table, there was missing paint noted and sheetrock exposed. The porous surface cannot be properly sanitized to prevent cross contamination of infectious diseases.

Staff #204 and 188 confirmed the findings.

### Procedure Room

Observed in the Procedure Room on 8/19/2019, there were sterile and non-sterile supplies being stored in the same locked cabinet. Unsterile equipment was found stacked on top of sterile instruments that were being used for minor procedures. The temperature and humidity were not being monitored in this area.

Staff #188 confirmed the above findings.

An interview was conducted on 8/15/2019, after 10:00 AM, with Staff #204. Staff #204 was asked if the portable ultrasound equipment was clean. Staff #204 stated, it is supposed to be cleaned before it is placed in this room. Staff #204 was asked how she identified clean or dirty equipment. Staff #204 stated, "there is no specific process in place to identify clean equipment."
An interview was conducted with Staff #188 on 8/15/2019, at 10:40 AM. Staff #188 was asked if storage of sterile supplies, sterile instruments, and non-sterile supplies on the same shelf was the usual practice for this clinic. Staff #188 stated, "yes, this is our supply room for all supplies." Staff #188 was asked if the temperature and humidity were monitored, Staff #188 stated, "no it was not monitored, and he was not aware it needed to be for general supplies." Staff #188 was asked if the temperature and humidity were monitored in the Procedure Room where sterile pain procedures were being performed, and sterile supplies and instruments were stored. Staff #188 stated, "no, it is not monitored in here."

A review of ANSI/AAMI ST79:2017 revealed the following:

"11.1 Sterile Storage
Sterile items should be stored under environmentally controlled condition that reduces the potential for contamination ..."

A review of the AORN Perioperative Standards and Recommended Practices,

"Temperature should be maintained between 68 degrees F to 75 degrees Fahrenheit (20 degrees to 23 C) within the operating room suite. General work areas in sterile processing should be maintained between 68 degrees to 73 degrees F.

Relative humidity should be maintained between 20% and 60% within the perioperative suite,
including operating rooms, recovery area, cardiac catheterization rooms, endoscopy rooms, instrument processing areas, and sterilizing areas and should be maintained below 60% in sterile storage areas.

Low humidity increases the risk of electro static charges, which pose a fire hazard in an oxygen-enriched environment or when flammable agents are in use and increases the potential for dust. High humidity increases the risk of microbial growth in areas where sterile supplies are stored, or procedures are performed.

Humidity should be monitored and recorded daily using a log format or documentation provided by the HVAC (heating, ventilation, and air conditioning) system.

Temperature should be monitored and recorded daily using a log format or documentation provided by the HVAC (heating, ventilation, and air conditioning) system.

MOHS AND DERMASURGERY CENTER

An observation tour was conducted on 8/21/2019, at 9:40 AM, with Staff #379 and #324. The following was observed. The door to Patient Room 4 was open and accessible to all staff and patients. The room was unoccupied by staff or a patient. Inside the room was a mayo tray (a removable instrument tray set on a movable stand) that was set up with sterile instruments and medications.

An interview was conducted with Staff #324 on...
### Statement of Deficiencies and Plan of Correction

**Name of Provider or Supplier:**

**University of Texas M D Anderson Cancer Center, the**

**Street Address, City, State, Zip Code:**

1515 Holcombe Blvd
Houston, TX 77030

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<td>Continued From page 219 8/21/2019, after 9:40 AM. Staff #324 was asked if the items on the mayo tray were sterile and set up to perform a minor procedure on a patient. Staff #324 said, &quot;yes.&quot; Staff #324 was asked how long the mayo tray had been set up and who was monitoring the room to ensure the supplies and instrumentation were not contaminated. Staff #324 stated, &quot;About 10 minutes and no one will come in here and no one monitors the room.&quot; Staff #324 was asked if she could ensure the sterile field or medications on the sterile field were not compromised in anyway. Staff #324 said, &quot;I can't guarantee that.&quot; An interview was then conducted with Staff #379. Staff #379 was asked if she could ensure the sterile field and the medications were not compromised to ensure patients safety since the room was left unattended and the door was open. Staff #379 stated, &quot;no, I cannot.&quot; Staff #324 and #379 confirmed the above findings. The patient room was left unattended and no one to monitor the sterile field and/or the medications to ensure they were not compromised for patients safety for greater than 15 minutes. Based on observation, review of documentation, and interview, it was determined that the hospital failed to ensure that the physical environment was monitored, and that worn patient care equipment was promptly replaced.</td>
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NAME OF PROVIDER OR SUPPLIER
UNIVERSITY OF TEXAS M D ANDERSON CANCER CENTER,THE

A 749

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The physical environment was not monitored and worn patient care equipment was not promptly replaced.

1.) On the afternoon of 8/14/2019, the instrument processing room for scopes located in the head and neck clinic on the 10th floor in the Lemaistre building revealed that there was a leaking pipe under the enclosed sink area. This processing room was where high-level disinfection was performed and a leaking pipe in this enclosed undersink area potentially enhances the possibility of bacterial growth. In an interview with Staff PSC #195 and Staff #185-Clinical Administrative Director, the finding was confirmed.

2.) During a tour of the 8th floor Mays building on the morning of 8/14/2019, it was observed in chemotherapy room 53 (ACB 8.1422) that the blue vinyl covering of the patient mattress had multiple (approximately 35) small cracks and splits in the covering. In room 50 (ACB 8.1537) the blue vinyl covering of the patient mattress had multiple (approximately 100) small cracks and splits in the covering. In room 8, there were multiple cracks and splits on the mattress (approximately 10). In room treatment room 6, there were multiple cracks and splits on the vinyl on the mattress. Inside Procedure room 6, the procedure table had a one inch tear in the vinyl. Inside the Anxioysis room there was what appeared to be tape residue on the mattress. In an interview with Staff #129-Admin Director Ambulatory Infusion on the morning of 8/14/2019 it was confirmed that the above referenced mattresses were cracked and one was dirty. Also
### Summary Statement of Deficiencies

**Findings:**

During a tour of the first floor pharmacy, the following was observed:

- Dark brown bottles were observed on the floor, out of the bin for repackaging without the tops. This can cause dirt, dust, debris to contaminate the medication during repackaging.

- Pharmacy printer sitting on a rolling wooden pallet. The pallet was visibly dirty. Unsealed wood was porous and cannot be adequately cleaned.

- Scale for weighing medications was visibly soiled in repackaging area.

- Mixer for blending medication ingredients was rusted and finish was wearing. Rusted surfaces cannot be adequately sanitized.

- Scale for weighting medication was visibly soiled in repackaging area.

- IV storage room off of main pharmacy:

  - Base boards were missing, leaving gaps for rodents and insects to enter the storage room.
  - Gap traps moisture from floor cleaning, along...
### Statement of Deficiencies and Plan of Correction

#### UNIVERSITY OF TEXAS M D ANDERSON CANCER CENTER, THE

**Name of Provider or Supplier:**

**Street Address, City, State, Zip Code:**

1515 HOLCOMBE BLVD
HOUSTON, TX 77030

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**Summary Statement of Deficiencies**

**ID** | **Prefix** | **Tag** | **Description**
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A 749 | | | Continued From page 222

- with dirt and debris, providing environment for growth of bacteria, mold, mildew and fungus.
- Broken pieces of wooden pallets, dirt and debris was observed on the floor in the IV storage room.
- Cardboard boxes of sterile IV fluids were sitting on the concrete floor. Cardboard can absorb moisture and grow bacteria, mold and mildew.
- IV fluids out of the packing boxes were observed on the dirty floor.
- Trash was observed on the floor and a white paper bag with supplies of unknown origin and quality.
- Paper sacks of IV fluids of unknown origin were observed. Per staff fluids were being returned from floor to room without being inspected to ensure they could be safely restocked.
- IV tubing was observed in paper sacks sitting on concrete floor. Boxes of sterile IV fluid was sitting on concrete floor.

- During a tour of the first floor inpatient pharmacy the following was observed:
  - Chemical cleaning agents stored in a manner the created the potential for boxes of sterile IV fluids to become contaminated should chemicals leak.
  - 0.45% Sodium Chloride IV solution stored on shelf underneath chemical cleaning agents.
  - Chemical cleaning cloths (Super Sani Cloths) were stored between boxes of sterile IV fluid. This
### SUMMARY STATEMENT OF DEFICIENCIES

*Each deficiency must be preceded by full regulatory or LSC identifying information*

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| A 749 | Continued From page 223 | created a situation where boxes of sterile fluids could become contaminated with chemicals should they leak from the cleaning wipe boxes.  

During a tour of the first floor Inpatient Pharmacy and Inventory Storage Room, the following was observed:

Computer workstation in inventory control area with torn surface, exposing unsealed fiberboard. Fiber board is porous and cannot be adequately sanitized.

During a tour of the emergency center the following was observed:

The bottom medication bins in the medication dispenser were visibly soiled with dust and dirt. Bottom shelf of medication refrigerator and shelves in the refrigerator doors were visibly soiled with dirt and dried spills. This creates situation for medications to become contaminated.

During a tour of PG 4 Medication Dispenser in the medication room, the following was observed:

Bottom shelf and shelves in the door of the medication refrigerator were visibly soiled with dirt and dried spills. Rust was observed on the refrigerator shelves. You cannot clean rust. The rubber sealant at the bottom of the refrigerator was torn, pieces were missing. This creates a situation for the temperature to be in-correct causing medications not to be effective.
## Statement of Deficiencies and Plan of Correction

### Name of Provider or Supplier
UNIVERSITY OF TEXAS M D ANDERSON CANCER CENTER, THE

### Street Address, City, State, Zip Code
1515 HOLCOMBE BLVD
HOUSTON, TX 77030

### ID, Prefix, Tag

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### Summary Statement of Deficiencies

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The findings were confirmed by staff # 52, 51, 140, and 139 during the tour.

Based on observation, interview, and document review, the facility failed to develop a system for monitoring potential infectious risk for one (physical therapy) inpatient service within the main campus and 5 (League City, West Houston, Sugar Land, Mohs/Dermasurgery, and Diagnostic imaging) of 11 (Woodlands, Memorial City, The Center for advanced Biomedical Imaging, Radiology Outpatient Center, Proton Therapy Center), patient services provided off the main campus.

Findings:

On 8/12/2019, during a tour of the inpatient physical therapy department the following observations were made.

Inpatient service hospital based:

Physical Therapy (PT)

In a patient treatment bay, two (2), foam filled vinyl covered positioning pillows were observed resting on the floor near the bed. The staff member, providing the department tour, picked both pillows up from the floor and placed them on a patient ready bed without sanitizing them.

Also, during the PT department tour, the clean supply room was observed with both clean and dirty supplies and equipment stored in the room. The PT Director staff #16 explained that everything stored, supplies as well as equipment...
A 749 Continued From page 225

was clean. When asked what was the process for insuring patient use equipment was sanitized prior to returning to the clean storage room, she replied, "they wipe it down after use". When further questioned as to how was that insured she replied, "I trust them to wipe it down". A cast saw, used to removed plaster or fiberglass casts, was observed on a stainless steel cart, stored in the clean store room. The saw blade had visible white debris particles on it and the tray the saw rested in had measurable cast saw dust in the tray. When staff #16 was asked if the saw and cart were clean, she replied, "no".

Out patient services off campus:

League City
On 8/13/2019, in the afternoon a tour of the facility revealed clean storage rooms housed both patient use equipment as well as single use patient supplies. No staff member could provide the process for insuring clean equipment was sanitized prior to return to the clean storage room. Rolling standards, Blood Pressure devices, cuffs, and monitors were all found in clean storage rooms.

The above findings were confirmed by Staff #286

High level disinfection and sterilization was required after surgical instruments were used. The instruments were transported to and from League City and the main campus via a vehicle also used to transport soiled linen, potentially making the sterile instruments contaminated upon arrival.
A 749 Continued From page 226

West Houston

In a patient treatment room a drawer was pulled open to reveal, 8 of 11 peel packs of sterile surgical instruments were found to have been packed and sterilized with the hinged instruments in a closed position. Each peel pack had a paper form visible intended to hold the instruments in an open position, of the 11 peel packs but only 3 were packaged properly with the paper form in use, holding the instruments open for sterilization. The 8 peel packs were removed by staff for re-sterilization. The temperature in the room was monitored but the humidity was not.

A clean storage room was observed with 2 pair of clean crutches resting on the floor and 4 rolling walkers resting on the floor. Supplies or immobile equipment on the floor makes cleaning the floors difficult to avoid contamination with clean equipment.

The above findings were confirmed by staff #286.

Mohs/Dermasurgery

A sterile storage room for sterile procedural supplies was observed with a stainless steel cart in the room. A sign on the outside of the cart indicated the cart was used to transport sterile instrument from the main campus back to the center after sterilization. The stainless steel cart was considered contaminated since the cart was transported in a non sterile cargo vehicle and rolled though sidewalks and facility corridors on its way to the sterile supply room. The temperature of the room was monitored but the humidity was not.
Continued From page 227

Also observed in the sterile supply room was a liquid sanitizer stored on a wire shelf above paper goods and sterile instruments in sterile paper wraps.

A clean store room was observed with patient equipment on the floor and on shelving. There was no indication that the equipment had been sanitized after patient use and prior to return to the clean store room. The store room also held a large bag of Holiday decorations and paper goods. A stainless steel table was stored in the room with an empty caddy for an "E" cylinder sized Oxygen tank. Staff could not explain any process other than "They wipe the equipment down with Sani wipes prior to storage".

A long call light cord was observed hanging on the floor. The staff was observe picking it up the end which was on the floor and clipping it to the top of the cord without sanitizing the cord or push button.

Diagnostic Imaging

A clean supply room was observed with sterilized instruments, cystoscopes, and sterile biopsy needles stored in the same room with clean and non-clean supplies including squeeze balls for patient use and a can of spray sanitizer. The temperature in the room was monitored but the humidity was not.

A wheel chair was observed stored in the clean linen closet along with a blue linen collection bin. No staff was sure the wheel chair had been cleaned after patient use.

The above findings were confirmed by staff #286.
Sugar Land
High level disinfection and sterilization was required after surgical instruments were used. The instruments were transported to and from Sugar Land and the main campus via a vehicle also used to transport soiled linen, potentially making the sterile instruments contaminated upon arrival.

The storage room for the sterile instruments was monitored for temperature but was not monitored for humidity.

On 8/19/2019 staff #1 and Staff #261 confirmed the facility did not monitor humidity in rooms which held sterile equipment or supplies in the outpatient setting. The facility representatives confirmed they follow the ASHRAE standards. A document was provided for review explaining the outpatient facility's followed the guidelines for ASHRAE (American Society of Heating, Refrigeration, and Air-Conditioning Engineers) specifying building automation systems. ASHRAE addendum "h" to 170-2013 recommends a temperature range of 72-78, maximum humidity 60% for sterile storage rooms.

If sterile instruments are stored in a room, the room is considered sterile.

The hospital Infection Control Plan included AAMI (Association for the Advancement of Medical Instrumentation) as a national standard, the hospital followed to ensure sterility of surgical instruments. AAMI recommends a temperature range of 64-75 and a humidity range of 35-75%.
The hospital had no process to monitor and record humidity in the outpatient settings. They neither monitored and followed ASHRAE or AAMI. Based on observation, interview, and record review, the facility failed to ensure maintenance of a sanitary physical environment. This failure resulted in:

- a) 1 of 1 storage rooms had a mop bucket and mops stored in it. There was no floor sink.
- b) 1 of 1 cabinets had supplies stored under the sink.
- c) 1 of 1 plastic bags of respiratory supplies was hung from the wall. The biohazard container was positioned such that the bag rested atop the container.
- d) 1 of 1 storage rooms had corrugated boxes stored on the floor.
- e) 1 of 1 sump rooms was very dirty. This had the potential of being tracked by staff into the Radiation Treatment Center.
- f) 2 of 2 ceiling tiles were either missing or cocked to one side.

a) Storage Room. Observation on 8/21/2019, at 10:00 AM, of a room designated as Storage GB.3789 in the basement of the Radiation Treatment Center showed two (2) mop buckets, three (3) mops (one was on the floor), a buffer, and buffing supplies. There was no floor sink in the room.
In an interview with Staff 48 (Environmental Health & Safety) on 8/21/2019, at 10:00 AM, he stated that he did not know why the housekeeping equipment and supplies were in this room.

b) Storage Under Sink.
Observation on 8/21/2019, at 10:15 AM, of the Vitals Area GB.3676 in the Radiation Treatment Center showed two (20 rolls of toilet tissue in the cabinet under the sink.

In an interview with Staff 48 (Environmental Health & Safety) on 8/21/2019, at 10:15 AM, he stated supplies should not be stored in cabinets under sinks.

c) Respiratory Supplies.
Observation on 8/21/2019, at 10:15 AM, of Exam Room GB.3618 in the Radiation Treatment Center showed a biohazard container in the far right corner of the room. The container was positioned in such a way that it was difficult maneuver around the exam table to get to it. There were two (2) plastic bags of respiratory supplies. The lowest bag was resting on top of the biohazard container.

In an interview with Staff RN #384 on 8/21/2019, at 10:15 AM, he stated that the plastic bags of respiratory supplies should not be touching the biohazard container and the biohazard container needed to be relocated.

d) Corrugated Boxes.
**Summary Statement of Deficiencies**

<table>
<thead>
<tr>
<th>Observation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>a)</strong> ETV Holding Room G7.3534</td>
<td>Observation on 8/21/2019, at 11:00 AM, of the ETV Holding Room G7.3534 showed four (4) corrugated boxes sitting on the floor. The boxes contained oxygen tank holders. In an interview with Staff 43 (Environmental Health &amp; Safety) on 8/21/2019, at 11:00 AM, he stated the corrugated boxes should not be on the floor.</td>
</tr>
<tr>
<td><strong>e)</strong> Sump Room</td>
<td>Observation on 8/21/2019, at 10:00 AM, of Sump Room GB.3786 in the basement of the Radiation Treatment Center showed trash, pieces of metal, hair nets, and muddy water on the floor. A spider was also crawling in one of the corners of the room. In an interview with Staff 48 (Environmental Health &amp; Safety) on 8/21/2019 at 10:15 AM, he stated the sump room had the potential to be an infection control issue.</td>
</tr>
<tr>
<td><strong>f)</strong> Ceiling Tiles</td>
<td>Observation on 8/14/2019, at 11:00 AM, of the Medical Arts Center in The Woodlands showed that a ceiling tile was cocked sideways in a Janitor’s Closet WTC2.10.10, located on the second floor. Observation on 8/21/2019, at 11:30 AM, of a hallway in G7 showed that a ceiling tile just outside room G7.3220C was missing. In an interview with Staff 43 (Environmental Health &amp; Safety) on 8/21/2019, at 11:30 AM, he</td>
</tr>
</tbody>
</table>
### SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
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</thead>
<tbody>
<tr>
<td>A 749</td>
<td>Continued From page 232</td>
<td></td>
</tr>
<tr>
<td>A 940</td>
<td>SURGICAL SERVICES</td>
<td></td>
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</tbody>
</table>

#### A 749
Continued From page 232

stated that the ceiling tiles should be in place, adding that this was an infection control issue.

Record review of Maintenance Infection Control Risk Assessment (not dated or timed) revealed:
"Table C - Description of Infection Control Precautions by Class ... Class II ... 5. Immediately replace ceiling tile(s) displaced for visual inspection."

#### A 940
SURGICAL SERVICES

CFR(s): 482.51

If the hospital provides surgical services, the services must be well organized and provided in accordance with acceptable standards of practice. If outpatient surgical services are offered the services must be consistent in quality with inpatient care in accordance with the complexity of services offered.

This CONDITION is not met as evidenced by:

Based on observation, record review, and interview the facility failed to:

- A. ensure sterile surgical linen packs that contained surgical gowns, drapes, and towels were sterilized according to manufacturer recommendations.
- B. ensure sterile surgical linen packs that contained surgical gowns, drapes, and towels were transported in a manner that would protect the sterile items from moisture, excessive humidity, and condensation caused by temperature extremes.
- C. ensure there was a process in place to monitor the sterilization and transport of sterile linen
A. BUILDING ____________________________

 PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 450076

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 450076

(X2) MULTIPLE CONSTRUCTION
A. BUILDING
B. WING

(X3) DATE SURVEY COMPLETED
08/23/2019

NAME OF PROVIDER OR SUPPLIER
UNIVERSITY OF TEXAS M D ANDERSON CANCER CENTER, THE

STREET ADDRESS, CITY, STATE, ZIP CODE
1515 HOLCOMBE BLVD
HOUSTON, TX  77030

(X4) ID prefix TAG
SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

ID prefix TAG
PROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCES TO THE APPROPRIATE DEFICIENCY)

(X5) COMPLETION DATE

<table>
<thead>
<tr>
<th>A 940</th>
<th>Continued From page 233 packs from an outside contracted vendor to the surgery department.</th>
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<tbody>
<tr>
<td></td>
<td>D. ensure that surgical instruments were transported to an offsite surgery center in a manner that would protect the sterile instruments from moisture, excessive humidity, and condensation caused by temperature extremes.</td>
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<tr>
<td></td>
<td>E. ensure that an instrument loaner set that contained surgical implants (Zimmer/Biomet Plates) was sterilized according to the manufacturer recommendations.</td>
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<td>It was determined that these deficient practices posed an Immediate Jeopardy to patient health and safety and placed all patients having endoscopy procedures and/or surgery in the facility at risk for the likelihood of harm, serious injury, and possibly subsequently death.</td>
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<td></td>
<td>F. ensure that perioperative staff (operating room and Pre/Post anesthesia) had current competencies that were specific to the job they were performing in the facility in 4 (Staff #s 84, 267, 273, and 288) of 10 personnel records reviewed.</td>
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<tr>
<td></td>
<td>G. ensure a sanitary environment for the provision of surgical services in sixteen ( Mays ASC- Pre-Op Supply Room, Anesthesia Supply room, OR3, Interventional Radiology/Cath Lab PACU, Interventional Radiology, Cath Lab, Endoscopy Center, Main OR -Supply Core A&amp;B, OR1, OR16, OR21, OR22, storage room in main OR hallway, Pre-Operative room P503, and Pavilion tower core supply room) of sixteen</td>
</tr>
</tbody>
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FORM CMS-2567(02-99) Previous Versions Obsolete
Event ID: F7QU11
Facility ID: 810041
If continuation sheet Page 234 of 268
A 940 Continued From page 234
areas observed.

Findings:

During a tour on August 15, 2019, at 9:00 a.m.
the following observations were made:

A. STERILIZATION OF LINEN PACKS

In the clean laundry room there were sterile
surgical linen packs stored on a permanent wire
rack lined on the wall and in transport racks. The
transport racks were plastic and wire racks.
Clean/unsterile laundry was stored in the same
room on the opposite side. There was no barrier
to separate the linens. The portable wire racks
that contained the sterile linen was coated in rust,
dust, dirt, and debris on the bottom shelf.

There was a pack identification label on the front
of the sterile packs. Some of the labels did not
have a load number or date of sterilization noted.

On one of the portable wire racks used to
transport the sterile linen packs from the outside
truck to the surgery department, the shrink wrap
was torn and did not cover the cart completely.
The linen was exposed to outside contaminates
(dust, dirt, insects, and microorganisms) when
unloaded from the transport truck.

Staff #277 was asked if the external wraps used
in the sterilization of the surgical linen packs were
impervious. Staff #277 stated, "yes." Staff #277
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<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
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<tr>
<td>A 940</td>
<td>Continued From page 235</td>
<td>was asked to open one of the sterile linen packs for observation. At 9:12 a.m., the outside wrapper was placed in a sink and water was turned on to check the impermeability of the drape. Observation of the drape after approximately 10 seconds of water running revealed water seeped through the drape.</td>
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<td>During a tour of the materials management department on August 15, 2019, at 10:00 a.m., observed sterile linen packs stored on a wire rack. There were several packs noted with a sterilization date of 2014; over 5 years ago.</td>
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<td>During an interview on August 15, 2019, after 2:00 P.M. Staff #10 was asked if the surgical staff were aware of the grid on the inside of the surgical linen packs indicating the number of sterilizations. Staff #10 said, she was aware of the grid and the parameters of sterilization.</td>
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<td>Review of several of the surgical linen pack grids on the outer sterilization wrap revealed that the grids were not dated with the start day of the sterilization cycle. The grids were marked with 0, 2, and 6. There was no clear indication on the grid of the number of sterilizations. Staff #10 was asked to explain the grid marks on linens. Staff #10 stated, &quot;I asked the same questions about 3 years ago during a tour of the offsite laundry. I have not been given a clear answer.&quot;</td>
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</table>
| | | | Review of the manufacturer IFU (Instructions for Use) titled, "Wrap Pel Surgical Wrappers Instruction for use" revealed the following: "Each
Review of the manufacturer IFU (Instructions for Use) titled, "PerVal Surgical Towels Instructions for Use" revealed the following: "OR towels are reusable through 50 wash, dry, and sterilization cycles."

Review of the manufacturer IFU (Instructions for Use) titled, "ComPel Surgical Gowns Instructions for Use revealed the following: "The ComPel Surgical gowns are reusable through 75 wash, dry, and sterilization cycles."

B. TRANSPORT OF STERILE SURGICAL LINEN PACKS

During an interview with Staff #277 on August 15, 2019, at 9:00 a.m., the following infection control issues were revealed:

Staff #277 reported the sterile surgical packs were transported from an offsite facility. Staff #277 stated, "The surgical linen packs are brought into the facility through materials management. The surgical linen packs are picked up in the morning by surgery and transported to the sterile/clean linen room. The portable linen racks have a shrink wrap around them and a cover on top of that."
A 940 Continued From page 237

Observations on August 15, 2019, after 9:00 a.m. in the sterile/clean area showed one of the portable wire racks used to transport the sterile linen packs from the outside truck to the surgery department had shrink wrap that was torn and did not cover the cart completely. The linen was exposed to outside contaminants (dust, dirt, insects, and microorganisms) when unloaded from the transport truck.

During an observation on August 15, 2019 after 12:45 p.m. the following was noted: A truck was parked at the loading dock outside materials management area to unload linen. The truck had clean linen in plastic carts with a plastic covering. There was no sterile linen on the truck.

Staff #143, was asked if the same type of truck was used to transport sterile linen packs for the operating room. Staff #143 stated, "yes." Staff #143 was asked if the truck used to transport sterile linen packs had the same wooden floor as the truck used to transport clean linen. Staff #143 said "yes." Staff #143 was asked if the truck used to transport sterile linen packs for the operating room had any type of environmental controls (temperature and humidity). Staff #143 said "no."

Staff #9 and Staff #10 confirmed the observations of the conditions of the transport truck.

Review of the ANSI/AAMI ST79:2017 Comprehensive guide to steam sterilization and sterility assurance in health care facilities revealed the following:
**A. BUILDING**

**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**STATEMENT OF DEFICIENCIES**

**C. STERILIZATION/TRANSPORT OF STERILE LINEN MONITORING**

During an interview on August 15, 2019, after 12:45 p.m., Staff #10 and Staff #9 were asked what monitoring was in place for the sterile linen contract. Staff #10 and Staff #9 confirmed the facility did not have a process to monitor the sterilization and transport for the sterile linen packs. Staff #10 stated, "I toured the offsite facility 3 years ago and asked several questions about sterilization. I have not been given any answers."

Staff #10 and Staff #9 were asked if they were knowledgeable of the process for transportation of the sterile linen packs from the offsite facility to the surgical department. Staff #10 and Staff #9 confirmed they were not.

**D. TRANSPORT OF STERILE SURGICAL INSTRUMENTS TO OFF SITE FACILITY**

During a tour of the sterile processing department
A 940 Continued From page 239 on August 20, 2019, after 1:00 p.m. the following observations were made:

Staff #27 was asked if the sterile processing department transported any instruments to off-site facilities. Staff #27 stated, "yes, we transport to Mohs Surgery Center". Staff #27 was asked what mode (vehicle) the facility used to transport the sterile instruments. Staff #27 stated, "I don't know. We decontaminate and sterilize the instruments but I do not know how they are transported. Staff #27 was asked who was responsible to monitor that. Staff #27 said that Staff #143 was.

An interview with Staff #143 on August 21, 2019 after 8:30 a.m. revealed the following:

Staff #143 was asked what mode (vehicle) was used to transport sterile instrument sets to the Mohs Surgery Center. Staff #143 stated, they were transported in instrument carts in one of the facility transport trucks. Staff #143 stated, the staff made sure the truck was clean and then proceeded with the transport. Staff #143 was asked if the transport truck was the same type of truck used to transport linen. Staff #143 stated, "yes". Staff #143 was asked if the truck used to transport sterile surgical instrument sets had wood floors. Staff #143 stated, "yes". Staff #143 was asked how the truck was decontaminated after each transport. Staff #143 stated, "we do a visual inspection and sweep the truck out if necessary." Staff #143 was asked if the truck was washed/decontaminated in-between transports. Staff #143 stated, "no we just sweep it if necessary". Staff #143 was asked if the truck used to transport dirty/contaminated instruments
A 940 Continued From page 240

would be the same truck to transport clean/sterile instruments. Staff #143 stated, "quite possibly yes." Staff #143 was asked if the temperature and humidity was monitored during transport of the sterile instruments. Staff #143 stated, "no".

Review of the transportation logs for sterile surgical instruments transported to and from Mohs Surgery Center from main sterile processing department revealed the following:

The sterile processing tracking form titled, "Mohs clinic" revealed 117 dirty/contaminated instrument trays were transported to MD Anderson sterile processing department at the main building from 8-1-2019 to 8-22-2019.

The sterile processing tracking form titled, "Department Mohs" revealed 316 sterile instruments/instrument trays were transported to Mohs Surgery Center from the main sterile processing department from 8-1-2019 to 8-21-2019.

Review of the facility policy titled, "Instrument and Equipment: Cleaning, Disinfection & Sterilization Policy" dated 7/30/2019 revealed the following:

"...J All transport vehicles (manual or motorized) should be constructed of materials that allow for proper decontamination processes ..."

...Appropriate cleaning and disinfection of carts, tables, and transport vehicles should be performed per AAMI recommendations ..."
Review of the ANSI/AAMI ST79:2017 Comprehensive guide to steam sterilization and sterility assurance in health care facilities revealed the following:

"11.3 Transport of sterile packaged items

11.3.1 General considerations
Sterile items should be transported in a manner that will protect the items from puncture and from contamination by moisture, excessive humidity, condensation caused by exposure to temperature extremes, insects, vermin, dust and dirt, excessive air pressures, and microorganisms."

Review of the ANSI/AAMI S179:2017 - Comprehensive guide to steam sterilization and sterility assurance in health care facilities revealed the following:

" ...11.3.5 Off-site transportation

C. The design and materials used in the construction of all transport vehicles (motorized or manual) should allow for appropriate decontamination, especially if the vehicles are to be used alternately for the transport of sterile/clean items and soiled items.

Vehicles used to transport sterile packages between health care facilities should

a) provide for the complete separation of clean and sterile items from contaminated items;

b) have a storage compartment that is completely enclosed; and
A 940 Continued From page 242

c) allow for ease of loading and unloading.

Carts containing sterile packages should be secured within the vehicle to prevent damage or contamination.

NOTE-All external shipping cartons are considered contaminated, even if they contain packaged sterile items. When vehicles are used, environmental conditions should be assessed while the vehicle is in motion and when it is not in motion. In geographical areas where high humidity is the norm, testing should be performed to determine the potential for absorbent items to become contaminated and for the contents of sterile packages to become wet from the condensate that can occur on metal or plastic surfaces. Vehicles that are loaded and ready for transport should not be left unattended in unsecured areas ...

E. STERILIZATION OF SURGICAL IMPLANT SETS

Review of the Pod B Main autoclave log for 5-20-2019 to 8-20-12019 revealed the following:

A sterilization autoclave entry on 6-21-2019 revealed a sterilization load for plates brought in from an outside representative. The plates were sterilized using One tray.

Review of the sterilizer load detail on 6-21-2019 for the sterilization of the above plates for Patient #328 revealed the plates were ran on a short cycle UISS (immediate use sterilization) of 10 minutes exposure time at 270 degrees. There was no dry time indicated on the load detail.
A 940 Continued From page 243

In an interview on 8-22-2019, after 4:00 p.m., Staff #27 was asked if the facility normally ran implant sets on IUSS cycles. Staff #27 stated, "No". Staff #27 was asked why this set was ran on an IUSS short cycle sterilization. Staff #27 stated, "Well it is my understanding the representative was late delivering the set and the patient was on the table".

Review of the manufacturer (Biomet) instruction on sterilization revealed the following:

"Sterilization
Flash (immediate use) sterilization is not recommended.

The hospital is responsible for an in-house procedure for the reassembly, inspection, and packaging of the implants after they are thoroughly cleaned in a manner that will ensure steam sterilant penetration and adequate drying. Provisions for protection of any sharp or potentially dangerous areas of the implants should also be recommended by the hospital.

Steam sterilizer manufacturer recommendations should always be followed ....

Table 3
U.S. Pre-Vacuum - Exposure Time - 4 minutes. Minimum Dry time 30 minutes."

Review of the facility policy titled, "Vendor provided (Loaner) instrumentation and sterile implants dated 1-9-2013 revealed the following:
A 940 Continued From page 244

"...3.0 Delivery/Pick Up of Sterile Implants

Sterile implants should be delivered one business day (24 hours) prior to the scheduled procedure (unless otherwise communicated) to the Nurse in charge located in the OR control room.

Staff #27 confirmed the findings on the sterilization of the implant sets on IUSS sterilization cycle.

F. COMPETENCIES

Review of personnel records on August 22, 2019 after 8:30 a.m. revealed the following:

Staff #84 was working as a surgical scrub technician at the ACB OR. There were competencies documented on 5-8-19 for precleaning procedural Instruments including scopes, probes, and instruments. There were competencies documented on 11-28-2018 for point of use precleaning, specimen management, and malignant hypothermia. There were no competencies documented in the personnel file for job specific competencies of a surgical scrub technician.

Staff #267 was working as a Pre-Operative and Post-Operative nurse at the outpatient endoscopy center in the main building. There was a job description in the personnel file signed on 4-30-2019 by the manager. Staff #267 had not signed/acknowledged it. There were endoscopy competency skills in the folder dated 11-14-2012; almost 7 years ago. There were no current competencies.
A. BUILDING ________________
(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:
  450076

B. WING ________________
(X3) DATE SURVEY COMPLETED
  08/23/2019

NAME OF PROVIDER OR SUPPLIER

UNIVERSITY OF TEXAS M D ANDERSON CANCER CENTER, THE

STREET ADDRESS, CITY, STATE, ZIP CODE
1515 HOLCOMBE BLVD
HOUSTON, TX 77030

(X4) ID PREFIX TAG

SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

(X2) MULTIPLE CONSTRUCTION
A. BUILDING ________________

ID PREFIX TAG

PROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

(X5) COMPLETION DATE

<table>
<thead>
<tr>
<th>ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
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<tbody>
<tr>
<td>A 940</td>
<td>Continued From page 245</td>
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</table>

Staff #273 was working as a RN circulator at the ACB OR. There were competencies documented on 5-8-19 for precleaning procedural instruments including scopes, probes, and instruments. There were competencies documented on 12-5-2018 for point of use precleaning, specimen management, and malignant hypothermia. There were no competencies documented in the personnel file for job specific competencies of a RN circulator.

Staff #288 was working as a surgical scrub technician at the ACB OR. There were competencies documented on 5-10-19 for precleaning procedural instruments including scopes, probes, and instruments. There were competencies documented on 12-6-2018 for point of use precleaning, specimen management, and malignant hyperthermia. There were no competencies documented in the personnel file for job specific competencies of a surgical scrub technician.

Staff #'s 370 & 371 confirmed the above findings in the personnel files.

G. SANITARY ENVIRONMENT

MAYS ASC

During a tour on August 13, 2019, at 9:50 a.m. the following observations were made:

PRE-OP SUPPLY CART
<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>COMPLETION DATE</th>
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<tbody>
<tr>
<td>A 940</td>
<td>Continued From page 246</td>
<td>A 940</td>
<td>There was a wire rack in the room where supplies were stored. Sterile supplies (Foley catheter kits) were stored on the same shelf as non-sterile items (Urinals). There were Sani-cloths (Germicidal cleaning wipes) stored above sterile supplies. There was a bin that stored sterile yankauer suction tips and non-sterile suction tubing in the same bin. There was a rolling plastic cart in the middle of the room that linen was stored on. The linen had a cloth linen covering on in that did not cover all the linen. Sheet and blanket on one of the shelves were hanging out and exposed to dust, dirt, and contaminants.</td>
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<td><strong>ANESTHESIA SUPPLY ROOM</strong></td>
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<td>There was a container sitting on the floor that was full of clean anesthesia circuits used to monitor patients during surgical procedures.</td>
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<td><strong>OPERATING ROOM 3</strong></td>
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<td>Outside of operating room 3 next to the scrub sinks, the linoleum floor had separated from the wall and exposed the sheetrock. There were scrapes and missing chips of paint above the same area.</td>
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<td>During a tour on August 14, 2019 the following observations were made:</td>
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<td></td>
<td><strong>CATH LAB/INTERVENTIONAL RADIOLOGY PACU</strong></td>
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<td><strong>PACU SUPPLY CLOSET</strong></td>
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</table>
A 940 Continued From page 247

There were sterile supplies (Fem Stop kit - Used for compression after removal of arterial sheaths to achieve hemostasis) stored on the same shelf as patient pillows in a plastic bag and operating room bouffant caps and patient socks. There was a package of Styrofoam patient cups stored on same shelf with sterile steri-strips (Skin closure strips used to secure and close small wounds) and Salem Sump nasogastric tube.

**EMERGENCY SUPPLY CART**

Sterile supply packs (Paracentesis and Drapes) were stored in the same drawer with non-sterile items (Fluid collection bottles, masks, and biohazard bags). There was a sterile chest tube insertion kit that expired 3-1-2019; over 5 months ago in a drawer and ready for patient use.

**NURSES DESK**

At the nurse's desk around the sink, the laminate was worn and had a hole towards the back. There was no way to properly sanitize it.

**CATH LAB SUPPLY CLOSET(G3.3445)**

There were sterile/non-sterile supplies stored in a stack of bins that was on the floor. The bins contained syringes, gloves, and gowns. There was a corrugated cardboard box full of surgical tape. There was a cardboard box that had sterile arterial sheaths used in cardiac catheterization procedures stored in it. There were two boxes of sterile right heart kits stored in corrugated boxes.
CATH LAB SUPPLY CLOSET (G3.3473)

The room was in disarray. There were sterile packs that contained sterile bowls on the floor. There was so much equipment stored in the room, it was pushed up against a cart containing sterile supplies. One of the Medtronic carts had sterile Medtronic cables used in cardiac procedures stored in corrugated boxes. The back wall had bins of sterile and non-sterile supplies stored together. There was a corrugated cardboard box that contained a regulatory accessory cable stored in it. There were patient positioner pads stored next to sterile packs. There was a Medtronic pacemaker generator stored in the closet and ready for patient use. The serial number was PKK107398R. There was no Biomed sticker on the generator.

ENDOSCOPY CENTER

PROCEDURE ROOM 7

During a patient tracer on August 16, 2019 the following observations were made:

There was a wedge patient positioner that had tears in the vinyl. There was a corner behind the door that was in disarray. There was a Patient warmer (Bair Hugger) on the floor. There was a portable ultrasound machine and a mobile computer station that was covered in dust. There was a vinyl pad stored behind them on the floor. The pad was covered in dust.
## Statement of Deficiencies and Plan of Correction

**A. Building**  
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**ID**  
**PREFIX**  
**TAG**  
**SUMMARY STATEMENT OF DEFICIENCIES**  
(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

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**PROVIDER'S PLAN OF CORRECTION**  
(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

### A 940

Continued From page 249

**PROCEDURE ROOM 6**

The room had two trash cans full of trash from previous patients and a linen hamper with dirty linen in it. Staff #269 was asked if the room had been cleaned. Staff #269 confirmed it had been cleaned. The wheel coverings on the anesthesia machine were coated in dust, dirt, and debris. The wheel casters on the supply cart were coated in rust. The air conditioning vent had been pushed into the wall and was coated in dust, dirt, and debris. There was a metal cart in the room that contained supplies for Gastrointestinal procedures. The plastic bins inside were coated in dust, dirt, and debris. There was a plastic cup that had irrigation needles in it. Observation of a manufacturer packet revealed the irrigation needles came in a package with a lot number and an expiration date. The irrigation needles were not being stored in the manufacturer package. There were biopsy forceps in a cabinet drawer that were stored in corrugated cardboard boxes. There were sterile Medivator Amplifeye devices stored in a cabinet drawer tightly wrapped with a rubber band. There was endoscopy equipment stored in the same drawer. The was a drawer that had clean linen bags stored on top of sterile endoscopy supplies. In the same drawer, there was sterile irrigation bottles and a container of decontamination wipes. There was a drawer that contained polyp traps used to collect polyps during endoscopy cases stored with office supplies (copy paper, staples, and paper rolls). There was a drawer that had sterile supplies (small bore pressure infusion extension set) stored with tattooing ink and date stamp. There was a cabinet that had an opened container of...
### Statement of Deficiencies and Plan of Correction

**A. Building ________________**

**B. Wing ________________**

**Provider/Supplier/CLIA Identification Number:**

450076

**State of Survey Completed:**

08/23/2019

**University of Texas M D Anderson Cancer Center, The**

**Street Address, City, State, Zip Code:**

1515 Holcombe Blvd
Houston, TX  77030

### Summary Statement of Deficiencies

(Each deficiency must be preceded by full regulatory or LSC identifying information)

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<tbody>
<tr>
<td>A 940</td>
<td>Continued From page 250</td>
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<td>alcohol, tattoo ink, pathology slides, and sterile endoscopy supplies stored on the same shelf.</td>
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</table>

**Main OR**

During a tour on August 19, 2019, after 8:30 a.m. the following observations were made:

**Supply Core A**

The baseboard outside the entry door was separated from the wall exposing sheetrock. There was a build-up of dust, dirt, and debris in the base of plastic bins storing sterile supplies/instruments.

In the equipment room storage, there was a ConMed Bipolar machine (used to control bleeding in surgical procedures) that the BioMed sticker expired 6/2019; over 2 months prior to the survey. The Bipolar machine was stored in an equipment room ready for patient use. There was a build-up of dust, dirt, and debris along the baseboards and corners of the floor in the room.

In the anesthesia storage room Pod A, the cabinet had missing chips and pieces of laminate on the cabinets and drawers. There was no way to properly sanitize them. The walls had peeling paint, scrapes, and chunks of the wall missing that exposed the sheetrock. There was a build-up of dust, dirt, and debris along the baseboards and corners. There were patient supplies (Oxygen nasal cannula) on the floor. There was a tool box stored on the same shelf.
A 940 Continued From page 251

and next to sterile supplies (Bougie endotracheal tube introducer). There was an anesthesia doppler with the battery covered and secured by sponges and tape. There was no way to sanitize the doppler. The doppler was stored and ready for patient use.

There was a locked cabinet that contained anesthesia gases. The base of the cabinet was coated in dust, dirt, and debris. The gases were stored next to white paper bags that were used to carry the gases into the operating room for surgical cases. The white bags were laying on the base of the cabinet that was covered in dust, dirt, and debris. Staff #366 confirmed the findings in the anesthesia storage room.

STERILE CORE B

Outside Operating room 24 on the core side, the plastic bumper guard was cracked and missing pieces of the end cap. There was a tear in the linoleum floor. There was an autoclave labeled, "IUSS Autoclave #1" in the core that had a build-up of rust. Staff #27 was asked when the last time the autoclave was cleaned. Staff #27 stated, "I don't know since it is outside of my area." Staff #9 later confirmed the autoclave had not been cleaned previously that she was aware of. Staff #9 stated, "We don't have a contract for cleaning on the core autoclaves. We do have a contract for PM's, but it does not involve cleaning".

There was a plastic storage container with wheels, that had several sterile supplies (surgical
A 940 Continued From page 252

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<tr>
<td>A 940</td>
<td>Continued From page 252 drapes, drill bits, and sutures stored in the drawers. The container was sitting on the floor. In one of the drawers, there was packages of sterile hooks. The packages had a rubber band tightly woven around them. Physical damage to the package, such as holes and tears can be caused by compression of the package.</td>
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**OPERATING ROOM 1**

Outside operating room 1 on the Core Side, the caulking in the linoleum floor had several areas that were cracked and disintegrated. There was a metal strip underneath the plastic bumper guard that had separated from the wall exposing sheetrock. There was rust on the wheel casters of metal racks storing sterile instruments. There was a metal rack with several bins storing sterile instruments that were full. The bins contained peel packs (Sterilization packs) stacked up and packed tightly in the bins. The packages were stored in a manner that would allow crush, bend, and puncture of the package compromising the sterility of the item.

**OPERATING ROOM 16**

The caulking in the linoleum floor had several areas that were cracked and disintegrated.

**OPERATING ROOM 21**

The Bair Hugger (Patient warmer unit) was stored on the floor. There was an IV (Intravenous) pole in the room that had a plastic plate attached to the base. There was tape and tape residue on the
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<td>A 940</td>
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<td>Continued From page 253 plastic. Underneath the plastic plate, at the point where the plate attached to the IV pole, there was a build-up of dust, dirt, and debris. There was rust on the wheel caster of a metal table in the room. On the base of the anesthesia machine there was a plastic film coating that had rips and tears in it. There was a build-up of dust, dirt, and debris under the plastic film coating. There was a LUXTEC headlamp that had a crack in the plastic. There was no way to properly sanitize the machine. There were several areas in the room that had cracked and disintegrating caulking in the floor. OPERATING ROOM 22 Outside of Operating Room 22 entry door on the core side, the baseboard had separated from the wall exposing sheetrock. PRE-OPERATIVE AREA, Room P503 The mattress on the stretcher had multiple cracks and tears in the mattress. There was no way to sanitize it properly. MAIN OR PAVILLION TOWER There were storage bins on a metal rack in the core. The bins contained sterile items (tube holder, steri-drapes, Ioban drapes). The base of those bins was coated in dust, dirt, debris, and hair. There were sterile wrapped items (urethral instruments, cotton rolls) stored in a bin. The...</td>
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A 940 Continued From page 254

external tape sterilization indicator (External tape sterilization indicators provide at-a-glance visual assurance that the package has been exposed to the steam sterilization process) was faded making it difficult to determine sterility. The bins storing these items were coated in dust, dirt, and debris.

Staff #12 confirmed the above sanitary environment findings.

INTERVENTIONAL RADIOLOGY:

During a tour of room #3 of the Interventional Radiology Area on 8/13/2019, at 1:10 PM, the following infection control issues were observed:

Observed a patient having a Renal biopsy with CT scan, there was a metal rolling cart in the procedure room approximately 2 feet from the patient. The metal cart was loaded with sterile packs and there was no protective covering to protect the sterile packs from contamination from the patient that was having a procedure. Also, in room #3, observed dust and lint on the air conditioner return vent.

An interview with Staff #11 on 8/13/2019 at 1:30 PM confirmed the above findings.

CATH LAB:

During a tour of the Cath lab room on 8/14/2019, at 10:00 AM, observed the following infection control issues:

1. The wall base was pulled apart from the wall
A 940 Continued From page 255 allowing dust and dirt to collect in the crack.

2. Plaster was missing from the wall underneath the hand sanitizer dispenser.

3. The paint was chipped along the trim of the glass protector window between the control room and the Cath lab procedure room.

4. In a drawer in the Cath Lab procedure room there was a blue plastic container that had brownish spillage in the container and there was sterile tegaderm being stored in the container.

5. The air conditioner return vent x 2 was covered in dust and lint.

6. In the drawer of the Cath Lab, found 2 purple top blood tubes that had expired 7/31/2019.

Surveyor observed Staff #113, #131, and #272 cleaning the Cath Lab procedure room after the Right Heart Cath procedure had been completed. The surveyor showed Staff # 16 Nurse Manager that there was blood on the C-Arm, blood on the ceiling, and blood left on the counter where staff had completed blood sample testing.

An interview with Staff # 16 Nurse Manager on 8/14/2019, at 10:40 AM, confirmed that there was blood found on the C-Arm, blood on the ceiling, and blood left on the counter.

ENDOSCOPY UNIT:

During the tour of the Motility procedure room on 8/16/2019, it was observed that after the motility probe (ManoScan high resolution Manometry)
A. BUILDING ____________________

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 450076

(X2) MULTIPLE CONSTRUCTION
A. BUILDING ____________________
B. WING ____________________

(X3) DATE SURVEY COMPLETED
08/23/2019

NAME OF PROVIDER OR SUPPLIER

UNIVERSITY OF TEXAS M D ANDERSON CANCER CENTER, THE

STREET ADDRESS, CITY, STATE, ZIP CODE
1515 HOLCOMBE BLVD
HOUSTON, TX  77030

(X4) ID PREFIX TAG

SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG

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A 940 Continued From page 256

A 940 was cleaned, it was taken from the container and stored in the original case. There was no process in place on how the protective case was cleaned prior to placing the high level disinfected ManoScan high resolution Manometry in the protective case.

An interview with Staff # 268 on 8/16/2019, at 10:00 AM, confirmed there was no process in place for cleaning the protective case.

While observing the endoscopy suite and in the preoperative area there were 2 carts observed. In one of the carts surveyor found pink colored blood tubes that had expired 3/31/2019.

An interview with Staff # 269 on 8/16/2019, at 10:30 AM, confirmed the pink colored tubes had expired on 3/31/2019.

STORAGE ROOM: (located in the main surgical area outside the main Surgical area)

During a tour on 8/15/2019, at 8:53 AM, entered a storage room that contained numerous supplies, linen, and equipment. The following infection control issues were observed:

1. Upon entering the room there was a distinct musty odor to the room.

2. The ceiling tile had a large brown circular substance that appeared to be where water had leaked. The ceiling tile was above the equipment and supplies.

3. There were stacks of equipment and furniture piled upon each other and underneath the...
A 940 Continued From page 257

equipment was wooden pallets. Mixed among the supplies and equipment was numerous open cardboard boxes. The surveyor was unable to see what was in the boxes due to the boxes were piled high on the equipment.

4. There was a large clear plastic bag full of supplies that was above the red fire line. The red line signifies items that should not be above the fire line. The surveyor was unable to see the supplies due to the bag being piled so high and in the corner of the room with numerous pieces of furniture and equipment in front of the plastic bag of supplies.

5. There were patient cleaning supplies stored with facility cleaning supplies in a cabinet. On the top shelf of the cabinet was packages of "Whole Earth" sugar sweetener.

6. There was a metal cart that had closed and open cardboard boxes. The open cardboard box contained a box with breast implant sizer.

7. On another large metal rolling cart in the middle of the room there was 6 large linen bags with clean linen hanging out of the linen bags. The surveyor asked what these linen bags were. Staff #277 stated, "The linen was from the physician lounge. The lounge was being remodel."

The storage room was in disarray and had a musty odor.

Cardboard boxes harbor parasites, insects, and microorganisms.
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**NAME OF PROVIDER OR SUPPLIER**

UNIVERSITY OF TEXAS M D ANDERSON CANCER CENTER, THE

**STREET ADDRESS, CITY, STATE, ZIP CODE**

1515 HOLCOMBE BLVD
HOUSTON, TX  77030

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| (X4) ID | SUMMARY STATEMENT OF DEFICIENCIES | PROVIDER'S PLAN OF CORRECTION | (X5) COMPLETION DATE |
| PREFIX | (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | |
| TAG | | | |
| A 940 | Continued From page 258 | A 940 | |

"External shipping containers have been exposed to unknown and potentially high microbial contamination. Also, shipping cartons, especially those made of corrugated material; serve as generators of and reservoirs for dust." (AAM1 ST46-Section 5.2 Receiving items).

Review of the AORN (Association of perioperative Registered Nurses) 2019 Perioperative Standards and Recommended Practices, Guidelines for Sterilization, revealed the following:

"...Recommendation IV.c. Supplies and equipment should be removed from external shipping containers and open-edged corrugated cardboard boxes before transfer to the sterile storage area or point of use.

External shipping containers and open-edged cardboard boxes may collect dust, debris, and insects during shipment and may carry contaminants into the surgical suite ..."

Review of ANSI/AAMI ST79:2017 revealed the following:

"11.1 Sterile Storage

Sterile items should be stored under environmentally controlled condition that reduces the potential for contamination. Supplies should be removed from external and web-edged shipping container before transport to any restricted area.. "

An interview with Staff #277 on 8/15/2019 at 9:00 AM confirmed the above findings.
<table>
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</table>
| A1005  | POST-ANESTHESIA EVALUATION  
CFR(s): 482.52(b)(3)  
[The policies must ensure that the following are provided for each patient:]  
A post-anesthesia evaluation completed and documented by an individual qualified to administer anesthesia, as specified in paragraph (a) of this section, no later than 48 hours after surgery or a procedure requiring anesthesia services. The post-anesthesia evaluation for anesthesia recovery must be completed in accordance with State law and with hospital policies and procedures, which have been approved by the medical staff and which reflect current standards of anesthesia care.  
This STANDARD is not met as evidenced by:  
ANESTHESIA POST EVALUATION  
Based on record review, and interview, the facility failed to ensure that the post anesthesia assessments were completed prior to the patient sufficiently recovering from anesthesia in 5 of 15 patients reviewed.  
This deficient practice had the likelihood to cause harm in all patients receiving anesthesia at the facility.  
Findings include:  
PATIENT #105  
Patient #105 underwent a MRI with/without contrast and anesthesia on 8-14-2019. The patient was admitted to the PACU (Post anesthesia care unit) at 10:12 a.m. Patient #105 met the discharge criteria for PACU at 11:15 a.m. | A1005 | 10/26/19 |
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</tr>
</thead>
</table>
| A1005 | Continued From page 260 | Patient #105 was discharged from PACU at 11:35 a.m.  
Review of the post-anesthesia assessment revealed the assessment was completed at 10:27 a.m., 45 minutes prior to the patient meeting the discharge criteria for PACU.  
PATIENT #236  
Patient # 236 underwent a MRI Cervical Thoracic Lumbar Spine with/without contrast on 8-12-2019. The patient was admitted to the PACU at 11:28 a.m. Patient #105 met the discharge criteria at 12:05 p.m. Patient #105 was discharged from PACU at 12:10 p.m.  
Review of the post-anesthesia assessment revealed the assessment was completed at 11:30 a.m., 2 minutes after the patient was admitted to the PACU and 35 minutes prior to the patient meeting discharge criteria for PACU.  
PATIENT #238  
Patient #238 underwent a flexible colonoscopy on 8-16-2019. The patient was admitted to PACU at 11:11 a.m. Patient # 238 met discharge criteria for PACU at 12:20 p.m. and was discharged from PACU at 12:53 p.m.  
Review of the post-anesthesia assessment revealed the assessment was completed at 11:25 a.m., 14 minutes after the patient was admitted to PACU and almost 1 hour prior to the patient meeting discharge criteria for PACU.  
PATIENT #239  
Patient #239 underwent a colonoscopy on 8-16-2019. The patient was admitted to PACU at 8:28 a.m. Patient #239 met discharge criteria | A1005 |  |  |
A1005 Continued From page 261

from PACU at 9:15 a.m. Patient #239 was discharged from PACU at 9:30 a.m.

Review of the post-anesthesia assessment revealed the assessment was completed at 9:08 a.m. The vital signs used on the post anesthesia assessment were from 8:50 a.m.

Interview with Staff #267 on August 16, 2019 after 10:00 a.m. revealed the following:

Staff #267 was asked when anesthesia was notified that the PACU patients were ready for post-anesthesia assessment/discharge. Staff #267 stated, "I just look in computer and see if the anesthesia post evaluation is complete." Staff #267 was asked if the anesthesia provider came to the bedside to evaluate the patient. Staff #267 stated, "I don't really know. I look in computer and if the evaluation is there, I discharge patient. I don't know if they come to the bedside or not."

PATIENT #242

Patient #267 underwent an exchange of right breast tissue expander for implant possible capsulorrhaphy and left breast augmentation with implant and mastopexy for symmetry on 8-19-2019. Patient #242 met discharge criteria for PACU at 1:45 p.m. Patient #242 was discharged from PACU at 2:02 p.m.

Review of the PACU nursing notes revealed that Patient #242 was admitted to PACU at 10:04 a.m. Vital signs at 10:04 a.m. were temperature 98.8, respiration rate of 16. Vital signs at 10:15 a.m. were documented as SpO2 95% on nasal cannula 2 liters per minute, pulse 72, blood pressure was 128/62. Vital signs documented at 10:30 revealed respirations at 8, blood pressure 113/56, pulse 70. There was no respiration rate
**Name of Provider or Supplier:**

**University of Texas M D Anderson Cancer Center, The**

**Address:**

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<tr>
<td>A1005</td>
<td>Continued From page 262</td>
<td></td>
<td>Noted until 10:55 a.m. Vital signs at 10:55 a.m. were respiration rate 8, pulse 70, blood pressure 113/56. There was no documentation in the nurses notes that addressed the change in condition. There was a nurse note at 11:06 a.m. that encouraged deep breathing. Respiration rate at 10:35 a.m. was 11. Respiration rate at 10:50 a.m. was 11. Respiration rate at 11:30 a.m. was 11. Respiration rate at 11:45 a.m. was 7. Oxygen saturation at 12:15 p.m. was 92% and respiration rate was 6. Pulse oximetry at 1:00 p.m. was 92%, no respiration rate was noted. There was no documentation in the nurses notes that the patient change in condition was addressed or reported to anesthesia or the physician.</td>
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Review of the post-anesthesia assessment revealed it was completed at 12:45 a.m., one hour prior to the patient meeting discharge criteria for PACU. The vital signs used in the post-anesthesia assessment were from 11:30 a.m., 2 ½ hours prior to the patient being discharged from PACU. The vital signs showed the patient was discharged with a respiratory rate of 9.

An interview with Staff #378 on 8-20-2019 after 8:30 a.m. revealed the following:

Staff #378 confirmed the findings for patient #242. Staff #378 was asked if staff was required to document a change in a patient's condition and report to the anesthesia staff/physician. Staff #378 confirmed they were. Staff #378 was asked if a patient would normally be discharged with a respiration of 9. Staff #378 confirmed they would not normally be discharged with a low respiration rate. Staff #378 was asked if anesthesia had a policy on post anesthesia evaluations in the
### Summary Statement of Deficiencies

#### A1005

**PACU area.** Staff #378 stated, "No we do not currently have a policy on post-anesthesia evaluations but have identified that as an issue and will be working on it."

Staff # 13 confirmed the above findings on post-anesthesia evaluations.

#### A1076

**OUTPATIENT SERVICES**

CFR(s): 482.54

If the hospital provides outpatient services, the services must meet the needs of the patients in accordance with acceptable standards of practice.

This CONDITION is not met as evidenced by: Based on observation, review of documentation, and interview, it was determined that the hospital failed to ensure that outpatient services were provided in a safe manner.

**Findings:**

Outpatient services were not provided in a safe manner as multiple issues were found to include:

Outpatients were receiving Ketamine infusions (Ketamine is a powerful drug which can be used for chronic pain control as well as anesthesia) without proper monitoring from nursing staff, and there were no competencies for the nursing staff administering the Ketamine. There were no policies or procedures for the administration of Ketamine in an outpatient setting. This increased the likelihood of an adverse patient outcome.

Cross refer to CFR 482.13(c)(2), A0144, Patient Rights: Care In Safe Setting

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### Statement of Deficiencies and Plan of Correction

**NAME OF PROVIDER OR SUPPLIER**

UNIVERSITY OF TEXAS M D ANDERSON CANCER CENTER, THE

**STREET ADDRESS, CITY, STATE, ZIP CODE**

1515 HOLCOMBE BLVD

HOUSTON, TX  77030

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**Summary Statement of Deficiencies**

*Each deficiency must be preceded by full regulatory or LSC identifying information*

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<td>A1005</td>
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<td><strong>Continued From page 263 PACU area. Staff #378 stated, &quot;No we do not currently have a policy on post-anesthesia evaluations but have identified that as an issue and will be working on it.&quot;</strong></td>
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| A1076     |     | **OUTPATIENT SERVICES**

CFR(s): 482.54

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Cross refer to CFR 482.13(c)(2), A0144, Patient Rights: Care In Safe Setting

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**Event ID:**

**Facility ID:**

Event ID: F7QU11  Facility ID: 810041
A1076 Continued From page 264

The hospital failed to ensure that emergency equipment (crash carts) were at all the outpatient locations, this increased the likelihood of an adverse patient outcome in the event of an emergency medical situation.

Cross refer to CFR 482.12(f)(3), A0094, Off-Campus Emergency Policies and Procedures

The hospital failed to protect the confidentiality of patient medical records from the potential of unauthorized access.

Cross refer to CFR 482.13(d), A0146, Patient Rights: Confidentiality Of Records

The hospital failed to ensure that staff monitored patient care supplies for expiration dates.

Cross refer to CFR 482.41(d)(2), A0724, Facilities, Supplies, Equipment Maintenance

The hospital failed to ensure that the physical environment was monitored for infection control issues and that worn patient care equipment (mattresses) were promptly replaced.

Cross refer to CFR 482.42(a)(1), A0749, Infection Control Program

The hospital failed to ensure that nursing staff monitored patient vital signs during blood and chemotherapy infusions.
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<td>A1076</td>
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<td>Continued From page 265</td>
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<tr>
<td>A1076</td>
<td></td>
<td>Cross refer to CFR 482.23(b), A0392, Staffing and Delivery of Care</td>
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<td>The hospital failed to ensure that outpatient services were integrated with inpatient services.</td>
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<td>Cross refer to CFR 482.54(a), A1077, Integration of Outpatient Services</td>
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<td>The hospital failed to ensure that there was documentation of the completion of identified quality improvement initiatives.</td>
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<td>A1077</td>
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<td>Cross refer to CFR 482.21(b)(2)(ii),(c)(1),(c)(3), A0283, Quality Improvement Activities</td>
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<tr>
<td>A1077</td>
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<td>INTEGRATION OF OUTPATIENT SERVICES</td>
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<td>CFR(s): 482.54(a)</td>
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<td>Outpatient services must be appropriately organized and integrated with inpatient services.</td>
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<td>This STANDARD is not met as evidenced by:</td>
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<td>Based on interview and document review, the facility failed to ensure that there was an organized outpatient program integrated with inpatient services in the Ambulatory Treatment Center (ATC); located at 1515 Holcombe Blvd, 2nd Floor.</td>
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| | | An interview was conducted on 8/14/2019, after 9:00 AM, with Staff #129. Staff #129 was asked how the ATC ensured their services were well organized and integrated with the inpatient services. Staff #129 said, "many of the patients that are discharged are seen in this clinic for
A1077 Continued From page 266 outpatient services. The inpatients are scheduled upon discharge for services such as, infusions, transfusions, injections, and pump (a device connected to a patient via intravenous line that continuously infuses chemotherapy) changes.” Staff #129 said, "we were informed of some problems in the last couple of weeks regarding scheduling a discharged patient for outpatient services." Staff #129 was asked, how was the problem identified and what corrective action was in place. Staff #129 said, "there has been a few patients that were discharged from inpatient services that were scheduled to have a pump changed at a specific time after discharge. The inpatient unit scheduled the outpatient appointment once the discharge order was written by the medical provider. If the patient was delayed being discharged no one rescheduled the outpatient appointment and the patients were arriving several hours before their appointment and we could not safely change their pump. These patients were having to wait extended hours in the waiting area until their scheduled appointment time.” Staff #129 was asked if there was a process in place to ensure the scheduling process was streamlined and corrected. Staff #129 said, "we had a meeting and discussed a corrective action plan last week.”

A review of the documentation titled, "CADD and Eclipse Home Infusion Pumps" revealed patient screening and education information. On page two of this document, there was a one-line sentence that read, "Need consistency in contact information for patients". Further review of this document revealed, there was no corrective action plan mentioned in the document. No further documentation was provided for review.
An interview was conducted with Staff #129 on 8/15/2019 after 9:00 AM. Staff #129 was asked what corrective action plan was in place to ensure the outpatient and inpatient services were well organized to ensure continuity of care. Staff #129 presented a document titled, "Proposal for inpatient to outpatient coordination of care with home infusion." This document was labeled as a "DRAFT" and had not been reviewed or approved by any committee or department leadership. The facility failed to have a well-organized scheduling process between their inpatient and outpatient services to ensure patient continuity.

Staff #129 confirmed the findings.