Baptist Health System

CMS Statements of
Deficiencies
and
Plans of Correction
(CMS Form 2567)

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 10/02/2014 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		450058	B. WING			i i	C 04/2014
	PROVIDER OR SUPPLIER MEDICAL CENTER			111	EET ADDRESS, CITY, STATE, ZIP CODE DALLAS STREET N ANTONIO, TX 78205		04/2014
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LABORATOR	7 DIRECTOR'S OR PROVID	DERVSUPPLIER REPRESENTATIVE'S SIGN	/ /	ESIDENT + CEO	(X6) DATE (O/9/14	

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LABORATOR'	DIRECTOR'S OR PROVI	DER/SUPPLIER REPRESENTATIVE'S SIGN	VATURE		TITLE		(X6) DATE

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Massachusetts Hospitals

CMS Statements of
Deficiencies
and
Plans of Correction
(CMS Form 2567)



DEVALL, PATRICK GOVERNOR

TIMOTHY P. MURRAY LIEUTENANT GOVERNOR JOHN W. POLANOWICZ SECRETARY

CHERYL BARTLETT INTERIM COMMISSIONER The Commonwealth of Massachusetts

Executive Office of Health and Human Services Department of Public Health Division of Health Care Quality 99 Chauncy Street,11th Floor, Boston, MA 02111

617-753-8000



June 12, 2013

Erik Wexler President & CEO ST VINCENT HOSPITAL 123 SUMMER STREET WORCESTER, MA 01608

RE: Complaint #: 13-0084 - NOTIFICATION PLAN OF CORRECTION IS REQUIRED

Dear Mr. Wexler:

As a result of an on-site investigation conducted by the Department of Public Health, Division of Health Care Quality (the Department), at ST VINCENT HOSPITAL, the Department determined that deficiencies were found to exist. The deficiencies were sent to the Centers for Medicare and Medicaid Services (CMS) for their review and determination. CMS has sent you the deficiencies stating you are in compliance with the Medicare Conditions of Participation. Enclosed is a copy of the complaint investigation findings from the survey and for your information, a statement of deficiency is also enclosed.

Providers found in compliance with the Conditions of Participation will continue to be "deemed" to meet applicable Federal Requirements based upon your accreditation of Healthcare Organizations (Joint Commission) or other federally approved accreditation organizations.

Under Federal disclosure rules, a copy of the findings of this survey may be released to the public within sixty (60) days from the close of the survey.

State regulations require you to submit your Plan of Correction (POC) to the Department by e-mail, using this email address: HCQComplaintPOC@MassMail.State MA.US.

The following must be observed when submitting your POC by email:

Submit your POC as a .pdf document

Title the email "POC for [facility] - Survey Ending [date of survey]"

St V. int 2/20- 2/28/13

INVESTIGATION REPORT

Reference # 13-0084

Page 1

Facility: ST VINCENT HOSPITAL 123 SUMMER STREET

WORCESTER, MA, 01608

Date Received:

Date Investigated: 92/20/2013, 02/21/2013, 02/22/2013

A. INVESTIGATORY STEPS:

1. PERSONS INTERVIEWED

Archythulla Technician Reputational Name #1 when breathent of Quality & Malery Elek Wandager #1 Director of Medical Staff Services Ultrasound Technician Cardiology Fellow Man-Invasive Cardiology Supervisor Patlent II Director of Quality Director of Risk Management Rick Manager 12 Complainant

2. RECORDS REVIEWED

Mehomandralogy Protocol Patient Education Sheets/Pamphlets Medical Records Acministrative Policies/Procedures Respiratory Policy/Procedure Patient Schedules Credential Files Discharge Instructions Complaint Investigation Performance Improvement Projects Meeting Minutes Meeting Minutes Incident/Variance Reports Joint Commission Reports

Printed: 06/10/2013 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1`'	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
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A1077	7:00 P.M. on 10/18/ Other telephoned a returned home from 2.) The Hospital's N "Intravenous Theral related to all intrave include the date, tim Four of 8 Outpatien IVs inserted during 2/21/13 (Patients #contain documentatime, catheter size of the size of t	1/12, Patient #1's Sign and said that Patient # in the DSE confused. It is possible to the DSE confused and the period of 10/18/11, #4, #5 and #6) did tion regarding the IV or site. It is possible to the period of 10/18/11, #4, #5 and #6) did tion regarding the IV or site. It is possible to the period of 10/18/11, #4, #5, #9 and #10 tion regarding the IV or site at the period of 10/18/11, #4, #5, #9 and #10 tion regarding the IV tion regarding the period of 10/18/11, #4, #5, #9 and #10 tion regarding the period of patients #1, #4 and the period file patients	dure titled entation ons is to site. who had 2 to not insertion dure titled entation, time and site. who had 12 to 0) did not removal atheter tients who iniod of 1 #5) did	A1077			

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ID Prefix	Summary Statement of Deficiencies	ID Prefix	Providers Plan of Correction	Comple tion
Tag		Tag	-	Date
I.	482.54(a) INTEGRATION OF OUTPATIENT SERVICES Oxygen administration without a physician's order.	Tag	 A. All technologists and nurses that care for patients in the Non-Invasive Cardiology Department were reeducated that: 1) Oxygen is a prescribed medication. 2) If a patient is on home Oxygen upon arrival, technologist may transfer to wall oxygen at the same dose so tank does not deplete while having test. 3) For inpatients, ticket to ride will document flow rate for O2- transfer to wall while the test is being performed. 4) If a patient arrives on room air and becomes short of breath and requires oxygen-a physician order must be obtained by an RN. 5) If the oxygen is subsequently discontinued during the same encounter, then this must be by physician order, and must be followed by an assessment of the patient's condition and a room air oxygen saturation measurement. (see Attachment 1) B Compliance with the above requirements will be measured by audits. A total of 70 medical record audits will be completed each month 	Date
			with results brought back to staff and reported to Cardiology PI. This auditing	

		will continue monthly until 4 months of 90% compliance is achieved. It will be periodically monitored thereafter as a standing item on Cardiology PI. C. The Oxygen Therapy Policy will be revised to clearly specify the above provisions for outpatients who may require oxygen therapy. (see Attachment 2-presented to Medical Executive Committee on 7/11/13) D. Patient instruction letters will be updated to include instructions for patients on home O2 to bring their O2 tank in with them with sufficient oxygen for travel. (ordered)	
A1077	Appropriate assessment of patients undergoing stress testing with abnormal VS or other findings on arrival	A. All technologists and nurses that care for patients in the Non-Invasive Cardiology Department were reeducated that: 1) VS will be taken upon arrival, including oxygen saturation for any patient who is on oxygen therapy at home/sending facility. 2) If a technologist observes that a patient is in respiratory distress or having difficulty ambulating, their vital signs are abnormal or the patient has complaints of pain or discomfort this will be brought to the attention of the RN/MD/NP/PA for further clinical assessment. This assessment will be documented by the responding clinician. (see Attachment 1) B. Compliance with the above requirements will be measured by audits. Audits of the same 70 medical record audits will be completed each month with results brought back to staff and reported to Cardiology PI. This auditing will continue monthly until 4 months of 90% compliance is achieved. It will be periodically monitored thereafter as a standing item on Cardiology PI.	

A1077	Patient's oxygen saturation level was not evaluated following discontinuation	All technologists and nurses that care for patients in the Non-Invasive Cardiology Department were reeducated that: If the oxygen is subsequently discontinued during the same	
		encounter, then this must be by physician order, and must be followed by an assessment of the patient's condition and a room air oxygen saturation measurement. (See 1) A. #5 above).	
		Patient must be back to baseline and stable prior to leaving department. (see Attachment 1)	
A1077	Documentation of IV site insertion, discontinuation, and condition of site.	All technologists and nurses that care for patients in the Non-Invasive Cardiology Department were reeducated that the following must be documented on each patient receiving an IV for an exam/test: IV insertion: to include date, time, size of catheter and site IV removal: to include date, time and assessment of (former) catheter site Cardiology Patient Care Flow Sheet has been updated to prompt documentation of the elements above. (see Attachment 3)	
		Compliance with the above requirements will be measured by audits. Audits of the same 70 medical record audits will be completed each month with results brought back to staff and reported to Cardiology PI. This auditing will continue monthly until 4 months of 90% compliance is achieved. It will be periodically monitored thereafter as a standing item on Cardiology PI.	

Attachment 1 ODD Voises

Non-Invasive Cardiology Corrective Action Plan for DPH citation received on 6/12/13

A complaint was filed after a patient had a Dobutamine Stress Echo on 10/18/13

An allegation of poor quality of care was determined valid because:

1. Patient was not provided with an appropriate clinical assessment:
Scheduled outpatient walked into department and appeared short of breath. Patient stated that he was on O2 at home but left his tank in the car. Tech checked his O2 Sat and put him on Oxygen.

• Techs usually have the initial encounter with patients in our department. It is their role to prep the patient for testing. The baseline vital signs are measured and recorded, the patient is interviewed and the test is explained to the patients. If the tech observes that the patients is in respiratory distress or having difficulty ambulating; the vital signs are abnormal or the patient has complaints of pain or discomfort this will be brought to the attention of the RN/MD/NP/PA for further clinical assessment. This assessment will be documented by the clinician.

2. Oxygen was administered without a physician order:

- Oxygen is a prescribed medication- If a patient is on Home Oxygen upon arrival, tech may transfer to wall at the same dose so tank does not deplete while having test. For inpatients, ticket to ride will document flow rate for O2- transfer to wall while test being performed.
- If a patient arrives on room air and becomes short of breath and requires oxygen-a physician order must be obtained by RN.
- If oxygen is discontinued must be a physician order and O2 sat documented on room air.

3. Patient's oxygen saturation level was not evaluated following discontinuation of the oxygen therapy.

Patient was brought to his vehicle by tech while still on O2. He arrived to the department on room air so he needed to be evaluated at room air again before his oxygen could be stopped. He had oxygen in his car but chose not to use it.

- Vital signs (O2 saturation, BP, HR) must be assessed pre/post procedure and documented.
- Patient must be back to baseline and stable prior to leaving department

Policies to be revie wed:

- Respiratory Care Services: Oxygen Therapy: Section D7
- Nursing Procedure Manual: Section B-10 IV Therapy

Dobutamine nursing flow sheet being updated to document:

- IV insertion: to include date, time, size of catheter and site
- IV removal: to include date, time and assessment of (former) catheter site
- Timing of vitals
- Patient's status at conclusion of test

Re-education of techs in NIC by supervisor, Bridget Smith

Re-education of nursing in MSD by director, Erica Dodge

Re-education of mid-levels and Cardiology Fellows by Division Chief,

Joseph Kirkpatrick, MD

Monthly audits to be performed by Bridget Smith- 70 charts to be reviewed using audit tool that has been developed by Quality Mnt. These audits will be shared with staff on a weekly basis at huddle and posted on huddle board in dept. The audits will be reported to Cardiology PI Committee on-going on a monthly basis.

Patient instruction letters will be updated to include instructions for patients on home O2 to bring their O2 tank in with them with sufficient oxygen for travel.

Saint Vincent Hospital an (DAM CALONION-6/0/13) Subject/Alert reviewed: COTECHOE Date of Meeting: \7 Date Signature **Printed Name**

	**Please retain a copy of the materials reviewed and all signatures collected in your unit/ department as well as send a completed copy to
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0	Percent complete to date: 10090
	Deteculoritied: 11/211
0	Manager/Director/Educator signature:

**Please make additional copies as needed

Signature collection template KC 3/2012

PAGE 01/01

Saint Vincent Hospital

Subject/Alert reviewed: DPH citation 6/12/13

Date of Meeting:

6-27-13

	6.21-13		
Printed Name	Printed Title	Signature	Date
Eleen P. De Martino	CCT	Eleen Holling Cel	6/27/13
Mena S. Mohand	Cardiac Tech	New mb	6-27-13
Homa Daneshwar	Cardia Sonogap	H. Janes hund.	6-27-17
Emelia George	EKG O.	Execution &	6-27-13
Lisa Docimo	EchoTech	Lisk!	6.27.13
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Rebecca Rathan	RCS	Reber Eith NCS	7.2.13
Ashlee Schandelner	(TAKE)	Oshley Chanel Meyer	7-3-13
KUSSFELL KUIPERS	EKG	Pr	7-3-13
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0	**Please retain a copy of the materials reviewed and all signatures collected in your
	unit/ department as well as send a completed copy to

o Indicate the total # of staff on your unit/dept that NEED this review 23

o Indicate the total # of staff on your unit that have completed review 16

o Percent complete to date: 70%

Date submitted: 7/8/13

Date submitted: 7/8/13

Manager/Director/Educator signature: Bridglt M Smith RDO

Supervisor - NonInvasive Cardiology

**Please make additional copies as needed

Signature collection template KC 3/2012

Non-Invasive Cardiology Corrective Action Plan for DPH citation received on 6/12/13.

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An allegation of poor quality of care was determined valid because:

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2. Oxygen was administered without a physician order:

- Oxygen is a prescribed medication- If a patient is on Home Oxygen upon arrival, tech may transfer to wall at the same dose so tank does not deplete while having test. For inpatients, ticket to ride will document flow rate for O2- transfer to wall while test being performed.
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- If oxygen is discontinued must be a physician order and O2 sat documented on room air.
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Patient was brought to his vehicle by tech while still on O2. He arrived to the department on room air so he needed to be evaluated at room air again before his oxygen could be stopped. He had oxygen in his car but chose not to use it.

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- Patient must be back to baseline and stable prior to leaving department

Policies to be reviewed:

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Patient instruction letters will be updated to include instructions for patients on home O2 to bring their O2 tank in with them with sufficient oxygen for travel.

Attachment 2

SAINT VINCENT HOSPITAL, INC.
WORCESTER, MASSACHUSETTS

SUBJECT: Oxygen Therapy

NO.

POLICY:

- **A.** Special precautions to prevent fire hazards due to the presence of an oxygen-enriched atmosphere will be followed as directed in the Safety Manual, Policy # 1.5.10.
- **B.** Oxygen is a prescribed medication and the Respiratory therapist/RN is responsible to follow this guideline when administering oxygen.

PURPOSE:

To assure the safe and effective use of oxygen therapy in both and inpatient and outpatient setting.

DEFINITIONS:

IMPLEMENTATION SAFETY:

- 1. No Smoking signs will be posted in main oxygen storage areas. Smoking is prohibited in all areas of the hospital.
- 2. Oxygen will not be used when there is a potential for ignition present. Examples include faulty electric outlets or equipment, source of static electrical discharge, use of friction toys, smoking.
- 3. Oxygen will be stored separately from flammable gasses or liquids.
- 4. Portable oxygen cylinders shall be stored and handled as specified in the Safety Policy Manual #1.5.7 "Use and Storage of Compressed Gases."
- 5. Medical gas systems will be provided and maintained in compliance with applicable codes and standards as stated in the Engineering and Facilities Policy Manual, #4.3 WMC (E.1, E.2, E.3).

IMPLEMENTATION INPATIENT:

- 1. When administering oxygen the Respiratory Therapist or RN will verify the physician order, which must include device type and Liter Flow or FIO2.
- 2. Frequency of administration will be continuous unless otherwise directed by the physician's order.
- 3. PRN oxygen orders will not be accepted. MD will be contacted for clarification.
- 4. On the hospital units the RN may start oxygen ordered via nasal cannula or in emergency situations via a non-rebreather. The Respiratory Therapist must be called to assist with the set-up of all other oxygen administration devices, including the non-rebreather. In special care areas (e.g. PACU) the nursing staff may set-up and use all forms of oxygen administration devices for which they have been trained.
- 5. For inpatients, ticket to ride will document flow rate for O2- transfer to wall while the test is being performed.
- 6. The Respiratory Therapist or RN will review the medical record, identify and assess the patient and explain the procedure prior to administering the oxygen therapy.
- 7. The Respiratory Therapist or RN will complete and document all patient education associated with oxygen therapy using the standard format.
- 8. Documentation of oxygen use and relevant patient assessment will be completed on the Medical/Surgical Flow Sheet.
- 9. Oxygen Therapy may be discontinued by a written physician order or by protocol.
- 10. The Registered Nurse will monitor and document oxygen levels on a regular basis. They will inform the covering Respiratory Therapist of any equipment or clinical problems associated with the oxygen therapy.
- 11. The Respiratory Therapist will monitor and maintain large volume nebulizers on a per shift basis. The nursing team will also regularly monitor oxygen delivery by this device to assure that it is functioning properly.

DATE ISSUED: SUPERSEDES DATE: NEW Page 1 of 1

	ENT HOSPITAL, INC. R, MASSACHUSETTS	ADMINISTRATIVE POLICY MANUAL Administration
SUBJECT:	Oxygen Therapy	NO.

IMPLEMENTATION OUTPATIENT:

- 1. If a patient is on home Oxygen upon arrival for any outpatient testing, technologist/nurse may transfer to wall oxygen at the same dose so tank does not deplete while having test.
- 2. If a patient arrives on room air and becomes short of breath and requires oxygen, a physicians order must be obtained by an RN. A Rapid Response may be activated if necessary.
- 3. If a technologist observes that a patient is in respiratory distress or their vital signs are abnormal or the patient has complaints of pain or discomfort this will be brought to the attention of the RN/MD/NP/PA for further clinical assessment. This assessment will be documented by the responding clinician.
- 4. If the oxygen is subsequently discontinued during the same encounter, then this must be by physician order, and must be followed by an assessment of the patient's condition and a room air oxygen saturation measurement.
- 5. Patient must be stable prior to leaving department if proceeding to home or returning to another facility.

Written by:	Date:	
Issued by:	Date:	
Approved by:	Date:	
DATE ISSUED:	SUPERSEDES DATE: NEW	Page 2 of 1

	NT HOSPITAL, INC.		ATIVE POLICY MANUAL dministration
SUBJECT:	Oxygen Therapy		NO.
Approved by:_	il.	Date:	
Approved by:_		Date:	
Approved by:_		Date:	
	Original Policy with Signatures on File	e in Administration	

DATE ISSUED: SUPERSEDES DATE: NEW Page 3 of 1

Attachment 3

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Saint Vincent Hospital Cardiology Patient Care Flow Sheet Pre-Procedure	MEDICATONS/AUPSING PROGRESS NOTES									Signature / Initials Date / Time			mL Void Total	boour about reducts. Ideal	Complete of CHAI A mondentage of man)		OUTPATIENT DISPOSITION:	Dissiprocedure leacting reviewed with patient / family; written instructions reviewed & provided I Med. Reconciliation reviewed with patient.	n No Change See discharge instruction sheet for medication	JANE TUSO Appled	met	Oischarge at (time): to □ Home □ Care Facility via □ Ambulatory □ Wheelchair □ Stretcher
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Saint Vincent Hospital
Cardiology Patient Care Flow Sheet
Pre-Procedure

Saint Vincent Hospital
Cardiology Patient Care Flow Sheet
Pre-Procedure

Focus / Problem	Patient Outcome (it outcome not met, see procedure note)
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AN Signature:

Date;

Chandley, Kelly

From:

Chandley, Kelly

Sent:

Monday, July 15, 2013 5:18 PM

To:

'HCQComplaintPOC@massmail.state.ma.us'

Subject:

POC for Saint Vincent Hospital Survey Ending 02.20.13-02.22.13

Attachments: POC for Saint Vincent Hospital Survey Ending 02.20.13-02.22.13.pdf

RE: Complaint # 13-0084- re: Survey 2/20 through 2/22/2013

To Whom It May Concern:

As requested, attached please find the Plan of Correction for the complaint named above. Auditing results will be submitted when completed under separate cover.

If I can be of further assistance, please contact me at 508-363-6086.

Kelly Chandley Director of Risk Management 508-363-6086 pg: 2356

pg: 2356 fax: 2/5186

When writing or responding, please remember that e-mail, under certain circumstances, may be discoverable or become public. This message (including any attachments) is confidential and intended solely for the use of the individual or entity to whom it is addressed, and is protected by law. If you are not the intended recipient, please delete the message (including any attachments) and notify the originator that you received the message in error. Any disclosure, copying, or distribution of this message, or the taking of any action based on it, is strictly prohibited. Any views expressed in this message are those of the individual sender, except where the sender specifies and with authority, states them to be the views of Vanguard Health Systems.

This footer also confirms that this email message has been scanned for the presence of computer viruses

Chandley, Kelly

From:

POC, Complaint (DPH) [complaint.poc@state.ma.us]

Sent:

Monday, July 15, 2013 5:18 PM

To:

Chandley, Kelly

Subject: Out of Office: POC for Saint Vincent Hospital Survey Ending 02.20.13-02.22.13

PLEASE DO NOT REPLY TO THIS EMAIL. THIS ACCOUNT HAS BEEN ESTABLISHED ONLY TO RECEIVE PLANS OF CORRECTION.

Thank you for contacting the Department of Public Health, Division of Health Care Quality by email. If you have submitted a scanned .pdf copy of your plan of correction, this auto reply will serve as confirmation that the Department is in receipt of your plan.

If you have emailed a scanned plan of correction, please do not mail or fax another copy of your plan to the Department.

The Department will review your plan for acceptance.

If there are questions or concerns regarding your plan as written, or additional information is required, a surveyor will contact you directly.

If your plan is acceptable, surveyors will conduct a follow-up review either on-site or by means of record review to ensure compliance. You will be notified of the Department's findings at some point after the date you have alleged compliance, and once the Department has made a determination as to your compliance.

Please do not submit requests for Informal Dispute Resolution (IDR) to this email address. For information regarding the IDR process for federal deficiencies for nursing homes please see: http://www.mass.gov/eohhs/docs/dph/quality/hcq-circular-letters/dhcq-1112554.pdf

If you have any questions concerning your complaint survey results, please contact the Complaint Unit at 617-753-8150.

If you have any questions concerning the processing of your plan of correction please contact Lee Berryman at 617-753-8164 or Angela McCarthy at 617-753-8154.

For all other matters, please contact the appropriate staff person with the Department, or visit the Division's website at: http://www.mass.gov/dph/dhcq. To reach the main operator for the Division of Health Care Quality, please call 617-753-8000.

AGAIN, PLEASE DO NOT REPLY TO THIS EMAIL. THIS ACCOUNT HAS BEEN ESTABLISHED ONLY TO RECEIVE PLANS OF CORRECTION.

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TITLE

(X6) DATE

6NCW11

MA DPH/Divison of Health Care Facility Licensure and STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION [X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPL A. BUILDING:	(X3) DATESURVEY COMPLETED						
		-		С						
	VLBSA				08/04/2014					
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE										
	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 115 LINCOLN STREET									
METROWEST MEDICAL CENTER FRAMINGHAM, MA 01701										
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETE PRIATE DATE					
P 024	Continued From pa	_	p024	(POR FOR PORT CONTINUE HIRES WILL BE EDUCE	TEO					
	and #2, for one pat	ferral Service Crisis Worker #1 ient (Patient #1), were medical record on 7/3/14 and		REGARDING THIS FICH DULING THEIR DRIENTS	Ariod.					
	Findings include:			HAVE BEEN NE	NI I					
	telephone at 2:45 F	#1 was interviewed by P.M. on 7/31/14. ERS Crisis requested an admission to		RE-EVALUATION OF THE	- FOR					
	the CDU on 7/3/14	for the Patient. ERS Crisis		EMERGENCY DEPARTMENT 24 HOURS, PER HOSPITA 24 HOURS, RE-EDUCAT	9L					
	Worker #1 said she	was told by an unidentified		MALIUY.	CAC I					
		that the Patient could not be U. ERS Crisis Worker #1 said		POLICY. THIS RE- BE STA OCCURRED AT THE STA	ER 8,					
		formation to her Supervisor.		MEETING DI						
				2014.	-					
		ent's medical record on 7/31/14		A Tinds: A	NEW					
1	and 8/4/14, indicated that the Patient arrived to the Emergency Department at 4:30 P.M. on 7/3/14, was seen by ERS Crisis Worker #1 and a 10 page evaluation form was completed.			LONG-TERM ACTIONS: A PROCESS IS NOW GEING	BUILT					
				DROCESS IS THE	d in					
					BEING					
	However, the plan	for the Patient was not		DESIGNED SO THAT ALL	NA 000 04					
	documented and the discussion with the Patient's Parent was not documented. The medical record review indicated that, on 7/5/14, the Patient was			DESIGNED SO THAT ALL INFORMATION WITH REGAR	0 TO A					
				INFORMATION WITH REGINAL BED SEARCH WILL BE CA	MINICE D.					
		ital #2 for a psychiatric		MARRATIVE DOCUMENTATION						
	hospitalization.			REGARCOTTO TO DONE NOT	SAMO					
	During interview at	2:00 P.M. on 8/4/14, the		DISUSSED	ATE.					
	Director of the ERS	said she also participated in		NE AS						
	the search for finding	ng the Patient an In-patient		FAMILIES, AS ATTO DE DONE AS WILL CONTINUE TO DE DONE AS DESCRIBED IN THE FIRST PART DESCRIBED IN ATTENDED IS						
	psychiatric bed.			OF THE POC. ATHERTA IS SCHEDULED TO GO LIVE						
	During interview wi	th ERS Crisis Worker #1 at		OCTOBER 2014. STAFE	<i>a</i>					
	2:45 P.M. on 7/31/	14, ERS Crisis Worker #1 said		TRAINING IS UNDERWIE	ly.					
	if a patient was in the	ne ED more than 24 hours,		2000	UCATED.					
		ERS re-evaluation of the		ALL ERS HAVE BEEN ED DOCUMENTATION WILL B						
	Patient.			MONITORED FOR COMPLIA	NCE					
	During interview wi	th ERS Crisis Worker #2. ERS								

MADPH/Divison of Health Care Facility Licensure and (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CUA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING: -C 08/04/2014 **VLSSA** STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 115 LINCOLN STREET METROWEST MEDICAL CENTER FRAMINGHAM, MA 01701 (XS) COMPLETE PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (X4) 1D PREFIX PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) DEFICIENCY) TAG pozy continued:) p024 P024 Continued From page 2 BY THE DIRECTOR OF THE Crisis Worker #2 said she met with the Patient EVALUATION AND REFERRAL and the Patient's Parent on 7/4/14 and discussed ONGOING the psychiatric admission for the Patient. There SERVICES (ERS) THROUGH was no documentation in the Patient's medical MONTHLY CHART REVIEWS OF record and there was no reevaluation of the 10 RANDOM CHARTS. IF THE Patient. ERS Crisis Worker #2 said on 7/5/14 she DOCUMENTATION IS NOT 100% spoke with the Patient's Parent and arranged for IN COMPLIANCE WITH THE the transferred to another hospital for a IMPROVED PROCESS AT THE psychiatric admission. There was no TIME OF THESE REVIEWS, documentation in the Patient's medical record to DOCUMENTATION DETAILS WILL BE ADDED TO OUR LEAN describe the services provided by the ERS. DAILY MANAGEMENT AROBLEM-On page one, on the initial Behavioral Medicine Evaluation Formwas written: Disposition at 3:00 SOLVING BOARD FOR ACTION P.M. on 7/5/14, hospital level of care, Hospital #2. AND DISCUSSED DAILY AT OUR GEMBA WALK OCCURRING AT 8:35 a.m. ON WEEKDAYS.

Detroit Medical Center

CMS Statements of
Deficiencies
and
Plans of Correction
(CMS Form 2567)



Leon A. Coleman Director

Corporate Regulatory & Governance 6071 West Outer Drive Lourdes Bldg., 7th Floor Detroit, MI 48235 Phone: (313) 993-0317 Fax: (313) 745-7929

Email: lcoleman@dmc.org

August 5, 2013

Kathy Cotter
Michigan Department of Licensing and Regulatory Affairs
BHCS/Health Facilities Division
611 W. Ottawa, 1st floor
Lansing, MI. 48909

Dear Ms. Cotter:

Attached please find the Children's Hospital of Michigan ESRD Plan of Correction in response to your letter dated July 25, 2013.

Should you have any questions regarding our responses, or require any changes in our submission, please contact either myself or Stanton M. Beatty at our office phone number listed above or via email.

Sincerely, Lean a. Colleman

Leon A. Coleman

PRINTED: 07/25/2013 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A BUILDING		(X3) DATE SURVEY COMPLETED	
		232328	B WING		07/1	0/2013
	OVIDER OR SUPPLIER	IGAN		REET ADDRESS CITY, STATE, ZIP CODE 3950 BEAUBIEN BLVD DETROIT, MI 48201		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EAC CORRECTIVE ACTION SHOULD BE CROS REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
V 000	INITIAL COMMENTS	3	V 000			
V 111	expansion from 7 to In-center Hemodialys Home Peritoneal Dia Home Peritoneal Dia Home Peritoneal Dia Home Peritoneal Dia Home Peritoneal Dia Home Peritoneal Dia Home Peritoneal Dia Home Peritoneal Dia The purpose of this ure-certification, relocation of the evaluated this facility deficiencies to be the requirements not in condicated. 494.30 IC-SANITAR' The dialysis facility manitary environment transmission of infectivements are unit and other public areas. This STANDARD is Surveyor: 30988 Based on observation failed to maintain a denvironment, resulting infectious agents to facility. Findings included to maintain and environment area, the found on all window dirt and dust was found the treatment area, the found on all window dirt and dust was found the surveyor.	as: 11 (9+2 isolation rooms), 11 stations. Isis Patients: 15 Ilysis Training Stations:1 Ilysis Patients: 12 Imannounced survey was for ation and expansion. The sing & Regulatory Affairs has and found the stated ose federal certification compliance on the date(s) Y ENVIRONMENT Inust provide and monitor at to minimize the tious agents within and if any adjacent hospital or not met as evidenced by: In and interview, the facility is alean and sanitary ag in the potential to spread 15 patients served at the	V 11	Unit cleaning commenced during survey patient areas, including support rooms a common areas received thorough cleanitems, dusting of items, and removal of i including thick dust and debris on windo dirt and dust in storage cupboards, disciclean linen bags on sink and garbage casubstance on bottom of sink, discarding supplies and gown, floors in treatment a discarding medication bottles, dirt on hadirt at nurses station, dirt on emergency on suction machine, dirt on supply cart, nurses station shelves, dirt on floor of mistation, dirt on drip tray, removal of bicalings from soiled utility rooms, dust and dequipment maintenance floor, removal of Wipes on dialysis storage room floor, reand changing of transport cart. Daily mistation, dirt on drip transport cart.	and ing of tems; w sills, arding an, pink art irea ard drive, cart, dirt dirt on urses rbonate debris on of Kim	
ABORATORY	DIRECTOR'S OR PROVIDER	VSUPPLIER REPRESENTATIVE'S SIGNATUR	E	/a TITLE!		(X5) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency when 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE COMP	SURVEY LETED
		232328	B. WING _		07/	10/2013
	OVIDER OR SUPPLIER	GAN	STREET ADDRESS, CITY, STATE, ZIP CODE 3950 BEAUBIEN BLVD DETROIT, MI 48201			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE CORRECTIVE ACTION SHOUL REFERENCED TO THE APP DEFICIENCY)	D BE CROSS-	(X5) COMPLETION DATE
V 111	open bags of clean linsink with the top of the of the clean linen pile dried on pink substanthe sink. A desk chair ragged, worn cover ground in the isolation throughout the treatment in the containing pills treatment chair at sta. These findings were a 7/9/2013 at approxim who stated, "yes, I see housekeepers are su treatments are comple Surveyor: 27408 On 07/09/13 at approximital tour of the dialy that the following equation that the following equation to the comput nurses' station, the toe emergency cart, the stop of the white emericant, shelves behind the underneath the nurse under the alcohol-bathat was located acroemergency cart. On 07/09/13 at 0945 "surfaces should be composited to ensure the procedures are being Surveyor: 26222	to have a sink that had two men piled on the edge of the e garbage can laying on top . The sink at station 2 had a noce covering the bottom of r full of art supplies with a own over the back was room (station 2). The floors, ment area were visibly dirty st and debris. A medication was found under the tion 6. all observed with staff F on ately 1100 during the tour e the dirt and dust, the pposed to clean after eted." ximately 0930 during the sis treatment area, observed ipment had soiled surfaces: er hard drive, behind the p surface of the white suction machine stored on gency cart, the clean supply he nurses' station, the floor s' station, and the drip tray sed hand hygiene station, ss from the white Staff D confirmed that the flusted, cleaned, and hat facility policy and	V1	log was developed, approved be Director and implemented. Unit cleanliness rounds were initiate are now completed daily by the and building Environmental Ser Areas of deficiency will be immediates by the EVS Supervision to immediately addressed will the Unit Director for resolution. rounding will be shared weekly and EVS leadership, Medical Dorganization's Chief Operating and President. Staff were re-ed 7/29/2013 staff meeting regardi importance of unit cleanliness, all supplies off the floor and repunsanitary issues or non-function. The Unit Manager is responsible and ongoing monitoring.	environmental and 7/24/2013 and Unit Manager vices Supervisor. ediately sor. Deficiencies be escalated to Results of unit with staff, unit virector and the Officer (COO) ducated at the including storing orting any oning equipment.	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			COMPLETED	
		232328	B. WING			07/	10/2013
	ROVIDER OR SUPPLIER	IGAN		39	EET ADDRESS, CITY, STATE, ZIP CODE 950 BEAUBIEN BLVD ETROIT, MI 48201		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	92953	PROVIDER'S PLAN OF CORRECTION (EA CORRECTIVE ACTION SHOULD BE CROS REFERENCED TO THE APPROPRIATE DEFICIENCY)	SS-	(X5) COMPLETION DATE
V 111	bicarbonate jugs des stored in room 2137 utility" with a biohazar This room contained directly adjacent to a biohazard sign, contablood lines. A trash stored adjacent to the storage shelving. On 7/9/13 at approximate chlorine test was labeled "equipment in dust and debris accurfloor of this room. On 7/9/13 at approximate dialysate concentrati Wipes" (cleaning clot cleaning solution) we on the floor in the dialon the treatment shift pieces of plastic miss the top of the cart cobroken off. Dried whon the cardboard and An interview on 7/9/1 staff #B, who was acconfirmed that storagings to be stored in reutility" was inapproprinat it was inapproprinatit was inapproprinatic was in	ignated as "clean" are being which was labeled "soiled and symbol label on the door. shelving for "clean" jugs, bin labeled with a red ained used dialyzers and can contained trash was also be "clean" bicarbonate jug "mately 1045 observed that being performed in a room naintenance". There was mulation observed on the "mately 1055 boxes of ons and boxes labeled "Kim this impregnated with the observed stored directly alysis storage room. In the cart that the bicarbonate jugs at the end was observed to have sing, and cardboard taped to overing where the plastic had alte precipitate was observed it plastic surfaces. 3 at approximately 1050 with companying on the tour, ye for "clean" bicarbonate oom, 2137 labeled "soiled iate. Staff B also confirmed ate to store soiled or care items adjacent to	V	111			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		232328	B. WING		07/	10/2013
	OVIDER OR SUPPLIER	HIGAN	3	REET ADDRESS, CITY, STATE, ZIP CODE 950 BEAUBIEN BLVD DETROIT, MI 48201		
(X4) ID PREFIX TAG	(EACH DEFICIENT	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EA CORRECTIVE ACTION SHOULD BE CROS REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
V 111	staff #B, who was a confirmed that the c	ge 3 imately 1055 interview with ccompanying on the tour, hlorine test was being where dust and debris have	V 111			
	staff #B, who was a confirmed that "Kim impregnated with cle	rimately 1145 interview with occompanying on the tour, Wipes" (cleaning cloths eaning solution) were ectly on the floor in the m.				
V 113	staff #B confirmed the transport bicarbonal treatment shift was of plastic missing, and	ic surfaces.	V 113	V113 W ear Gloves/Hand Hygiene All staff re-educated at the 7/29/13 staff		
	patient or touching t dialysis station. Staf	oves when caring for the he patient's equipment at the f must remove gloves and en each patient or station.		regarding hand hygiene and proper use personal protective equipment by the organization's infection control practition Compliance will be audited daily by the limited Manager/Designee. Audit tool will be deand implemented by 8/2/2013. Audit result the argenization's Chief Operating Condition.	ers. Unit veloped sults will ector	
	Surveyor: 30988 Based on observation review the facility fail gloves and performance	on, interview, and document iled to ensure proper use of ance of hand hygiene, ntial for the spread of		and the organization's Chief Operating C and President. The Unit Manager is res for correction and ongoing monitoring.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDI			(X3) DATE SURVEY COMPLETED		
		232328	B. WING _			07/	10/2013	
	OVIDER OR SUPPLIER	GAN		3950 E	ADDRESS, CITY, STATE, ZIP CODE BEAUBIEN BLVD OIT, MI 48201			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	292	PROVIDER'S PLAN OF CORRECTION (E CORRECTIVE ACTION SHOULD BE CRO REFERENCED TO THE APPROPRIAT DEFICIENCY)	oss-	(X5) COMPLETION DATE	
V 113	in-center hemodialys include: On 7/10/2013 at approbservation of access 3, the RN (staff N) was glove around the independent of the independent o	oximately 0730, during an sing of a perm cath at station as observed wrapping a extinger of staff's N right arm on the treatment atting on the glove. Staff N hygiene after silencing the to finish setting up a 0/13 at 0900 with staff N, supposed to put the glove imately 1145, a review of the odialysis: Infection Control" atted 2/20/09 states "4. a. in caring for the patient or equipment at the station hands cleansed" en 0730 and 0745, staff L itiating treatment with a er (CVC) for patient #2. handling the lines of the hen applied a pair of gloves and hygiene and cleaned the loved the contaminated in, without performing hand it of sterile gloves and te the initiation of the	V	113				
	The observations wer	e completed on 07/10/2013						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 3 A	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		232328	B. WING		07/	10/2013
	OVIDER OR SUPPLIER	GAN		REET ADDRESS, CITY, STATE, ZIP CODE 3950 BEAUBIEN BLVD DETROIT, MI 48201		
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V 113	Quality and Corporate confirmed the finding hand hygiene she state perform hand hygiene and after removing glandling the CVC line replied "she should he touching it."	745, with the Director of the Compliance (staff F) who is. When queried about sted, "staff are supposed to be before putting on gloves oves. When asked about the swithout gloves staff F ave had gloves on when	V 113			
V 116	STATION=DISP/DED Items taken into the of be disposed of, dedice patient, or cleaned are taken to a common cleanother patient. Nondisposable item and disinfected (e.g., covered blood pressured dedicated for use only Unused medication vials containing diluer alcohol swabs, etc.) to should be used only from the containing dilueration of the containing diluera	dialysis station should either ated for use only on a single and disinfected before being lean area or used on that cannot be cleaned adhesive tape, cloth are cuffs) should be	V 116	Unit Manager met with Infection control of 7/25/2013 and work flow process was reprevent patient clipboards from being metatween clean and dirty areas. All staff of to the new process to prevent cross contamination on 7/29/2013 at the unit semeeting. Education was provided by the organization's infection control practition Compliance will be monitored by the Uniform Manager/Designee daily utilizing a newly developed audit tool. Audit tool will be deand implemented by 8/2/2013. Audit reside to be shared weekly with staff, unit leaders Medical Director the organization's Chie Operating Officer and President. The Uniform Manager is responsible for correction and ongoing monitoring.	evised to oved educated taff ers. it y eveloped ults will hip, f	
	Surveyor: 28273 Based on observation failed to ensure that it treatment station are taken to a clean area spread of infectious of	not met as evidenced by: and interview, the facility eems placed/used at the disinfected before being resulting in the risk for rganisms to all 15 patients modialysis treatments.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	The same services and	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		232328	B. WING		07/10/2013	
	OVIDER OR SUPPLIER	CHIGAN	39	EET ADDRESS, CITY, STATE, ZIP CODE 50 BEAUBIEN BLVD ETROIT, MI 48201		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EA CORRECTIVE ACTION SHOULD BE CROS REFERENCED TO THE APPROPRIATE DEFICIENCY)	SS- COMPLETION	
V 116	was observed on the care for patients #8 stations contained top of the treatment observed removing the treatment mack gloves, took it over and placed it down disinfecting it. After computer, staff L the top of the treatment Staff L was then observed for patient #8 and to machine without distributions were all performing described above at On 07/10/2013 bett Director of Quality is	ween 0715 and 1000, staff L ne treatment floor providing 3 and #10. All the treatment a black clipboard stored on the t machine. Staff L was g the clipboard from the top of nine at station #8 without to the computer work station on the shelf without staff L entered data into the nen returned the clipboard to ment machine at station #8. served carrying out the same #10 taking the clipboard to the ork station that she had used hen returned it to station #10's sinfecting it. s practice from staff L, made of staff M and O, who the task in the same manner other treatment stations. ween 0715 and 1000, the and Corporate Compliance	V 116			
V 196	both staff L and state (staff A) was presed both staff M and Ocalways done that, I about taking it from and then back to the asked if the compudirty she stated "cleatment station, seand the machine and the machine and states."	nt during the observation of iff F and the Clinic Manager, int during the observations of Staff A stated "we have don't think that anyone thinks the machine to the computer in machine." When staff A was ter was considered clean or ean." When asked about the staff A stated that "the chair re considered dirty areas."	1 1	V196 Carbon Absorption/Monitoring/	18-18-19-19-19-19-19-19-19-19-19-19-19-19-19-	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		232328	B. WING			07/10/2013	
	OVIDER OR SUPPLIER	GAN		3	EET ADDRESS, CITY, STATE, ZIP CODE 950 BEAUBIEN BLVD ETROIT, MI 48201		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX CORRECTIVE ACTION SHOULD BE CRO		PROVIDER'S PLAN OF CORRECTION (EAR CORRECTIVE ACTION SHOULD BE CROS REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
V 196	Testing for free chlorichlorine should be pereach treatment day provided the pereach treatment and again provided the pereach treatment and again provided the pereach testing should be pereach thours. Results of monitoring or total chlorine should sheet. Testing for free chlorichlorine can be accorned to the pereach the pereach test with the pereac	ion: monitoring, testing freque, chloramine, or total rformed at the beginning of rior to patients initiating prior to the beginning of each are no set patient shifts, formed approximately every of free chlorine, chloramine, do be recorded in a log the ene-diamine (DPD) based and test strips. On-line to measure chloramine never test system is used, it ensitivity and specificity to levels described in [AAMI] is a maximum level of 0.1 frawn when the system has least 15 minutes. The enformed on-site, since decrease if the sample is the interview, the facility (reverse osmosis) system the end interview, the facility (reverse osmosis) system the end interview, the facility (reverse osmosis) system the end interview or total	V		Facilities Manager on 7/19/2013 regarding to run RO water line for 15 minutes prior sampling for free chlorine, chloramine are chlorine. Current testing log amended to start and stop times for 15 minute water. Test strips were ordered and arrived on for the samplings. All ESRD facilities engineering staff, and any other staff who for free chlorine, chloramine or total chloring be color blindness tested. Staff C was the color blindness upon hire and test result available as needed. Facilities Engineer responsible for monitoring and maintenate the log to ensure ongoing compliance.	to nd total include run. 08/05/13 o test rine will sted for s are ring is	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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	OVIDER OR SUPPLIER	GAN		REET ADDRESS, CITY, STATE, ZIP CODE 3950 BEAUBIEN BLVD DETROIT, MI 48201		
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V 196	the potential for patier patients served. Find the chlorine test, staff RO system is operating. Staff C responsion of a couple of relarification Staff C stapproximately 5-7 minutesting." On 7/9/13 at approximately 5-7 minutesting." Sys-DFU/MONITOR 5.4.4.1 Mixing system DFU/monitor/PM/log/If a concentrate mixing preparer should follow instructions for mixing amount of water. If a concentrate mixing number of bags or the should be determined. Manufacturer's recomfollowed regarding and and sanitization process.	led test result, resulting in ht harm for 15 incenter lings include: Inately 1045 while observing of C was asked how long the ring in the morning prior to ended that the RO system minutes," and upon further lated that "the system runs mutes in the morning prior to ended that he "has never been less." I/PM/LOG/SANITIZE Installing system is used, the line that he with the correct line of powder added and recorded. If y preventive maintenance endures, Records should be the date, time, person dure, and results (if	V 19	6 V226 DFU/Monitor/Log/Sanitize Staff re-educated 7/29/2013 by Unit Marregarding manufacturer's instructions fo preparing the bicarbonate solution. All strained on 7/29/2013 by Unit Manager ir of the monitor and a log was developed date) to maintain records for mixing the Testing strips were delivered on 08/05/1 bicarbonate solution testing. pHoenix m from Mesa Labs has been ordered. This equipment monitors pH and conductivity bicarbonate solution. This process will I soon as the equipment is delivered. Ant date of delivery 8/19/2013. Unit Manage monitor completion of the logs.	r taff were taff were the use (on what solution. 3 for nonitor to of begin as icipated	
			1			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		00 - 10 00 00 000	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		232328	B. WING			07/	10/2013
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(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG	0 1	PROVIDER'S PLAN OF CORRECTION (EA CORRECTIVE ACTION SHOULD BE CROS REFERENCED TO THE APPROPRIATE DEFICIENCY)	SS-	(X5) COMPLETION DATE
V 226	concentrate from pow according to the man	g either bicarbonate or acid /der should be monitored ufacturer's instructions.	V	226			
	Surveyor: 26222 Based on interview, the manufacturer's instruction mixing bicarbonate	not met as evidenced by: the facility failed to follow ctions and maintain records e solutions resulting in the arm for 15 patients served					
	facility does not have solutions. Staff A state Assistant (MA) mixes jugs in the mornings, Staff A stated that "the the storage shelf (loca 2137) and brings there bicarb mixing." Staff the individual packet filled up with RO (revet then the jug is placed When asked if there weach jugs' concentrate A confirmed that there this process." When solution after mixing to the proper concent that "the bicarbonate Directions for use on	it was discovered that the a log for mixing bicarbonate					
V 243	494.40(a) BICARB JU	JGS RINSED	V	243	V243 Bicarb Jugs Rinsed Daily/Store	d Dry	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		232328	B. WING		07/1	0/2013
	OVIDER OR SUPPLIER	GAN		REET ADDRESS, CITY, STATE, ZIP CODE 3950 BEAUBIEN BLVD DETROIT, MI 48201		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (E. CORRECTIVE ACTION SHOULD BE CRO REFERENCED TO THE APPROPRIATE DEFICIENCY)	SS-	(X5) COMPLETION DATE
V 243	daily/stored dry Bicarbonate concents with treated water an of each treatment day be rinsed with treated at the end of each tre This STANDARD is a Surveyor: 26222 Based on observation failed to properly rins jugs in a clean area r transmission of infect	ibution: bicarb jugs rinsed rate jugs should be rinsed d stored inverted at the end y. Pick-up tubes should also d water and allowed to air dry	V 243	Bicarbonate are no longer stored in the utility room after being rinsed. A room converted and will be used as a clean croom for rinsing and storing of the bicargings with a RO line in the room. This was 8/2/2013. All staff involved in the new pare educated by the Unit Manager on Compliance with storage of the bicarbo be audited daily by the Unit Manager/D and shared with staff, unit leadership, No Director, the organization's Chief Opera Officer and President. Director of Facilities will install an RO win a permanent room where the bicarbourgs will be cleaned. Installation will be completed by 8/19/2013. The Unit Managersponsible for correction and ongoing monitoring.	has been utility rbonate rill begin process 7/29/13. mate jugs resignee Medical ating vater line onate	₩
V 402	interview with Staff A bicarbonate jugs are "Soiled Utility" room 2 designated shelving vat approximately 115 Room 2137 does not but only municipal wat two-compartment sin jugs are rinsed in the steel sink, located in 494.60(a) PE-BUILDING-CONS SAFETY The building in which furnished must be co	STRUCT/MAINTAIN FOR	V 402	V402 Building Constructed for Safety Drywall patched and painted. Complete 7/30/2013 Hand held sprayer with shut off valve re and replaced with hand held shower tyl sprayer without shut off. Completed 7/2 An indirect waste or air gap will be instated the drain line for the ice machine prior to sewer line at the hand sink	emoved pe 29/2013. alled on	

(B): 15.50.50 (B) (B): 15.50 (B):		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	III E. E. Santon	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		232328	B. WING _		07	/10/2013	
	OVIDER OR SUPPLIER	GAN		STREET ADDRESS, CITY, STATE, ZIP CODE 3950 BEAUBIEN BLVD DETROIT, MI 48201			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR CORRECTIVE ACTION SHOU REFERENCED TO THE AI DEFICIENCY	ULD BE CROSS- PPROPRIATE	(X5) COMPLETION DATE	
V 402	Surveyor: 26222 Based on observation failed to maintain a sa incenter patients resurpatient outcomes. Findings include: On 7/9/13 at approximate ice machine was to the sewer line at the On 7/9/13 at approximate confirmed by staff B On 7/9/13 at approximate drywall were observed treatment stations who containers had been as	not met as evidenced by: n and interview the facility afe environment for all 15 alting in the risk for poor nately 1030 the drain line for observed directly connected e adjacent hand sink drain. nately 1030, this was nately 1020, holes in the d on the headwall of patient	V 4	. This work will be completed Responsible person is the Direction			
V 409	sprayer at the soiled to have a shut off valve. located downstream for vacuum breaker. On 1050, the location of the confirmed by staff B. 494.60(d)(1) PE-ER F. STAFF-INITIAL/ANNUTTHE dialysis facility more training and orientation preparedness to the state of the s	rom the atmospheric 7/9/13 at approximately the shut off valve was PREP JAL/INFORM PTS ust provide appropriate on in emergency staff. Staff training must be ed at least annually and	V 4	O9 V409 Emergency Preparedn All staff receive education reg codes upon hire. This training organization's Safety Director unit staff will be trained by 08/ Manager and Safety Officer in emergency/disaster procedure dialysis unit and its patient po specific emergency	arding emergency is provided by the Additionally, all 709/12 by Unit n es specific to the		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIP A. BUILDING	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		232328	B. WING		07/1	10/2013
	OVIDER OR SUPPLIER	GAN	s	REET ADDRESS, CITY, STATE, ZIP CODE 3950 BEAUBIEN BLVD DETROIT, MI 48201		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (I CORRECTIVE ACTION SHOULD BE CR REFERENCED TO THE APPROPRIA' DEFICIENCY)	oss-	(X5) COMPLETION DATE
V 409	informing patients of- (A) What to do; (B) Where to go, inclusion occasions when the go dialysis facility must be (C) Whom to contact while the patient is not contact information memergency phone nut instances when the directive phone calls distribution (unless the forward calls to a work such emergency condialysis machine if an This STANDARD is resurveyor: 30988 Based on interview the appropriate training a preparedness to all still	ading instructions for leographic area of the leographic area of the leographic area of the leographic area of the leographic area of the leographic area of the leographic area of the leographic area of the leographic area of the leographic area of the leographic area of the leographic actions of the leographic and leographic area of the leog	V 40	g preparedness plan will be developed to 08/09/13. This plan will include a descripation training on: what to do, where the event of an evacuation, whom to contain emergency occurs when the patient is facility, and how to disconnect themse the dialysis machine if an emergency of Evacuation training with the use of the Evacuation Chair will be completed. Additionally, all staff will be trained registre individual role in the evacuation of Current staff training will be completed 08/09/13. This training will also take planew employees upon hire and for all sannually thereafter. Training will be prothe Safety Director and Unit Manager. Evacuation drills will be performed at I annually and will be documented. The education plan was reviewed with and by the unit Medical Director. The Med Director, Unit Manager, and Chief Ope Officer are responsible for correction a ongoing monitoring.	ription of to go in the act if an not in the lives from occurs. Stryker arding process. I by ace for all taff ovided by east e approved ical erating	
V 520	during interview of state had been taught about preparedness, both sidefine their roles in the 494.80(d)(2) PA-FRE REASSESSMENT-UT In accordance with the paragraphs (a)(1) through the state of the sta	nd at approximately 1015 aff I, when asked what they at their role in emergency aff H & I were unable to e event of a disaster. QUENCY	V 52	OV520 Plan of Care for unstable patie The Pediatric Dialysis Patient Plan of policy and the Unstable Dialysis Patien have been reviewed and revised to increase specifically related to monthly of plan of care for unstable patients.	Care nt policy clude	

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: A. BUILDING		(X3) DATE SURVEY COMPLETED				
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	OVIDER OR SUPPLIER	GAN		3	EET ADDRESS, CITY, STATE, ZIP CODE 950 BEAUBIEN BLVD ETROIT, MI 48201		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFII TAG		PROVIDER'S PLAN OF CORRECTION (EA CORRECTIVE ACTION SHOULD BE CROS REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
V 520	but not limited to, pati (i) Extended or freque (ii) Marked deteriorati (iii) Significant change (iv) Concurrent poor runmanaged anemia a This STANDARD is r Surveyor: 27408 Based on document r determined that the fainterdisciplinary team comprehensive reass patient needs for 2 of reviewed (patient #2 a 07/09/13 at 1145 duri the following was conhospitalized from May days), and again from 2013 (10 days). Upon hospital, the patient refacility on 06/10/13. A titled "Nephrology-Diphysician stated that on 06/14/13. The phy the "Nephrology-Dialy 03/11/13, 04/03/13, a was also deemed as The last "Compreher Patient Assessment/O	nstable patients including, ents with the following: ent hospitalizations; on in health status; e in psychosocial needs; or nutritional status, and inadequate dialysis. The time tas evidenced by: eview and interview, it was acility failed to ensure the developed an individualized essment of all unstable 2 unstable records and #3). Findings include: On the medical record review firmed: patient # 2 was a 3rd to May 22nd, 2013 (17 a May 29th to June 7th, and discharge from the esumed care at the ESRD according to the documents alysis HD Clinic," the the patient was "unstable " sician also documented on a visis HD Clinic" visits for and 05/24/13, that the patient "unstable." asive Multidisciplinary	V		Policy Reviewed and revised on 7/19/20 will be approved by Medical Director. Un Manager will obtain approval of Division 8/5/2013. All staff was educated regardicompletion of a monthly revision of the pcare for unstable patients; including but limited to extended or frequent hospitaliz marked deterioration in health status, sigchange in psychosocial needs, poor nut status, unmanaged anemia and inadequidialysis. Unit staff was educated by the Manager and physician staff by the unit Director. All education to be completed to 08/24/13. Staff nurses will audit medical weekly for compliance beginning 8/5/20 results will be shared monthly with unit sleadership, Medical Director and Chief Cofficer. The Medical Director, Unit Mana Chief Operating Officer are responsible correction and ongoing monitoring.	nit Chief by ing lan of not zations, gnificant ritional tate Unit Medical by I records 13. Audit staff, Operating ager, and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	2 0	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
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	OVIDER OR SUPPLIER	IGAN		STREET ADDRESS, CITY, STATE, ZIP CODE 3950 BEAUBIEN BLVD DETROIT, MI 48201	•		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT CORRECTIVE ACTION SHOULD B REFERENCED TO THE APPRO DEFICIENCY)	BE CROSS-	(X5) COMPLETION DATE	
V 520	"Pediatric Dialysis Pa CHM MOD PC 005, 02/20/09, revealed the comprehensive reast with a revision of the conducted annually a stable patients and a (patients)." On 07/10/13 at 1000 confirmed with Staff Surveyor: 30988 On 7/10/13 at approx review for patient #3 identified as unstable	, a review of the policy titled attent Plan of Care" number: with an effective date of nat under Provisions, #6, "A sessment of each patient plan of care will be and prn (as needed) for t least monthly for unstable 0, these findings were	V 5	20			
V 542	of care completed fo The next plan of care where the patient wat On 07/10/13 at 1150 "there are no addition #3)." 494.90(a) POC-IDT II The interdisciplinary care for each patient This STANDARD is Surveyor: 28273 Based on record revireview, the facility fail members of the Inter involved in the devel of Care (PPOC) for 1	r patient # 3 in March 2013. e found was dated "4/13/13" es made stable. , interview of staff A revealed hal plans of care (for patient DEVELOPS PLAN OF CARE team must develop a plan of	V 5	V542 Interdisciplinary POC Dietician re-educated regarding proporticipation in, and documentation multidisciplinary care planning me 7/11/2013 by the Unit Nurse Mana Completion of the Nutrition section Pediatric Plan of Care by the Mult Team will be audited monthly. Audibe shared monthly with staff, unit Medical Director, and the organiza Operating Officer. The Medical Diresponsible for correction and ongmonitoring.	en after eetings on ager. In and the idisciplinary dit results will leadership, ation's Chief rector, Unit ficer are		

F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		223	CORRECTIVE ACTION SHOULD BE CRO	SS-	(X5) COMPLETION DATE
poor patient outcome for the twelve patient Findings include: On 07/09/2013 at 1 record for patient # patient dated 09/20 documentation by the section titled "nutrity". On 07/09/2013 at 1 PPOC was confirmed and staff G. When all lack of documentation in the area of the section to the sect	nes and unmet patient needs ints being served by the facility. 130, review of the medical 5 revealed a PPOC for the i/2012. The PPOC lacked he dietician in the entire ion". 500, the lack of findings in the ed and discussed with staff A staff A was queried about the ion she stated "we have some of nutrition." 100, during an interview with book place about the lack of ne nutritional section of the ed, staff I did not give an the documentation was not 2013 at 1145, of the "DMC of Michigan" policy number , effective date 01/17/2009, it ion (Pediatric Plan of Care) I.	V	542			
desired by the patie member." 494.90(b)(1) POC- IDT & PT The patient's plan of (i) Be completed by	ent or the patient's family COMPLETED/SIGNED BY of care must- the interdisciplinary team,	V	Tea All : dur imp	am staff were re-educated by the Unit N ing the 7/29/2013 staff meeting rega portance of signing, dating and timin	lanager arding the g all	
	SUMMARY (EACH DEFICIENT REGULATORY OF MICE Continued From particle particles and poor patient outcome for the twelve patient findings include: On 07/09/2013 at 1 record for patient # patient dated 09/26 documentation by the section titled "nutrity on 07/09/2013 at 1 PPOC was confirm and staff G. When a lack of documentation in the area of the completed. On 07/10/2013 at 1 staff I, discussion to documentation in the PPOC. When querie explanation of why completed. A review on 07/10/2 Children's Hospital CHM MOD PC 001 revealed on page 5 "K. PPOC Complet The PPOC will be of IDT including the patient by the patient member." 494.90(b)(1) POC-01 IDT & PT The patient's plan of (i) Be completed by	ROVIDER OR SUPPLIER N'S HOSPITAL OF MICHIGAN SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 15 poor patient outcomes and unmet patient needs for the twelve patients being served by the facility. Findings include: On 07/09/2013 at 1130, review of the medical record for patient #5 revealed a PPOC for the patient dated 09/26/2012. The PPOC lacked documentation by the dietician in the entire section titled "nutrition". On 07/09/2013 at 1500, the lack of findings in the PPOC was confirmed and discussed with staff A and staff G. When staff A was queried about the lack of documentation she stated "we have some issues in the area of nutrition." On 07/10/2013 at 1100, during an interview with staff I, discussion took place about the lack of documentation in the nutritional section of the PPOC. When queried, staff I did not give an explanation of why the documentation was not completed. A review on 07/10/2013 at 1145, of the "DMC Children's Hospital of Michigan" policy number CHM MOD PC 001, effective date 01/17/2009, revealed on page 5: "K. PPOC Completion (Pediatric Plan of Care) I. The PPOC will be completed by members of the IDT including the patient and/or patient family if desired by the patient or the patient's family member." 494.90(b)(1) POC-COMPLETED/SIGNED BY	ROVIDER OR SUPPLIER N'S HOSPITAL OF MICHIGAN SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 15 poor patient outcomes and unmet patient needs for the twelve patients being served by the facility. Findings include: On 07/09/2013 at 1130, review of the medical record for patient #5 revealed a PPOC for the patient dated 09/26/2012. The PPOC lacked documentation by the dietician in the entire section titled "nutrition". On 07/09/2013 at 1500, the lack of findings in the PPOC was confirmed and discussed with staff A and staff G. When staff A was queried about the lack of documentation she stated "we have some issues in the area of nutrition." On 07/10/2013 at 1100, during an interview with staff I, discussion took place about the lack of documentation in the nutritional section of the PPOC. When queried, staff I did not give an explanation of why the documentation was not completed. A review on 07/10/2013 at 1145, of the "DMC Children's Hospital of Michigan" policy number CHM MOD PC 001, effective date 01/17/2009, revealed on page 5: "K. PPOC Completion (Pediatric Plan of Care) I. The PPOC will be completed by members of the IDT including the patient and/or patient family if desired by the patient or the patient's family member." 494.90(b)(1) POC-COMPLETED/SIGNED BY IDT & PT The patient's plan of care must- (i) Be completed by the interdisciplinary team,	ROVIDER OR SUPPLIER N'S HOSPITAL OF MICHIGAN SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 15 poor patient outcomes and unmet patient needs for the twelve patients being served by the facility. Findings include: On 07/09/2013 at 1130, review of the medical record for patient #5 revealed a PPOC for the patient dated 09/26/2012. The PPOC lacked documentation by the dietician in the entire section titled "nutrition". On 07/09/2013 at 1500, the lack of findings in the PPOC was confirmed and discussed with staff A and staff G. When staff A was queried about the lack of documentation she stated "we have some issues in the area of nutrition." On 07/10/2013 at 1100, during an interview with staff I, discussion took place about the lack of documentation in the nutritional section of the PPOC. When queried, staff I did not give an explanation of why the documentation was not completed. A review on 07/10/2013 at 1145, of the "DMC Children's Hospital of Michigan" policy number CHM MOD PC 001, effective date 01/17/2009, revealed on page 5: "K. PPOC completion (Pediatric Plan of Care) I. 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On 07/10/2013 at 1100, during an interview with staff I, discussion took place about the lack of documentation in the nutrition section of the PPOC. When queried, staff I did not give an explanation of why the documentation was not completed. A review on 07/10/2013 at 1145, of the "DMC Children's Hospital of Michigan' policy number CHM MOD PC 001, effective date 01/17/2009, revealed on page 5: "K. PPOC Completion (Pediatric Plan of Care) I. The PPOC will be completed by members of the IDT including the patient and/or patient family if desired by the patient or the patient's family member." 49.9.0(b)(1) POC-COMPLETED/SIGNED BY IDT & PT The patient's plan of care must. (i) Be completed by the interdisciplinary team,	ROWIDER OR SUPPLIER N'S HOSPITAL OF MICHIGAN SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL, REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 15 poor patient outcomes and unmet patient needs for the twelve patients being served by the facility. Findings include: On 07/09/2013 at 1130, review of the medical record for patient fare we have some issues in the area of nutrition." On 07/09/2013 at 1500, the lack of findings in the PPOC was confirmed and discussed with staff A and staff G. When staff A was queried about the lack of documentation she stated "we have some issues in the area of nutrition." On 07/10/2013 at 1100, during an interview with staff I, discussion took place about the lack of documentation in the nutritional section of the PPOC. When queried, staff Id dind tigve an explanation of why the documentation was not completed. 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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	75-20 man assessment	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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	OVIDER OR SUPPLIER	IGAN	3	REET ADDRESS, CITY, STATE, ZIP CODE 950 BEAUBIEN BLVD DETROIT, MI 48201		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD REFERENCED TO THE APPRIDEFICIENCY)	BE CROSS-	(X5) COMPLETION DATE
V 556	patient or the patient chooses not to sign to must be documented with the reason the something the patient of the solution of the patient of	team members, including the 's designee; or, if the patient he plan of care, this choice on the plan of care, along ignature was not provided. In our met as evidenced by: It was and interview, the facility hat all the members of the disciplinary team (IDT) met not review all aspects of the 1 of 2 peritoneal patient 1 of 5 in-center charts reviewed, for a total larts (#2, #3, #5 #6, and #7). In during document review of the comprehensive ent assessment for patient to that the plan of care was embers of the Interdisciplinary by the physician and the social ere completed). These findings were	V 556	care and multidisciplinary patient including signatures of the patien medical record audit specific to the was created 7/22/2013. Staff numedical records weekly for comp beginning 8/5/2013. Audit results monthly with unit staff and leader Director and Chief Operating Offi Medical Director and Unit Manag responsible for correction and on monitoring.	at care giver. A the dialysis unit trees will audit diance twill be shared reship, Medical ticer. The ter are	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		232328	B. WING		07/10/2013	
	OVIDER OR SUPPLIER	GAN		REET ADDRESS, CITY, STATE, ZIP CODE 1950 BEAUBIEN BLVD DETROIT, MI 48201		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EAG CORRECTIVE ACTION SHOULD BE CROS REFERENCED TO THE APPROPRIATE DEFICIENCY)		
V 556	record for a pediatric patient (patient #5), ro of care (PPOC) for pasignatures and dates lacked a signature artwo of the three doct. The PPOC for Augus and dates for the Die Patient Care Giver. The PPOC for Septer signatures and dates Worker and the Patien The PPOC for Septer signature and date for the above findings we discussed with staff #4	200, review of the medical home peritoneal dialysis evealed three pediatric plans atient #5 all lacking complete of the IDT members and ad date for the Care Giver on aments. St 9, 2011, lacked signatures tician, Social Worker and mber 13, 2011 lacked for the Dietician, the Social nt Care Giver. The Dietician. The Dietician and the Dietician and the Dietician. The Dietician and the Dietic Manager) on who stated "we have some	V 556			
V 625	This CONDITION is Surveyor: 28273 Based on document of facility failed to comp Quality Assessment of the areas of aggregation improvement of caimprovement plans a performance improve potential for poor patiunmet patient care go	review and interview the ly with the Condition of Performance Improvement in tied data, developed plans are, monitored outcomes of and prioritized plans for ment resulting in the ent outcomes and ongoing oals for all 27 patients m the facility. Findings	V 625	The unit Medical Director & Unit Manage develop a QAPI plan specific to the dialy department by 08/24/13. The plan will id program goals, metrics, auditing and trei methods, reporting structure. Medical D and Chief Operating Officer will impleme quality assurance and performance improvement program by 08/24/13 that encompasses, at a minimum: aggregate related to quality indicators, plans for improvement of care and monitoring out of such plans, and prioritizing plans for improvement based on potential severity including monitoring indicators to ensure improved health outcomes, quality indicator treflect performance components, more medical injuries and errors, monitoring tracking of grievances and	sis entify nding irector nt a d data comes	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A Section occurs		CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		232328	B. WING _			07/1	10/2013	
	ROVIDER OR SUPPLIER	IGAN		39	EET ADDRESS, CITY, STATE, ZIP CODE 950 BEAUBIEN BLVD ETROIT, MI 48201			
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V 625 V 627	(V-627) Failure to har monitoring indicators outcomes. (V-628) Failure to moreflect performance of (V-634) Failure to more errors. (V-636) Failure to more and use patient satistic (V-638) Failure to more improvement. (V-639) Failure to primit improvement activities 494.110(a)(1) QAPI-0 INDICATORS=IMPRIME	ve ongoing program to ensure improved health conitor quality indicators that components. conitor medical injuries and conitor and track grievances faction surveys. conitor performance coritize performance cs. CONGOING;USES COVEMENT		627	patient satisfaction, monitoring and prior performance improvement. The unit Me Director will lead the monthly unit multidisciplinary Quality Council. The ne created Dialysis QAPI Dashboard will be reviewed at each Quality Council meetin performance improvement plans will be developed by the team as needs are ide V627 QAPI Ongoing QAPI Program The Hospital will ensure that the QAPI	dical wly e g and ntified.		
	an ongoing program improvement in healt medical errors by usi measures associated outcomes and with the reduction of medical. This STANDARD is Surveyor: 28273 Based on quality meet the facility failed to shorogram that continuatends outcomes and plan when needed, reidentification of quality opportunities. Finding On 07/09/2013 at 113 quality documents lat	errors. not met as evidenced by: eting review and interview, now evidence of an ongoing ously monitors indicators, I develops an improvement esulting in the lack of ty improvement			includes, but is not limited to, an program that achieves measurable important health outcomes and reduction of errors by using indicators or performeasures associated with improved outcomes and with the identificat	ongoing rovement medical formance defends of the uncil will leasures, oment of ng goals, rrently in ent plans eeded for w will be g at the ing. The		

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(health outcomes - physical and mental functioning, and patient survival) were documented or monitored and when indicated developed an improvement plan to improve health outcomes and reduce medical errors. A review of the two quality documents labeled "quality meeting minutes," provided by staff A (one each dated January 24, 2013 and June 11, 2013), revealed that the Quality Committee did review some quality indicators but failed to aggregate and trend data outcomes and develop action plans to improve those outcomes. On 07/10/2013 at 1315 during interview with staff A, when queried about quality indicators, trending outcomes and action plans she stated: "When we have a quality meeting we discuss things that need to be looked at." When asked to see the data in regards to trending and action plans taken to improve outcomes, staff A was unable to produce the data. V 628 V 628 QAPI Quality Indicator Tracking The dialysis facility must measure, analyze, and track quality indicators or other aspects of performance that the facility adopts or develops that reflect processes of care and facility indicators or other aspects of performance that the facility adopts or develops that reflect processes of care and facility indicators, and monitoring of, assessment and improvement of care, medical injuries/errors, patient satisfaction and grievance intervention, infection control compliance, prioritize surveyor: 28273	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFI	X CORRECTIVE ACTION SHOUL REFERENCED TO THE APP	D BE CROSS-	COMPLETION	
facility failed to monitor all aspects of the End Stage Renal Disease (ESRD) program by monthly tracking of aggregate data with progress toward goals of influencing desired patient		(health outcomes - ph functioning, and patie documented or monit developed an improvement of the two quality of the two quality meeting minus (one each dated Janua 2013), revealed that the review some quality in aggregate and trend action plans to improvement of the two quality in aggregate and trend action plans to improvement of the two quality meeting need to be looked at data in regards to trend to improve outcomes produce the data. 494.110(a)(2) QAPI-MEASURE/AN INDICATORS The dialysis facility meting track quality indicator performance that the that reflect processes operations. These performent influence or relator be the outcomes the surveyor: 28273 Based on document facility failed to monit	hysical and mental ent survival) were tored and when indicated rement plan to improve reduce medical errors. A ality documents labeled utes," provided by staff A uary 24, 2013 and June 11, the Quality Committee did ndicators but failed to data outcomes and develop we those outcomes. 15 during interview with staff ut quality indicators, trending plans she stated: "When we had we discuss things that "When asked to see the nding and action plans taken to staff A was unable to hat yet a sor other aspects of facility adopts or develops of care and facility erformance components atte to the desired outcomes hemselves. In the quality indicators and develop we those outcomes are to the desired outcomes hemselves. In the quality indicators and develop we discuss things that "When we have discuss things that "When asked to see the nding and action plans taken to the desired outcomes are of the desired outcomes hemselves. In the quality indicators and develop we have a service of the end outcomes hemselves.		The Hospital will ensure the dia measures, analyzes, and tracks indicators or other aspects of puthe facility adopts or develops the facility adopts or develops the processes of care and facility of Specifically, a Dialysis QAPI Dadeveloped which includes all reindicators, and monitoring of, as improvement of care, medical in patient satisfaction and grievan infection control compliance, primprovement activities, organizes monthly tracking of aggregate of	alysis facility s quality erformance that that reflect perations. ashboard was equired quality ssessment and njuries/errors, ace intervention, rioritize ational goals, data with progress		

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V 628	logs of the assessmin the facility, resultir missed/un-identified improvement related patient satisfaction 8 infection control common on 07/10/2013 at 11 documentation titled and tracking docume facility did not keep of logs for analyzing and to influence desired the logs for tracking by the Clinic Managed documentation did not prioritized and dialysis adequated on 07/10/2013 at 13 minutes and tracking confirmed with the CD During the interview review of the tracking confirmed with the CD During the interview review of the tracking lifection Rates-2013 documentation (data for "Home PD Infectid data for May 2013 at 13 minutes for May 2013 at 13 minutes and tracking confirmed with the CD During the interview review of the tracking lifection Rates-2013 documentation (data for "Home PD Infectid data for May 2013 at 13 minutes and tracking confirmed with the CD During the interview review of the tracking lifection Rates-2013 documentation (data for "Home PD Infectid data for May 2013 at 13 minutes and tracking lifection Rates-2013 documentation (data for May 2013 at 13 minutes and tracking lifetimes and tracking lifetimes and tracking confirmed with the CD During the interview review of the tracking lifetimes and tracking confirmed with the CD During the interview review of the tracking lifetimes and tracking confirmed with the CD During the interview review of the tracking lifetimes and tracking confirmed with the CD During the interview review of the tracking lifetimes and tracking confirmed with the CD During the interview review of the tracking lifetimes and tracking confirmed with the CD During the interview review of the tracking lifetimes and tracking confirmed with the CD During the interview review of the tracking lifetimes and tracking confirmed with the CD During the interview review of the tracking lifetimes and tracking lifetimes and tracking lifetimes and tracking lifetimes and tracking li	g current, their monitoring ent and improvement of care on in the potential for opportunities for a to medical injuries/errors, a grievance intervention and opliance. Findings include: 30 a review of the "quality meeting minutes" entation revealed that the complete and up- to- date and tracking quality indicators patient outcomes. Review of quality indicators, provided er (staff A) revealed that the ot address medical intervention activities. "quality meeting minutes" for ata regarding infection rates by. The quality meeting minutes are quality ESRD conditions for a quality ESRD conditions for a quality ESRD conditions for a logs were discussed and a linic Manager (staff A). On 07/10/2013 at 1315, a g log titled "Hemodialysis"	V 628	allows easy review of progres and facilitates the creation of tir The dashboard was created 7/2 implemented 8/1/2013. Respon the Medical Director and the Officer.	mely action plans. 29/2013, and was ssible persons are	

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V 628 V 634	The program must income the following: (vi) Medical injuries a identification. This STANDARD is Surveyor: 28273 Based on document of facility failed to include injuries and medical exassessment Perform Program minutes discipotential for missed comprovement of paties served by the facility. On 07/10/2013 at 133 the tracking logs and the Clinic Manager (swas no tracking comproduced errors or made the Clinic Manager states.	PI-INDICATOR-MEDICAL clude, but not be limited to, and medical errors not met as evidenced by: review and interview, the le variance data for medical error reporting in the Quality ance Improvement (QAPI) cussion resulting in the apportunities for nt care for all 27 patients	33		V634 QAPI Tracking for Medical injuries/errors and errors is accomplished in the organization electronic reporting program. Beginning 8/1/2013, monthly reports will be run and resulting data will be included on the Dia QAPI dashboard and reported at the Dia Quality Council. The Medical Director, UM anager and Chief Operating Officer are responsible for correction and ongoing monitoring.	on's d the alysis alysis nit	
V 636	& GRIEVANCES	API-INDICATOR-PT SATIS clude, but not be limited to, on and grievances.	v		V636 QAPI Beginning 8/1/2013, a monthly report of grievances will be provided and reported Dialysis QAPI Dashboard at the Dialysis Council. The Medical Director, Unit Man Chief Operating Officer are responsible correction and ongoing monitoring.	on the Quality ager and	
	This STANDARD is	not met as evidenced by:					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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V 636	facility failed to include satisfaction and patie Quality Assessment R (QAPI) Program result missed opportunities care for all 27 patient Findings include: On 07/10/2013 at 137 the tracking logs and the Clinic Manager (sof patient satisfaction When queried, the Clinave not done any satisfaction when queried, the Clinave not had any gride anything in the meeting 494.110(b) QAPI-MONITOR/ACTIMPROVE The dialysis facility material performance, take accept performance to ensure sustained over time. This STANDARD is a Surveyor: 28273 Based on review of the Performance Improved documentation and in ensure that it continuation and tracks performance resulting in unidentified.	review and interview, the e variance data for patient int grievance reports in the Performance Improvement Iting in the potential for for improvement of patient is served by the facility. 15, interview and review of quality meeting minutes with taff A), revealed no tracking or grievances for 2013. inic Manager stated "we itisfaction surveys and we evances, so there is not ing minutes about it." ITTRACK/SUSTAIN ust continuously monitor its tions that result in ments, and track re that improvements are not met as evidenced by: the Quality Assessment ement (QAPI) terview, the facility failed to ously monitors, takes action ce improvement outcomes, ed opportunities for improved all 27 patients receiving		638	The Unit Manager and Manager of the organization's Patient & Family Relation department are currently creating a satis survey for Dialysis patients and families survey will be completed and implement 08/24/13. Survey results will be reported Dialysis QAPI Dashboard and reported Dialysis Quality Council monthly. The M Director and Unit Manager are responsicorrection and ongoing monitoring. V638 QAPI Monitoring/Tracking/Sustantial Continuous monitoring of performance improvement, tracking performance improvement, tracking performances for continuous improvement, and are clearly noted on the Dialystoshboard. The dashboard will become effective 8/1/2013. Data for the previous months has been loaded into the dashboard medical Director, Unit Manager and Operating Officer are responsible for coand ongoing monitoring.	sfaction . The ted by d on the at the edical ble for dicators, mance for ent over sis QAPI s 6 oard. I Chief	

AND PLAN OF	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE COMP	SURVEY
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V 638	documentation with the revealed a lack of date months of May and Justian of the documented date unmet goals for the 1-4 (ICHD) patients in the Management and Born Review of data for Hot (HPD) patients received for May and June 2013 documented. QAPI date patients receiving HP The tracking documented did not identify a facility 67% of patient are be 9-11." The document as to what percentage this range. The QAPI "goal for Nutritional St	15, review of the QAPI ne Clinic Manager (Staff A), na documentation for the une 2013. A further review nata for April 2013, revealed 4 in-center hemodialysis ne areas of Albumin ne and Mineral Metabolism. The Peritoneal Dialysis ring services for the months 3 revealed no data nata for April 2013 revealed 9 D services from the facility. Int for Anemia Management nity goal. It read that "6/9= tween Hemoglobin range of did not identify a facility goal ne of the patients they want in HPD document identified a tatus as >80% of dialysis um Albumin >3.5." The	V 63	88		
V 639	interview with the Clin 07/10/2013 at 1315, we the specific goals/targ identified/documented Bone and Mineral Ma	d for Anemia Management, nagement and Serum ed "I gave you all the quality have." ORITIZING TVITIES	V 63	g V639 QAPI Prioritizing Improve Activities Action plans will be prioritized by the Director based on prevalence and s problem identified. The QAPI plan v	e Medical severity of the	
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V 639	and giving priority to it affect clinical outcome. This STANDARD is a Surveyor: 28273 Based on document a facility failed to incorpand prioritize perform resulting in the potent outcomes for all 27 particles from the facility. Finding the quality documents titled "quality documents also lacked improvement projects high priority, moderat meeting targeted outcomes for all 27 particles from the facility. Finding the quality documents also lacked improvement projects high priority, moderat meeting targeted outcomes for all 27 particles from the facility. Finding the quality documents also lacked improvement projects high priority, moderat meeting targeted outcomes for all 27 particles from the facility. Finding the quality documents also lacked improvement projects high priority, moderat meeting targeted outcomes for all 27 particles from the facility of	ment, considering ity of identified problems improvement activities that es or patient safety. not met as evidenced by: eview and interview the orate data reports results ance improvement actions ial for poor patient atients receiving services ings include: 5, during review of lity," it was determined that ation lacked data for the and June 2013. The quality id designation as to what the facility considered a e priority or low priority for come goals. When the Clinic queried about the ed "No, that has not been bout the lack of data for the une staff A stated "I just ne numbers yet." P-QAPI PROGRAM onsibilities include, but are owing: int and performance			improvement projects with severity level priority, moderate priority, or low priority indicator in meeting targeted outcome garage The QAPI plan will be completed by 08/The Medical Director and Unit Manager responsible for correction and ongoing monitoring. V712 Medical Director Responsibility Unit Medical Director and COO is responsible aspects the dialysis QAPI program. Unit Medical Director (with input from the Unit Manager) will develop a QAPI plan specthe dialysis department by 08/24/13. The	for each oals. 24/13. are nsible for Jnit it cific to	
	Surveyor: 28273 Based on document r	not met as evidenced by: eview and interview, it was ledical Director failed to			will identify program goals, metrics, aud trending methods, and reporting structu August, 2013, the unit Medical Director the monthly unit multidisciplinary Quality and will ensure the presence of a quality assurance and performance improvements.	re. As of will lead Council	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X1) PROVIDER/SUPPLIER/CLIA (DENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
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ce improvement aspects of the dialysis hed quality indicators e improvement (see citations listed)	V 712	established quality indicators and include prioritized performance improvement probased on deficiencies identified during decollection and analysis. The newly created Dialysis QAPI Dashboard will be reviewed each Unit Quality Council meeting month performance improvement plans will be developed and implemented. The minute Council will reflect all QAPI activities. Dia QAPI data and activities will be reported organization's Leadership Performance	es jects ata ed ed at aly and es of the alysis to the	
ilities include, but are ; g, and performance. et as evidenced by: edical director failed to f members received training in emergency bilities resulting in the utcomes in the event of dings include: erview with staff H at with staff I at asked what they were reparedness both staff	V 713	The Unit Medical Director and COO are ultimately responsible for staff education training and performance. The Medical I and Unit Manager will collaborate to deteducation and training needs, disaster/emergency training needs, facil provision of training and monitor staff performance to ensure the safe provisio patient care, which will be a standing ite Quality Council. The Medical Director wincluded in all decision making regarding educational needs, manner of training, a monitoring techniques. The Medical Director Unit Manager will create an Education Pincluding emergency preparedness job responsibilities for all unit staff by 08/09/plan will include education required, how be provided and by whom, timelines for	Director ermine tate the n of m at the ill be n od ctor and lan,	
	an operational quality ce improvement aspects of the dialysis hed quality indicators e improvement (see citations listed) 8, V-639 AFF ED, TRAINING & dilities include, but are: g, and performance. et as evidenced by: edical director failed to f members received training in emergency bilities resulting in the atcomes in the event of dings include: erview with staff H at with staff I at asked what they were reparedness both staff e their roles in the	232328 B. WING	STREET ADDRESS, CITY, STATE, ZIP CODE 3950 BEAUBIEN BLVD DETROIT, MI 48201 NT OF DEFICIENCIES BE PRECEDED BY FULL ENTIFYING INFORMATION) an operational quality are improvement aspects of the dialysis hed quality indicators e improvement (see citations listed) 8, V-639 AFF ED, TRAINING & V 713 V 714 W 715 W 715 W 715 PREFIX TAG PREFIX TAG PREPIX TAG PROVIDERS PLAN OF CORRECTION (PACION ELEA CORRECTION SHOULD BE COR TAG REFERENCED TAG PREPIX TAG PREPIX TAG PREPIX TAG PREPIX TAG PREPIX TAG PREPIX TAG PREPIX TAG PREPIX TAG PREPIX TAG PREPIX TAG PREPIX TAG PROVIDER PLAN OF CORRECTION (PACION ELEA CORRECTION SHOULD BE COR TAG REFERENCED TAG PREPIX TAG PREPIX TAG PROVIDER PLAN OF CORRECTION (PACION ELEA PREPIX TAG PREPIX TAG PROVIDER TAG PROVIDER TAG PROVIDER TAG PREPIX TAG PROVIDER TAG PROVIDER TAG PROVIDER TAG PROVIDER TAG PREPIX PROVIDER TAG PREPIX PROVIDER TAG PREPIX PROVIDER TAG PRE	STREET ADDRESS, CITY, STATE, ZIP CODE 3950 BEAUBIEN BLVD

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K 000	to be in compliance w		К	000			

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.

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

TITLE

(X6) DATE



always there.

Iris A. Taylor, Ph.D., R.N. EVP & President Detroit Receiving Hospital & University Health Center 4201 St. Antoine Detroit, MI 48201 Phone: 313-745-3104 Fax: 313-966-7206

July 17, 2013

Rick Brummette
Department of Licensing and Regulatory Affairs
Health Facilities Division
Specialized Health Services Section
611 W. Ottawa
P.O. Box 30664
Lansing, MI 48909

Re: Psychiatric Program Survey Report

Dear Mr. Brummette:

Attached please find the Plan of Correction for Detroit Receiving Hospital's Psychiatric Program Survey of June 27, 2013.

Included in the Plan of Correction are the corrections/actions for each deficiency as well as our Implementation Plan and Audit Plan which are highlighted in yellow and green respectively.

Should you have any questions regarding our responses, or require any changes in our submission, please either contact Leon A. Coleman at 313-993-0317 or myself at 313-745-3104.

Sincerely,

Isles (). July w FLD. Iris Taylor, PhD, RN

Executive Vice President & President

Detroit Receiving Hospital

Rick Brummette, Section Manager Health Facilities Division Specialized Health Services Section

Re: Detroit Receiving Hospital Psychiatric Program Survey Report

Dear Mr. Brummette: Attached please find the corrective plan of action to address deficiencies identified in survey findings.

ω			2			_	SC
Patient did not receive a follow- up dietary assessment, including psychosocial assessment to determine if he had funds to eat.			Patient did not receive discharge instructions for the address for follow-up outpatient psychiatric treatment.			Patient did not receive a psychosocial assessment to determine if he had knowledge, resources and/or barriers to fill a prescription.	SURVEY FINDINGS
ω	Reg		2	Reg		-	PL
Dietary assessment / ability to secure nutrition A <u>MHT Intake Screen</u> form (Attachment 4) revised to include more specific information on current nutritional status and actions taken (i.e. providing fluids/nourishment at time of arrival in Crisis Center). Unless contraindicated, all patients receive box meal and beverage on arrival in Crisis Center. Patients provided with three meals and snacks each day of stay.	copies of all community resources/referral documents given to the patient will be included in the patient's medical record. Responsible for Plan of Action: Patient Care Services, Director of Psychiatry	 B. Updated general community resources on <u>Emergency Psychiatry Discharge Instructions</u> C Community Resource Guides (see 1B above) to be provided as appropriate to address identified needs. Xerox 	Discharge Instructions for Follow-Up Outpatient Psychiatric Treatment A. Revised <u>Emergency Psychiatry Discharge Instructions</u> (Attachment 3) to include community resources/referrals for identified discharge needs (see 1A) including post-discharge appointment location address and telephone number	Responsibility for Plan of Action: Patient Care Services, Director of Psychiatry	B Updated Community Resources Guides: Shelter, Food Bank, Prescription Assistance, Community Mental Health Clinic (Attachment 2)	Knowledge/Resources/Barriers to Filling Prescription A Developed/Implemented a <u>Post-Discharge Continuation of Care Needs Assessment</u> form (Attachment 1). The form documents the collaborative efforts between the assigned Social Worker and Registered Nurse and patient to identify discharge needs and provide community resources/referrals. Areas included in this needs assessment are: ability to obtain appropriate nutrition, safe living arrangements, discharge medication assistance, discharge transportation assistance, and chronic disease management.	PLAN OF ACTION (POA)

W

Post-Discharge Continuation of Care Needs Assessment form (See 1A above) documents collaborative efforts between the assigned Social Worker and Registered Nurse to identify nutritional needs and ability to obtain



ATTACHMENT 1

Emergency Psychiatry (Adult) Post-Discharge Continuation of Care Needs Assessment Next Level of Care Recommendation Discharge to Shelter Home Adult Foster Care (AFC) Transitional Housing Inpatient Psychiatric Facility Nursing Home Residential Substance Abuse Medical Facility Other: Registered Nurse and Social Worker collaborate with the patient to identify discharge needs and resources for patients whose Next Level of Care Recommendation is: Discharge to Shelter, Home, AFC or Transitional Housing Social Work Assessment Nutrition Resource provided Does the patient have resources to obtain food on a daily basis? ☐ Yes ☐ No Describe: Personal income Bridge card Family/Friends Community Organizations ☐ Other Living Arrangements Resource provided Are the patient's current living arrangements safe? Yes Can the patient return to current living arrangements? Yes No Is the patient willing to return to current living arrangements? Yes No Community Mental Health Follow-Up Care Appointment Resource provided Does patient have outpatient mental health provider? ☐ Yes ☐ No Patient refuses follow-up treatment Patient has previously scheduled appointment Discharge Medication Assistance Resource provided Does the patient have financial resources to obtain discharge medications? ☐ Yes ☐ No ☐ NA ☐ Yes ☐ No ☐ NA Does the patient know where to fill discharge prescriptions? Guardian Notification Resource provided Has guardian been notified of admission to Emergency Psychiatry-Crisis Center? Yes No NA Is guardian in agreement with Next Level of Care Recommendation? ☐ Yes ☐ No ☐ NA Registered Nurse Assessment Discharge Transportation Assistance Resource provided Does the patient have safe transportation to their discharge destination? ☐ Yes ☐ No Chronic Disease Management Resource provided Does the patient have a plan for continued care for chronic disease/condition? ☐ Yes ☐ No ☐ NA Clothing Resource provided Is patient's clothing adequate/appropriate for season (e.g. coat in winter, footwear)? ☐ Yes ☐ No RN Signature Date Time MSW Signature Date Time

Shelters

ATTACHMENT 2

Shelter Hot Line: Salvation Army (800) 274-3583

Warming Center-Winter Only (313) 963-7829

Salvation Army (800) 274-3583 Chatman House (313) 963-7829

Coalition on Temporary Housing (COTS) 26 Peterboro

T.C. Simmons 10501 Orangelawn

(313) 831-3777

(313) 934-3331

Men / Women / Families

Men / Women / Children

Detroit Rescue Mission 3535 Third Street

NSO Walk-In Shelter 3430 third Street

(313) 993-6703

(313) 832-3100

Men Only / Walk-In / Opens at 5PM

Men / Women / No beds / Opens at 5PM

New Life Rescue Mission 2600 18th Street

(313) 237-0390

Men / No Beds / Opens at 5PM

Domestic Violence Shelters

Interim House Call (313) 861 5300 First Step Call (734) 722-6800 or (888) 453-5900

Youth / Adolescent Shelters

Covenant House 2659 Martin Luther King Counter Points 715 Inkster

(313) 463-2500 Youth / Adolescents (313) 563 5005 or (866) 672-4357 Boys / Girls ages 10-20

Alternatives for Girls 903 W Grand Blvd

Off the Streets 680 Virginia Park

(313) 361-4000 or (888) 234-3919

(313) 873-0678

Ruth Ellis Second Story (313) 867-6936

Gay / Lesbian Youth ages 12-24

cdm rev 7/2013

Places to Find a Meal Near Detroit Receiving Hospital

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DISCUSSION AND LEGISCOIL			
Capuchin Community Center	8:30 AM to 9:00 PM	Everyday but Sunday	1760 Mt Elliott
Cass Community United Methodist	12 Noon	Saturday	3901 Cass
Cass Park Baptist Center	9:00 AM to 9:30 AM Breakfast 11:15 AM Lunch	Monday & Wednesday	2700 Second Street
Central United Methodist	10:30 AM to 12:00 PM	Monday & Thursday	23 E Adams
Crossroads	12:00 PM to 3:00 PM	Sunday	92 E Forest
First Presbyterian Church	11:00 AM to 12:30 PM	Wednesday	2930 Woodward
Fort Street Open Door	9:00 AM to 11:00 AM	Thursday	631 W. Fort Street
Just Love Ministries	10:00 AM to 12:00 PM	Monday, Thursday & Friday	481 W. Colombia
Manna Meals	9:00 AM to 11:00 AM	Monday, Tuesday, Wednesday, Friday, Saturday	1950 Trumbull
St Dominic's Church	10:00 AM to 11:00 AM	Everyday, but Thursday	1421 W. Warren
St Leo's Church	11:30 AM - 1:30 PM	Everyday, but Sunday	4860 15th Street
Trinity Episcopal Church	12:00 PM to 2:00 PM	Saturday	1519 Martin Luther King Blvd

DINNER

DINNER			
Detroit Rescue Mission	5:30 PM to 6:00 PM	Everyday	3535 Third Street
Salvation Army-Bagley	12:00 PM to 3:00 PM	Everyday	601 Bagley
Salvation Army-Harbor Inn	6:00 PM to 8:00 PM	Everyday	2642 Park

Low Cost Prescription Assistance

PharmModD Pharmacy / Doctors Pharmacy 3423 Woodward Ave Detroit, 48201 Phone (313) 832-4819 Fax (313) 832 4812	CrossRoads Pharmacy East Side 14641 East Jefferson (313) 822-5200 West Side 2424 West Grand Blvd, Corner of 15th Street-near Henry Ford Hospital (313) 831-2000
Hours Monday-Friday 9:00 AM to 5:30 PM Saturday 9:00 AM to 2:00 PM \$4.00 Prescriptions	Hours Monday-Friday 9:00 AM to 4:00 PM Saturday 9:00 AM to 12:00 PM Provides a one-time 15-day supply of medications You must call for an appointment
Herman Kiefer 1151 Taylor Detroit 48202 (313) 876-4846	World Medical Relief 11745 Rose Park Blvd Detroit 48026 (313) 866-5333
Hours Monday-Friday 9:00 AM to 5:00 PM You must call for an appointment	Call for an appointment if you are 62 years or older to see if you quality for Senior Prescription Program

Additional Pharmacies	Call for hours and eligibility for free/low cost medications
Advanced Care Pharmacy- Metro	Advance Care Pharmacy-NEGC
2051 W Grand Blvd	12800 E Warren
Detroit, 48208	Detroit, 48215
(313) 309-1084	(313) 347-2025
Advanced Care Pharmacy-NC	Advanced Care Pharmacy
24788 Forterra Drive	22170 W Nine Mile Road
Warren 48089	Southfield 48034
(586) 758-7000	(248) 799-8125
Davis Cut Rate Drugs	Jana Drugs
14039 W. McNichols Rd	1684 Fort Street
Detroit 48235	Lincoln Park 48146
(313) 861-9300	(313) 383-5700

Specialty Prescription Assistance Programs

Michigan Lupus Foundation 26507 Harper Avenue St Clair Shores 48081

(586) 775-8310

Hours

Monday-Friday

9:00 AM to 5:00 PM

Provides one-time emergency prescription assistance for patients with Lupus

Myasthenia Gravis Association 17117 W Nine Mile Road Suite # 1745 Southfield 48085

(248) 423-9700 or (800) 227-1763

Hours

Monday-Friday

8:30 AM to 4:00 PM

Provides help in obtaining mail-order supplies needy patients diagnosed with Myasthenia Gravis

Michigan Parkinson Foundation 30161 Southfield Rd Southfield 48075

(248) 433-1011 or (800) 852-9781

Hours

Monday-Friday

8:30 AM to 8:00 PM

Medication assistance for patients with Parkinson's disease.

Hemophilia Foundation of Michigan 117 N First Street, Suite 40 Ann Arbor, 48104

(734) 761-2535 or (800) 482-3041

Hours

Monday-Friday

9:00 AM to 5:00 PM

Helps cover medications for needy adults and children with hemophilia



Detroit Receiving Hospital and University Health Center Emergency Psychiatric Crisis Center 4201 St Antoine, Detroit, Michigan 48201

(313) 745-3546 or (313) 966-8747

Community Mental Health Clinics

Adult Well-Being Services 1423 Field Avenue Detroit, MI 48214 313-924-7860

Adult Well-Being Services 5555 Conner, Suite 1000 Detroit, 48213 313-347-2070

Adult Well-Being Services 6700 Middlebelt Road Romulus, 48174 734-629-5000

Arab-American and Chaldean Council (ACC) 62 W. 7 Mile Road Detroit, 48203 313-893-6172

Arab-American and Chaldean Council 16921 W. Warren Road Detroit, 48228 313-581-7287

Community Care Services 26184 W Outer Drive Lincoln Park, 48146 313-389-7500

Community Care Services 25 Owen Street Belleville, 48111 734-697-7880

Community Care Services 26650 Eureka, Suite A Taylor, 48186 734-955-3550

Detroit Central City Community Mental Health, Inc. 10 Peterboro Detroit, 48201

313-831-3160

Detroit East Community Mental Health Center 11457 Shoemaker Detroit, 48213 313-331-3435 Detroit East Community Mental Health Center 3646 Mt. Elliott Detroit, 48207 313-921-4700

Detroit East Community Mental Health Center 6309 Mack Detroit, 48207 313-921-4700

Development Centers, Inc 24424 W McNichols Detroit 48219 (313) 531-2500

Guidance Center 13101 Allen Road #500 Southgate 48195 (734) 785 7700

Hegira Programs, Inc 8623 N Wane Road, #200 Westland 48185 (734) 458-4601

Lincoln Behavioral Services 9315 Telegraph Road Redford, 48239 313-450-4500

Lincoln Behavioral Services 24425 Plymouth Road Redford, 48239 313-450-0411

Lincoln Behavioral Services 14500 Sheldon Road, Suite 160 Plymouth, 48170 734-459-5590

Neighborhood Services Organization (NSO) 220 Bagley, #1200 Detroit, 48226 (313) 961-7990

New Center Community Mental Health, Inc 2051 W Grand Blvd Detroit 48215 (313_ 961-3200



Detroit Receiving Hospital and University Health Center Emergency Psychiatric Crisis Center 4201 St Antoine, Detroit, Michigan 48201

(313) 745-3546 or (313) 966-8747

Community Mental Health Clinics

New Center North Park 10001 Puritan Detroit, 48235 (313) 494-4000

North Central Community Mental Health Center 17141 Ryan Road Detroit, MI 48212 313-369-1717

North Central Community Mental Health Center 4321 E. McNichols Detroit, MI 48212 313-369-1717

Northeast Guidance Center 12800 E Warren Detroit, 48215 (313) 824-8000

Sinai Grace Outpatient Services 14230 W. McNichols Detroit, MI 48234 313-966-3100

Southwest Solutions 1700 Waterman Detroit, 48209 (313) 841 7474

Team Mental Health Services 2939 Russell Street Detroit, MI 48207 313-396-5300

Team Mental Health Services 19170 Eureka Road Southgate, MI 48195 734-324-8326

University Psychiatric Services 3901 Chrysler Service Drive Detroit, MI 48207 (313) 577-1396



Gateway Community Health has a 24 hour a day 7 days a week phone number for you to call if you have ANY questions about your placement, medication(s) or any thing concerning your care.

1-800-973-4283

Gateway Community Health Outpatient Clinics

Adult Well Being Services 1143 Field Street Detroit, 48213

(313) 347-2070 Prescription Assistance Available

Arab-American & Chaldean Council (ACC) 62 W 7 Mile Detroit 48203

(313) 893-6172 Prescription Assistance Available

Community Care Services-Taylor 26650 Eureka Taylor 48180

(734) 955-3550 Prescription Assistance Available

Community Care Services-Belleville 416 Sumpter Rd, Building B Belleville 48111

(734) 389-7546 Prescription Assistance Available

Community Care Services-Lincoln Park 26184 W Outer Drive Lincoln Park 48186

(313) 389-7525 Prescription Assistance Available

Detroit Central City CMH, Inc 10 Peterboro Detroit 48201

(313) 831-3160 Prescription Assistance Available

Gateway Detroit East, Inc 11457 Shoemaker Detroit 48213

(313) 331-3435 Prescription Assistance Available

Lincoln Behavioral Services 9315 Telegraph Redford 48239

(313) 450-4500 Prescription Assistance Available

A.C.C.E.S.S. 6451 Schaefer Road Dearborn 48126

(313) 945-8128 Prescription Assistance Available

University Physician Group-Livonia 16836 Newburgh Road Livonia 48154

(313) 577-7607

Sinai Grace Hospital 14230 W McNichols Detroit 48235

(313) 966-4880

Team Mental Health Services 14799 Dix-Toledo Road Southgate 48195

(734) 274-3700 Prescription Assistance Available

Team Mental Health Services 2939 Russell Street Detroit 48207

(313) 396-5300 Prescription Assistance Available

University Physicians Group-University Psychiatry 3901 Chrysler Service Drive Detroit 48207

(313) 577-1396

FOR MEDICATIONS IF YOU HAVE NO INSURANCE

Davis Drugs (across from Sinai-Grace Outpatient Clinic) 14039 W. McNichols, Detroit 48235 (313) 861 - 9300

Cobb Pharmacy 4603 S. Wayne Rd, Wayne 48185 (734) 728 - 6000

Or Any Out Patient Clinic listed above with

Prescription Assistance Available

Tell them you are a Gateway Community Health member.

Your Gateway Community Health Number is



ATTACHMENT 3

1010

E	mergency Psychiatry Di	scharge Instruct	ions			Victoria de la composición dela composición de la composición de la composición de la composición dela composición dela composición dela composición de la c
	A follow-up care appoint	ment has been m	nade for you	at		
	Location					
	Address					
	Date / Time					
	Please call		to s	chedule your fo	ollow up app	ointment
	assist you in planning for ources and referrals	your continuing c	are needs w	e are offering y	ou the follow	wing community
	Food Banks / Meal Cent	ters		Veterans Assis	tance	
	Low Cost Prescription A	ssistance		Health Care CI	inics	
	Shelters / Alternative Ho	ousing		Domestic Viole	nce Assista	nce
	Community Mental Heal	th Clinics		Substance Abu	ise Treatme	nt
D	ischarge Transportation A	ssistance 🛭 I	Bus Ticket is	ssued	☐ Cab V	oucher issued
р.	atient		Social	Worker		
				150		
O.	ignature		_ Olgilat			
Dis	scharge Medications					
TI	he following medications h	ave been prescri	bed for you			
N	ame	Dose	Route	Fraguency	# Given	Source
14	ame	Dose	Noute	Frequency	# Given	
						Prescription
						Prescription
						Prescription
The 1 2 3	e patient has been instruction Goals, benefits, and risks machinery or driving until a lmportance of cooperating. The need to follow-up with	of medication(s) ir adapted to the effe with the treatmen	ncluding takir ects of any m t plan and re	edication(s) fraining from su	bstance abu	se
	provided instructions may					
4	There can be no guarante					
5	The option of returning to nearest Emergency Depart					
	unpleasant medication sid					, and a second property of the second propert
	he above discharge instru understand and agree with		ined and/or	reviewed with r	me and my o	questions answered.
Ρ	atient's Signature					

Additional Community Resources

Detroit Receiving Hospital Emergency Psychiatric Department 4201 St. Antoine, Detroit, Mi 48201 (313) 745-3540 or (313) 966-8747 24 Hour Crisis Line-Suicide Hotline (313) 224-7000 Alcoholics Anonymous Hotline (313) 831-5550 Narcotics Anonymous Hotline (248) 543-7200 Gamblers Anonymous (888) 844-2891

Substance Abuse Services

Access Center at Herman Kiefer Complex
1151 Taylor, Building #1, Detroit MI,
1st Floor Room 110 (enter on John C Lodge entrance of main building)

Hours of Operation 07:00 AM to 5:00 PM Monday through Friday

For questions and treatments services call: 1 (800) 467 2452 24 hours / 7 days a week

Harbor Light Treatment Center-Detox 3737 Lawton, Detroit, MI 1 (313) 361-6136.

<u>Drug Program Information for Detroit Residents Only</u> Call 1 (800) 467 2452 (24 hours / 7 days a week).

If you have a Private Health Insurance or HMO / Clinic Plan Medicaid Contact your insurance provider for a substance abuse referral.

Thank you for choosing Detroit Receiving Hospital



ATTACHMENT 4

Emergency Psychiatry (MHT Intake Screen	(Adult)					
		Transitional Housing Emergency Departmen	☐ AFC It ☐ Transfer from:			
Accompanied by		Transitional / AFC Staf ED Staff:	f □ Unaccompanied □ Other:			
Petition Completed by		☐ None	□ NA			
Temperature	Diabetic? No	Yes If Yes, notify	RN and obtain CBG sultsTime completed			
Pulse		lood Pressure Problement taking medication fo	as? No Yes or this condition? No Yes			
Respirations	Asthmatic? Difficulty pulse oximetry	Breathing? No	Yes If yes, notify RN and obtain Results%			
Blood Pressure	If yes, is the patient t	☐ No ☐ Yes, last sei: taking medication for th -	nis condition?			
Pain Yes No If yes, notify RN	Suspect intoxication?	? ☐ No ☐ Yes	equested Results			
	List any tubes/drains None	lines, prosthesis, appl	iances or ambulatory aides			
When was your last Meal?		Visual Body Scan/Se	earch conducted by Signature/title			
What did you last eat?		Vicual Body Codinico	aron conducted by dignature title			
What did you last eat?		Clothing/Property sea	arched / secured by Signature/title			
Notify RN if intake appears in <u>Unless contraindicated</u> , offer		Valuables secured b	y Signature/title			
Offered Yes No	Contraindicated	Medication(s) secure	ed by Signature/title			
Patient Response	Patient Response Accepted Refused					
Completed by	Completed by Reviewed by					
MHT Signature	Date Time	RN Signature	Date Time			



Leon A. Coleman Director, Accreditation and Compliance

Corporate Audit & Compliance 6071 West Outer Drive Lourdes Bldg., 7th Floor Detroit, MI 48235 Phone: (313) 993-0317

Fax: (313) 745-7929

August 25, 2010

Department of Community Health Bureau of Health Services 611 West Ottawa 1st floor, Ottawa Building P.O. Box 30664 Lansing, MI 48909 Attn: Richard Benson

Regarding: Harper University Hospital, CMS Provider # 230104

a. Coleman

Dear Sirs/Madam:

Attached for filing with your office is the Plan of Correction "PoC" for the deficiency sited by CMS at our April 6, 2010 and June 24, 2010 surveys.

Should you have any questions or concerns regarding the plan of correction, or need any additional information please do not hesitate to contact me.

Sincerely,

León A. Coleman

LAC/ams

Attachment(s)

PRINTED: 8/17/2010 FORM APPROVED OMB NO. 0938-0391

07477		C INCOICAID SERVICES		ON	MB NO. 0938-0391
AND PLA	ENT OF DEFICIENCIES AN OF CORRECTION	(X1)PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 230104	A.		(X3) DATE SURVEY COMPLETED
HARPER	F PROVIDER OR SUPPLIE	R	3990 JOH	ADDRESS, CITY, STATE, ZIP CODE N R STREET MI. 48201	06/24/2010
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	TEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE

A 000	INITIAL COMMENTS	A 000		T
	Surveyor: 15195 This survey was conducted for the purpose of state monitoring. The department has evaluated and found the facility non-compliant with state licensure and/or federal certification requirements on the dates(s) specified.	٠		8
A 057	Harper University Hospital and Hutzel Women's Hospital = Campus A DMC Surgical Hospital = Campus B 482.12(b) CHIEF EXECUTIVE OFFICER	A 057		
	The governing must appoint a chief executive officer who is responsible for managing the hospital.			
	This STANDARD is not met as evidenced by: Surveyor: 28267 Based on interview and record review the governing body failed to appoint a single chief executive officer who is responsible for managing the facilities that are under a single CMS Certification Number (CNN). Findings include:		The organization has been restructured effective September 1 2010, such that the President of Campus A is responsible for the management of both Campus A and Campus B. The	9/1/10
	On 6/22/10 at approximately 0830 during a visit to Campus B it was stated by staff # M that Campus B has their own President and that they are a separate facility from Campus A.		hospital has appointed a RN to serve as Vice President for Campus B's Administration & Patient Care. The new position will be onsite at Campus B and report to the hospital President in	
	On 6/23/10 at approximately 0900 during the governing body interview when queried about the CEO that was appointed by the governing body to head up both Campus A and Campus B, staff #EE stated "We are not set up that way."		regards to administration issues and to the hospital's VP Patient Care Services in regards to nursing services.	
	On 6/23/10 at approximately 0915 during the governing body interview staff # FF presented a System Executive Organizational Chart that indicated that four (4) different facilities with three (3) different CMS Certification Numbers all had a Senior Vice President over each			77

ABOBATORY DIRECTOR'S OR PROVIDER/SUPPLIERS REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement and instruith on salari

Peesident

8.25.10

PRINTED: 8/17/2010 FORM APPROVED OMB NO. 0938-0391

AND PL	AN OF CORRECTION	(X1)PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	A.	TIPLE CONSTRUCTION BUILDING WING	(X3) DATE SURVEY COMPLETED
NAME O	F PROVIDER OR SUPPLIEF	230104			06/24/2010
	UNIVERSITY HOSPITAL		3990 JOH	ADDRESS, CITY, STATE, ZIP CODE IN R STREET , MI. 48201	
PREFIX TAG	LEACH DEFICIENCY MUST	TEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY TIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	DRE COMPLETE
A 057	Continued From				
A 117	Corporate (System) Pre	nen respectively report to a sident/Chief Executive Officer. RIGHTS: NOTICE OF RIGHTS	A 057		
A 123	A hospital must inform a appropriate, the patient' under State law), of the furnishing or discontinui possible. This STANDARD is not Surveyor: 28273 Based on record review to provide all Medicare Message from Medicare Message from Medicare Findings include: Review of records on the on 06/23/2010, 3 of 3 M #78) records did not confrom Medicare." During 1300, Employee O confit 29, #77 and # 78 were been admitted for more records did not contain to "Important Message from say that she was unfaminot seen it prior to obtain registration. 482.13(a)(2)(iii) PATIEN GRIEVANCE DECISION At a minimum: In its resolution of the griprovide the patient with a contains the name of the	each patient, or when s representative (as allowed patient's rights, in advance of ng patient care whenever met as evidenced by: and interview, the facility failed patients with the "Important to document." The Psychiatric Unit at Campus B edicare patient's (#29, #77 & etain the "Important Message interview on 06/23/2010 @ etain the tredit interview that patient's etail medicare recipients, had than 2 days and that the effective document in Medicare." She went on to compare the Medicare recipients and had be not allowed than 2 the second to the text of the text	A 123	"Important Message from Medic Missing 1. Implemented process to provide Important Message from Medicare forms to Psychiatric patients. 2. Educated Staff on process. 3. Weekly monitoring done by addepartment manager until complian achieved for 6 months. 4. Vice President of Operations/Pacare Services to ensure findings a action plans presented monthly to Leadership Performance Improven and Medical Safety Coordinating Committee.	8/9/10 8/6/10 8/20/10 tient
	grievance, the results of date of completion. This STANDARD is not a Surveyor: 28273				
LABORAT	ORY DIRECTOR'S OR PRO	VIDER/SUPPLIERS REPRESENTAT	IVE'S SIGN.	ATURE TITLE	(X6) DATE
					, ,, -,

PRINTED: 8/17/2010 FORM APPROVED OMB NO. 0938-0391

STATEM	MENT OF DEFICIENCIES	(X1)PROVIDER/SUPPLIER/CLIA	1		OMB N	O. 0938-0391
AND PL	AN OF CORRECTION	IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) [DATE SURVEY
			B.	WING	'	COMPLETED
NAME O	F PROVIDER OR SUPPLIEF	230104	1			06/24/2010
			STREET	ADDRESS, CITY, STATE, ZIP CODE		
	R UNIVERSITY HOSPITAL	5	3990 JOH DETROIT	N R STREET MI. 48201		
(X4) ID PREFIX	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT	ION	(X5)
TAG	OR LSC IDEN	BE PRECEDED BY FULL REGULATORY TIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	COMPLETE DATE
Δ 123	Continued From sees 6					
A 123	the facility failed to prove #86 & #87) with a writter resolution of a grievance. Meeting with Employee at 1300, she began the you I'm not following the what she meant by the that patients had not be resolution of their grievary patients #84, #86 & #8' written responses sent to resolution of the grievary unable to provide any difference for patient #8 Review of Detroit Medic 06/22/2010, Title: Patient Complaints Policy No: 107/01/08 reads under Provide and the determined by Patient/Cappropriate site staff) to including those involving the involved physician in designee, must send a written response to the days, notifying them of the complaint, the name and person, the steps taken complaint and the date of 482.13(c)(1) PATIENT For the patient has the right This STANDARD is not Surveyor: 27408 Based on observation, it failed to properly protect were registered for out provided in the steps that the steps that the steps that the steps that the date of the patient has the right that the patient has the right tha	ord review and policy review, ide 4 of 11 patients' (#84, #85, in response regarding the e. M at Campus B on 06/23/2010 interview by stating "I'll just tell e policy." When queried about statement she went on to say en sent a letter regarding ance. Review of the files for 7 confirmed that there were no to patients in regards to a fine they filed. Employee M was occumentation/file regarding the 5. all Center (DMC) policy on the 8 Family Grievance and CLN 033 Effective Date: rovisions 7. "In matters suest Relations (or other be Medical Grievances, grare rendered by a physician, management, or facility assigned written response, reviewed by e complainant(s), within 30 the disposition of their diaddress of the hospital contact to review and resolve the of completion." RIGHTS: PERSONAL PRIVACY to personal privacy. The was determined that the facility is the privacy of patients who extient surgical services in the	A 123	Written Grievance Resolution Response 1. New Patient Relations Representative hired. 2. Process per Tier 1 policy to be implemented to ensure that med grievances have a written resolu response. 3. Monthly monitoring by Quality Department until 100% compliant is achieved for 6 months. 4. Vice President of Operations/It Care Services to ensure findings action plans presented monthly the Leadership Performance Improvement Medical Safety Coordinating Committee.	ical tion ce rate atient and o ement	8/16/10 8/25/10 8/25/10
	pre op area on Campus	B. Findings include:	li li			
LABORAT	ORY DIRECTOR'S OR PRO	VIDER/SUPPLIERS REPRESENTAT	IVE'S SIGN	ATUDE		
		TIDE TOOL FELLING REPRESENTA	IVE S SIGN	ATURE TITLE		(X6) DATE
Any definit	angu statement anding with a					

PRINTED: 8/17/2010 FORM APPROVED OMB NO. 0938-0391

	ENT OF DEFICIENCIES N OF CORRECTION	(X1)PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	A. E	IPLE CONSTRUCTION BUILDING	(X3) DA	(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER			STREET A	DDRESS, CITY, STATE, ZIP CODE	06	/24/2010	
HARPER	UNIVERSITY HOSPITAL			N R STREET			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST E	TEMENT OF DEFICIENCIES SE PRECEDED BY FULL REGULATORY TIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDENCY)	DBE	(X5) COMPLETE DATE	
A 143	Continued From page 3		A 143				
0.144	During observation on Carea on Campus B it was posted the patients last surgeon's name, and the procedure. Patient name accessible for public vie Room Nurse Manager aprivacy, she indicated the this identifying informatic employed for the facility #AA was unable to explaining used by staff.	16/22/10 at 1000 of the pre-op as determined that the facility name, first initial, age, e status of the surgical ness were being utilized and were wing. When the Operating AA was queried about patient nat the facility had been posting on since she had been. The Operating Room Nurse ain why the monitor was still	A 144	Patient Privacy in the Pre-Op At 1. The surgical Electronic Trackin Board will not display the age of the patient, date of birth or the surgical procedure on the tracking board in pre-op area.	g he al	9/7/10	
A 144	A 144 482.13(c)(2) PATIENT RIGHTS: CARE IN SAFE SETTING The patient has the right to receive care in a safe setting. This STANDARD is not met as evidenced by: Surveyor: 26222 Based upon observation, interview, and record review, the facility failed to provide a safe environment for patients in the Hemodialysis Unit of Campus A and the Psychiatric Unit of Campus B. Findings include: On 6/22/10 at 10:45 AM during the tour of the Hemodialysis unit at Campus A, it was discovered that batches of bicarbonate to be used in the dialysis solution are not being recorded when mixed. Standard of Practice ANSI/AAMI RD52:2004 states that bicarbonate solutions shall be used within 24 hours of when mixed. Interview with Clinical Manager III confirmed that there is no mixing log for bicarbonate solutions. Daily log sheets available in the unit did not include bicarbonate mixing records. On 6/22/10 at 10:45 AM during the tour of the Hemodialysis unit at Campus A, during an interview with the Clinical Manager III, it was discovered that			Hemodialysis Safety: Bicarbona 1. Clinical Manager implemented recording of mixing for bicarbonat solutions on daily log. 2. Staff educated by Clinical Man 3. Conduct weekly audits by unit management to ensure complianc 4. Findings and action plans pres to Leadership Performance Improvement and Medical Safety Coordinating Committee monthly unit PI committee by Clinical Man Hemodialysis Safety:Water Har 1. Clinical Manager implemented hardening testing daily.	ager. and ager. dness	8/19/10 8/27/10 8/30/10	
LABORAT	ORY DIRECTOR'S OR PRO	Daily log sheets available in the DVIDER/SUPPLIERS REPRESENTAT	TIVE'S SIGN	ATURE TITLE		(X6) DATE	
						-	

PRINTED: 8/17/2010 FORM APPROVED OMB NO. 0938-0391

STATEME	ENT OF DEFICIENCIES	(X1)PROVIDER/SUPPLIER/CLIA	(V2) \$41 II 7	TIDI C CONOTRILICATION		J. 0938-0391	
AND PLA	N OF CORRECTION	IDENTIFICATION NUMBER				ATE SURVEY	
		I SELLIN IONLIGIT HOMBEN	Α.	BUILDING	0	COMPLETED	
		230104	В.	WING			
NAME OF	PROVIDER OR SUPPLIER	200107	STORET	DDDDCC OITY OTHER TIP COL		06/24/2010	
8		•	SIKEEIA	ADDRESS, CITY, STATE, ZIP CODE			
Lean communication	UNIVERSITY HOSPITAL			N R STREET MI. 48201			
(X4) ID	SUMMARY STAT	EMENT OF DEFICIENCIES	ID.	PROVIDER'S PLAN OF CORRECTION			
PREFIX	(EACH DEFICIENCY MUST E	BE PRECEDED BY FULL REGULATORY	PREFIX	(EACH CORRECTIVE ACTION SHOULD	אינ	(X5) COMPLETE	
TAG	OR LSC IDEN	TIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROP	PRIATE	DATE	
				DEFICIENCY)	INVIL	DATE	
A 144	Continued From page 4			[a a			
	Committee From page 4		A 144	Selected staff educated by Clini	cal	6/23/10	
				Manager.		Marina Janes Noto	
	unit did not include hard	lness checks. Standard of		3. Documentation on log sheets is		6/23/10	
8	Practice ANSI/AAMI RD	52:2004 specifies that hardness		maintained by department.			
	shall be tested at the en	d of each treatment day, and		4. Conduct weekly audits by unit			
	that timers shall be ched	cked at the beginning of each		management to ensure compliance	.	7/19/10	
	day and interlocked with	the RO system		5. Results are reported quarterly to	-		
				5. Results are reported quarterly (י ו	3rd Quarter	
				Environment of Care Committee.	0.00	2010	
				6. Findings and action plans prese	ented		
				to Leadership Performance			
				Improvement and Medical Safety			
				Coordinating Committee monthly t	ov l		
				Safety Officer and unit PI committee	ee hv		
	7			Clinical Manager.	,		
	On 6/24/10 between 11:	30 AM and 2:30 PM based		Cirinda manager.	- 8		
	upon observation, it was	discovered that the cabinet		Unlocked Cabinet Under Sink			
	underneath the hand sin	ik in the Psych Unit of Campus			orana managari		
	B was unlocked.	ik in the Esych Offic of Campus		Items found in unlocked cabinet	were		
				discarded.		6/29/10	
	Chemical cleaners were	found to be stored in this		2. Had lock installed - WO 15398			
	cabinet unsecured. Add	fitionally, staff food items were			- 1	8/6/10	
	found stored in this cabi	net. All other cabinets in the					
	room containing activitie	es supplies were observed			- 4		
	locked.			7-			
58	Surveyor: 27065						
	Based on observation is	nterview and policy review, the		-			
	facility foiled to answer	nterview and policy review, the					
	facility failed to ensure p	attent safety by properly					
8	securing items in two pa	tient care areas and following					
	policies to reduce the ris	k of infection in three patient					
	areas. Findings include:						
	On 6/21/10 at 1120 one	crumpled-up mask was		Crumpled Mask			
	observed stored with cle	an patient protective equipment		Removed mask from area.	- 1	6/21/10	
- 1	outside patient #3's room	n on Campus A. Patient #3's		2 Detroit Medical Control of the	. 1	7/1/10	
	door indicated that costs	act precautions were in effect.		2. Detroit Medical Center Infection		,,,,,,	
	These findings were son	ifirmed by staff member WW.		Control annual NetLearning			
	mese intumys were con	mined by start member vvvv.		competencies completed by all sta	ff.		
	0-004/40						
	Un 6/21/10 at approxima	ately 1400 one pair of scissors		Disposable supplies			
	was observed in the med	dication cart drawer, on the		1. Scissors and tweezers discarde	d.	6/21/10	
	psychiatric unit at Camp	us B, with whitish substance on		2. Daily shift change checklist for		8/19/10	
	the blades. At the same	time, one opened suture		Medication Room amended to incl	ahu	J. 10/ 10	
	removal kit package, cor	ntaining a scissors and		checking for any improper items in			
	tweezers, was observed	a voicesio dila			·		
LARODAT				medication cart.			
LYDOKY I	OK I DIRECTOR'S OR PRO	VIDER/SUPPLIERS REPRESENTAT	IVE'S SIGN	ATURE TITLE		(X6) DATE	

PRINTED: 8/17/2010 FORM APPROVED OMB NO. 0938-0391

CENTE	RS FOR MEDICARE 8	MEDICAID SERVICES				APPROVED
STATEMENT OF DEFICIENCIES (X1)PROVIDER/SUPPLIER/CLIA				TIDLE CONSTRUCTION		0. 0938-0391
AND PLA	AN OF CORRECTION	IDENTIFICATION NUMBER				DATE SURVEY
		Note the Property of the	В.	WING	,	COMPLETED
NAMEO	E DROWINED OR SURBLUE	230104		2		06/24/2010
MAINE	F PROVIDER OR SUPPLIER		STREET	ADDRESS, CITY, STATE, ZIP CODE		00.24/2010
HARPER	UNIVERSITY HOSPITAL					
	TOWN THE STATE OF THE		3990 JOH	IN R STREET		
(X4) ID	SUMMARY STAT	EMENT OF DEFICIENCIES	ID	, MI. 48201		
PREFIX	(EACH DEFICIENCY MUST B	E PRECEDED BY FULL REGULATORY	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD	N RF	(X5) COMPLETE
TAG	OR LSC IDEN	TIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROP	RIATE	DATE
				DEFICIENCY)		
A 144	T C1:- 1 5		,			
A 144	Continued From page 5		A 144			
	A4 4 4 4 0					
	At 1440 an unsecured n	netal grate was observed in the		Unsecured Metal Grate		
	patient court yard on the	psychiatric unit Campus B.		1. Secured grate to ground on day	of	C/D4/40
	Oneseting were cor	firmed by the Vice President of	li .	survey.		6/21/10
	Operations/Patient Care	Services for Campus B.	l	N-000000		
	Police 2 IC 022 det 14	10.4 (0.7)				
	Policy 2 IC 033, dated 1	/31/07 states:	li .			
	"Disposable supplies are	s used according to the	2			
	manufacturer guidelines	and not reused."				
	S					
	Surveyor: 28267	WWW. Targetter in the con-		Unsecured IV cart		6/21/10
	On 6/21/10 at approxima	ately 1045 during the		Cart locked immediately.		6/21/10
	observational tour an IV	cart containing intravenous		2. Additional IV cart keys ordered a	and	6/22/10
	catheter needles and su	pplies was found and		distributed to ED staff.		
	bod word) and the in a	om 17. In patient rooms (a four		ED Management monitoring car	t	6/22/10
	and unattended Dett to	IV cart that was found unlocked		daily to ensure lock is engaged who	en	
	nationts and/esvisiters	ne IV carts were accessible by		not attended.	i i	
	by stoff # E at the time	These findings were confirmed				
	gueried about the sected	f the findings. Staff # F when				3:
	carte should be looked a	being secured stated "the IV It all times unless they are				
	attended by a staff mem	her"				
	attended by a stall mem	uei .				
	Surveyor: 15195			0111		
		tour of the 3 rd floor postpartum		Old Medication		2772772
	and neonate areas on 6	221/10 at approximately 1215,		Old cart removed and discarded		8/19/10
	an infant old medication	cart with neonate intravenous				
	supplies in the utility root	m was noted to be dirty with		, P		
	brown/orange material	This observation was verified				
	with the Manager Postpa	ortum # Let the time				
A 168	482 13(a)(5) PATIENT D	RIGHTS: RESTRAINT OR	4 400			
	SECLUSION	MONTO. RESTRAINT OR	A 168			
	The use of restraint or se	eclusion must be in accordance				
	with the order of a physic	cian or other licensed				
	independent practitioner	who is responsible for the care				
	of the patient as specifie	d under \$482 12/c) and		1		
	authorized to order restr	aint or seclusion by hospital				
	policy in accordance with	State law		1		
	Fanty in accordance will	otate law.		1		
	This STANDARD is not i	met as evidenced by:			1	
	Surveyor: 27408	not as evidenced by.		1	i	
LABORAT		VIDER/SUPPLIEDS DEDDESENTAT				

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

TITLE

(X6) DATE

PRINTED: 8/17/2010 FORM APPROVED OMB NO. 0938-0391

A 386 A	STATEM AND PLA	ENT OF DEFICIENCIES IN OF CORRECTION	(X1)PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	Α.	TIPLE CONSTRUCTION BUILDING	(X3) DATE SURVEY COMPLETED	
HARPER UNIVERSITY HOSPITAL 3980-JOHN R STREET DETROIT, MI. 48201 SUMMARY STATEMENT OF DEFICIENCIES OF LISC IDENTIFYING INFORMATION) A 168 Continued From page 6 Based on interview and record review, the facility failed to obtain an order for restraints from the attending physician for 1 of 3 (#15) patients restrained. Findings include: Record review of patient #15's open chart revealed that there was an order from the physician's assistant for restraints dated 06/20/10 at 0611 for 'soft limb x.2' (restraints). The attending physician for 'soft imb x.2' (restraints). The attending physician for erestraint dated 06/20/10 at 0611 for 'soft limb x.2' (restraints). The attending physician and was incomplete for patient #15. A 386 482.23(a) ORGANIZATION OF NURSING SERVICES The hospital must have a well-organized service with a plan of administrative authority and delineation of responsibilities for patient care. The director of the nursing service must be a licensed registered nurse. He or she is responsible for the operation of the service, including determining the types and numbers of nursing personnel and staff necessary to provide nursing care for all areas of the hospital. This STANDARD is not met as evidenced by: Surveyor: 28267 Based on interview and record review the facility failed to ensure the organization of one Registered nurse. He or she is responsible for the operation of of ensure the organization of one Registered nurse. He or she is responsible for the operation of one Registered Nurse (RN). Findings include: On 6/22/10 at approximately 0830 during a visit to Campus B it was stated by staff # M that Campus B has	NAMEO		230104	В.	WING	06/24/2040	
CASHOD PREFIX CACH DEFICIENCY MUST BE PRECEDED BY PULL REQUIATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG CACH DEFICIENCY MUST BE PRECEDED BY PULL REQUIATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY	NAME O	F PROVIDER OR SUPPLIER	27 4 (A) 1 20 (A) 1 2 (A) 1 4	STREET ADDRESS, CITY, STATE, ZIP CODE			
A 168 Continued From page 6 Based on interview and record review, the facility failed to obtain an order for restraints form the physician for 1 of 3 (#15) patients restrained. Findings include: Record review of patient #15's open chart revealed that there was an order from the physician's assistant for restraints dated 60/20/10 at 061/20/10 to 161 for "soft limb x 2" (restraints). The attending physician failed to complete the restraint order. Interview with the Vice President of Outpatient Services on 6/24/10 on at 1130, confirmed that the order needed to be co signed by the attending physician and was incomplete for patient #15. A 386 A 386 A 386 A 282.23(a) ORGANIZATION OF NURSING SERVICES The hospital must have a well-organized service with a plan of administrative authority and delineation of responsibilities for patient care. The director of the nursing service must be a licensed registered nurse. He or she is responsible for the operation of the service, including determining the types and numbers of nursing personnel and staff necessary to provide nursing personnel and staff necessary to provide nursing personnel and staff necessary to provide nursing personnel and staff necessary to provide nursing care for all areas of the hospital. This STANDARD is not met as evidenced by: Surveyor: 28267 Based on interview and record review the facility failed to ensure the organization of a single hospital-wide nursing service must be a licensed registered nurse. He or she is responsible for the operation of the service, including determining the types and numbers of nursing personnel and staff necessary to provide nursing care for all areas of the hospital. This STANDARD is not met as evidenced by: Surveyor: 28267 Based on interview and record review the facility failed to ensure the organization of a single hospital-wide nursing service under the direction of one Registered nurse. He or special to the nursing service under the direction of one Registered nurse. He organization of a single hospital-wid		10 to 200					
Based on interview and record review, the facility failed to obtain an order for restraints from the attending physician for 1 of 3 (#15) patients restrained. Findings include: Record review of patient #15's open chart revealed that there was an order from the physician's assistant for restraints dated 06/20/10 at 0611 for 'soft limb x 2' (restraints). The attending physician failed to complete the restraint order. Interview with the Vice President of Outpatient Services on 6/24/10 on at 11:30, confirmed that the order needed to be co signed by the attending physician and was incomplete for patient #15. A 386 482.23(a) ORGANIZATION OF NURSING SERVICES The hospital must have a well-organized service with a plan of administrative authority and delineation of responsibilities for patient care. The director of the nursing service must be a licensed registered nurse. He or she is responsible for the operation of the service, including determining the types and numbers of nursing personnel and staff necessary to provide nursing care for all areas of the hospital. This STANDARD is not met as evidenced by: Surveyor: 28267 Based on interview and record review the facility failed to ensure the organization of a single hospital-wide nursing service under the direction of one Registered Nurse (RIV). Findings include: On 6/22/10 at approximately 0830 during a visit to Campus B it was stated by staff #M that Campus B has	PREFIX	LACH DEFICIENCY MUST B	E PRECEDED BY FULL REGULATORY	ID PREFIX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	ORF COMPLETE	
Based on interview and record review, the facility failed to obtain an order for restraints from the attending physician for 1 of 3 (#15) patients restrained. Findings include: Record review of patient #15's open chart revealed that there was an order from the physician's assistant for restraints dated 06/20/10 at 0611 for 'soft limb x 2' (restraints). The attending physician failed to complete the restraint order. Interview with the Vice President of Outpatient Services on 6/24/10 on at 11:30, confirmed that the order needed to be co signed by the attending physician and was incomplete for patient #15. A 386 482.23(a) ORGANIZATION OF NURSING SERVICES The hospital must have a well-organized service with a plan of administrative authority and delineation of responsibilities for patient care. The director of the nursing service must be a licensed registered nurse. He or she is responsible for the operation of the service, including determining the types and numbers of nursing personnel and staff necessary to provide nursing care for all areas of the hospital. This STANDARD is not met as evidenced by: Surveyor: 28267 Based on interview and record review the facility failed to ensure the organization of a single hospital-wide nursing service under the direction of one Registered Nurse (RIV). Findings include: On 6/22/10 at approximately 0830 during a visit to Campus B it was stated by staff #M that Campus B has	A 168	Continued From none 6					
plan of administrative authority and delineation of responsibilities for patient care. The director of the nursing service must be a licensed registered nurse. He or she is responsible for the operation of the service, including determining the types and numbers of nursing personnel and staff necessary to provide nursing care for all areas of the hospital. This STANDARD is not met as evidenced by: Surveyor: 28267 Based on interview and record review the facility failed to ensure the organization of a single hospital-wide nursing service under the direction of one Registered Nurse (RN). Findings include: On 6/22/10 at approximately 0830 during a visit to Campus B it was stated by staff # M that Campus B has		Based on interview and to obtain an order for rephysician for 1 of 3 (#15 include: Record review of patient there was an order from restraints dated 06/20/1 (restraints). The attendithe restraint order. Interview with the Vice Fon 6/24/10 on at 1130, of to be co signed by the a incomplete for patient #1	record review, the facility failed straints from the attending patients restrained. Findings it #15's open chart revealed that the physician's assistant for 0 at 0611 for "soft limb x 2" ng physician failed to complete President of Outpatient Services confirmed that the order needed thending physician and was 15. ON OF NURSING SERVICES		1. Rotating ICU Physicians educat monthly on restraint order requirer 2. Policy 1CLN 008 Restraint Use (Non-Psychiatric Setting) changed "only physicians can order restrain 3. Electronic Medical Record (EM updated to restrict restraint orderin physicians only. RN/NP/PA may of a verbal or phone order for initial restraint application from the attemphysician. 4. Subsequent EMR restraint rene orders are the responsibility of the attending physician 5. Audit compliance with restraint of monthly. 6. Vice President Medical Affairs (VPMA) to present findings and acplans to Leadership Performance Improvement and Medical Safety Coordinating Committee and Medical Medical Medical Safety	nents. 5/2010 Adult to 9/1/10 ts". R) 9/14/10 gg to obtain ding 9/14/10 ewal 9/14/10 orders tion	
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIERS REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE	LABORAT	plan of administrative authority and delineation of responsibilities for patient care. The director of the nursing service must be a licensed registered nurse. He or she is responsible for the operation of the service, including determining the types and numbers of nursing personnel and staff necessary to provide nursing care for all areas of the hospital. This STANDARD is not met as evidenced by: Surveyor: 28267 Based on interview and record review the facility failed to ensure the organization of a single hospital-wide nursing service under the direction of one Registered Nurse (RN). Findings include: On 6/22/10 at approximately 0830 during a visit to Campus B it was stated by staff # M that Campus B has is a separate facility from Campus A. In addition staff #		IVE'S SIGN.	One Director of Nursing Service: The organization has been restruct effective September 1 2010, such the President of Campus A is responsible for the management of Campus A and Campus B. The hospital has appointed a RN to ser Vice President for Campus B's Administration & Patient Care. The position will be onsite at Campus B report to the hospital President in regards to administration issues an the hospital's VP Patient Care Servin regards to nursing services.	s 9/1/10 that f both ve as e new 3 and d to vices	
(X6) DATE					11166	(AO) DATE	

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AND PLA	ENT OF DEFICIENCIES N OF CORRECTION	(X1)PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	A.	TIPLE CONSTRUCTION BUILDING	(X3) D	ATE SURVEY OMPLETED
		230104	В.	WING		
NAME OF	PROVIDER OR SUPPLIER		STREET	ADDRESS, CITY, STATE, ZIP CODE	0	6/24/2010
Sort	UNIVERSITY HOSPITAL		3990 JOH	N R STREET MI. 48201		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST B	EMENT OF DEFICIENCIES E PRECEDED BY FULL REGULATORY TIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DRE	(X5) COMPLETE DATE
A 386	Continued From page 7		1.000			
,,,,,,	Continued From page 7		A 386			
	M stated "I am the CNO the President."	for this facility and I report to		-		
A 450	with staff # UU. When s regarding the set up and indicated that the corres Campus A and Campus the respective campus.	I reporting structure, she ponding Chief Nursing Office at B report to their President at In addition, the Chief Nursing d the one at Campus B report sing Officer.	A 450			
	complete, dated, timed, electronic form by the peor evaluating the service hospital polices and produced This STANDARD is not Surveyor: 28267 Based on record review to ensure that 4 of 4 (#3)	met as evidenced by: and interview the facility failed 1, #39, #45, #83) hard copy mplete, accurate, and legible.		Blank Resuscitation Designation Order Form 1. VPMA to educate physicians a LIPs to complete resuscitation for institute through physician pour institute through physician physic	nd m on	9/15/10
	observational tour and me charts on unit 4-WS (new of patient # 39 consisted and inaccurate medical rather form titled "Resuscit was placed in the patient Staff # Y stated that if this sometimes a note will be note. After reviewing the Staff # Y stated that no oprogress notes either.	nedical record review of open proscience) the medical record of the following incomplete records: ation Designation Order Form at schart and was not filled out. It is form is not filled out in the physician's progress rephysician's progress notes discussion was noted in the		inpatients through physician news posters in Doctors' Lounge, eleva sheets, Doctors' Dining Room tab cards, and Medical Staff Operatio Committee. 2. Quality & Compliance to audit resuscitation designation forms completion compliance monthly. 3. VPMA to present findings and a plans to Leadership Performance Improvement and Medical Safety Coordinating Committee and Medical Staff Operating Committee month	action	
LABORAT	LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIERS REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE					
-						

PRINTED: 8/17/2010 FORM APPROVED OMB NO 1939 0304

AND PLA	ENT OF DEFICIENCIES AN OF CORRECTION	(X1)PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING COMPLET B. WING			
NAME O	NAME OF PROVIDER OR SUPPLIER				06/24/2010	
HARPER	R UNIVERSITY HOSPITAL		3990 JOH	ADDRESS, CITY, STATE, ZIP CODE N R STREET MI. 48201		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST B	EMENT OF DEFICIENCIES E PRECEDED BY FULL REGULATORY TIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIATE OF THE APPR	BE COMPLETE	
A 450	Continued From page 8		A 450	Ι		
v	A form titled "Acknowled for Health Care" was four record and was absent to patient #45's medical confirmed by staff # Y at The medical staff by law document indicates under and Advance Directives' directive, if known, must when admitted, in according a code change, document for Health Park 1997.	dgement of Advance Directive and in patient #39's medical of documentation and belonged record. This finding was a the time of the finding. It is rules and regulations are section Q titled "Code Status", "Code status and advance be designated on all patients d with DMC policy. In the event mentation must be present to	A 400	Blank & Misfiled Acknowledgem of Advance Directive for Health (Form 1. Registration Director to educate on form completion requirements. 2. Monthly audit conducted by department management. 3. Findings and action plans prese to Leadership Performance Improvement and Medical Safety Coordinating Committee monthly a department staff.	Staff 8/23/10 9/1/10 nted	
	indicate the reason for c Surveyor: 28273 Based on record review to ensure that 1 of 4 (#3 was complete, accurate, During record review (of Campus A on 06/21/201 02/14/2010 titled "Patien incomplete. The area fo "Authorization to Release were left blank.	and interview the facility failed 1) hard copy medical record and legible. Findings include: expired patient # 31) at 0 at 1400, a document dated t Expiration Form" was r documentation of e Body and Body Released by" P at the time of record review, ment should have been		Patient Expiration Form section: Authorization to Release Body at Body Released By 1. Process revised: HIM to notify Security when Funeral Home arrive pick up patient. Security will pick up Patient Expiration Form from HIM a escort Funeral Home staff sign form after body released. Security will reform to HIM. 2. Revise 3 HUHHWH CLN 8410 PMortem policy. 3. Security and HIM Directors to educate staff 4. Audit conducted by HIM management monthly. 5. Findings and action plans present to Leadership Performance Improvement and Medical Safety Coordinating Committee monthly and department staff.	9/30/10 es to ond n esturn ost 9/7/10 8/30/10	
A 466	CONSENT	IT OF RECORD-INFORMED	A 466	department staff.	20	
LABORAT	staff, or by Federal or Sta	54339 - 2 333	IVE'S SIGN	ATURE TITLE	(X6) DATE	

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 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 required to continued program participation.

(X6) DATE

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STATEMENT OF DEFICIENCIES (X1)PROVIDER/SUPPLIER/CLIA				O	MB NO. 0938-0391
AND PLA	IN OF CORRECTION	(X1)PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 230104	A. 1	TIPLE CONSTRUCTION BUILDING WING	(X3) DATE SURVEY COMPLETED
NAME OF	PROVIDER OR SUPPLIER		STREET	ADDRESS, CITY, STATE, ZIP CODE	06/24/2010
HARPER	UNIVERSITY HOSPITAL	81	3990 JOH	N R STREET MI. 48201	
PREFIX TAG	(EACH DEFICIENCY MUST B	EMENT OF DEFICIENCIES E PRECEDED BY FULL REGULATORY FIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE
A 466	Continued From page 9		A 466		
	written patient consent.				
	to ensure that a properly	and interview the facility failed executed informed consent in 3 of 14 (#38, #57, #59)		Informed Consent	
	charts on unit 4-WS (net of patient # 38 consisted Surgery, Invasive and/or	nedical record review of open proscience) the medical record of a form titled "Consent for Diagnostic Procedures.		Revised policy 1 CLN 006 Inform Consent for Medical/ Surgical Treatment, and Diagnostic Procedu include writing out the specific procedure to be performed.	
	the facility utilized for evi process contained under procedure(s) is (are): B s that the procedure was the sphenoidal electrodes" a	Sphenoidal. Staff # DD stated he "placement of bilateral and that the procedure wasn't poose to be, this finding was		VPMA to educate physicians and LIPs to complete consent correctly through physician newsletter, poste Doctors' Lounge, elevator tip sheets Doctors' Dining Room table cards, a Medical Staff Operations Committee 3. Department of Anesthesia to aud consents monthly.	rs in s, and e. it
A 491	Medical/Surgical Treatme does not contain specific	titled "Informed Consent for ent, and Diagnostic Procedure instructions to indicate writing e to be performed and consent	A 491	 Findings and action plans present to Leadership Performance Improvement, Surgical Committee, Medical Safety Coordinating Command Medical Staff Operating Commitmentally by VPMA. 	and ittee
2	The pharmacy or drug st administered in accordar principles.	orage area must be nce with accepted professional			
	facility failed to ensure th	aterview and policy review, the pat medications dispensed to a not stored on the medication			

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

TITLE

(X6) DATE

PRINTED: 8/17/2010 FORM APPROVED OMB NO. 0938-0391

STATEM	ENT OF DEFICIENCIES	(VA)DDOUIDEGIGUEDUES			OMB NO	0. 0938-0391
AND PLA	AN OF CORRECTION	(X1)PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 230104	Α.	TIPLE CONSTRUCTION BUILDING WING	_ 0	ATE SURVEY COMPLETED
and warments-of-	F PROVIDER OR SUPPLIED UNIVERSITY HOSPITAL	R		NDDRESS, CITY, STATE, ZIP CODE		7072472010
WALLE.			DETROIT,			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	TEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY ITIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
	-					
A 491	Continued From page	10	A 491		I	

Policy 2 MED 300 states: "There must be regular inspection of mediations stored in patient care areas of the hospitals and clinics with the purpose of determining proper labeling, product stability, product safety, and proper storage condition." The policy states that a pharmacist or designee is responsible for inspections in all areas were medications are stored. On 6/21/10 at approximately 1400, inspection of the medication act not the psychiatric unit on Campus B, revealed medications dispensed to five discharged patients (#66, #67, #68, #69 and #70). The Coordinator of Pharmacy Services at Campus B confirmed these findings and stated that she did not know who was responsible for removing these items from the medication cart. In addition, one Advair Diskus 100/50 with no patient name was noted. These findings were confirmed by the Vice President of Operations/Patient Care Services to ensure findings and action plans presented monthly to Leadership Performance Improvement and Medical Safety Coordinating Committee. A 700 A 701 A 701 A 701 A 701 A 701 Patient Medications 1. Revised Discharge Form to add Medication act checked for home medication. 2. Educated staff by department management. 3. Revised Discharge Form to add Medication act checked for home medication. 2. Educated staff by department management. 3. Revised Discharge Form to add Medication act checked for home medication. 2. Educated staff by department management. 3. Revised Discharge Form to add Medication act checked for home medication. 2. Educated staff by department management. 3. Revised Discharge Form to add Medication act checked for home medication. 4. Process implemented by pharmacy to label dvair Disks 100/50 with patient name. 5. Weekly auditing by Quality Department for 6 months. 6. Vice President Operations/Patient Care Services to ensure findings and action plans presented monthly to Leadership Performance Improvement and Medication act. A 700 A 701 A 702 A 703 A 704 A 705 A 706 A 707 A 707 A 708 A 708	A 491	Continued From page 10	A 491		T
A 700 482.41 PHYSICAL ENVIRONMENT The hospital must be constructed, arranged, and maintained to ensure the safety of the patient, and to provide facilities for diagnosis and treatment and for special hospital services appropriate to the needs of the community. This CONDITION is not met as evidenced by: Surveyor: 15195 The facility failed to provide and maintain a safe environment for patients and staff. This is evidenced by the Life Safety Code deficiencies identified. See A-710. 4 701 482.41(a) MAINTENANCE OF PHYSICAL PLANT A 701		Policy 2 MED 300 states: "There must be regular inspection of mediations stored in patient care areas of the hospitals and clinics with the purpose of determining proper labeling, product stability, product safety, and proper storage condition." The policy states that a pharmacist or designee is responsible for inspections in all areas were medications are stored. On 6/21/10 at approximately 1400, inspection of the medication cart on the psychiatric unit on Campus B, revealed medications dispensed to five discharged patients (#66, #67, #68, #69 and #70). The Coordinator of Pharmacy Services at Campus B confirmed these findings and stated that she did not know who was responsible for removing these items from the medication cart. In addition, one Advair Diskus 100/50 with no patient name was noted. These findings were confirmed by the Vice President of Operations/Patient		1. Revised Discharge Form to add Medication cart checked for home medication. 2. Educated staff by department management. 3. Revised process for returning patient home medications on discharge. 4. Process implemented by pharmacy to label Advair Diskus 100/50 with patient name. 5. Weekly auditing by Quality Department for 6 months. 6. Vice President Operations/Patient Care Services to ensure findings and action plans presented monthly to Leadership Performance Improvement and Medical Safety Coordinating	8/11/10 8/11/10 6/25/10
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		This CONDITION is not met as evidenced by: Surveyor: 15195 The facility failed to provide and maintain a safe environment for patients and staff. This is evidenced by the Life Safety Code deficiencies		50	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIERS REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

PRINTED: 8/17/2010 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION AME OF PROVIDER OR SUPPLIER HARPER UNIVERSITY HOSPITAL 230104 A BUILDING STREET ADDRESS, CITY, STATE, ZIP CODE 3990 JOHN R STREET DEFROIT ML 48201 FREFIX A DUILDING (EACH DEFOILED WINST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) A SUDJAMP STATEMENT OF DEFICIENCIES FREFIX A 701 Continued From page 11 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 evidence by: Surveyor; 26222 Based upon observation and record review, the facility failed to maintain the hospital environment to assure the safety of patients. Findings include: On 6/22/10 6/23/10, and 6/24/10 between the hours of 0.8:20 AM and 3:00 PM, based upon observation, it was discovered that Coffee dispensing machines in patient pantries throughout Campus A are not being completed on a regular basis. Facilities Manager # FFF confirmed that the eyewash station in SCH sold in Webber South Mechanical Room of Campus A are not being completed on a regular basis. Facilities Manager # FFF confirmed that the eyewash station in SWS is not needed in that location. On 6/22/10 at 12:00 PM, based upon observation, it was discovered that the Respite Nurseries are being used for sold and 2270, Deft Machanical Room of Campus A are not being completed on a regular basis. Facilities Manager # FFF confirmed that the eyewash station in SWS is not needed in that location. On 6/22/10 at 12:00 PM, based upon observation, it was discovered that the Respite Nurseries are being used for storage on 2 Webber North of Campus A Respite Nurseries are being used for storage on 2 Webber North of Campus A Respite Nurseries are being used for storage on 2 Webber North of Campus A Respite Nurseries are being used for storage on 2 Webber North of Campus As a Room 2235 and 2227). Clinical Manager 13/10 stated during interview 0/22/10 at 22.00 PM based upon beservation, it was discovered that the Respite Nurseries are being used for	STATEM	ENT OF DEFICIENCIES	(X1)PROVIDER/SUPPLIER/CLIA	T (240) - 24111	0	MB N	O. 0938-0391
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HARPER UNIVERSITY HOSPITAL (A)	NAME O	F PROVIDER OR SUPPLIES	230104				06/24/2010
Continued From page 11 Continued From page 12 Complete Cross-Reference to 10 the Appropriate DATE ONT		THE THE PLANT OF THE P		STREET	ADDRESS, CITY, STATE, ZIP CODE		
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PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) A 701 Continued From page 11 hospital environment that the safety and well-being of patients are assured. This STANDARD is not met as evidence by: Surveyor: 26222 Based upon observation and record review, the facility failed to maintain the hospital environment to assure the safety of patients. Findings include: On 6/22/10, 6/23/10, and 6/24/10 between the hours of 8:00 AM and 3:00 PM, it was discovered that coffee dispensing machines in patient partities throughout Campus A are not equipped with proper backflow prevention devices on water intellines. On 6/22/10 between the hours of 9:00 AM and 3:00 PM, it was discovered through observation have weekly testing logs for eyewash stations located in 8 Webber South, (8WS) soled utility room and 6 Webber South Mechanical Room of Campus A are not being completed on a regular basis. Facilities Manager # FFF confirmed that the eyewash station in 8WS is not needed in that location. On 6/22/10 at 1:50 PM, based upon observation, it was discovered that the exhaust in the tollet room in Exam Room 7 and the tollet room adjacent to Exam Room 6 in 3-Labor Reception Center (LRC) at Campus A is not functioning. On 0/22/10 at 2:30PM, based upon observation, it was discovered that the exhaust in the tollet room in Exam Room 7 and the tollet room adjacent to Exam Room 6 in 3-Labor Reception Center (LRC) at Campus A is not functioning. On 0/22/10 at 2:30PM, based upon observation, it was discovered that the Respite Nurseries are being used for storage on 2 Webber North of Campus A, (Rooms 2335 and 2227). Clinical Manager JJJ stated during interview 6/22/10 at 2.27 in PM truseries are rearely used because most babies room-in with the mothers, and that Room 2227 is never used for babies, and				3990 JOH	IN R STREET		
A 701 A 701 Continued From page 11 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 evidence by: Surveyor: 26222 Based upon observation, it was discovered that coffee dispensing machines in patient pantries throughout Campus A are not equipped with proper backflow prevention devices on water inlet lines. On 6/22/10 activement of 9.00 AM and 3.00 PM, it was discovered through observation that weekly testing logs for eyewash stations located in 8 Webber South (RWS) soiled utility room and 6 Webber South Mechanical Room of Campus A are not being completed on a regular basis. Facilities Manager #FFF confirmed that the eyewash station in 8WS is not needed in that location. On 6/22/10 at 1:50 PM, based upon observation, it was discovered that the exhaust in the tolet room adjacent to Exam Room 7 and the tolet room adjacent to Exam Room 6 in 3-Labor Reception Center (LRC) at Campus A is not functioning. On 6/22/10 at 2:00 PM, based upon observation, it was discovered that the exhaust in the tolet room adjacent to Exam Room 6 in 3-Labor Reception Center (LRC) at Campus A is not functioning. On 6/22/10 at 2:00 PM, based upon observation, it was discovered that the exhaust in the tolet room adjacent to Exam Room 6 in 3-Labor Reception Center (LRC) at Campus A is not functioning. On 6/22/10 at 2:00 PM, based upon observation, it was discovered that the Respite Nurseries are being used for storage on 2 Webber North of Campus A (Rooms 2235 and 2227). Clinical Manager JJJ stated during interview 6/22/10 at 2:04 PM that nurseries are rarely used because most babies room-in with the mothers, and that Room 2227 is never used for babies, and	(X4) ID	SUMMARY STAT	TEMENT OF DEFICIENCIES		, MI. 48201		
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hospital environment must be developed and maintained in such a manner that the safety and wellbeing of patients are assured. This STANDARD is not met as evidence by: Surveyor: 26222 Based upon observation and record review, the facility failed to maintain the hospital environment to assure the safety of patients. Findings include: On 6/22/10, 6/23/10, and 6/24/10 between the hours of 8:00 AM and 3:00 PM, based upon observation, it was discovered that coffee dispensing machines in patient pantries throughout Campus A are not equipped with proper backflow prevention devices on water inlet lines. On 6/22/10 between the hours of 9:00 AM and 3:00 PM, it was discovered through observation hat weekly testing logs for eyewash stations located in 8 Webber South Mechanical Room of Campus A are not being completed on a regular basis. Facilities Manager # FFF confirmed that the eyewash station in 8WS is not needed in that location. On 6/22/10 at 1:50 PM, based upon observation, it was discovered that the exhaust in the toilet room adjacent to Exam Room 6 in 3-Labor Reception Center (LRC) at Campus A is not functioning. On 6/22/10 at 2:30 PM, based upon observation, it was discovered that the exhaust in the toilet room adjacent to Exam Room 6 in 3-Labor Reception Center (LRC) at Campus A is not functioning. On 6/22/10 at 2:30 PM, based upon observation, it was discovered that the Respite Nurseries are being used for storage on 2 Webber North of Campus A (Rooms 2235 and 2227). Clinical Manager JJJ stated during interview 6/22/10 at 2:40 PM that nurseries are rarely used because most babies room-in with the mothers, and that Room 2227 is never used for babies, and					OLI IOILIO I		
hospital environment must be developed and maintained in such a manner that the safety and wellbeing of patients are assured. This STANDARD is not met as evidence by: Surveyor: 26222 Based upon observation and record review, the facility failed to maintain the hospital environment to assure the safety of patients. Findings include: On 6/22/10, 6/23/10, and 6/24/10 between the hours of 8:00 AM and 3:00 PM, based upon observation, it was discovered that coffee dispensing machines in patient pantries throughout Campus A are not equipped with proper backflow prevention devices on water inlet lines. On 6/22/10 between the hours of 9:00 AM and 3:00 PM, it was discovered through observation hat weekly testing logs for eyewash stations located in 8 Webber South Mechanical Room of Campus A are not being completed on a regular basis. Facilities Manager # FFF confirmed that the eyewash station in 8WS is not needed in that location. On 6/22/10 at 1:50 PM, based upon observation, it was discovered that the exhaust in the toilet room adjacent to Exam Room 6 in 3-Labor Reception Center (LRC) at Campus A is not functioning. On 6/22/10 at 2:30 PM, based upon observation, it was discovered that the exhaust in the toilet room adjacent to Exam Room 6 in 3-Labor Reception Center (LRC) at Campus A is not functioning. On 6/22/10 at 2:30 PM, based upon observation, it was discovered that the Respite Nurseries are being used for storage on 2 Webber North of Campus A (Rooms 2235 and 2227). Clinical Manager JJJ stated during interview 6/22/10 at 2:40 PM that nurseries are rarely used because most babies room-in with the mothers, and that Room 2227 is never used for babies, and	A 701	Continued From page 1	1				(m)
maintained in such a manner that the safety and well-being of patients are assured. This STANDARD is not met as evidence by: Surveyor: 26222 Based upon observation and record review, the facility failed to maintain the hospital environment to assure the safety of patients. Findings include: On 6722/10, 6723/10, and 6724/10 between the hours of 8:00 AM and 3:00 PM, based upon observation, it was discovered that coffee dispensing machines in patient pantries throughout Campus A are not equipped with proper backflow prevention devices on water inlet lines. On 6722/10 between the hours of 9:00 AM and 3:00 PM, it was discovered through observation that weekly testing logs for eyewash stations located in 8 Webber South (McAnnical Room of Campus A are not being completed on a regular basis. Facilities Manager # FFF confirmed that the eyewash station in 8WS is not needed in that location. On 6/22/10 at 1:50 PM, based upon observation, it was discovered that plastic laminate is damaged at charting stations on 4 Webber South, and at the 4ICU Nurse Station in Campus A. On 6/22/10 at 2:00 PM, based upon observation, it was discovered that the exhaust in the toilet room in Exam Room 7 and the toilet room adjacent to Exam Room 6 in 3-Labor Reception Center (LRC) at Campus A is not functioning. On 6/22/10 at 2:30PM, based upon observation, it was discovered that the Respite Nurseries are being used for storage on 2 Webber North of Campus A (Rooms 2235 and 2227). Clinical Manager JJJ stated during interview 6/22/10 at 2:40 PM that nurseries are rarely used because most babies room-in with the mothers, and that Room 2227 is never used for babies, and	,,,,,,	hospital environment	1	A 701			
This STANDARD is not met as evidence by: Surveyor: 26222 Based upon observation and record review, the facility failed to maintain the hospital environment to assure the safety of patients. Findings include: On 6/2210 (23/10, and 6/24/10 between the hours of 8:00 AM and 3:00 PM, based upon observation, it was discovered that coffee dispensing machines in patient pantries throughout Campus A are not equipped with proper backflow prevention devices on water inlet lines. On 6/22/10 between the hours of 9:00 AM and 3:00 PM, it was discovered through observation that weekly testing logs for eyewash stations located in 8 Webber South Mechanical Room of Campus A are not being completed on a regular basis. Facilities Manager # FFF confirmed that the eyewash station in 8/WS is not needed in that location. On 6/22/10 at 1:50 PM, based upon observation, it was discovered that plastic laminate is damaged at charting stations on 4 Webber South, and at the 4ICU Nurse Station in Campus A. On 6/22/10 at 2:00 PM, based upon observation, it was discovered that the expectation in the toilet room of in 3-Labor Reception Center (LRC) at Campus A is not functioning. On 6/22/10 at 2:30 PM, based upon observation, it was discovered that the Respite Nurseries are being used for storage on 2 Webber North of Campus A (Rooms 2235 and 2227). Clinical Manager JJJ stated during interview 6/22/10 at 2:40 PM that nurseries are rerely used because most babies room-in with the mothers, and that Room 2227 is never used for babies, and		mospital environment m	ust be developed and				
This STANDARD is not met as evidence by: Surveyor: 26222 Based upon observation and record review, the facility failed to maintain the hospital environment to assure the safety of patients. Findings include: On 6/22/10, 6/23/10, and 6/24/10 between the hours of 8:00 AM and 3:00 PM, based upon observation, it was discovered that coffee dispensing machines in patient pantries throughout Campus A are not equipped with proper backflow prevention devices on water inlet lines. On 6/22/10 between the hours of 9:00 AM and 3:00 PM, it was discovered through observation that weekly testing logs for eyewash stations located in 8 Webber South (BWS) soiled utility room and 6 Webber South Mechanical Room of Campus A are not being completed on a regular basis. Facilities Manager # FFF confirmed that the eyewash station in 8V/S is not needed in that location. On 6/22/10 at 1:50 PM, based upon observation, it was discovered that plastic laminate is damaged at charting stations on 4 Webber South, and at the 4ICU Nurse Station in Campus A. On 6/22/10 at 2:00 PM, based upon observation, it was discovered that the exhaust in the toilet room in Exam Room 7 and the toilet room adjacent to Exam Room 6 in 3-Labor Reception Center (LRC) at Campus A is not functioning. On 6/22/10 at 2:30PM, based upon observation, it was discovered that the Respite Nurseries are being used for storage on 2 Webber North of Campus A (Rooms 2235 and 2227). Clinical Manager JJJ stated during interview 6/22/10 at 2:40 PM that nurseries are rarely used because most babies room-in with the mothers, and that Room 2227 is never used for babies, and		maintained in such a ma	anner that the safety and well-		3		
Based upon observation and record review, the facility failed to maintain the hospital environment to assure the safety of patients. Findings include: On 6/22/10, 6/23/10, and 6/24/10 between the hours of 8:00 AM and 3:00 PM, based upon observation, it was discovered that coffee dispensing machines in patient pantries throughout Campus A are not equipped with proper backflow prevention devices on water inlet lines. On 6/22/10 between the hours of 9:00 AM and 3:00 PM, it was discovered through observation that weekly testing logs for eyewash stations located in 8 Webber South (8WS) soiled utility room and 6 Webber South Mechanical Room of Campus A are not being completed on a regular basis. Facilities Manager # FFF confirmed that the eyewash station in 8WS is not needed in that location. On 6/22/10 at 1:50 PM, based upon observation, it was discovered that plastic laminate is damaged at charting stations on 4 Webber South, and at the 4ICU Nurse Station in Campus A. On 6/22/10 at 2:00 PM, based upon observation, it was discovered that the exhaust in the toilet room in Exam Room 7 and the toilet room adjacent to Exam Room 6 in 3-Labor Reception Center (LRC) at Campus A is not functioning. On 6/22/10 at 2:30PM, based upon observation, it was discovered that the Respite Nurseries are being used for storage on 2 Webber North of Campus A (Rooms 223 and 2227). Clinical Manager JJJ stated during interview 6/22/10 at 2:40 PM that nurseries are rarely used because most babies room-in with the mothers, and that Room 2227 is never used for babies, and		being of patients are as	sured.				
Based upon observation and record review, the facility failed to maintain the hospital environment to assure the safety of patients. Findings include: On 6/22/10, 6/23/10, and 6/24/10 between the hours of 8:00 AM and 3:00 PM, based upon observation, it was discovered that coffee dispensing machines in patient pantries throughout Campus A are not equipped with proper backflow prevention devices on water inlet lines. On 6/22/10 between the hours of 9:00 AM and 3:00 PM, it was discovered through observation that weekly testing logs for eyewash stations located in 8 Webber South (8WS) soiled utility room and 6 Webber South Mechanical Room of Campus A are not being completed on a regular basis. Facilities Manager # FFF confirmed that the eyewash station in 8WS is not needed in that location. On 6/22/10 at 1:50 PM, based upon observation, it was discovered that plastic laminate is damaged at charting stations on 4 Webber South, and at the 4ICU Nurse Station in Campus A. On 6/22/10 at 2:00 PM, based upon observation, it was discovered that the exhaust in the toilet room in Exam Room 7 and the toilet room adjacent to Exam Room 6 in 3-Labor Reception Center (LRC) at Campus A is not functioning. On 6/22/10 at 2:30PM, based upon observation, it was discovered that the Respite Nurseries are being used for storage on 2 Webber North of Campus A (Rooms 223 and 2227). Clinical Manager JJJ stated during interview 6/22/10 at 2:40 PM that nurseries are rarely used because most babies room-in with the mothers, and that Room 2227 is never used for babies, and							
Based upon observation and record review, the facility failed to maintain the hospital environment to assure the safety of patients. Findings include: On 6/22/10, 6/23/10, and 6/24/10 between the hours of 8:00 AM and 3:00 PM, based upon observation, it was discovered that coffee dispensing machines in patient pantries throughout Campus A are not equipped with proper backflow prevention devices on water inlet lines. On 6/22/10 between the hours of 9:00 AM and 3:00 PM, it was discovered through observation that weekly testing logs for eyewash stations located in 8 Webber South (8WS) soiled utility room and 6 Webber South Mechanical Room of Campus A are not being completed on a regular basis. Facilities Manager # FFF confirmed that the eyewash station in 8WS is not needed in that location. On 6/22/10 at 1:50 PM, based upon observation, it was discovered that plastic laminate is damaged at charting stations on 4 Webber South, and at the 4ICU Nurse Station in Campus A. On 6/22/10 at 2:00 PM, based upon observation, it was discovered that the exhaust in the toilet room in Exam Room 7 and the toilet room adjacent to Exam Room 6 in 3-Labor Reception Center (LRC) at Campus A is not functioning. On 6/22/10 at 2:30PM, based upon observation, it was discovered that the Respite Nurseries are being used for storage on 2 Webber North of Campus A (Rooms 223 and 2227). Clinical Manager JJJ stated during interview 6/22/10 at 2:40 PM that nurseries are rarely used because most babies room-in with the mothers, and that Room 2227 is never used for babies, and	Ü	This STANDARD is not	met as evidence by:	4 4 4 4 4 4 4	1		B .
failed to maintain the hospital environment to assure the safety of patients. Findings include: On 6/22/10, 6/23/10, and 6/24/10 between the hours of 8:00 AM and 3:00 PM, based upon observation, it was discovered that coffee dispensing machines in patient proper backflow prevention devices on water inlet lines. On 6/22/10 between the hours of 9:00 AM and 3:00 PM, it was discovered through observation that weekly testing logs for eyewash stations located in 8 Webber South (8WS) soiled utility room and 6 Webber South Mechanical Room of Campus A are not being completed on a regular basis. Facilities Manager #FFF confirmed that the eyewash station in 8WS is not needed in that location. On 6/22/10 at 1:50 PM, based upon observation, it was discovered that plastic laminate is damaged at charting stations on 4 Webber South, and at the 4ICU Nurse Station in Campus A. On 6/22/10 at 2:00 PM, based upon observation, it was discovered that the exhaust in the toilet room in Exam Room 7 and the toilet room adjacent to Exam Room 6 in 3-Labor Reception Center (LRC) at Campus A is not functioning. On 6/22/10 at 2:30PM, based upon observation, it was discovered that the Respite Nurseries are being used for storage on 2 Webber North of Campus A (Rooms 2335 and 222/7). Clinical Manager JJJ stated during interview 6/22/10 at 2:40 PM that nurseries are rarely used because most babies room-in with the mothers, and that Room 2227 is never used for babies, and	il ic	Surveyor: 26222					
failed to maintain the hospital environment to assure the safety of patients. Findings include: On 6/22/10, 6/23/10, and 6/24/10 between the hours of 8:00 AM and 3:00 PM, based upon observation, it was discovered that coffee dispensing machines in patient proper backflow prevention devices on water inlet lines. On 6/22/10 between the hours of 9:00 AM and 3:00 PM, it was discovered through observation that weekly testing logs for eyewash stations located in 8 Webber South Mechanical Room of Campus A are not being completed on a regular basis. Facilities Manager #FFF confirmed that the eyewash station in 8WS is not needed in that location. On 6/22/10 at 1:50 PM, based upon observation, it was discovered that plastic laminate is damaged at charting stations on 4 Webber South, and at the 4ICU Nurse Station in Campus A. On 6/22/10 at 2:00 PM, based upon observation, it was discovered that the exhaust in the toilet room in Exam Room 7 and the toilet room adjacent to Exam Room 6 in 3-Labor Reception Center (LRC) at Campus A is not functioning. On 6/22/10 at 2:30PM, based upon observation, it was discovered that the Respite Nurseries are being used for storage on 2 Webber North of Campus A (Rooms 2335 and 222/7). Clinical Manager JJJ stated during interview 6/22/10 at 2:40 PM that nurseries are rarely used because most babies room-in with the mothers, and that Room 2227 is never used for babies, and		Based upon observation	and record review, the facility		1	39	
safety of patients. Findings include: On 6/22/10, 6/23/10, and 6/24/10 between the hours of 8:00 AM and 3:00 PM, based upon observation, it was discovered that coffee dispensing machines in patient pantries throughout Campus A are not equipped with proper backflow prevention devices on water inlet lines. On 6/22/10 between the hours of 9:00 AM and 3:00 PM, it was discovered through observation that weekly testing logs for eyewash stations located in 8 Webber South (8WS) soiled utility room and 6 Webber South Mechanical Room of Campus A are not being completed on a regular basis. Facilities Manager #FFF confirmed that the eyewash station in 8WS is not needed in that location. On 6/22/10 at 1:50 PM, based upon observation, it was discovered that plastic laminate is damaged at charting stations on 4 Webber South, and at the 4ICU Nurse Station in Campus A. On 6/22/10 at 2:00 PM, based upon observation, it was discovered that the exhaust in the toilet room in Exam Room 7 and the toilet room adjacent to Exam Room 6 in 3-Labor Reception Center (LRC) at Campus A is not functioning. On 6/22/10 at 2:30PM, based upon observation, it was discovered that the Respite Nurseries are being used for storage on 2 Webber North of Campus A (Rooms 2235 and 2227). Clinical Manager JJJ stated during interview 6/22/10 at 2:40 PM that nurseries are rarely used because most babies room-in with the mothers, and that Room 2227 is never used for babies, and		failed to maintain the ho	spital environment to assure the		1	- 1	
Findings include: On 6/22/10, 6/23/10, and 6/24/10 between the hours of 8:00 AM and 3:00 PM, based upon observation, it was discovered that coffee dispensing machines in patient proper backflow prevention devices on water inlet lines. On 6/22/10 between the hours of 9:00 AM and 3:00 PM, it was discovered through observation that weekly testing logs for eyewash stations located in 8 Webber South Mechanical Room of Campus A are not being completed on a regular basis. Facilities Manager # FFF confirmed that the eyewash station in 8WS is not needed in that location. On 6/22/10 at 1:50 PM, based upon observation, it was discovered that plastic laminate is damaged at charting stations on 4 Webber South, and at the 4ICU Nurse Station in Campus A. On 6/22/10 at 2:00 PM, based upon observation, it was discovered that the exhaust in the toilet room in Exam Room 7 and the toilet room adjacent to Exam Room 6 in 3-Labor Reception Center (LRC) at Campus A is not functioning. On 6/22/10 at 2:30PM, based upon observation, it was discovered that the Respite Nurseries are being used for storage on 2 Webber North of Campus A (Rooms 2323 and 2227). Clinical Manager JJJ stated during interview 6/22/10 at 2:40 PM that nurseries are rarely used because most babies room-in with the mothers, and that Room 2227 is never used for babies, and		safety of nations	opilar environment to assure the	,	1		Į.
On 6/22/10, 6/23/10, and 6/24/10 between the hours of 8:00 AM and 3:00 PM, based upon observation, it was discovered that coffee dispensing machines in patient proper backflow prevention devices on water inlet lines. On 6/22/10 between the hours of 9:00 AM and 3:00 PM, it was discovered through observation that weekly testing logs for eyewash stations located in 8 Webber South (8WS) soiled utility room and 6 Webber South Mechanical Room of Campus A are not being completed on a regular basis. Facilities Manager # FFF confirmed that the eyewash station in 8WS is not needed in that location. On 6/22/10 at 1:50 PM, based upon observation, it was discovered that plastic laminate is damaged at charting stations on 4 Webber South, and at the 4ICU Nurse Station in Campus A. On 6/22/10 at 2:00 PM, based upon observation, it was discovered that the exhaust in the toilet room in Exam Room 7 and the toilet room adjacent to Exam Room 6 in 3-Labor Reception Center (LRC) at Campus A is not functioning. On 6/22/10 at 2:30 PM, based upon observation, it was discovered that the Respite Nurseries are being used for storage on 2 Webber North of Campus A (Rooms 2235 and 2227). Clinical Manager JJJ stated during interview 6/22/10 at 2:40 PM that nurseries are rarely used because most babies room-in with the mothers, and that Room 2227 is never used for babies, and	1			-		- 3	
discovered that coffee dispensing machines in patient pantries throughout Campus A are not equipped with proper backflow prevention devices on water inlet lines. On 6/22/10 between the hours of 9:00 AM and 3:00 PM, it was discovered through observation that weekly testing logs for eyewash stations located in 8 Webber South Mechanical Room of Campus A are not being completed on a regular basis. Facilities Manager #FFF confirmed that the eyewash station in 8WS is not needed in that location. On 6/22/10 at 1:50 PM, based upon observation, it was discovered that the exhaust in the toilet room in Exam Room 7 and the toilet room adjacent to Exam Room 6 in 3-Labor Reception Center (LRC) at Campus A is not functioning. On 6/22/10 at 2:30 PM, based upon observation, it was discovered that the Respite Nurseries are being used for storage on 2 Webber North of Campus A (Rooms 2235 and 2227). Clinical Manager JJJ stated during interview 6/22/10 at 2:40 PM that nurseries are rarely used because most babies room-in with the mothers, and that Room 2227 is never used for babies, and			Jon Well		Anne Anne Anne Anne Anne Anne Anne Anne	1	
discovered that coffee dispensing machines in patient pantries throughout Campus A are not equipped with proper backflow prevention devices on water inlet lines. On 6/22/10 between the hours of 9:00 AM and 3:00 PM, it was discovered through observation that weekly testing logs for eyewash stations located in 8 Webber South Mechanical Room of Campus A are not being completed on a regular basis. Facilities Manager # FFF confirmed that the eyewash station in 8WS is not needed in that location. On 6/22/10 at 1:50 PM, based upon observation, it was discovered that plastic laminate is damaged at charting stations on 4 Webber South, and at the 4ICU Nurse Station in Campus A. On 6/22/10 at 2:00 PM, based upon observation, it was discovered that the exhaust in the toilet room in Exam Room 7 and the toilet room adjacent to Exam Room 6 in 3-Labor Reception Center (LRC) at Campus A is not functioning. On 6/22/10 at 2:30 PM, based upon observation, it was discovered that the Respite Nurseries are being used for storage on 2 Webber North of Campus A (Rooms 2235 and 2227). Clinical Manager JJJ stated during interview 6/22/10 at 2:40 PM that nurseries are rarely used because most babies room-in with the mothers, and that Room 2227 is never used for babies, and		011 0/22/10, 0/23/10, an	d 6/24/10 between the hours of		Coffee Dispensing Machines		74540
pantries throughout Campus A are not equipped with proper backflow prevention devices on water inlet lines. On 6/22/10 between the hours of 9:00 AM and 3:00 PM, it was discovered through observation that weekly testing logs for eyewash stations located in 8 Webber South Mechanical Room of Campus A are not being completed on a regular basis. Facilities Manager #FFF confirmed that the eyewash station in 8WS is not needed in that location. On 6/22/10 at 1:50 PM, based upon observation, it was discovered that plastic laminate is damaged at charting stations on 4 Webber South, and at the 4ICU Nurse Station in Campus A. On 6/22/10 at 2:00 PM, based upon observation, it was discovered that the exhaust in the toilet room in Exam Room 7 and the toilet room adjacent to Exam Room 6 in 3-Labor Reception Center (LRC) at Campus A is not functioning. On 6/22/10 at 2:30 PM, based upon observation, it was discovered that the Respite Nurseries are being used for storage on 2 Webber North of Campus A (Rooms 2235 and 2227). Clinical Manager JJJ stated during interview 6/22/10 at 2:40 PM that nurseries are rarely used because most babies room-in with the mothers, and that Room 2227 is never used for babies, and		8:00 AM and 3:00 PM, E	based upon observation, it was		Equipped coffee dispensing		//15/10
pantries throughout Campus A are not equipped with proper backflow prevention devices on water inlet lines. On 6/22/10 between the hours of 9:00 AM and 3:00 PM, it was discovered through observation that weekly testing logs for eyewash stations located in 8 Webber South (8WS) soiled utility room and 6 Webber South Mechanical Room of Campus A are not being completed on a regular basis. Facilities Manager # FFF confirmed that the eyewash station in 8WS is not needed in that location. On 6/22/10 at 1:50 PM, based upon observation, it was discovered that plastic laminate is damaged at charting stations on 4 Webber South, and at the 4ICU Nurse Station in Campus A. On 6/22/10 at 2:00 PM, based upon observation, it was discovered that the exhaust in the toilet room in Exam Room 7 and the toilet room adjacent to Exam Room 6 in 3-Labor Reception Center (LRC) at Campus A (sooms 2235 and 2227). Clinical Manager JJJ stated during interview 6/22/10 at 2:40 PM that nurseries are rarely used because most babies room-in with the mothers, and that Room 2227 is never used for babies, and		discovered that coffee d	ispensing machines in patient		machines in patient pantries with n	roper	
proper backflow prevention devices on water inlet lines. On 6/22/10 between the hours of 9:00 AM and 3:00 PM, it was discovered through observation that weekly testing logs for eyewash stations located in 8 Webber South Mechanical Room of Campus A are not being completed on a regular basis. Facilities Manager # FFF confirmed that the eyewash station in 8WS is not needed in that location. On 6/22/10 at 1:50 PM, based upon observation, it was discovered that plastic laminate is damaged at charting stations on 4 Webber South, and at the 4ICU Nurse Station in Campus A. On 6/22/10 at 2:00 PM, based upon observation, it was discovered that the exhaust in the toilet room in Exam Room 7 and the toilet room adjacent to Exam Room 6 in 3-Labor Reception Center (LRC) at Campus A is not functioning. On 6/22/10 at 2:30PM, based upon observation, it was discovered that the Respite Nurseries are being used for storage on 2 Webber North of Campus A (Rooms 2235 and 2227). Clinical Manager JJJ stated during interview 6/22/10 at 2:40 PM that nurseries are rarely used because most babies room-in with the mothers, and that Room 2227 is never used for babies, and		pantries throughout Can	npus A are not equipped with		backflow prevention devices on wa	ter	
On 6/22/10 between the hours of 9:00 AM and 3:00 PM, it was discovered through observation that weekly testing logs for eyewash stations located in 8 Webber South (8WS) soiled utility room and 6 Webber South Mechanical Room of Campus A are not being completed on a regular basis. Facilities Manager # FFF confirmed that the eyewash station in 8WS is not needed in that location. On 6/22/10 at 1:50 PM, based upon observation, it was discovered that plastic laminate is damaged at charting stations on 4 Webber South, and at the 4ICU Nurse Station in Campus A. On 6/22/10 at 2:00 PM, based upon observation, it was discovered that the exhaust in the toilet room in Exam Room 7 and the toilet room adjacent to Exam Room 6 in 3-Labor Reception Center (LRC) at Campus A is not functioning. On 6/22/10 at 2:30PM, based upon observation, it was discovered that the Respite Nurseries are being used for storage on 2 Webber North of Campus A (Rooms 2235 and 2227). Clinical Manager JJJ stated during interview 6/22/10 at 2:40 PM that nurseries are rarely used because most babies room-in with the mothers, and that Room 2227 is never used for babies, and		proper backflow prevent	ion devices on water inlet lines		inlet lines	ici	
it was discovered through observation that weekly testing logs for eyewash stations located in 8 Webber South (8WS) soiled utility room and 6 Webber South Mechanical Room of Campus A are not being completed on a regular basis. Facilities Manager # FFF confirmed that the eyewash station in 8WS is not needed in that location. On 6/22/10 at 1:50 PM, based upon observation, it was discovered that plastic laminate is damaged at charting stations on 4 Webber South, and at the 4ICU Nurse Station in Campus A. On 6/22/10 at 2:00 PM, based upon observation, it was discovered that the exhaust in the toilet room in Exam Room 7 and the toilet room adjacent to Exam Room 6 in 3-Labor Reception Center (LRC) at Campus A is not functioning. On 6/22/10 at 2:30PM, based upon observation, it was discovered that the Respite Nurseries are being used for storage on 2 Webber North of Campus A (Rooms 2235 and 2227). Clinical Manager JJJ stated during interview 6/22/10 at 2:40 PM that nurseries are rarely used because most babies room-in with the mothers, and that Room 2227 is never used for babies, and		On 6/22/10 between the	hours of 9:00 AM and 3:00 PM		mierinies.	- 1	
testing logs for eyewash stations located in 8 Webber South (8WS) soiled utility room and 6 Webber South Mechanical Room of Campus A are not being completed on a regular basis. Facilities Manager # FFF confirmed that the eyewash station in 8WS is not needed in that location. On 6/22/10 at 1:50 PM, based upon observation, it was discovered that plastic laminate is damaged at charting stations on 4 Webber South, and at the 4ICU Nurse Station in Campus A. On 6/22/10 at 2:00 PM, based upon observation, it was discovered that the exhaust in the toilet room in Exam Room 7 and the toilet room adjacent to Exam Room 6 in 3-Labor Reception Center (LRC) at Campus A is not functioning. On 6/22/10 at 2:30PM, based upon observation, it was discovered that the Respite Nurseries are being used for storage on 2 Webber North of Campus A (Rooms 2235 and 2227). Clinical Manager JJJ stated during interview 6/22/10 at 2:40 PM that nurseries are rarely used because most babies room-in with the mothers, and that Room 2227 is never used for babies, and		it was discovered through	th observation that wookly		Formula District		
South (8WS) soiled utility room and 6 Webber South Mechanical Room of Campus A are not being completed on a regular basis. Facilities Manager # FFF confirmed that the eyewash station in 8WS is not needed in that location. On 6/22/10 at 1:50 PM, based upon observation, it was discovered that plastic laminate is damaged at charting stations on 4 Webber South, and at the 4ICU Nurse Station in Campus A. On 6/22/10 at 2:00 PM, based upon observation, it was discovered that the exhaust in the toilet room in Exam Room 7 and the toilet room adjacent to Exam Room 6 in 3-Labor Reception Center (LRC) at Campus A is not functioning. On 6/22/10 at 2:30PM, based upon observation, it was discovered that the Respite Nurseries are being used for storage on 2 Webber North of Campus A (Rooms 2235 and 2227). Clinical Manager JJJ stated during interview 6/22/10 at 2:40 PM that nurseries are rarely used because most babies room-in with the mothers, and that Room 2227 is never used for babies, and		testing logs for avoyage	etations land did weekly				7/45/40
Mechanical Room of Campus A are not being completed on a regular basis. Facilities Manager # FFF confirmed that the eyewash station in 8WS is not needed in that location. On 6/22/10 at 1:50 PM, based upon observation, it was discovered that plastic laminate is damaged at charting stations on 4 Webber South, and at the 4ICU Nurse Station in Campus A. On 6/22/10 at 2:00 PM, based upon observation, it was discovered that the exhaust in the toilet room in Exam Room 7 and the toilet room adjacent to Exam Room 6 in 3-Labor Reception Center (LRC) at Campus A is not functioning. On 6/22/10 at 2:30PM, based upon observation, it was discovered that the Respite Nurseries are being used for storage on 2 Webber North of Campus A (Rooms 2235 and 2227). Clinical Manager JJJ stated during interview 6/22/10 at 2:40 PM that nurseries are rarely used because most babies room-in with the mothers, and that Room 2227 is never used for babies, and	į.	Court (DIAC) it- it street	stations located in 8 Webber		 Removed 8WS eyewash station 	. 1	
completed on a regular basis. Facilities Manager # FFF confirmed that the eyewash station in 8WS is not needed in that location. On 6/22/10 at 1:50 PM, based upon observation, it was discovered that plastic laminate is damaged at charting stations on 4 Webber South, and at the 4ICU Nurse Station in Campus A. On 6/22/10 at 2:00 PM, based upon observation, it was discovered that the exhaust in the toilet room in Exam Room 7 and the toilet room adjacent to Exam Room 6 in 3-Labor Reception Center (LRC) at Campus A is not functioning. On 6/22/10 at 2:30PM, based upon observation, it was discovered that the Respite Nurseries are being used for storage on 2 Webber North of Campus A (Rooms 2235 and 2227). Clinical Manager # FFF confirmed that the mothers, and that Room 2227 is never used for babies, and procedure for 6WS Mechanical Room reviewed & station added to Inventory List. 3. Facilities management educated staff and is monitoring completion of log monthly. Plastic Laminate 1. Repaired plastic laminate at charting stations on 4 Webber South. 2. Repair plastic laminate at the 4ICU Nurse Station. Exhaust in Toilet Room 1. Repaired exhaust in toilet room of exam room #7 and toilet room adjacent to exam room #6 in 3-LRC. Respite Nurseries 1. Removed file cabinets/chair in Respite Nurseries on 2WN. Areas to remain as Respite Nurseries.		South (8445) solled utilit	y room and 6 Webber South		2. Weekly eyewash station testing		8/19/10
completed on a regular basis. Facilities Manager # FFF confirmed that the eyewash station in 8WS is not needed in that location. On 6/22/10 at 1:50 PM, based upon observation, it was discovered that plastic laminate is damaged at charting stations on 4 Webber South, and at the 4ICU Nurse Station in Campus A. On 6/22/10 at 2:00 PM, based upon observation, it was discovered that the exhaust in the toilet room in Exam Room 7 and the toilet room adjacent to Exam Room 6 in 3-Labor Reception Center (LRC) at Campus A is not functioning. On 6/22/10 at 2:30 PM, based upon observation, it was discovered that the Respite Nurseries are being used for storage on 2 Webber North of Campus A (Rooms 2235 and 2227). Clinical Manager # FFF confirmed that the eyewash station in 8WS is not not six and is monitoring completion of log monthly. Plastic Laminate 1. Repaired plastic laminate at charting stations on 4 Webber South. 2. Repair plastic laminate at the 4ICU Nurse Station. Exhaust in Toilet Room 1. Repaired exhaust in toilet room of exam room #7 and toilet room adjacent to exam room #7 and toilet room adjacent to exam room #6 in 3-LRC. Respite Nurseries 1. Removed file cabinets/chair in Respite Nurseries on 2WN. Areas to remain as Respite Nurseries.	1	Mechanical Room of Ca	mpus A are not being		procedure for 6WS Mechanical Ro	om	
confirmed that the eyewash station in 8WS is not needed in that location. On 6/22/10 at 1:50 PM, based upon observation, it was discovered that plastic larminate is damaged at charting stations on 4 Webber South, and at the 4ICU Nurse Station in Campus A. On 6/22/10 at 2:00 PM, based upon observation, it was discovered that the exhaust in the toilet room in Exam Room 7 and the toilet room adjacent to Exam Room 6 in 3-Labor Reception Center (LRC) at Campus A is not functioning. On 6/22/10 at 2:30 PM, based upon observation, it was discovered that the Respite Nurseries are being used for storage on 2 Webber North of Campus A (Rooms 2235 and 2227). Clinical Manager JJJ stated during interview 6/22/10 at 2:40 PM that nurseries are rarely used because most babies room-in with the mothers, and that Room 2227 is never used for babies, and	i i	completed on a regular i	basis. Facilities Manager # FFF		reviewed & station added to Invent	OLA	
On 6/22/10 at 1:50 PM, based upon observation, it was discovered that plastic laminate is damaged at charting stations on 4 Webber South, and at the 4ICU Nurse Station in Campus A. On 6/22/10 at 2:00 PM, based upon observation, it was discovered that the exhaust in the toilet room in Exam Room 7 and the toilet room adjacent to Exam Room 6 in 3-Labor Reception Center (LRC) at Campus A is not functioning. On 6/22/10 at 2:30 PM, based upon observation, it was discovered that the Respite Nurseries are being used for storage on 2 Webber North of Campus A (Rooms 2235 and 2227). Clinical Manager JJJ stated during interview 6/22/10 at 2:40 PM that nurseries are rarely used because most babies room-in with the mothers, and that Room 2227 is never used for babies, and)	confirmed that the eyew	ash station in 8WS is not			.,	
On 6/22/10 at 1:50 PM, based upon observation, it was discovered that plastic laminate is damaged at charting stations on 4 Webber South, and at the 4ICU Nurse Station in Campus A. On 6/22/10 at 2:00 PM, based upon observation, it was discovered that the exhaust in the toilet room in Exam Room 7 and the toilet room adjacent to Exam Room 6 in 3-Labor Reception Center (LRC) at Campus A is not functioning. On 6/22/10 at 2:30 PM, based upon observation, it was discovered that the Respite Nurseries are being used for storage on 2 Webber North of Campus A (Rooms 2235 and 2227). Clinical Manager JJJ stated during interview 6/22/10 at 2:40 PM that nurseries are rarely used because most babies room-in with the mothers, and that Room 2227 is never used for babies, and	1	needed in that location.				ctaff	0110110
discovered that plastic laminate is damaged at charting stations on 4 Webber South, and at the 4ICU Nurse Station in Campus A. On 6/22/10 at 2:00 PM, based upon observation, it was discovered that the exhaust in the toilet room in Exam Room 7 and the toilet room adjacent to Exam Room 6 in 3-Labor Reception Center (LRC) at Campus A is not functioning. On 6/22/10 at 2:30PM, based upon observation, it was discovered that the Respite Nurseries are being used for storage on 2 Webber North of Campus A (Rooms 2235 and 2227). Clinical Manager JJJ stated during interview 6/22/10 at 2:40 PM that nurseries are rarely used because most babies room-in with the mothers, and that Room 2227 is never used for babies, and	3						0/19/10
discovered that plastic laminate is damaged at charting stations on 4 Webber South, and at the 4ICU Nurse Station in Campus A. On 6/22/10 at 2:00 PM, based upon observation, it was discovered that the exhaust in the toilet room in Exam Room 7 and the toilet room adjacent to Exam Room 6 in 3-Labor Reception Center (LRC) at Campus A is not functioning. On 6/22/10 at 2:30 PM, based upon observation, it was discovered that the Respite Nurseries are being used for storage on 2 Webber North of Campus A (Rooms 2235 and 2227). Clinical Manager JJJ stated during interview 6/22/10 at 2:40 PM that nurseries are rarely used because most babies room-in with the mothers, and that Room 2227 is never used for babies, and		On 6/22/10 at 1:50 PM	based upon observation, it was			A S	
Stations on 4 Webber South, and at the 4ICU Nurse Station in Campus A. On 6/22/10 at 2:00 PM, based upon observation, it was discovered that the exhaust in the toilet room in Exam Room 7 and the toilet room adjacent to Exam Room 6 in 3-Labor Reception Center (LRC) at Campus A is not functioning. On 6/22/10 at 2:30 PM, based upon observation, it was discovered that the Respite Nurseries are being used for storage on 2 Webber North of Campus A (Rooms 2235 and 2227). Clinical Manager JJJ stated during interview 6/22/10 at 2:40 PM that nurseries are rarely used because most babies room-in with the mothers, and that Room 2227 is never used for babies, and		discovered that plastic la	minate is damaged at charting				
Station in Campus A. On 6/22/10 at 2:00 PM, based upon observation, it was discovered that the exhaust in the toilet room in Exam Room 7 and the toilet room adjacent to Exam Room 6 in 3-Labor Reception Center (LRC) at Campus A is not functioning. On 6/22/10 at 2:30 PM, based upon observation, it was discovered that the Respite Nurseries are being used for storage on 2 Webber North of Campus A (Rooms 2235 and 2227). Clinical Manager JJJ stated during interview 6/22/10 at 2:40 PM that nurseries are rarely used because most babies room-in with the mothers, and that Room 2227 is never used for babies, and		stations on 4 Webber Sc	outh and at the AICLI Nurse				8/25/10
On 6/22/10 at 2:00 PM, based upon observation, it was discovered that the exhaust in the toilet room in Exam Room 7 and the toilet room adjacent to Exam Room 6 in 3-Labor Reception Center (LRC) at Campus A is not functioning. On 6/22/10 at 2:30 PM, based upon observation, it was discovered that the Respite Nurseries are being used for storage on 2 Webber North of Campus A (Rooms 2235 and 2227). Clinical Manager JJJ stated during interview 6/22/10 at 2:40 PM that nurseries are rarely used because most babies room-in with the mothers, and that Room 2227 is never used for babies, and		Station in Campus A	out, and at the 4100 Nurse		i. Repaired plastic laminate at cha	rting	5/20/10
Room 7 and the toilet room adjacent to Exam Room 6 in 3-Labor Reception Center (LRC) at Campus A is not functioning. On 6/22/10 at 2:30PM, based upon observation, it was discovered that the Respite Nurseries are being used for storage on 2 Webber North of Campus A (Rooms 2235 and 2227). Clinical Manager JJJ stated during interview 6/22/10 at 2:40 PM that nurseries are rarely used because most babies room-in with the mothers, and that Room 2227 is never used for babies, and		On 6/22/10 at 2:00 Date	boood was about 11 11		stations on 4 Webber South.		8/27/10
Room 7 and the toilet room adjacent to Exam Room 6 in 3-Labor Reception Center (LRC) at Campus A is not functioning. On 6/22/10 at 2:30PM, based upon observation, it was discovered that the Respite Nurseries are being used for storage on 2 Webber North of Campus A (Rooms 2235 and 2227). Clinical Manager JJJ stated during interview 6/22/10 at 2:40 PM that nurseries are rarely used because most babies room-in with the mothers, and that Room 2227 is never used for babies, and		dispersed to the	based upon observation, it was		2. Repair plastic laminate at the 410	วบ	SELLIO
in 3-Labor Reception Center (LRC) at Campus A is not functioning. On 6/22/10 at 2:30PM, based upon observation, it was discovered that the Respite Nurseries are being used for storage on 2 Webber North of Campus A (Rooms 2235 and 2227). Clinical Manager JJJ stated during interview 6/22/10 at 2:40 PM that nurseries are rarely used because most babies room-in with the mothers, and that Room 2227 is never used for babies, and		discovered that the exha	lust in the toilet room in Exam		Nurse Station.		
in 3-Labor Reception Center (LRC) at Campus A is not functioning. On 6/22/10 at 2:30PM, based upon observation, it was discovered that the Respite Nurseries are being used for storage on 2 Webber North of Campus A (Rooms 2235 and 2227). Clinical Manager JJJ stated during interview 6/22/10 at 2:40 PM that nurseries are rarely used because most babies room-in with the mothers, and that Room 2227 is never used for babies, and		Room / and the toilet ro	om adjacent to Exam Room 6		Exhaust in Toilet Room		
functioning. On 6/22/10 at 2:30PM, based upon observation, it was discovered that the Respite Nurseries are being used for storage on 2 Webber North of Campus A (Rooms 2235 and 2227). Clinical Manager JJJ stated during interview 6/22/10 at 2:40 PM that nurseries are rarely used because most babies room-in with the mothers, and that Room 2227 is never used for babies, and		in 3-Labor Reception Ce	nter (LRC) at Campus A is not			of	7/15/10
discovered that the Respite Nurseries are being used for storage on 2 Webber North of Campus A (Rooms 2235 and 2227). Clinical Manager JJJ stated during interview 6/22/10 at 2:40 PM that nurseries are rarely used because most babies room-in with the mothers, and that Room 2227 is never used for babies, and		functioning.			exam room #7 and toilet room adia	cent	
discovered that the Respite Nurseries are being used for storage on 2 Webber North of Campus A (Rooms 2235 and 2227). Clinical Manager JJJ stated during interview 6/22/10 at 2:40 PM that nurseries are rarely used because most babies room-in with the mothers, and that Room 2227 is never used for babies, and Respite Nurseries 1. Removed file cabinets/chair in Respite Nurseries on 2WN. Areas to remain as Respite Nurseries.		On 6/22/10 at 2:30PM. b	ased upon observation it was		to exam room #6 in 3-1 PC	Cent	
for storage on 2 Webber North of Campus A (Rooms 2235 and 2227). Clinical Manager JJJ stated during interview 6/22/10 at 2:40 PM that nurseries are rarely used because most babies room-in with the mothers, and that Room 2227 is never used for babies, and Respite Nurseries 1. Removed file cabinets/chair in Respite Nurseries on 2WN. Areas to remain as Respite Nurseries.		discovered that the Rest	oite Nurseries are being used		to examinoun #0 in 3-ERO.		
2235 and 2227). Clinical Manager JJJ stated during interview 6/22/10 at 2:40 PM that nurseries are rarely used because most babies room-in with the mothers, and that Room 2227 is never used for babies, and 1. Removed file cabinets/chair in Respite Nurseries on 2WN. Areas to remain as Respite Nurseries.		for storage on 2 Webber	North of Campus A /Pooms		Boonite Numeri		
interview 6/22/10 at 2:40 PM that nurseries are rarely used because most babies room-in with the mothers, and that Room 2227 is never used for babies, and		2235 and 2227\ Clinical	Manager III eteted dudes		Respite Nurseries		
used because most babies room-in with the mothers, and that Room 2227 is never used for babies, and		interview 6/22/40 at 2.40	Manager JJJ Stated during				7/14/10
and that Room 2227 is never used for babies, and		interview 0/22/10 at 2:40	rivi that nurseries are rarely		Respite Nurseries on 2WN. Areas	to	MARKET 445-155
and that Room 2227 is never used for babies, and		used because most babi	es room-in with the mothers,		remain as Respite Nurseries.		
sometimes room 2235 is used for babies if needed.		and that Room 2227 is n	ever used for babies, and		1		
		sometimes room 2235 is	used for babies if needed.				

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TITLE

(X6) DATE

PRINTED: 8/17/2010 FORM APPROVED OMB NO. 0938-0391

STATEM	ENT OF DEFICIENCIES	(X1)PROVIDER/SUPPLIER/CLIA	T (3/0) 11111		DWR M	O. 0938-0391
AND PLA	N OF CORRECTION	IDENTIFICATION NUMBER	(X2) MUL	TIPLE CONSTRUCTION	(X3) [DATE SURVEY
		IDENTIFICATION NUMBER	Α.	BUILDING	1 (COMPLETED
-00003,65,4, m		230104	В.	WING	1	
NAME OF	F PROVIDER OR SUPPLIER	230104				06/24/2010
	THE THE ENGLISH OF COLUMN		SIREETA	ADDRESS, CITY, STATE, ZIP CODE		
	UNIVERSITY HOSPITAL		3990 JOH DETROIT	N R STREET , MI. 48201		
(X4) ID PREFIX	SUMMARY STAT	EMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION)N	(X5)
TAG	OR LSC IDEN	E PRECEDED BY FULL REGULATORY TIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DBF	COMPLETE DATE
4 704						
A 701	Continued From page 1.	2	A 701			
	On 6/22/10 at 2:15 PM.	based upon observation, it was				
	discovered that the ice r	nachine located in the Pantry of				
	Labor and Delivery/LDR	P (Campus A) has a drain line				
	for the ice hin that is dire	ectly connected to the waste		Accessed to the second		
	drain,	schy connected to the waste		Ice Machine		7/15/10
		0.444		Repaired ice machine drain line	for	1710/10
	On 6/23/10 between 8:3	0 AM and 9:30 AM, based upon		ice bin located in the pantry of Lal	оог	
	observation, it was disco	overed that the kitchen of		and Delivery/LDRP.		
	Campus A has damage	in the following areas, walls at				
	cart washing, walls outs	ide of pot/pan washing, coving				
	tiles at cart storage, cov	ing and floor tiles in walk-in-		Main Kitchen		
	cooler corridor.	S = 1 = 1 = 1 = 1 = 1 = 1 = 1 = 1 = 1 =		Repair Kitchen (Main) walls at a	2222	
		, based upon observation, it				8/27/10
	was discovered that the	walls are damaged in the		wash and walls outside of pot/par	wasn	
	transportation storage of	nd Environmental Services		area.		
	Equipment Doom (Com-	nu Environmental Services		2. Repair cove tiles at cart storage	≥ ,	9/15/10
	Equipment Room (Camp	ous A).		cove and floor tiles in walk-in-cool	er	
	On 6/23/10 at 11:00 AM	, based upon observation, it		corridor.		
	was discovered that their	e is debris accumulation on the				
	floor of the walk in coole	r in the central pharmacy of	70	Repaired Walls		
	Campus A.	P . The ACT DE SACROLA COLOR SECTION AND A SACROLA COLOR SECTION A SACROLA COLOR SECTION AND A SACROLA COLOR SECTION AND A SACROLA COLOR SECTION AND A SACROLA COLOR SECTION AND A SACROLA COLOR SECTION AND A SACROLA COLOR SECTION AND A SACROLA COLOR SECTION A SACROLA COLOR SECTION A SACROLA COLOR SECTION A SACROLA COLOR SECTION A SACROLA COLOR SECTION A SACROLA COLOR SECTION A SACROLA COLOR SECTION A SACROLA COLOR SECTION A SACROLA COLOR SECTION A		1. In the transportation storage ro	om.	7/15/10
	On 6/23/10 at 12:45 PM	based upon observation, the		2. In EVS equipment room	2111	8/23/10
	following areas were obs	served damaged in the		2. III L VO equipment room		100 100 100 100 101 101
	Laboratory Department	of Campus A: Plastic laminate		Cleaned Debris		
	countertons of HI A Rice	chemical genetics, blood bank,				
\$	specimen processing et	at lab, and flow cytometry.		1. On the floor of the walk-in coole	er in	6/24/10
i 9	specificit processing, st	at lab, and flow cytometry.		central pharmacy.		
	Desiral demons b.					
	to tube station)	served in blood bank (adjacent		Plastic Laminate		
	to tube station) and spec	cimen processing (behind hand		Repair plastic laminate countertop	s are	9/15/10
	sink).	D 100/2002/00 1900/01 60 100/01		damaged in the following areas: H	LA	9/15/10
	On 6/24/10 between 8:0	0 and 9:00 AM, based upon		Lab, Biochemical genetics, Blood	Bank.	
	observation it was discor-	vered that the following areas of		Specimen Processing, Stat Lab, a	nd	
	the Surgery Department	of Campus A are damaged:		Flow Cytometry.		
	cabinet and door frame of	damage throughout cores 1,2,		The Sylamony.		
	and 3.	J J Jul. 40, 60 1, L,		Repair Drywall		
1		30 AM and 2:30 PM, based		1 Popoir desuell in bland to the		8/27/10
7	upon observation and re	cord review it was discovered		Repair drywall in blood bank		8/27/10
1	that evewagh stations as	e not being tested as a second		Repair drywall Specimen proce	ssing.	J.E. / 10
1	hasin in the fallender !	e not being tested on a weekly		Surgery Department Repairs	5990	
	basis in the following loc	ations of Campus B: Exam		 Repair damaged cabinets, door 		9/6/10
	room 1 of the emergency	department and		frames, throughout Cores 1, 2 and		5,0,10
	housekeeping room 104	3.		Surgery Department (OR Suite).	2-15-140-15-00E	
	On 6/24/10 between 11:3	30 AM and 2:30 PM, based		Eyewash Station Testing		
	upon observation it was	discovered that there is the		Emergency department and	1	

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AND PLAN OF CORRECTION (X1)PROVIDER/SUPPLIER/CLIF		(X1)PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING (X3) DATE SU COMPLE			
NAME OF	F BB01 #B== 0= 0	230104			06/24/2010	
NAME O	F PROVIDER OR SUPPLIER		STREET	ADDRESS, CITY, STATE, ZIP CODE	00/24/2010	
	UNIVERSITY HOSPITAL		3990 JOHN R STREET DETROIT, MI, 48201			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST B	TEMENT OF DEFICIENCIES SE PRECEDED BY FULL REGULATORY TIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
A 701	underneath hand sinks in Clean Utility room; counterneath hand sinks in Clean Utility room; counterneath and the Pantry of Psych Unit; contertop backsplash of damage in main kitchen to the wall; plastic lamin in main kitchen. On 6/24/10 between 11: upon observation, debris in the following areas of of pantry in Psych Unit; used for shelving, under PVC drain line and floor the floor drain at the 3 content of floor drain at the 3 content of floor drain at the	es damage in Campus B: holes in ED exam rooms and ortho tertop damage in Radiology X-1 tape; damaged flooring in offee cart damaged in Pantry of nate damage at hand sink in lab; damage at dirty sink in lab; wall where papers have been taped ate damage at beverage station 30 AM and 2:30 PM, based accumulation was discovered Campus B: behind ice machine in kitchen: underneath crates meath cookline prep sink on the ing; in walk-in-freezer; and in compartment sink. 30 AM and 2:30 PM, based determined that chemical ached to mop sink faucets in compartment sink. 30 AM and 2:30 PM, based determined that chemical ached to mop sink faucets in compartment of the built in eaker (AVB) subjecting AVB to safety FROM FIRE a provided in the section — et the applicable provisions of the National Fire Protection for of the Office of the Federal the NFPA 101 2000 edition of used January 14, 2000, for the in accordance with 5 U.S.C. in A copy of the Code is	A 701	housekeeping management educal staff and monitoring completion of 12. Department management monitoring for weekly documentation. Repairs 1. Repaired holes underneath hand sinks in ED exam rooms - WO 1542. Repaired Ortho Clean Utility room WO 15434 3. Repaired Countertop damage in Radiology X-Ray 1 - WO 15399 4. Repaired Damaged flooring in Prof Psych Unit - WO 15402 5. Repaired Plastic laminate at han sink in lab and countertop backsplad damage at dirty sink in lab - WO 16. Repaired Wall damage in main kitchen - WO 15404 7. Repaired Plastic laminate at beverage station in main kitchen - 15403 8. Cleaned behind ice machine of pantry in Psych Unit, underneath colline prep sink on PVC drain line and floor, walk-in-freezer, and floor drain the 3 compartment sink. 9. Installed shelving in kitchen. 10. Installed water wasting tee's in Rooms 1012, 1043 and 1061 housekeeping closets. WO 15422	og. oring 6/25/10 7/28/10 7/28/10 7/30/10 8/18/10 antry 7/28/10 7/28/10 7/28/10 7/28/10 7/28/10 7/28/10 7/28/10	
	available for inspection a Resource Center, 7500 S MD or at the National Ar- Administration (NARA).	at the CMS Information Security Boulevard, Baltimore, chives and Records			5.	

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AND PLA	ENT OF DEFICIENCIES IN OF CORRECTION	(X1)PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	Α. Ι	TIPLE CONSTRUCTION BUILDING WING	(X3) DATE SURVEY COMPLETED
NAME O	F PROVIDER OR SUPPLIER	230104		ADDRESS, CITY, STATE, ZIP CODE	06/24/2010
	UNIVERSITY HOSPITAL		3990 JOH	N R STREET MI. 48201	
(X4) ID PREFIX TAG	LEACH DEFICIENCY MUST E	TEMENT OF DEFICIENCIES SE PRECEDED BY FULL REGULATORY TIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI DEFICIENCY)	JLD BE COMPLETE
A 710	regulations/ibr_lovation Copies may be obtained Protection Association, MA 02269. if any chang incorporated by reference the Federal Register to a (ii) Chapter 19.3.6.3.2, a adopted edition of the Li (2) After consideration findings, CMS may Life Safety Code wh result in unreasonal but only if the waive health and safety of (3) The provisions of the in a State where CM code imposed by Si patients in hospitals This STANDARD is not Surveyor: 15191 Based upon on-site obse by Life Safety Code (LSi 2010, the facility does not	ederal_register/code_of_federal as.html d from the National Fire 1 Batterymarch Park, Qunicy, es in the edition of the Code are ce, CMS will publish notice in announce the changes. exception number 2 of the SC does not apply to hospitals. of State Survey agency waive specific provisions of the nich, if rigidly applied, would ble hardship upon the facility, ar does not adversely affect the f the patients. e Life Safety Code do not apply MS finds that a fire and safety tate law adequately protects is. met as evidenced by: ervation and document review C) surveyors on June 21-24, ot comply with the applicable	A 710		
A 724	See the K-tags on the Clark for Life Safety Code. 482.41(c)(2) FACILITIES MAINTENANCE Facilities, supplies, and to ensure an acceptable This STANDARD is not a Surveyor: 27408 Based on observation ar	dition of the Life Safety Code. MS-2567 dated June 24, 2010, S, SUPPLIES EQUIPMENT equipment must be maintained level of safety and quality. met as evidenced by: Ind interview the facility failed to test strips and control solutions	A 724		
LABORAT	ORY DIRECTOR'S OR PRO	VIDER/SUPPLIERS REPRESENTAT	IVE'S SIGN	ATURE TITLE	(X6) DATE

PRINTED: 8/17/2010 FORM APPROVED

STATEM: AND PLA	ENT OF DEFICIENCIES N OF CORRECTION	(X1)PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULT	TIPLE CONSTRUCTION	(X3) [DATE SURVEY
	Control of the Contro		B.	BUILDING		COMPLETED
NAME OF	PROVIDER OR SUPPLIER	230104	STREET	ADDRESS CITY STATE TIP CORE		06/24/2010
			SIREELA	ADDRESS, CITY, STATE, ZIP CODE		
(X4) ID	UNIVERSITY HOSPITAL			N R STREET MI. 48201		
PRÉFIX TAG	(EACH DEFICIENCY MUST B	EMENT OF DEFICIENCIES SE PRECEDED BY FULL REGULATORY TIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DBE	(X5) COMPLETE DATE
A 724	Continued F	_		•		
A 124	Continued From page 1	5	A 724			
	bottles (supplies) were li Findings include:	cept current and not outdated.		Glucometer Test Strips and consolutions 1. Quality Department developed		
	On tour of the Pre-opera 1000 on Campus B, it w	ative holding area on 6/22/10 at		checklist for Point of Care supply	5	7/23/10
	glucometer test strips we opened, and the control	ere not dated when they were solutions bottles were outdated ager #AA confirmed these		dating, including glucometer test and control solutions bottles. 2. Department management educ		7/27/10
	findings.	ger woo committee trese		monthly.	Point of Care Coordinator to audit onthly. Vice President Operations/Patient	
A 726	CONTROLS	ION, LIGHT, TEMPERATURE	A 726	action plans presented monthly to Leadership Performance Improve and Medical Safety Coordinating Committee.)	
	There must be proper ve controls in pharmaceutic appropriate areas.	entilation, light, and temperature cal, food preparation, and other		Service States and America		
	This STANDARD is not Surveyor: 26222					
	proper lighting in patient areas. Findings include:	, the facility failed to provide care and food preparation				
	On 6/23/10 between 8:3 observation it was discort	0 AM and 9:30 AM based upon vered that the kitchen of evels in all walk-in-coolers		Lighting 1. Restored lighting in Kitchen wa	lk-in	8/25/10
	below the minimum 20 for (Illuminating Engineering	coot-candles of illumination g Society of North America, g, Lighting for Heath Facilities).		coolers to minimum 20 foot-candl illumination. WO #327997	es of	
	On 6/22/10 at 2:15 PM b	eased upon observation lighting				
	at hand sinks in Rooms	3412 and 3212 of Campus A 20 foot-candles, respectively.		Restored lighting at hand sink i room 3212 to minimum 30 foot-ca of illumination WO #327996.		7/20/10
	illumination required (Illu of North America, IESNA Heath Facilities).	minating Engineering Society A Publication CP29, Lighting for		Restored lighting at hand sink i room 3412 to minimum 30 foot-ca of illumination WO #327995	n indles	7/19/10
	On 6/23/10 at 11:30 AM	based upon observation,				

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AND PLA	N OF CORRECTION	IDENTIFICATION NUMBER	(A2) MULI	TIPLE CONSTRUCTION		DATE SURVEY
		The state of the s	B. 1	BUILDING		COMPLETED
		230104	J 5.	WING		
NAME OF	PROVIDER OR SUPPLIER		STREET A	DDRESS, CITY, STATE, ZIP CODE	1	06/24/2010
	UNIVERSITY HOSPITAL			N R STREET		
(X4) ID	SUMMARY STAT	EMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF CORRECTION		
PRÉFIX TAG	(EACH DEFICIENCY MUST B	E PRECEDED BY FULL REGULATORY FIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROX DEFICIENCY)	DRF	(X5) COMPLETE DATE
A 700	[6 . II . I					- TOWN
A 726	Continued From page 1	6	A 726			
	lighting levels at hand si Evaluation and Emerger Campus A are below the required. Lighting levels On 6/23/10 at 1:30 PM, cardiac cath lab 3 scrub at 35 foot-candles; minimodal candles (IESNA Publication On 6/24/10 at 9:00 AM, idiscovered that the hand Processing (located in the Receiving Hospital) had foot-candles minimum re CP29). On 6/24/10 between 11: upon observation it was in the cardiac room of the Campus B were recorde lighting levels at the handles in the cardiac to the campus B were recorded lighting levels at the handles of the campus B were recorded lighting levels at the handles of the campus B were recorded lighting levels at the handles of the campus B were recorded lighting levels at the handles of the campus B were recorded lighting levels at the handles of the campus B were recorded lighting levels at the handles of the campus B were recorded lighting levels at the handles of the campus B were recorded lighting levels at the handles of the campus B were recorded lighting levels at the handles of the campus B were recorded lighting levels at the handles of the campus B were recorded lighting levels at the handles of the campus B were recorded lighting levels at the handles of the campus B were recorded lighting levels at the handles of the campus B were recorded lighting levels at the latter the campus B were recorded lighting levels at the latter the campus B were recorded lighting levels at the latter the campus B were recorded lighting levels at the latter the campus B were recorded lighting levels at the latter the	nks in Diagnostic and any Department South of a 30 foot-candles of illumination recorded at 14 foot-candles. Dased upon observation, the sink lighting level was recorded num required level is 75 foot-tion CP29). Dased upon observation it was a sink in the Central Sterile are basement level of Detroit lighting levels less than the 30 equired (IESNA Publication 30 AM and 2:30 PM based discovered that the hand sinks be Emergency Department of at 14 and 18 foot-candles; d sink in the Psych unit orded at 7 foot-candles. (30	A 120	4. Restored lighting at hand sinks in D/E and Emergency Department South to minimum 30 foot-candles of illumination WO #327998 5. Restored lighting at scrub sinks in Cardiac Cath Lab #3 to minimum 75 foot-candles of illumination WO #327999 6. Restored lighting at hand sinks in the Central Sterile Processing to minimum 30 foot-candles of illumination. 7. Restored lighting at hand sinks in the cardiac room of the Emergency Department of Campus B to minimum 30 foot-candles of illumination WO #15391		7/19/10 8/27/10 7/12/10 7/28/10
A 747	avoid sources and transic communicable diseases program for prevention, of infections and communications and communications and communications and communications are compared to provide a sanitary environment of the compus A, and the kitch B. This practice could at Endoscopy suite in Campserved food from the kitch Campus B. Findings inclined.	e a sanitary environment to missions of infections and There must be an active control and investigation of table diseases. There must be an active control and investigation of table diseases. There must be an active control and investigation of table diseases. There are evidenced by: The and interview, the facility failed dironment and avoid sources of doscopy Procedure Rooms at the en of Campus A and Campus and Campus and Campus A, as well as all patients then of Campus A and	A 747	8. Restored lighting at hand sinks Psych Unit Activities Room to min 30 foot-candles of illumination WC #15392	imum	7/30/10

PRINTED: 8/17/2010 FORM APPROVED OMB NO 0938-0391

STATEM	ENT OF DEFICIENCIES	(X1)PROVIDER/SUPPLIER/CLIA	(V2) 841 II 3	TIDLE CONCEDUCATION	MD MO. 0939-0391
AND PLA	N OF CORRECTION	IDENTIFICATION NUMBER	(AZ) MOL	TIPLE CONSTRUCTION	(X3) DATE SURVEY
ne seven		I DETTINION NOWIBER	l A.	BUILDING	COMPLETED
	2	230104	B. WING		
NAME OF	PROVIDER OR SUPPLIER	200104	CTOCCT	1000000	06/24/2010
105508		•	SIKEEI	ADDRESS, CITY, STATE, ZIP CODE	
	UNIVERSITY HOSPITAL			N R STREET . MI. 48201	
(X4) ID	SUMMARY STAT	EMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	1 (95)
PREFIX TAG	(EACH DEFICIENCY MUST B	BE PRECEDED BY FULL REGULATORY TIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
		CONTROL DE LA CO			
A 747	Continued From page 1	7	A 747		
	CANTINE S		6.3.00.00.00	1	
	that scopes used in proceeding the procedure room price decontamination room, were observed to have to dispensers removed. Interview with Staff # LL confirmed that sinks in to longer used for handwashing sink locate for handwashing purpose confirmed that soap and removed to dedicate sing the procedure of the pr	ation Room, it was discovered cedures are gross cleaned in or to be being brought into the Sinks in the Procedure Rooms the soap and paper towel L on 6/23/10 at 11:30 AM he Procedure Rooms are no shing, and are dedicated to ff # LLL stated that staff used a red in an alcove in the corridor res. Facilities Manager # FFF paper towel dispensers were ks within the rooms for scope rooms into the corridor was		Hand Washing Sinks 1. Installed hand sinks with soap are paper towel dispensers in each roo	8/25/10 om.
	observation, it was deterinfestation is present in the washing area of the kitch were observed flying area accumulation was observed; which are breeding on 6/23/10 between 8:3 observation, a food preport Campus A was observed food preparate hand hygiene. General employee, and the emplimediately.	the dish machine area and cart hen of Campus A. Drain flies bund in these areas. Bio-film wed in floor drains in these are grounds for these files. D AM and 9:30 AM, based upon paration employee in the kitchen wed adjusting their hair net and dion activities without performing Manager KKK addressed the oyee washed hands		Cleaning Needed 1. Treat dish machine and all kitche floor drains monthly to remove fly infestation and biofilm accumulation WO#328003. 2. Food Service Management to monitor daily and report to facilities any additional treatment necessary 3. Facilities to monitor drains month Hand Hygiene Campus A 1. Department Management educa all employees on hand hygiene. 2. Audit conducted by department management monthly. 3. Findings and action plans preser	8/25/10 8/25/10 if / 8/25/10 hly. 6/28/10
	observation a dishwashi	0 PM and 2:30 PM, based uponing employee at Campus B was dishes and clean dishes without in tasks.		to Leadership Performance Improvement and Medical Safety Coordinating Committee monthly a department staff.	

staff on separating clean and dirty LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIERS REPRESENTATIVE'S SIGNATURE

TITLE

1. Department management educated

Hand Hygiene Campus B

(X6) DATE

6/24/10

PRINTED: 8/17/2010 **FORM APPROVED** OMB NO. 0938-0391

AND PLA	N OF CORRECTION	(X1)PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING COMPL		
		230104	В. 1	WING	00/04/0040
NAME O	PROVIDER OR SUPPLIER		STREET A	DDRESS, CITY, STATE, ZIP CODE	06/24/2010
	UNIVERSITY HOSPITAL		3990 JOHN R STREET DETROIT, MI. 48201		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST B	EMENT OF DEFICIENCIES IE PRECEDED BY FULL REGULATORY TIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE
A1005	resources. Policies on a include the delineation of anesthesia responsibiliti that the following are properties and resources. Polices include the delineation of anesthesia responsibiliti that the following are properties include the delineation of anesthesia responsibiliti that the following are properties. This STANDARD is not Surveyor: 27408 Based on records review failed to follow their preceptation of the preceptatio	st be consistent with needs and anesthesia procedure must of pre-anesthesia and postes. The policies must ensure exided for each patient: at be consistent with the needs on anesthesia procedures must of pre-anesthesia and postes. The policies must ensure exided for each patient: met as evidenced by: wed and interview the agency anesthesia policy for 1 of 2 exided. Findings include: 6/22/10 at Campus B, it was op holding area patient # 50's eanesthesiologist had prest for induction area on the Record when the patient hadn't ery. The "Anesthesia Record atient name, date, or any other the nurse administrator of a 1100. NT POST-ANESTHESIA	A1002	processes. 2. Audit conducted by department management monthly. 3. Findings and action plans prese to Leadership Performance Improvement and Medical Safety Coordinating Committee monthly a department staff. Anesthesia Record Pre-signed 1. Anesthesial Record Pre-signed 1. Anesthesial Record Pre-signed 2. Audit conducted by department monthly. 3. Vice President Operations/Patie Care Services to ensure findings a action plans presented monthly to Leadership Performance Improven and Medical Safety Coordinating Committee monthly.	of 6/29/10 es, 7/2/10 nt nd

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 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

required to continued program participation.

PRINTED: 8/17/2010 FORM APPROVED OMB NO. 0938-0391

STATEM	ENT OF DEFICIENCIES	(VA)55041555451554		O		O. 0938-0391
AND PLA	N OF CORRECTION	(X1)PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULT	TIPLE CONSTRUCTION	(X3) E	DATE SURVEY
		IDENTIFICATION NUMBER	A.	BUILDING		COMPLETED
and the second		230104	В.	WING		
NAME O	F PROVIDER OR SUPPLIEF	250704	STREET	ADDRESS, CITY, STATE, ZIP CODE		06/24/2010
			O INCL.	ADDRESS, CITT, STATE, ZIP CODE		
	UNIVERSITY HOSPITAL			N R STREET MI. 48201		
(X4) ID PREFIX	SUMMARY STA	TEMENT OF DEFICIENCIES	DI	PROVIDER'S PLAN OF CORRECTION	N	(X5)
TAG	OR I SC IDEN	BE PRECEDED BY FULL REGULATORY TIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULD	DBE	COMPLETE
	OK ESS IDEN	THE FING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROP	RIATE	DATE
			1	DEFICIENCY)		
A1005	Continued From page 1	0				,
71003	Continued From page 1	9	A1005			
	medical staff and which anesthesia care. This STANDARD is not	have been approved by the reflect current standards of met as evidenced by:				
	Surveyor: 27408	5.53				
	Based on records review	wed and interview the facility		Post Anesthesia Documentation	1	
	failed to ensure a post a	anesthesia evaluation had been		1. Anesthesia staff educated by	•	6/29/10
	documented within 48 h	nours after surgery for 1 of 13		Specialist in Chief on documentati	on	
	(patient # 55) records re	eviewed. Findings include:		requirements.		
And the second s	the review of the clinica	d surgery on 06/02/10. During I record on 6/22/10, it was noted	2. Audit conducted by department			
	a 48 hour post anesthes	sia evaluation had not been r the nursing unit's dinical		monthly to Leadership Performance	e	
	supervisor to look for the	e presence of the post		Improvement and Medical Safety Coordinating Committee.		
	anesthesia evaluation o	n the clinical record produced		oooramating committee.		
	no document confirming	such.				
	These findings were dis leadership team during	cussed with the hospitals the exit conference on 6/22/10				
	at Campus B.	SOS SOS PELLOS DE SE SARRO DE COMPOSITO SE POR SARRO DE POR SOR ES PARA DE POR SARRO DE PORTE ACESA DA SARRO D				
A1100	482.55 EMERGENCY S	SERVICES	A1100			
	The hospital must meet	the emergency needs of				
	patients in accordance v practice.	with acceptable standards of				
	This CONDITION is not	met as evidenced by:				
	Surveyor: 28267					
	Based on record review	and interview the facility failed	20 99 111 50			
	to meet the patient's pai	in and vital sign needs in the				
		at Campus B. Findings				
	include:					
	On 6/22/10 at approxima	ately 0930 during an		Emergency Department Pain		
	observational tour and o	open medical record review at		Assessment & Management		
	Campus B emergency of	department the following 3 out of	9	Department Manager re-educate	ed	6/23/10
	4 patients (#41, #42, #4	3) pain needs were not met:		ED staff to Policy 2 ED 047 Patien		0/23/10
	Patient #41 came into th	ne ED with a left little finger		Assessment Documentation.	•	
	injury. A thorough pain	assessment was not completed		2. Manager monitoring compliance	٠	6/28/10
LABORAT		OVIDER/SUPPLIERS REPRESENTAT	IVE'S SIGN	ATURE TITLE		(VC) DATE
		THE THEORY I EIGHTO INCHINEDENTA	INE O SIGN	ATONE IIILE		(X6) DATE

PRINTED: 8/17/2010 FORM APPROVED OMB NO. 0938-0391

STATEME	NT OF DEFICIENCIES	(X1)PROVIDER/SUPPLIER/CLIA	(X2) MULT	TIPLE CONSTRUCTION	(X3) DATE SURVEY
AND PLA	N OF CORRECTION	IDENTIFICATION NUMBER	A. 1	A. BUILDING	
		230104	B. WING		COMPLETED
NAME OF	PROVIDER OR SUPPLIER	230104	STREET	ADDRESS, CITY, STATE, ZIP CODE	06/24/2010
			OTREETA	CONESS, CITT, STATE, ZIP CODE	
	UNIVERSITY HOSPITAL		3990 JOH DETROIT,		
(X4) ID PREFIX	SUMMARY STAT	EMENT OF DEFICIENCIES SE PRECEDED BY FULL REGULATORY	ID	PROVIDER'S PLAN OF CORRECTIO	
TAG	OR LSC IDEN	TIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETE RIATE DATE
	PERSONAL VINEY (1997)				
A1100	Continued From page 2	0	A1100	weekly until 100% compliant for 6	· · · · · · · · · · · · · · · · · · ·
	but there was document	tation that her finger was		months.	
	"aching". No pain medic	cation was administered in the		3. Vice President Operations/Patie	nt
	emergency department	or no reassessment of pain		Care Services to ensure findings a	
	prior to discharge.	Oracle Automorphic State (Communication Communication Comm		action plans presented monthly to	
	B. W. J. W. G.			Leadership Performance Improven	nent
	Patient #42 came into the	e ED with a complaint of chest		and Medical Safety Coordinating	
	the ED at 1257 and his	The patient was admitted into		Committee and ED staff.	
	rated his pain a 5 out of	pain was assessed, the patient 10. The patient was then			
	discharged at 1543 with	no reassessment of pain and			
	no medication was admi	inistered to the patient for pain			
	during his admission.	instered to the patient for pain			
	during this duthlission,				
	Patient #43 came into th	ne ED with a complaint of acute			
	back pain. The patient's	s pain was assessed upon			
	admission into the ED 2	257 and had rated her pain as a		D	
	7 out of 10 then her pair	was reassessed again at 2312			
	and the patient rated he	r pain as a 5 out of 10. The			
	patient was discharged	from the emergency department			1
	within 22 minutes and n	o documentation that the			
	patient's complaint of pa	ain was addressed.			
	On 6/22/40 at anneation	-t-b-4045			
	facility policy and process	ately 1015 upon review of the dure titled "Pain Management"			
	Policy No. 1 CLN 043	nder the section titled Policy has			
	documented "All nations	s will have their pain assessed			
	and managed."	o will have their pain assessed			1
	On 6/22/10 at approxima	ately 0930 during an			
	observational tour and o	pen medical record review at		Emergency Department Vital Sig	ıns
	Campus B emergency d	epartment the following 2 of 2		1. Department Manager re-educate	
	(#42, #44) out of a total	sample of 4 emergency		ED staff to Policy 2 ED 047 Patient	
	department patients vita	I signs were not taken within		Assessment Documentation.	6/28/10
	one hour of their dischar	rge as follows:	N. N	Manager monitoring compliance	0.23/10
	Dotion #40	31-1-W - F		weekly until 100% compliant for 6	
	Patient #42 was admitte			months.	
	set of vital ciana document	discharged at 1543. The only		3. Vice President Operations/Patie	
	set of vital signs docume	ented was at 135/.		Care Services to ensure findings a	na
	Patient #44 was admitte	d into the Emergency		action plans presented monthly to	
	Denartment at 2037 and	d into the Emergency discharged at 2245. The only		Leadership Performance Improven and Medical Safety Coordinating	nent
LAROBAT		OVIDER/SUPPLIERS REPRESENTA	IN ITIO DICE		
PUDOLAL	ON DIRECTOR S OR PRO	VIDER/SUPPLIERS REPRESENTA	IVE'S SIGN	ATURE TITLE	(X6) DATE

PRINTED: 8/17/2010 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1)PROVI		(VA)DDOMDEDICHDDIJESISHI	T		CIND IV	7. 0930-0391
AND PLAN OF CORRECTION		(X1)PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	Α.	FIPLE CONSTRUCTION BUILDING WING		OATE SURVEY COMPLETED
		230104	J			06/24/2010
NAME OF	F PROVIDER OR SUPPLIEF	3	STREET	ADDRESS, CITY, STATE, ZIP CODE		00/24/2010
	UNIVERSITY HOSPITAL			N R STREET , MI. 48201		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST I	TEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY ITIFYING INFORMATION)	PREFIX TAG	D PROVIDER'S PLAN OF CORRECTION EFIX (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETE DATE
A1100	Continued From page 2	21	A1100	Committee and ED staff.		
	set of vital signs documented was at 2041.					
	facility policy and proce Documentation/Data Co the section Provision th Signs may include temp blood pressure, pain, G Capillary Blood Glucose patients discharged from	ately 1015 upon review of a dure titled "Patient Assessment, ollecting" has documented under e following: number 4 – "Vital berature, respiratory rate, pulse, lasgow Coma Score (GSC) and e." and number 5. stated "All in the emergency department ken within one hour prior to admission.				
	The above findings were the times posted above	e witnessed and confirmed at by staff # M.				

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

TITLE

(X6) DATE

PRINTED: 08/17/2010 FORM APPROVED OMB NO. 0938-0391

STATEM	ENT OF DEFICIENCIES	Louises		0	MB NO. 0938-0391	
	N OF CORRECTION	(X1)PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE CONSTRUCTION	(X3) DATE SURVEY	
AND FLA	N OF CORRECTION	IDENTIFICATION NUMBER	A. BUILI	DING 01 - Harper University Hospital	COMPLETED	
			B. WING		301111 22125	
NAME OF	DDO: IIDER OF SHEE	230104			06/24/2010	
NAIVIE OF	PROVIDER OR SUPPLIEF	8	STREET ADDRESS, CITY, STATE, ZIP CODE			
			000-00000000000000000000000000000000000	3000		
HARPER	UNIVERSITY HOSPITAL		3990 JOHN R STREET			
			DETROIT,	(1) The Control of th		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO	N (X5)	
PREFIX TAG	(EACH DEFICIENCY MUST I	BE PRECEDED BY FULL REGULATORY	PREFIX	(EACH CORRECTIVE ACTION SHOULD		
IAG	OR LSC IDEN	TIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROP		
				DEFICIENCY)	DATE.	

K 000	INITIAL COMMENTS	14 000	
14 000	INTIAL COMMENTS	K 000	
	Surveyour:13546		
	This Federal Monitoring Life Safety Code (LSC) survey		
	was conducted on 06/21, 23, 24/2010 between the		
	times of 9:00 AM and 5:00 PM. The 2000 edition of the LSC (NFPA 101), existing section, was used in		
	conjunction with the requirements of 42 CFR 483.70		
	(a). The facility does not meet the standard.		
	The gunier consists distillation is to it is		
	The survey consisted of the main building Harper University Hospital located in Detroit, This will be known		
	as building 1. Also surveyed was DMC Surgery Center		
	located in Madison Heights. This will be known as		
	building 2.		
	The building details are as follows.		
	4000 131 Pr. SPHOLINGSHAMMOANW		
	Building 1 Harper-construction type: 10-stories Type II		
	(222). The building is partially sprinkler protected. The facility has a total capacity of 506 beds at the time of		
	the survey and was at full capacity during the survey.		
	Building 2 DMC Surgery-construction type: Type I (332). Building is fully sprinkled and has a total capacity		
	of 36 beds at the time of the survey.		
K 047	CONTRACTOR OF SEPTEMBER AND AND AND AND AND AND AND AND AND AND		
K 017	NFPA 101 LIFE SAFETY CODE STANDARD	K017	
	Corridors are separated from use areas by walls		
	constructed with at least ½ hour fire resistance rating. In		
	sprinklered buildings, partitions are only required to		
	resist the passage of smoke. In non-sprinklered		
	buildings, walls properly extend above the ceiling. (Corridor walls may terminate at the underside of		
	ceilings where specifically permitted by Code. Charting		
	And clerical stations, waiting areas, dining rooms, and activity spaces may be open to the corridor under		
	certain conditions specified in the Code. Gift shops may		
	be separated from corridors by non-fire rated walls if the		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIERS REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Maris	President	8.25.10
Anu deficience of the first state I D COICKEN		

PRINTED: 08/17/2010 FORM APPROVED OMB NO. 0938-0391

AND PLA	ND PLAN OF CORRECTION (X1)PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER					DATE SURVEY COMPLETED
NAME O	F PROVIDER OR SUPPLIER	230104	STREET ADDRESS, CITY, STATE, ZIP CODE			06/24/2010
	UNIVERSITY HOSPITAL		3990 JOH	N R STREET		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST B	EMENT OF DEFICIENCIES E PRECEDED BY FULL REGULATORY FIFYING INFORMATION)	ID PREFIX TAG	MI. 48201 PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	RF	(X5) COMPLETE DATE
K 017	Continued From page 1					
, cii	gift shop is fully sprinkle 19.3.6.1, 19.3.6.2.1, 19.	3.6.5	K 017			
	failed to provide corridor least 30 minute fire-resis the LSC section 19.3.6.1	was determined that the facility walls that could provide at stance rating in accordance with 1, 19.3.6.2.1. This deficient affect all occupants of the				
	Findings include:					
	On 06/23/10 the followin	g observations were made:				
	penetration (approximate Building basement corric the door marked 6870A.	AM, Observed an unsealed ely 1/8" wide) in the Brush for, above the ceiling tile, above This penetration would not noke and heat into the corridor		Sealed penetration above the ceilin above door marked 6870A to preve the spread of smoke and heat into corridor (K-017.1)	ent	8/25/10
	These findings were obs Facility Maintenance Dire	erved and confirmed by the ector during the inspection.				
K 018	NFPA 101 LIFE SAFETY	CODE STANDARD	K 018			
	constructed of 13/4 inch capable of resisting fire f sprinklered buildings are passage of smoke. There closing of the doors. Doo suitable for keeping the omeeting 19.3.6.3.6 are p	ertical openings, exits, or estantial doors, such as those solid-bonded core wood, or or at least 20 minutes. Doors in only required to resist the esis no impediment to the ers are provided with a means door closed. Dutch doors ermitted. 19.3.6.3				
	health care facilities.	ted by CMS regulations in all				
LABORAT	ORY DIRECTOR'S OR PRO	VIDER/SUPPLIERS REPRESENTAT	IVE'S SIGN	ATURE TITLE		(X6) DATE

DEPARTMENT OF HEALTH AND HUMAN SERVICES **CENTERS FOR MEDICARE & MEDICAID SERVICES** STATEMENT OF DEFICIENCIES

AND PLAN OF CORRECTION

(X1)PROVIDER/SUPPLIER/CLIA

IDENTIFICATION NUMBER

PRINTED: 08/17/2010 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY

AND FEAR OF CORRECTION		IDENTIFICATION NUMBER	A. BUIL B. WING	DING 01 – Harper University Hospital	COMPLETED	
NAME O	F PROVIDER OR SUPPLIER	230104			06/24/2010	
HARPER	HARPER UNIVERSITY HOSPITAL		STREET ADDRESS, CITY, STATE, ZIP CODE 3990 JOHN R STREET DETROIT, MI. 48201			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	RE COMPLETE	
K 018	Continued From page 2		K 018			
	of smoke and/or able to accordance with the LSC	e facility failed to provide d close and resist the passage provide a positive latch in	N 010			
	W. C.	a a				
	On 06/24/2010, the follow	wing observations were made:				
	penetration (approximate leading to the Radiology	AM, Observed an unsealed ely ¼" wide) in the corridor door Reception, across from room would not prevent the spread of corridor.		Sealed penetration in corridor door leading to Radiology Reception, acr from room G252 to prevent the spre of smoke and heat into the corridor (K-018.1)	8/25/10 ross ead	
	These findings were obs Corporate Fire Safety Ins Surveyor: 27171	erved and confirmed by the spector.				
	of smoke and/or able to paccordance with the LSC	close and resist the passage provide a positive latch in				
	On 06/24/2010, the follow	ving observations were made:				
	At approximately 11:14 A door to the 10 th floor Pan not fully close to a positiv	M, Observed that the West try (Webber South Bldg.) did te latch.		Adjusted closer on 10 th floor Pantry fully close to a positive latch (K-018.		
	These findings were obse Corporate Plant Operation	erved and confirmed by the ons Manager.				
K 020	NFPA 101 LIFE SAFETY	CODE STANDARD	K 020			
LABORAT	ORY DIRECTOR'S OR PROV	VIDER/SUPPLIERS REPRESENTAT	IVE'S SIGN	ATURE TITLE	(X6) DATE	

(X2) MULTIPLE CONSTRUCTION

PRINTED: 08/17/2010 FORM APPROVED OMB NO. 0938-0391

AND PLA	IN OF DEFICIENCIES IN OF CORRECTION	(X1)PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER			(X3) DATE SURVEY COMPLETED	
NAME OF	F PROVIDER OR SUPPLIER	230104		06/24/2010		
			STREET	ADDRESS, CITY, STATE, ZIP CODE		
(X4) ID	UNIVERSITY HOSPITAL		3990 JOH DETROIT,	N R STREET MI. 48201		
PREFIX TAG	(EACH DEFICIENCY MUST E	EMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY TIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	RE COMPLETE	
V 000	0 "					
K 020	chutes, and other vertical enclosed with construction rating of at least one how accordance with 8.2.5.6 This STANDARD is not Surveyor: 13546 Based on observation the hour fire resistive separates accordance with the LSG deficient practice could got the facility. On 06/21/2010, the folloop At approximately 11:14 adoor HAR-42 is sticking positive latch. This pene heat to enter the stairwess.	its, light and ventilation shafts, all openings between floors are on having a fire resistance our. An atrium may be used in 19.3.1.1. In the facility failed to provide 1-ation for the vertical openings in 2 section 19.3.1.1. This potentially affect ALL occupants wing observations were made: AM, Observed that the stairwell and does not fully close to a tration would allow smoke and il.	K 020	Adjusted all doors along stairwell HA 42 to fully close to a positive latch (K-020.1)	AR- 8/23/10	
LABORAT	Surveyor: 18760 Based on observation the hour fire resistive separate accordance with the LSC practice could potentially facility. Findings include: On 06/23/2010, the followant of the conduit penetration (approximately 9:45 And conduit penetration (approximately HUH-47 (2nd flow would allow smoke and hour of these findings were obsections.	e facility failed to provide 1- tion fro the vertical openings in Section 19.31.1. This deficient affect All occupants of the wing observations were made: M, Observed an unsealed roximately ½" wide) protruding above the door to exit access or Brush Bldg. This penetration neat to enter the stairwell. erved and confirmed by the ons Manager.		Sealed penetration protruding throug 2-hr fire wall above door to stairwell HUH-47 to prevent the spread of smand heat into the stairwell (K-020.2)		
LABORATO	ORY DIRECTOR'S OR PRO	VIDER/SUPPLIERS REPRESENTAT	IVE'S SIGNA	TURE TITLE	(X6) DATE	
					(, 52	

PRINTED: 08/17/2010 FORM APPROVED OMB NO. 0938-0391

STATEM	MENT OF DEFICIENCIES	(X1)DDOVIDED OF THE SECOND		0	MB NC	0.0938-0391
AND PLAN OF CORRECTION (X1)PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		(X2) MUL	TIPLE CONSTRUCTION	(X3) D.	ATE SURVEY	
	B. WING		DING 01 – Harper University Hospital	C	OMPLETED	
		230104	B. WIN	<u> </u>		
NAME O	F PROVIDER OR SUPPLIEF	3	STREET	ADDRESS, CITY, STATE, ZIP CODE	0	6/24/2010
HADDER	I LINUX EDOLET		J.M.E.L.	ABBRESS, CITT, STATE, ZIP CODE		
(X4) ID	R UNIVERSITY HOSPITAL			IN R STREET , MI. 48201		
PREFIX	(EACH DEFICIENCY MUST F	TEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY	ID	PROVIDER'S PLAN OF CORRECTION	N	(X5)
TAG	OR LSC IDEN	TIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE RIATE	COMPLETE DATE
14 000	I a					
K 020	Continued From page 4		K 020		T	
	Stairwell door HUH-32 ((Webber North Bldg.) at room		Repaired door to stairwell HUH-32	on 3	8/23/10
	3502 did not fully close	to a positive latch. This		Webber North at room 3502 to fully	,	
	deliciency would allow s	smoke and heat to enter the		close to a positive latch(K-020.3)	- 1	
	stairwell.			,		
	Those findings were all	construction of the second			1	
	Facility Maintenance Di	served and confirmed by the rector				
	07474				1	
	Surveyor: 27171				- 1	
	based on observation tr	ne facility failed to provide 1-				
	accordance with the LCC	ation for the vertical openings in				
	accordance with the LS	C section 19.3.1.1. This				
	of the facility.	potentially affect all occupants				
	of the facility.					
	Findings include:					
	On 06/21/2010, the follo	wing observations were made:				
	At approximately 11:32	AM, Observed that stairwell		Repaired door to stairwell HUH-32		8/23/10
	door HUH-32 (10" floor,	Webber South Bldg.) did not		10WS to fully close to a positive late	oh	0/23/10
	fully close to a positive la	atch. This deficiency would		(K-020.4)	311	
	allow smoke and heat to	enter the stairwell.		WO #: 328058		
	These findings were obs	served and confirmed by the				
	Plant Operations Manag	er ved and confirmed by the				
	. Idit operations wanay	GI.				
	At approximately 11:36	AM, Observed that stairwell		Popoired door to stain wall I II II I I I		0.00.4.0
	door HUH-36 (10th floor	Webber South Bldg.) does not		Repaired door to stairwell HUH-36 (on i	8/25/10
	fully close to a positive la	atch. This deficiency would		10WS to fully close to a positive late (K-020.5)	n	
	allow smoke and heat to	enter the stairwell.		(11-020.5)		
	These findings were obs	erved and confirmed by the				
	Plant Operations Manag	er.			- 1	
1/ 00=						
K 025	NFPA 101 LIFE SAFETY	Y CODE STANDARD	K 025			
	0					
	Smoke parriers are cons	tructed to provide at least a				
	one nair nour fire resista	nce rating in accordance with				
	o.s. Smoke barriers may	terminate at an atrium wall.				
	vvindows are protected b	by fire-rated glazing or by wired				
LABODAT	glass panels and steel fr	ames. A minimum of two				
LABORAT	ORY DIRECTOR'S OR PRO	VIDER/SUPPLIERS REPRESENTAT	IVE'S SIGN	ATURE TITLE		(X6) DATE

PRINTED: 08/17/2010 FORM APPROVED OMB NO. 0938-0391

AND PLA	AN OF CORRECTION	(X1)PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 – Harper University Hospital		(X3) DATE SURVEY COMPLETED	
NAME O	E DDOVIDED OD GUDDU	230104	B. WING		06/24/2010	
INAME	F PROVIDER OR SUPPLIER		STREET	ADDRESS, CITY, STATE, ZIP CODE	00/21/2010	
	R UNIVERSITY HOSPITAL			N R STREET MI. 48201		
PREFIX TAG	(EACH DEFICIENCY MUST B	EMENT OF DEFICIENCIES IE PRECEDED BY FULL REGULATORY TIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
V 025	C1:15					
K 025	Dampers are not require barriers in fully ducted h conditioning systems. Continued from page 6 19.3.7.3, 19.3.7.5, 19.1.0 This STANDARD is not Surveyor: 13546 Based on observation the smoke barriers that wou hour fire resistance ratin sections 19.3.7.3, 19.3.7 deficient practice could professional than the facility. Findings include: On 06/23/10, the following At approximately 10:00 A	are provided on each floor. ed in duct penetrations of smoke eating, ventilating, and air 6.3, 19.1.6.4 met as evidenced by: de facility failed to provide ld provide at least a one half g in accordance with the LSC 2.5, 19.1.6.3, 19.1.6.4. This potentially affect All occupants and observations were made: AM, Observed an unsealed lely 2" wide) through the crossall at room 8601. This moke and heat to travel	K 025	Sealed penetration through cross- corridor smoke barrier at room 860 prevent the smoke and heat to trave between smoke compartment (K-02	el	
	These findings were obs Facility Maintenance Dire	erved and confirmed by the ector.				
	At approximately 10:37 A of missing drywall (above across from room 8702.	AM, Observed a 3" x 5" section e ceiling tile) in the corridor,		Repaired drywall in corridor across room 8702 (K-025.2)	from 8/25/10	
	These finding were obse Facility Maintenance Dire	rved and confirmed by the ector.				
		observations were made:				
LADODA	At approximately 1:00 PM	M, Observed three sealed floor		Sealed three floor penetration in Bru	ısh 8/25/10	
LABORAT	ORY DIRECTOR'S OR PRO	VIDER/SUPPLIERS REPRESENTAT	IVE'S SIGN	ATURE TITLE	(X6) DATE	

PRINTED: 08/17/2010 FORM APPROVED OMB NO. 0938-0391

AND PLA	N OF CORRECTION	IDENTIFICATION NUMBER	A. BUIL B. WING	TIPLE CONSTRUCTION DING 01 – Harper University Hospital		ATE SURVEY OMPLETED
NAME OF	PROVIDER OR SUPPLIER	230104		ADDRESS, CITY, STATE, ZIP CODE	0	6/24/2010
HARPER UNIVERSITY HOSPITAL		3990 JOH	N R STREET			
(X4) ID PREFIX	SUMMARY STAT (EACH DEFICIENCY MUST B	EMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY	ID PREFIX	PROVIDER'S PLAN OF CORRECTIO	N	(X5)
TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	RIATE	COMPLETE DATE
V 025	0					
K 025	Continued From page 6	2" wide) in the Brush Building	K025	Building Telephone Closet at eleva	itor	
	Telephone Closet, at the	e elevator foyer. This deficiency		foyer to prevent smoke and heat to	5	
	would allow smoke and	heat to travel between floors.		travel between floors (K-025.3)		
		served and confirmed by the				
		ng observations were made:				
	At approximately 2:02 P	M, Observed multiple unsealed		Sealed multiple wall penetrations a	bove	8/25/10
	cross-corridor smoke ha	ximately 2" wide) above the rrier doors at room 3712. This		cross-corridor smoke barrier doors	at	
	deficiency would allow s	moke and heat to travel		room 3712 to prevent the spread or smoke and heat between smoke		
	between smoke compar	tments.		compartments (K-025.4)		
	These findings were obs facility Maintenance Dire	served and confirmed by the ector.				
	smoke barriers that would hour fire resistance rating sections 19.3.7.3, 19.3.7	e facility failed to provide Id provide at least a one half g in accordance with the LSC 7.5, 19.1.6.3, 19.1.6.4. This potentially affect All occupants				
	On 06/23/10, the following	ng observations were made:				
	open penetration (approx wall, above the ceiling tile entrance to the Surgical	AM, Observed an unsealed kimately 3" x 3") in the 2-hr fire e, (approximately 3' from the Lounge, on the 2 nd floor of the iciency would allow smoke and moke compartments.		Sealed open penetration in 2-hr fire above ceiling from entrance to Surg Lounge – actually on 1 st floor Brush Building - to prevent smoke and he travel between smoke compartment (K-025.5)	ical at to	8/25/10
	These findings were obse Corporate Operations Die	erved and confirmed by the rector.				
	Surveyor: 27171					
	Based on observation the	e facility failed to provide				
LADCOL	smoke barriers that would	d provide at least a one half				
LABORAT(DRY DIRECTOR'S OR PRO	VIDER/SUPPLIERS REPRESENTAT	IVE'S SIGNA	ATURE TITLE		(X6) DATE

STATEMENT OF DEFICIENCIES

PRINTED: 08/17/2010 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1)PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		(X2) MUL	TIPLE CONSTRUCTION	(X3) DATE SURVE	
	20 AUGUS 39 ABAD 38	220404	A. BUIL B. WING	DING 01 – Harper University Hospital	COMPLETED
NAME OF PROVIDER OR SUPPLIER		STREET	ADDRESS, CITY, STATE, ZIP CODE	06/24/2010	
(X4) ID	UNIVERSITY HOSPITAL		3990 JOH	IN R STREET , MI. 48201	
PREFIX TAG	(EACH DEFICIENCY MUST E	EMENT OF DEFICIENCIES IE PRECEDED BY FULL REGULATORY TIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE
(025	deficient practice could of the facility. Findings include:	ng in accordance with the LSC 7.5, 19.1.6.3, 19.1.6.4. This potentially affect all occupants	K 025		
	At approximately 11:38 a section of the cable tray smoke barrier (near the Floor, Webber South Bu	AM, Observed an unsealed located at the cross-corridor I.C.U. Elevators, on the 10 th ilding) wall.		Sealed section of cable tray at cros corridor smoke barrier (near ICU elevators on 10 th floor) (K-025.6)	s- 8/25/10
	At approximately 11:42 / penetration (Approximate corridor smoke barrier, (er. AM, Observed an unsealed pipe ely 2" wide) through the crossocated near 10-1.C.U. Electrical uilding). This deficiency would		Sealed pipe penetration through crocorridor smoke barrier (near electric closet in Hemodialysis, on 10 th floor prevent smoke and heat to travel between smoke compartments (K-025.7)	al
	At approximately 1:13 Pt conduit penetration in the wall. (located on the easi station, in the Webber So	M, Observed an unsealed e cross-corridor smoke barrier side of the 9 th floor nurses buth Building).		Sealed conduit penetration (9WS Nurses Station) to prevent smoke a heat to travel between smoke compartments (K-025.8)	8/25/10 nd
	At approximately 1:33 PN section of the cable tray			Sealed section of cable tray (9WS cross-corridor smoke barrier at sout entrance into 9ICU) (K-025.9)	8/25/10 h
PODATO	DRY DIRECTOR'S OR PRO				M

PRINTED: 08/17/2010 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION (X1)PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		A. BUIL	FIPLE CONSTRUCTION DING 01 – Harper University Hospital	(X3) DATE SURVEY COMPLETED	
NAME O	F PROVIDER OR SUPPLIER	230104		No.	06/24/2010
			STREET	ADDRESS, CITY, STATE, ZIP CODE	
(X4) ID	UNIVERSITY HOSPITAL			N R STREET MI. 48201	
PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
K 025	Continued From page 8			T	
1025	Continued From page 8		K 025		
	These findings were obs Plant Operations Manag	served and confirmed by the ger.			
	At approximately 1:40 P section of cable tray. Lo smoke barrier wall, near	M, Observed an unsealed cated at the cross-corridor I.C.U. Room 8522.		Sealed cable tray at cross-corridor smoke barrier wall near room 8522 (8ICU) (K-025.10)	8/25/10
	These findings were obs Plant Operations Manag	served and confirmed by the jer.			
K 027	NFPA 101 LIFE SAFET	Y CODE STANDARD	K 027		
	minute fire protection rai thick solid bonded wood plates that do not excee the door are permitted. I with 7.2.1.14. Doors are closing in accordance w are not required to swing	b barriers have at least a 20- ting or are at least 13/4-inch core. Non-rated protective d 48 inches from the bottom of Horizontal sliding doors comply self-closing or automatic ith 19.2.2.2.6. Swinging doors g with egress and positive 19.3.7.5, 19.3.7.6, 19.3.7.7			
	This STANDARD is not	met as evidenced by:			
	the smoke barrier doors	e facility failed to provide for to be self-closing or automatic th the LSC section 19.2.2.2.6. ould potentially affect All			
	Findings include:				
	On 06/23/10, the following	g observations were made:			
LARCE	located at room 5719, die This deficiency would alle between smoke compart	corridor smoke barrier doors, d not function when tested. ow smoke and heat to travel ments.		Repaired coordinator on cross-corriesmoke barrier doors located at room 5719 to prevent smoke and heat to travel between smoke compartment (K-027.1)	1
LABORAT	UKY DIRECTOR'S OR PRO	VIDER/SUPPLIERS REPRESENTAT	IVE'S SIGNA	ATURE TITLE	(X6) DATE

PRINTED: 08/17/2010 FORM APPROVED OMB NO. 0938-0391

AND PL	AND PLAN OF CORRECTION (X1)PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		(X2) MUL	TIPLE CONSTRUCTION DING 01 – Harper University Hospital	(X3) DATE SURVEY
		220104	B. WING	G	COMPLETED
NAME C	NAME OF PROVIDER OR SUPPLIER		STREET	ADDRESS, CITY, STATE, ZIP CODE	06/24/2010
HARPEI (X4) ID	R UNIVERSITY HOSPITAL			N R STREET , MI. 48201	
PREFIX TAG	(EACH DEFICIENCY MUST B	EMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY TIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
K 027	Continued From page 9		14 007		
		served and confirmed by the	K 027		
	1/8" gap between the ed barrier doors, adjacent t would allow smoke and compartments. These findings were obs Facility Maintenance Dir			Sealed 1/8" gap between edges of cross-corridor smoke barrier doors, adjacent to room 3820 to prevent smoke and heat to travel between smoke compartments (K-027.2)	8/23/10
	At approximately 11:27 of corridor smoke barrier of 10 th floor Webber-South close. This deficiency we travel between smoke continued to the continued of the	erved and confirmed by the ector.		Repaired smoke barrier doors adjact to 10 th floor, south entrance to Hemodialysis to fully close to preve smoke and heat to travel between smoke compartments (K-027.3) WO #: 328060	
	Corridor smoke barrier w. Webber South nurse's st ceiling. This deficiency w travel between smoke co	rved and confirmed by the		Extended smoke barrier wall to ceiling to prevent smoke and heat to travel between smoke compartments (9WS Nurses Station) (K-027.4)	
K 029	NFPA 101 LIFE SAFETY	CODE STANDARD	K 029		
LABORAT	doors) or an approved au system in accordance will protects hazardous areas automatic fire extinguishi areas are separated from resisting partitions and do and non-rated or field-ap	s. When the approved ng system option is used, the n other spaces by smoke pors. Doors are self-closing plied protective plates that do			
LABORAT	UKY DIRECTOR'S OR PRO	VIDER/SUPPLIERS REPRESENTAT	IVE'S SIGNA	ATURE TITLE	(X6) DATE

PRINTED: 08/17/2010 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1)PROVIDER/SUPPLIER/CLIA		(AS) WITH.	TIPLE CONSTRUCTION	MB NO. 0938-0391	
AND PLA	N OF CORRECTION	IDENTIFICATION NUMBER	A. BUIL	(X3) DATE SURVEY COMPLETED	
230104			B. WING	3	10 15430W 5024
NAME OF PROVIDER OR SUPPLIER		STREET	ADDRESS, CITY, STATE, ZIP CODE	06/24/2010	
HARPER	UNIVERSITY HOSPITAL		1	N R STREET	
(X4) ID	SUMMARY STAT	THENT OF DESIGNATION		MI. 48201	
PREFIX TAG	(EACH DEFICIENCY MUST B	EMENT OF DEFICIENCIES IE PRECEDED BY FULL REGULATORY TIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
K 029	Continued From page 4	0			
K 029	permitted. 19.3.2.1	om the bottom of the door are	K 029		
	This STANDARD is not	met as evidenced by:			
	the protection of hazard	ne facility failed to provide for ous areas in accordance with I. This deficient practice could upants of the facility.			
	Findings include:				
	On 6/21/10, the following	g observations were made:			
	At approximately 12:46 PM, Observed that the door to clean utility room/storage room 3627 requires a self-closer. This deficiency would allow smoke and heat to enter the exit corridor.			Room 3627 does not exist, the only clean utility room/storage room on t unit is 3617 and the door has a self closer, preventing smoke and heat	to
	These findings were obs Corporate Fire Safety Ins	erved and confirmed by the spector.		travel between smoke compartment (K-029.1)	ts
	At approximately 10:01 A trash receptacle in the B 3820.	AM, Observed an unapproved rush Center corridor at room		Removed unapproved trash recepta (K-029.2)	acle 8/23/10
	These findings were obse Corporate Fire Safety Ins	erved and confirmed by the spector.			
	At approximately 2:46 PM supply room 8701 does r requirement.	M, Observed that the door to not meet the 45-minute rating		Install replacement door for supply room 8701 that meets the 45-minute rating requirement (K029.3)	=
	Corporate Fire Safety Ins	-5.40055600000		To be installed by 9/19/10 Responsible: Director of Facility Engineering and Construction	
	penetration between the This deficiency would allo exit corridor. These findings were obse	M, Observed an unsealed wall corridor and the room 8701. ow smoke and heat to enter the erved and confirmed by the		Sealed wall penetration between corridor and room 8701 to prevent smoke and heat to enter the exit corridor (K-029.4)	8/25/10
LABUKAT	DRY DIRECTOR'S OR PROV	/IDER/SUPPLIERS REPRESENTAT	VE'S SIGNA	TURE TITLE	(X6) DATE
					and 95%

PRINTED: 08/17/2010 FORM APPROVED OMB NO. 0938-0391

STATEME	NT OF DEFICIENCIES	(X1)PROVIDER/SUPPLIER/CLIA	(VO) 141113	OI	MB NO. 0938-0391
AND PLAI	N OF CORRECTION	IDENTIFICATION NUMBER	A. BUIL	IPLE CONSTRUCTION	(X3) DATE SURVEY
			B. WING	DING 01 – Harper University Hospital	COMPLETED
NAME OF		230104	D. WINC		
NAME OF	PROVIDER OR SUPPLIER	8	STREET A	DDDECC CITY OTATE TIP CO.	06/24/2010
12 (0.000) (0.000)			STREET	DDRESS, CITY, STATE, ZIP CODE	
HARPER	UNIVERSITY HOSPITAL		3990 101	N R STREET	
			DETROIT,		
(X4) ID	SUMMARY STAT	TEMENT OF DEFICIENCIES	ID ID		
PREFIX	(EACH DEFICIENCY MUST E	BE PRECEDED BY FULL REGULATORY	PREFIX	PROVIDER'S PLAN OF CORRECTION	(X5)
TAG	OR LSC IDEN	TIFYING INFORMATION)	TAG	(EACH CORRECTIVE ACTION SHOULD	BE COMPLETE
			IAG	CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	RIATE DATE
K 020	0				

Corporate Fire Safety Inspector. At approximately 2:49 PM, Observed that the door to supply room 8712 that meets the 45-minute rating requirement. These findings were observed and confirmed by the Corporate Fire Safety Inspector. At approximately 12:46 PM, Observed that the door to Janitor's Closet 7702 does not self-close and latch. This deficiency would allow smoke and heat to enter the exit corridor. These findings were observed and confirmed by the Corporate Fire Safety Inspector. At approximately 12:46 PM, Observed an unsealed wall penetration (Approximately 1" x 2" wide) above the door to Janitor's closet 7702. This deficiency would allow smoke and heat to enter the exit corridor. These findings were observed and confirmed by the Corporate Fire Safety Inspector. At approximately 2:49 PM, Observed that the storage room door, at entrance to 6-Brush center, is not rated. These findings were observed and confirmed by the Corporate Fire Safety Inspector. At approximately 2:49 PM, Observed that the storage room door, at entrance to 6-Brush center, is not rated. These findings were observed and confirmed by the Corporate Fire Safety Inspector. At approximately 2:49 PM, Observed that the storage room door, at entrance to 6-Brush center, is not rated. These findings were observed and confirmed by the Corporate Fire Safety Inspector. At approximately 2:55 PM, Observed that the door to Install a rated door for storage room at 68 Center (K-029.8) To be installed by 9/19/10 Responsible: Director of Facility Engineering and Construction 8/23/10 Install replacement door for supply room 8712 that meets the 45-minute rating requirement. (K-029.5) To be installed by 9/19/10 Responsible: Director of Facility Engineering and Construction				DEFICIENCY)	
Corporate Fire Safety Inspector. At approximately 2:49 PM, Observed that the door to supply room 8712 does not meet the minimum 45-minute rating requirement. These findings were observed and confirmed by the Corporate Fire Safety Inspector. At approximately 12:46 PM, Observed that the door to Janitor's Closet 7702 does not self-close and latch. This deficiency would allow smoke and heat to enter the exit corridor. At approximately 12:46 PM, Observed and confirmed by the Corporate Fire Safety Inspector. At approximately 12:46 PM, Observed an unsealed wall penetration (Approximately 1" x 2" wide) above the door to Janitor's closet 7702. This deficiency would allow smoke and heat to enter the exit corridor. These findings were observed and confirmed by the Corporate Fire Safety Inspector. At approximately 2:49 PM, Observed that the storage room door, at entrance to 6-Brush center, is not rated. These findings were observed and confirmed by the Corporate Fire Safety Inspector. At approximately 2:49 PM, Observed that the storage room door, at entrance to 6-Brush center, is not rated. These findings were observed and confirmed by the Corporate Fire Safety Inspector. At approximately 2:55 PM, Observed that the storage room door, at entrance to 6-Brush center, is not rated. These findings were observed and confirmed by the Corporate Fire Safety Inspector. At approximately 2:55 PM, Observed that the door to Safety Inspector.	K 029	Continued From page 11	T		
supply room 8712 does not meet the minimum 45- minute rating requirement. These findings were observed and confirmed by the Corporate Fire Safety Inspector. At approximately 12:46 PM, Observed that the door to Janitor's Closet 7702 does not self-close and latch. This deficiency would allow smoke and heat to enter the exit corridor. These findings were observed and confirmed by the Corporate Fire Safety Inspector. At approximately 12:46 PM, Observed an unsealed wall penetration (Approximately 1" x 2" wide) above the door to Janitor's closet 7702. This deficiency would allow smoke and heat to enter the exit corridor. These findings were observed and confirmed by the Corporate Fire Safety Inspector. At approximately 2:49 PM, Observed that the storage room door, at entrance to 6-Brush center, is not rated. These findings were observed and confirmed by the Corporate Fire Safety Inspector. At approximately 2:49 PM, Observed that the storage room door, at entrance to 6-Brush center, is not rated. These findings were observed and confirmed by the Corporate Fire Safety Inspector. At approximately 2:49 PM, Observed that the storage room door, at entrance to 6-Brush center, is not rated. These findings were observed and confirmed by the Corporate Fire Safety Inspector. At approximately 2:55 PM, Observed that the door to At approximately 2:55 PM, Observed that the door to		Corporate Fire Safety Inspector.	K 029	Install replacement door for supply	
At approximately 12:46 PM, Observed that the door to Janitor's Closet 7702 does not self-close and latch. This deficiency would allow smoke and heat to enter the exit corridor. These findings were observed and confirmed by the Corporate Fire Safety Inspector. At approximately 12:46 PM, Observed an unsealed wall penetration (Approximately 1" x 2" wide) above the door to Janitor's closet 7702. This deficiency would allow smoke and heat to enter the exit corridor. These findings were observed and confirmed by the Corporate Fire Safety Inspector. At approximately 2:49 PM, Observed that the storage room door, at entrance to 6-Brush center, is not rated. These findings were observed and confirmed by the Corporate Fire Safety Inspector. At approximately 2:55 PM, Observed that the door to At approximately 2:55 PM, Observed that the door to Install a rated door for storage room at 6B Center (K-029.8) To be installed by 9/19/10 Responsible: Director of Facility Engineering and Construction		supply room 8712 does not meet the minimum 45- minute rating requirement.		rating requirement (K-029.5) To be installed by 9/19/10 Responsible: Director of Facility	
Janitor's Closet 7702 does not self-close and latch. This deficiency would allow smoke and heat to enter the exit corridor. These findings were observed and confirmed by the Corporate Fire Safety Inspector. At approximately 12:46 PM, Observed an unsealed wall penetration (Approximately 1" x 2" wide) above the door to Janitor's closet 7702. This deficiency would allow smoke and heat to enter the exit corridor. These findings were observed and confirmed by the Corporate Fire Safety Inspector. At approximately 2:49 PM, Observed that the storage room door, at entrance to 6-Brush center, is not rated. These findings were observed and confirmed by the Corporate Fire Safety Inspector. At approximately 2:49 PM, Observed that the storage room door, at entrance to 6-Brush center, is not rated. These findings were observed and confirmed by the Corporate Fire Safety Inspector. At approximately 2:55 PM, Observed that the door to the corporate Fire Safety Inspector. At approximately 2:55 PM, Observed that the door to the corporate Fire Safety Inspector. At approximately 2:55 PM, Observed that the door to the corporate Fire Safety Inspector. At approximately 2:55 PM, Observed that the door to the corporate Fire Safety Inspector. At approximately 2:55 PM, Observed that the door to the corporate Fire Safety Inspector. At approximately 2:55 PM, Observed that the door to the corporate Fire Safety Inspector. At approximately 2:55 PM, Observed that the door to the corporate Fire Safety Inspector. At approximately 2:55 PM, Observed that the door to the corporate Fire Safety Inspector.		Corporate Fire Safety Inspector.		Room 7702 is an office that is occupied	8/23/10
Corporate Fire Safety Inspector. At approximately 12:46 PM, Observed an unsealed wall penetration (Approximately 1" x 2" wide) above the door to Janitor's closet 7702. This deficiency would allow smoke and heat to enter the exit corridor. These findings were observed and confirmed by the Corporate Fire Safety Inspector. At approximately 2:49 PM, Observed that the storage room door, at entrance to 6-Brush center, is not rated. These findings were observed and confirmed by the Corporate Fire Safety Inspector. At approximately 2:55 PM, Observed that the door to the storage room at 6B Center (K-029.8) To be installed by 9/19/10 Responsible: Director of Facility Engineering and Construction		Janitor's Closet 7702 does not self-close and latch. This deficiency would allow smoke and heat to enter the exit corridor.		by one person, closer not required. The janitors closet door across from room 7702 adjusted to self close and latch to prevent smoke and heat to enter the	
penetration (Approximately 1" x 2" wide) above the door to Janitor's closet 7702. This deficiency would allow smoke and heat to enter the exit corridor. These findings were observed and confirmed by the Corporate Fire Safety Inspector. At approximately 2:49 PM, Observed that the storage room door, at entrance to 6-Brush center, is not rated. These findings were observed and confirmed by the Corporate Fire Safety Inspector. At approximately 2:55 PM, Observed that the door to Install a rated door for storage room at 6B Center (K-029.8) To be installed by 9/19/10 Responsible: Director of Facility Engineering and Construction		Corporate Fire Safety Inspector. At approximately 12:46 PM, Observed an unsealed wall			8/25/40
At approximately 2:49 PM, Observed that the storage room door, at entrance to 6-Brush center, is not rated. These findings were observed and confirmed by the Corporate Fire Safety Inspector. At approximately 2:55 PM, Observed that the door to		penetration (Approximately 1" x 2" wide) above the door to Janitor's closet 7702. This deficiency would allow smoke and heat to enter the exit corridor.		across from room 7702; the wall above room 7702 was also checked to verify no penetrations.	6/25/10
These findings were observed and confirmed by the Corporate Fire Safety Inspector. At approximately 2:55 PM, Observed that the door to		Corporate Fire Safety Inspector.			
At approximately 2:55 PM, Observed that the door to		room door, at entrance to 6-Brush center, is not rated. These findings were observed and confirmed by the Corporate Fire Safety Inspector.		6B Center (K-029.8) To be installed by 9/19/10 Responsible: Director of Facility	
6812 (K-029.9) To be installed by 9/19/10		the storage closet at room 6812 is not rated.			
Corporate Fire Safety Inspector. Responsible: Director of Facility Engineering and Construction		Corporate Fire Safety Inspector.		Responsible: Director of Facility Engineering and Construction	
At approximately 2:49 PM, Observed that the door to storage room 6605A does not have a self-closer. Installed self-closer on door to storage room 6605A (K-029.10) 8/23/10	LABORA	storage room 6605A does not have a self-closer.		Installed self-closer on door to storage room 6605A (K-029.10)	8/23/10

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

TITLE

(X6) DATE

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PRINTED: 08/17/2010 FORM APPROVED OMB NO. 0938-0391

1	STATEME	ENT OF DEFICIENCIES	(V1)DDO\#DED/QUBBUIED			MR M	O. 0938-039 [,]	ı
١	AND PLA	N OF CORRECTION	(X1)PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE CONSTRUCTION	(X3)	DATE SURVEY	
١		. O COMILECTION	IDENTIFICATION NUMBER	A. BUII	LDING 01 – Harper University Hospital		COMPLETED	
l			230104	B. WIN	G			
	NAME OF	PROVIDER OR SUPPLIER	200104	CTDEET	ADDRESS SITE OF		06/24/2010	
				SIREEI	ADDRESS, CITY, STATE, ZIP CODE			
		UNIVERSITY HOSPITAL		3990 JOH DETROIT	IN R STREET , MI. 48201			
ı	(X4) ID PREFIX	SUMMARY STAT	EMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	AI .	(VE)	_
	TAG	OR LSC IDEN	E PRECEDED BY FULL REGULATORY TIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	RE	(X5) COMPLETE DATE	
_					221.01411017			-
l	K 029	Continued From page 12	2	K 029			T	_
١		These findings were obs	served and confirmed by the	11.020				
l		Corporate Fire Safety In	spector.					
l								
l		At approximately 2:19 P	M. Observed that the		Install sprinkler to room 5718	li li		
		dimensions of the clean	linen/storage room 5718		(K-029.11)			
		exceed 100 square feet	and is not sprinkler protected.		To be installed by 8/31/10			
١					Responsible: Director of Facility			
		These findings were obs	erved and confirmed by the		Engineering and Construction			
		Corporate Fire Safety In:	spector.		Engineering and Construction			
		At approximately 2:57 PI	M, Observed heat producing		T 27			
		appliances were observe	ed in staff lounge 5708. This		Install sprinkler (K-029.12)			
		room is not sprinkled or	have a rated door with closer.		To be installed by 8/31/10			
		This deficiency would all	ow smoke and heat to enter the		Responsible: Director of Facility			-
		exit corridor.	ow shoke and near to enter the		Engineering and Construction			
		orm comaci,						
		These findings were obs Corporate Fire Safety Ins	erved and confirmed by the spector.					
		At approximately 2:58 PM	M Observed wiring and		D			
		combustibles not properly	y secured inside of Mechanical		Removed wiring and combustibles t	hat	8/25/10	
		closet 2627.	y secured monde of Mechanical		were not properly secured inside of			
					mechanical closet 2627			
		These findings were obse	erved and confirmed by the		(K-029.13)			1
		Facility Maintenance Dire	ector.					1
		0						
		Surveyor: 18760	88 000					
		Based on observation the	e facility failed to provide for					1
		the protection of hazardo	us areas in accordance with					1
		the LSC section 19.3.2.1.	This deficient practice could					ı
		potentially affect All occur	pants of the facility.					1
		Findings include:						
		On 6/21/10 the faller-i	ahaa ati					
		on orz ir to, the following	observations were made:					
		At approximately 11:32 A	M, Observed that the door to		Possissed decests 11 to 1111			
		the Soiled Linen Room m	arked G114/1114a did not		Repaired door to soiled utility room	, [8/25/10	
		close to a positive latch	This deficiency would allow		G114/114a to close to a positive late	:h		
		smoke and heat to enter t	the exit corridor		(K-029.14)	- 1		
			SAR GOITIGOI.					
		These findings were obse	erved and confirmed by the					

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

TITLE

(X6) DATE

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Corporate Fire Safety Inspector.

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STATEM	ENT OF DEFICIENCIES	(X1)PROVIDER/SUPPLIER/CLIA	(VO) 141 II :	C	MB NO. 0938-0391
AND PLA	AN OF CORRECTION	IDENTIFICATION NUMBER	(AZ) MUL	TIPLE CONSTRUCTION	(X3) DATE SURVEY
		TO THE MONIBLE	A. BUIL B. WING	DING 01 – Harper University Hospital	COMPLETED
NAME OF		230104	D. VVIIV		
NAME OF	F PROVIDER OR SUPPLIEF	?	CTDEET	DDDDDDD OUTV OT	06/24/2010
			SIKEELA	ADDRESS, CITY, STATE, ZIP CODE	
HARPER	UNIVERSITY HOSPITAL				
	THE THE PARTY HOSPITAL		3990 JOH	N R STREET	
(X4) ID	0.000		DETROIT,	MI. 48201	
PREFIX	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	
7 (21) Table 10 (1)	(EACH DEFICIENCY MUST E	BE PRECEDED BY FULL REGULATORY	PREFIX	(EACH CORRECTIVE ACTION SHOW	(*,0)
TAG	OR LSC IDEN	TIFYING INFORMATION)	TAG	(EACH CORRECTIVE ACTION SHOULD	D BE COMPLETE
			i no	CROSS-REFERENCED TO THE APPROF DEFICIENCY)	PRIATE DATE
				DETICIENCY)	
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1 029	Continued From page 1	3	14 000		

K 029	Continued F		- 20 0000000000000000000000000000000000	
1 029	Continued From page 13	K 029		
	At approximately 11:50 AM, Observed that the door to the Weber Building O.R. janitor's closet did not close to a positive latch. This deficiency would allow smoke and heat to enter the exit corridor.		Repaired door to janitors closet in OR to close to a positive latch (K-029.15)	8/25/10
	These findings were observed and confirmed by the Corporate Fire Safety Inspector.			
	At approximately 1:25 PM, Observed that the door to the Wendy's kitchen janitor's closet did not close to a positive latch. This deficiency would allow smoke and heat to enter the exit corridor.		Repaired door to janitors closet in Wendy's kitchen to close to a positive latch (K-029.16)	8/19/10
	These findings were observed and confirmed by the Corporate Fire Safety Inspector.			2
	At approximately 1:35 PM, Observed ceiling tiles missing in the Webber Building ground floor service elevator area.		Replaced ceiling tile in Webber 1 st floor service elevator (K-029.17) WO #: 328067	8/23/10
	These findings were observed and confirmed by the Corporate Fire Safety Inspector.			
	At approximately 10:20 AM, Observed an unsealed wall penetration (Approximately 3" x 3" in diameter) in the Brush Building Upper Café janitor's closet. This deficiency would allow smoke and heat to enter the exit corridor.		Sealed wall penetration in janitors closet in cafeteria to prevent smoke and heat to enter the exit corridor(K-029.18)	8/25/10
	These findings were observed and confirmed by the Corporate Fire Safety Inspector.			
	At approximately 10:25 AM, observed that the door to the Upper Café Storage Room in the Brush Building did not close to a positive latch.		Repaired door to storage room in cafeteria to close to a positive latch (K-029.19)	8/25/10
	These findings were observed and confirmed by the Corporate Fire Safety Inspector.			
LABORAT	At approximately 10:40 AM, Observed that the ceiling tile in the 1 st floor Brush Building Hospitality Storage		Replaced ceiling tile in Hospitality Storage Room (catering) (K-029.20)	8/23/10

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TITLE

(X6) DATE

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STATEMENT OF DEFICIENCIES (X1)PROVIDER/SUPPLIER/CLIA			(X2) MIII	TIPLE CONSTRUCTION	NO. 0938-0391
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUIL	DING 01 – Harper University Hospital	(X3) DATE SURVEY COMPLETED	
			B. WING	G	COMPLETED
NAME OF	F PROVIDER OR SUPPLIER	230104	077777		06/24/2010
			STREET	ADDRESS, CITY, STATE, ZIP CODE	
	UNIVERSITY HOSPITAL			N R STREET , MI. 48201	
(X4) ID	SUMMARY STAT	EMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(VE)
PRÉFIX TAG	OR LSC IDEN	E PRECEDED BY FULL REGULATORY TIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLETE
K 029	Continued From Taxa 4	,			
1025	Continued From page 1 room is missing.	4	K 029	WO #330528	
	These findings were obe	served and confirmed by the			
	Corporate Fire Safety In	spector			
	osiporato i ne calety in	specior.			
	At approximately 10:55	AM, Observed an unsealed		Sociad paratration in EVO 4	2/2-1/2
	penetration (Approximat	ely 1" x 6" in diameter) in the		Sealed penetration in EVS storage room to prevent smoke and heat to	8/25/10
	Brush Basement EVA S	torage Room. This deficiency		enter the exit corridor(K-029.21)	
	would allow smoke and	heat to enter the exit corridor.		Cities the exit comdot(K-029.21)	
	These findings were obs	served and confirmed by the			
	Corporate Fire Safety In	spector.			
	At				
	At approximately 11:00 /	AM, Observed an unsealed		Sealed conduit penetration protruding	g 8/25/10
	through the corridor wall	1" in diameter) protruding		through wall in basement kitchen to	
	hasement kitchen. This	deficiency would allow smoke		prevent smoke and heat to enter the	
	and heat to enter the exi	t corridor		exit corridor	
	and the chief the chi	r comaci.		(K-029.22)	
	These findings were obs	erved and confirmed by the			
	Corporate Fire Safety In	spector.			
		00 • 000 • 000 0 0 0 0 0 0 0 0 0 0 0 0			
	At approximately 11:00 A	AM, Observed a concrete block		Repaired concrete wall in basement	8/25/10
	missing (Approximately	6" x 12") missing from the		kitchen storage room to prevent smo	ke
	corridor wall in the Brush	Building basement kitchen		and heat to enter the exit corridor	1,4,900
	heat to enter the exit cor	ciency would allow smoke and		(K-029.23)	
	near to enter the exit cor	ridor.			
	These findings were obs	erved and confirmed by the			
	Corporate Fire Safety Ins	spector.			
	At approximately 1:05 PM	M, Observed that the 4 th floor		Adjusted door to clean linen room on	8/19/10
	Weber North clean linen	room door did not close to a		4WN to close to a positive latch	0/19/10
	positive latch.			(K-029.24)	
	The Carl				
	These findings were obs	erved and confirmed by the			
	Corporate Fire Safety Ins	spector.			
	At approximately 11,00 a	M Observed · ·			
	nenetration around a six	M, Observed an unsealed		Sealed penetration around pipe in	8/25/10
	penetration around a pipe	ugh the rear wall of the 4 th floor		janitors closet across from room 4445	5
	Weber South janitor's clo	ugh the rear wall of the 4" floor set, adjacent to room 4445.		on 4WS to prevent smoke and heat to	0
	This deficiency would all	ow smoke and heat to enter the		enter the exit corridor (K-029.25)	
LABORAT	ORY DIRECTOR'S OR PRO	VIDER/SUPPLIERS REPRESENTAT	IVE'S SICN	ATURE	
	enamenteense trenos reflectificações de la 🕶 🗎 💟	TO THE MEDENTAL	IVE O OIGINA	ATURE TITLE	(X6) DATE

PRINTED: 08/17/2010 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION (X1)PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		A. BUIL	TIPLE CONSTRUCTION DING 01 – Harper University Hospital G	(X3) DATE SURVEY COMPLETED	
NAME O	F PROVIDER OR SUPPLIER	230104			06/24/2010
			STREET	ADDRESS, CITY, STATE, ZIP CODE	
(X4) ID	R UNIVERSITY HOSPITAL			N R STREET , MI. 48201	
PREFIX TAG	(EACH DEFICIENCY MUST E	EMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY TIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
K 029	Continued From page 1	5	14 000	T	
	exit corridor.	5	K 029		
	These findings were obs	served and confirmed by the			
	Corporate Fire Safety In	spector.			
	Surveyor: 27171				
	Based on observation th	ne facility failed to provide for			
	the protection of hazard	ous areas in accordance with			
	the LSC section 19.3.2.	This deficient practice could upants of the facility.			
	Findings include:				
	On 6/21/10, the following	g observations were made:			
	to the HVAC duct in the	AM, Observed an unsealed proximately 1" in diameter) next 11 th floor North Penthouse efficiency would allow smoke t corridor.		Sealed penetration next to HVAC d on 11 th floor in Plumbers Shop to prevent smoke and heat to enter the exit corridor (K-029.26)	100000 0000000000000000000000000000000
	These findings were obs Facility Maintenance Dir	erved and confirmed by the ector			
	At approximately 1:50 Pl tiles at the HVAC unit in South Building.	M, Observed missing ceiling room 8450 in the Webber		Replaced ceiling tiles in room 8450 8WS (K-029.27) WO # 330530	on 8/25/10
	These findings were obs Facility Maintenance Dire	erved and confirmed by the ector			
	large diameter conduit po in diameter) in Room 544	M, Observed two unsealed enetrations (Approximately 4" 44, Webber South Building. ow smoke and heat to enter the		Sealed two penetrations in room 54 on 5WS to prevent smoke and heat enter the exit corridor (K-029.28)	44 8/25/10 to
	These findings were obs Facility Maintenance Dire	erved and confirmed by the ector			
K 038	NFPA 101 LIFE SAFETY	CODE STANDARD	K 038		
LABORAT	ORY DIRECTOR'S OR PRO	VIDER/SUPPLIERS REPRESENTAT	IVE'S SIGNA	ATURE TITLE	(X6) DATE
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STATEM	ENT OF DEFICIENCIES	(X1)PROVIDER/SUPPLIER/CLIA	(VO) 14111 5	0	MB NO. 0938-0391
AND PLA	N OF CORRECTION	IDENTIFICATION NUMBER	A. BUII	TIPLE CONSTRUCTION	(X3) DATE SURVEY
			B. WING	DING 01 – Harper University Hospital	COMPLETED
NAME OF	PROVIDER OR SUPPLIEF	230104			06/24/2010
I WANTE OF	PROVIDER OR SUPPLIER	{	STREET A	DDRESS, CITY, STATE, ZIP CODE	00/24/2010
HARPER (X4) ID	UNIVERSITY HOSPITAL			N R STREET	
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K 020	0 " 1-				

			DEFICIENCY)	
K 038	Continued From page 16			
	Softmacd From page 10	K 038		
	Exit access is arranged so that exits are ready accessible at all times in accordance with section 7.1. 19.2.1			
	This STANDARD is not met as evidenced by:			
	Surveyor: 18760 Based on observation the facility failed to provide approved exit access in accordance with the LSC section 19.2.1. This deficient practice could potentially affect All occupants of the facility.			
	Findings include:			
	On 6/23/10, the following observations were made:			
	At approximately 11:00 AM, Observed that the door to the "Old Sump Room" was secured with a clasp and pad lock, that prevents the door from being opened from the egress side.		Removed clasp and pad lock and installed hardware to allow the door to be opened from the egress side (K-038.1)	8/25/10
	These findings were observed and confirmed by the Facility Maintenance Director			
	At approximately 10:05 AM, Observed exit access at the 2 nd floor Brush Surgical Suite was obstructed by a 6-ft slab of ¾ inch plywood laid across the stairway.		Removed wood plank to allow unobstructed exit access (K-038.2)	8/23/10
	These findings were observed and confirmed by the Facility Maintenance Director.			
	At approximately 10:25 AM, Observed that the exit door at the 1 st floor Doctors Dining Room in the Brush Building was obstructed by chairs.		Removed chairs from exit to allow unobstructed exit access. Signage was be placed to instruct occupants not to block the exit doors.	8/25/10
	These findings were observed and confirmed by the Facility Maintenance Director.		(K-038-3)	
	At approximately 10:35 AM, Observed that the rear door to the exit access corridor, in the Brush Building Upper Café, has a dead bolt lock.		Removed deadbolt from rear door to the in the cafeteria and replaced with	8/25/10
LABORAT	ORY DIRECTOR'S OR PROVIDER/SUPPLIERS PEDDESENTATI	VEID 015::	hardware to allow for egress (K-038.4)	

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

TITLE

(X6) DATE

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STATEM	ENT OF DEFICIENCIES AN OF CORRECTION	(X1)PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE CONSTRUCTION	(X3) DATE SURVEY
ANDID	IN OF CORRECTION	IDENTIFICATION NUMBER	A. BUIL	DING 01 – Harper University Hospital	COMPLETED
NAME OF		230104	B. WING	3	06/24/2010
NAME O	F PROVIDER OR SUPPLIER		STREET	ADDRESS, CITY, STATE, ZIP CODE	00/24/2010
	UNIVERSITY HOSPITAL			N R STREET MI. 48201	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST B	EMENT OF DEFICIENCIES IE PRECEDED BY FULL REGULATORY TIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
K 038	Continued From page 1	7	K 000		
	o o minded i form page i	,	K 038		
	These findings were obs Facility Maintenance Dir	served and confirmed by the rector.			
	At approximately 10:40	AM, Observed that the door to		Removed deadbolt from door in EV	S BIDEIAO
	the exit access corridor	in the Brush Building basement Room has a dead bolt lock.		storage room and replaced with hardware to allow for egress (K-038	
	These findings were obs Facility Maintenance Dir	served and confirmed by the ector.			
	the exit access corridor i	AM, Observed that the door to in the Brush Building Basement brage Room has a dead bolt		Removed deadbolt from door in transportation storage room (Brush Basement) and replaced with hardw to allow for egress (K-038.6)	8/25/10 vare
	These findings were obs Facility Maintenance Dir	served and confirmed by the ector.			
K 039	NFPA 101 LIFE SAFET	Y CODE STANDARD	K 039		
	Width of aisles or corrido serving as exit access is	ors (clear and unobstructed) at least 4 feet. 19.2.3.3			
	This STANDARD is not i	met as evidenced by:			
	Surveyor: 27171	e facility failed to provide exit			
	access in accordance wi This deficient practice co occupants of the facility.	th the LSC section 19.2.3.3.			
	Findings include:				
	On 06/23/10, the following	ng observations were made:			
	At approximately 1:15 PN being stored in the corrid Webber South Building.	M, Observed a patient bed lor, by Room 9411, in the		Bed was removed from 9WS corridor during the visit. Staff educated on maintaining corridor clearance. Unit leaders monitor their areas daily and	. 5.20.10
LABORI	Facility Maintenance Dire	erved and confirmed by the ector.		periodic rounds are conducted. (K-039 1)	
LABORAT	ORY DIRECTOR'S OR PRO	VIDER/SUPPLIERS REPRESENTAT	IVE'S SIGN	ATURE TITLE	(X6) DATE

PRINTED: 08/17/2010 FORM APPROVED OMB NO. 0938-0391

STATEM	ENT OF DEFICIENCIES	(X1)PROVIDER/SUPPLIER/CLIA	(V2) MIII -	IDI E CONCEDITORIO		D. 0938-0391
AND PLA	N OF CORRECTION	IDENTIFICATION NUMBER	A. BUIL	TIPLE CONSTRUCTION DING 01 – Harper University Hospital		DATE SURVEY
			B. WING	G		COMPLETED
NAME O	F PROVIDER OR SUPPLIER	230104	070		r	06/24/2010
		·	STREET	ADDRESS, CITY, STATE, ZIP CODE		
	UNIVERSITY HOSPITAL			N R STREET MI. 48201		
(X4) ID PREFIX	SUMMARY STAT	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N	(X5)
TAG	OR LSC IDEN	BE PRECEDED BY FULL REGULATORY TIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	RF	COMPLETE DATE
14.040						
K 046	Continued From page 1	8	K 046			
	NFPA 101 LIFE SAFET	Y CODE STANDARD				
	Emergency lighting of a provided in accordance	t least 1 ½ hour duration is with 7.9, 19,2,9.1.				
	This STANDARD is not					
	Surveyor: 18760 Based on observation th	ne facility failed to provide				
	emergency lighting in ac 19.2.9.1.	ccordance with the LSC section				
	This deficient practice co occupants of the facility.	ould potentially affect All				
	At approximately 11:10 / emergency lighting in the	g observations were made: AM, Observed that the e brush Building Basement ess stairway did not operate		Repaired emergency lighting in Bru Basement Substation #1 (K-046.1)	sh	7/15/10
	These findings were obs Facility Maintenance Dire	served and confirmed by the ector.				
K 047	NFPA 101 LIFE SAFETY	Y CODE STANDARD	K 047			
	with section 7.10 with co	s are displayed in accordance intinuous illumination also y lighting system. 19.2.10.1				
	This STANDARD is not r	met as evidenced by:				
	Surveyor: 18760 Based on observation the and directional signs in a section 19.2.10.1. This contentially affect All occur	deficient practice could				
	Findings include:					
LABORAT	On 06/23/10, the followin	ng observations were made: VIDER/SUPPLIERS REPRESENTAT	NEIC CLOS	ATURE		
	S DINEGION S ON PRO	VIDEIVOUPPLIERS REPRESENTAT	IVE'S SIGNA	ATURE TITLE		(X6) DATE

PRINTED: 08/17/2010 FORM APPROVED

STATEM	ENT OF DEFICIENCIES	(X1)DDOVIDED (CUDDIVIDE)	T	ON	IB NO. 0938-0391
AND PLA	N OF CORRECTION	(X1)PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	A. BUII B. WIN	TIPLE CONSTRUCTION LDING 01 – Harper University Hospital G	(X3) DATE SURVEY COMPLETED
NAME O	F PROVIDER OR SUPPLIER	230104			06/24/2010
			STREET	ADDRESS, CITY, STATE, ZIP CODE	
(X4) ID	UNIVERSITY HOSPITAL			IN R STREET , MI. 48201	
PREFIX TAG	(EACH DEFICIENCY MUST E	EMENT OF DEFICIENCIES E PRECEDED BY FULL REGULATORY TIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLETE DATE
K 047	Continued From 1 - 4		,		
1 047	Continued From page 1	9	K 047		
	exit directional signs loc Basement to identify the	served and confirmed by the		Install exit directional signs in Webb South sub-basement (K-047.1) To be installed by 8/31/10 Responsible: Director of Facility Engineering and Construction	er
	from the Weber Building identified with an exit significant the second of the second o	served and confirmed by the		Install exit signage to exit door from "Old Sump Room" (K-047.2) To be installed by 8/31/10 Responsible: Director of Facility Engineering and Construction	
	Corporate Fire Safety In	spector.			
	On 6/23/10, the following	g observations were made:			
	directional signs in the V	AM, Observed that there are no Veber Sub-Basement Tunnel "Old Am-Cart elevator is not in.		Installed directional signage in Webb Sub-basement tunnel (K-047.3) Installed exit sign at exit door by the	per 8/25/10 8/25/10
	These findings were obs Corporate Fire and Safe	erved and confirmed by the ty Inspector		"Old Amscar" elevator	
	On 06/23/10, the following	ng observations were made:			
	to the Administration Sui	M, Observed that the exit door te, located in the 2 nd Floor C, does not have an exit sign.		Installed exit signage at exit door to Administration Suite at stairwell HUH 4C (K-047.4)	8/25/10
	These findings were obs Corporate Fire Safety In:	erved and confirmed by the spector.			
	On 06/23/10, the following	ng observations were made:			
	At approximately 11:10 A	AM, observed there are no exit		Installed directional signage from Bru Building basement Substation #1 to 6	

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

Sub-Station #1 to the exit access stairway.

Corporate Fire Safety Inspector.

These findings were observed and confirmed by the

TITLE

access stairway(K-047.5)

Building basement Substation #1 to exit

(X6) DATE

PRINTED: 08/17/2010 FORM APPROVED OMB NO. 0938-0391

AMP PLAN OF CORRECTION AMP PLAN OF CORRECTION NUMBER 230104 NAME OF PROVIDER OR SUPPLIER HARPER UNIVERSITY HOSPITAL 230104 230104 SIMMARY STATEMENT OF DEFERENCES OR PROVIDER (SACH DEFICIENCE) TAG CONTINUED SIMMARY STATEMENT OF DEFERENCES OR PREFIX TAGE CONTINUED SIMMARY STATEMENT OF DEFERENCES OR LEGISLATION IN LARGE TO PREFIX TAGE CONTINUED SIMMARY STATEMENT OF DEFERENCES OR LEGISLATION IN LARGE TO PROVIDER SILVAN OF CORRECTION SHOULD BE PREFIX TAGE CONTINUED SIMMARY STATEMENT OF DEFERENCES OR THE SILVAN OF CORRECTION SHOULD BE PREFIX TAGE CONTINUED SILVAN OF CORRECTION SHOULD BE PROVIDED BY FIGHL REGULATORY OR LEGISLATORY OR RECORD TO LEGISLATORY OR LEGISLATORY DIRECTOR OR RECORD TO LEGISLATORY OR LEGISLATORY OR RECORD TO LEGISLATORY OR LEGISLATORY OR RECORD TO LEGISLATORY OR LEGISLATORY DIRECTOR OR PROVIDER/SUPPLIERS REPRESENTATIVE'S SIGNATURE (X2) DATE SURVEY COMPLETED (069/24/2910 3090 JOHN R STREET DEFICIENCY STAND OF CORRECTION (169/24/2910 MILESTON OR STREET DEFICENCY OR LEGISLATORY OR RECORD OR LEGISLATORY OR LEGISLATORY OR RECORD OR RECORD OR LEGISLATORY OR LEGISLATORY OR LEGISLATORY OR RECORD OR LEGISLATORY OR LEGI	STATEM	ENT OF DEFICIENCIES	(X1)PROVIDER/SUPPLIER/CLIA	(VO) MILLI	TIDLE CONCERNATION	MB NO. 0938-0391
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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 above are disclosable 90 disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is required to continued program participation.

PRINTED: 08/17/2010 FORM APPROVED OMB NO. 0938-0391

STATEM	ENT OF DEFICIENCIES	(X1)PROVIDER/SUPPLIER/CLIA	(V2) MIII 7		MB NO. 0938-0	
AND PLA	N OF CORRECTION	IDENTIFICATION NUMBER	A RUII	FIPLE CONSTRUCTION DING 01 – Harper University Hospital	(X3) DATE SURV	
		A CONTRACTOR OF	B. WING	3	COMPLETE	:D
NAME OF		230104	1 =		06/24/2010	
NAME OF	F PROVIDER OR SUPPLIER	R	STREET	ADDRESS, CITY, STATE, ZIP CODE	00/24/2010	
HARDER	UNIVERSITY HOSPITAL					
TIANT EN	ONIVERSITY HOSPITAL			N R STREET		
(X4) ID	SUMMARY STAT	TEMENT OF DEFICIENCIES		MI. 48201		
PREFIX	(EACH DEFICIENCY MUST E	BE PRECEDED BY FULL REGULATORY	PREFIX	PROVIDER'S PLAN OF CORRECTION	(X5)	
TAG	OR LSC IDEN	TIFYING INFORMATION)	TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE COMPLE	
				DEFICIENCY)	RIATE DATE	
K 062	Continued From page 2	1	K062			
	page 2	ish	1002			
	Surveyor 18760					
		nd/or review of records the				
	facility failed to provide	decumentation that the				
	automatic aprinkles and	documentation that the				
	in coordenae with the	em is maintained and/or tested				
	in accordance with the L	SC sections 19.7.6, 4.6.12,				
	9.7.5. This deficient pra	actice could potentially affect All				
	occupants of the facility.					
	Findings include:					
	55.00 (***********************************					
	On 06/21/10, the followi	ng observations were made:				
		-				
	At approximately 10:45	AM. Observed that the		Place appropriate signage on sprin	vlor	
	automatic sprinkler valve	e drain located in the Webber		valve drain (K-062.5)	(iei	
	Building Sub-Basement	did not have a sign to identify		To be installed by 8/31/10		
	its purpose.	ald not have a sign to identity		Popposible: Disease of Facility		
	no parpose.			Responsible: Director of Facility		
	These findings were sho	copied and southerned by the		Engineering and Construction		
	Corporate Fire Safety In	served and confirmed by the				
	Corporate Fire Safety in	spector.				
	At approximately 1:30 D	M Observable to the control of the		- 10 March 1	0000 Paris (000000000000000000000000000000000000	
	at approximately 1:30 P	M, Observed that combustible		Storage removed at time of visit and	d is 6/21/10	
	storage was within 18" o	of the automatic sprinkler heads		monitored during rounds		
	in the Weber Building Pl	harmacy Storage Room.		(K-062.6)		
				8 12		
	These findings were obs	served and confirmed by the				
	Corporate Fire Safety In	spector.				
	At approximately 1:25PN	M, Observed that the automatic		Replaced escutcheon plate on	8/23/10	
	sprinkler head located in	the Webber North Building		automatic sprinkler head located in	0/23/10	
	room 3435 is missing an	escutcheon plate		room 3435 (3WN) (K-062.7)		
	J	plate.		WO #: 330531	1	
	These findings were obs	served and confirmed by the		WO #. 330531		
	Corporate Fire Safety In	spector			1	
	corporate i ne calety in	specior.				
K 064	NEDA 101 LICE CACETY	V CODE CTANDADD	14004			
11 004	NFPA 101 LIFE SAFET	I CODE STANDARD	K064			
	Dardahla Saara dia dia					
	Portable life extinguishe	rs are provided in all health			1	
	care occupancies in acc	ordance with 9.7.4.1. 19.3.5.6,				
	NFPA 10	***			1	
LABORAT	ORY DIRECTOR'S OR PRO	VIDER/SUPPLIERS REPRESENTAT	IVE'S SIGN	ATURE TITLE	(X6) DAT	E
					(NO) DAT	_

PRINTED: 08/17/2010 FORM APPROVED OMB NO. 0938-0391

STATEM	ENT OF DEFICIENCIES	(X1)PROVIDER/SUPPLIER/CLIA	T (VO) 14111	0	MB NO. 0938-039
AND PLA	AN OF CORRECTION	IDENTIFICATION NUMBER	(X2) MUL	TIPLE CONSTRUCTION	(X3) DATE SURVEY
		ISELLIN IONLIGIT NOMBER	B. WING	DING 01 – Harper University Hospital	COMPLETED
		230104	D. WIN	3	00/04/004
NAME O	F PROVIDER OR SUPPLIER		STREET	ADDRESS, CITY, STATE, ZIP CODE	06/24/2010
HADDED	LINIVEDOITY LIGATITY			DETALLOS, OTT, OTATE, ZIF CODE	
HARPER	UNIVERSITY HOSPITAL			N R STREET	
(X4) ID	SUMMARY STAT	TEMENT OF DEFICIENCIES		, MI. 48201	
PREFIX	(EACH DEFICIENCY MUST F	BE PRECEDED BY FULL REGULATORY	ID	PROVIDER'S PLAN OF CORRECTION	N (X5)
TAG	OR LSC IDEN	TIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD	BE COMPLETE
	Constant and Const		IAG	CROSS-REFERENCED TO THE APPROPE	RIATE DATE
				DETICIENCY)	
K 064	Continued From page 2	2	14.004		
	Continued 1 form page 2	2	K 064		
	This STANDARD is and				
	This STANDARD is not	met as evidenced by:			
	Suprover: 19760				1
	Surveyor: 18760	99			1
	based on observation a	nd/or review of records the			
	facility failed to provide f	fire extinguishers in accordance			
	with the LSC section 19	.3.5.6. This deficient practice			
	could potentially affect A	All occupants of the facility.	1		
		12 22.9			i i
	Findings include:				
	On 06/23/10, the following	ng observations were made:			1
	At approximately 1:10PM	M. Observations that the		Mounted fire extinguisher in Wendy	3- 04040
	portable fire extinguishe	rs located in the Wendy's		kitchen (K-064.1)	r's 8/19/10
	restaurant kitchen was n	not mounted to the wall		Michell (N-004.1)	
	Total and Mitorien Was I	iot mounted to the wall.		WO #: 330532	
	These findings were obs	served and confirmed by the			
	Facility Maintenance Dir	ester			
	r denity Maintenance Dir	ector.			
	At approximately 10:05	AM Observed the next-blasses			
	extinguisher legated in the	AM, Observed the portable fire		Mounted fire extinguisher outside o	f 8/19/10
	extinguisher located in the	ne i floor Brush Center		Doctors Dining Room (K-064.2)	
	Doctors Dining Room wa	as not mounted to the wall.		WO #: 330533	
	There for direct				
	These findings were obs	erved and confirmed by the			
	Facility Maintenance Dire	ector.			
	At approximately 11:10A	M, Observed the portable fire		Mounted fire extinguisher in Decon	8/19/10
	extinguisher located in the	ne Brush Building Basement		Mechanical/Electrical Room (K-064	
	De-Con Mechanical/Elec	ctrical Room is not mounted to	1	WO #: 330535	,
	the wall.				1
	These findings were obs	erved and confirmed by the			
	Facility Maintenance Dire	ector.			
	=	885.731			
K 069	NFPA 101 LIFE SAFETY	CODE STANDARD	K 069		
		000000000000000000000000000000000000000	1. 003		
	Cooking facilities are pro	tected in accordance with 9.2.3			
	19.3.2.6, NFPA 96	neoted in accordance with 9.2.5			
	This standard is not met	as evidenced but			
	o standard is not met	as evidenced by.			
LABORAT	OBY DIDECTORIS OF THE	105500000000000000000000000000000000000			
LABOKAI	OKT DIRECTOR'S OR PRO	VIDER/SUPPLIERS REPRESENTAT	IVE'S SIGN	ATURE TITLE	(X6) DATE
					B 8

PRINTED: 08/17/2010 FORM APPROVED OMB NO. 0938-0391

STATEM	ENT OF DEFICIENCIES	(X1)PROVIDER/SUPPLIER/CLIA	(VO) MILLS	UIDI E GOLIGE	MB NO. 0938-0391
AND PLA	N OF CORRECTION	IDENTIFICATION NUMBER	A. BUIL	TIPLE CONSTRUCTION	(X3) DATE SURVEY
			B. WING	DING 01 – Harper University Hospital	COMPLETED
		230104	J. Wilde		06/24/2010
NAME OF	PROVIDER OR SUPPLIER		STREET A	ADDRESS, CITY, STATE, ZIP CODE	00/24/2010
HARPER	UNIVERSITY HOSPITAL				
THAIR LIC	CHIVERSHIT HOSPITAL			N R STREET	
(X4) ID	SUMMARY STAT	EMENT OF DEFICIENCIES	DETROIT,		
PREFIX	(EACH DEFICIENCY MUST B	BE PRECEDED BY FULL REGULATORY	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD	N (X5) BE COMPLETE
TAG	OR LSC IDEN	TIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR	RIATE DATE
				DEFICIENCY)	
14.000	10				
K 069	Continued From page 2	3	K 069		
	0				
	Surveyor 18760.	440 50 500 50 50 500			
	Based on observation a	nd/or review of records the			
	facility failed to provide	cooking facilities in accordance			
	with the LSC section 19	.3.2.6. This deficient practice			
	could potentially affect A	All occupants of the facility.			
	Findings in the				
	Findings include:				
	On 06/21/10, the follows:	ng observations were made:			
	On oorz mio, the following	ng observations were made:			
	At approximately 1:20PM	M, Observed the manual station		Panaired manual station for Manual	0/00/40
	for the Wendy's hood su	innression system was		Repaired manual station for Wendy	
	damaged and the seal v	vas broken		hood suppression system (K-069.1)
	admaged and the scar v	vas biokeii.		WO #: 328102	
	These findings were obs	served and confirmed by the			
	Corporate Fire Safety In	spector			
	Corporato i ne dalety in	speciol.			
	At approximately 1:25PM	M, Observed that the kitchen		Properly installed kitchen hood grea	0/40/40
	hood grease filters in the	e Wendy's restaurant were not		filters in Wendy's to eliminate gaps	ase 8/19/10
	installed properly and ha	ad an approximate two 1/4" gaps		between filters (K-069.2)	
	between the filters.	gapo		WO #: 330537	
				VVO #. 330337	
	These findings were obs	served and confirmed by the			
	Corporate Fire Safety In	spector.			
**********	n and a second s	*			
K 076	NFPA 101 LIFE SAFETY	Y CODE STANDARD	K076		
	Medical gas storage and	administration areas are			
	protected in accordance	with NFPA 99, Standards for			
	Health Care Facilities.				
	(a) Oxygen storage local	ations of greater than 3,000 cu.			
	ft. are enclosed by a	one-hour separation.			
	***	22 200			
	(b) Locations for supply	systems of greater than 3,000			
		he outside. NFPA 99 4.3.1.1.2,			
	19.3.2.4.				
	TI: 07	10 St. 10 St. 10 St. 10 St. 10 St. 10 St. 10 St. 10 St. 10 St. 10 St. 10 St. 10 St. 10 St. 10 St. 10 St. 10 St			
	This STANDARD is not it	met as evidenced by:			
	Cumum 40540				
LABODAT	Surveyor: 13546				
LABOKAT	ORY DIRECTOR'S OR PRO	VIDER/SUPPLIERS REPRESENTAT	IVE'S SIGNA	ATURE TITLE	(X6) DATE
					5, 350

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AND PL	ENT OF DEFICIENCIES AN OF CORRECTION	(X1)PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	A. BUIL	TIPLE CONSTRUCTION DING 01 – Harper University Hospital	(X3) DATE SURVEY COMPLETED
NAME O	E DD0/4050 00 00	230104	B. WIN		06/24/2010
NAME O	F PROVIDER OR SUPPLIER		STREET	ADDRESS, CITY, STATE, ZIP CODE	00/24/2010
(X4) ID	R UNIVERSITY HOSPITAL			N R STREET , MI. 48201	
PREFIX TAG	(EACH DEFICIENCY MUST E	EMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY TIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
K 076	Continued From page 2				
	Based on observation the protection of medical gas 99. This deficient practic occupants of the facility.	ne facility failed to provide ses in accordance with NFPA ce could potentially affect all	K 076		
	Findings include:				
	On 06/21/10, the following	ng observations were made:			
	At approximately 1:46Pl oxygen cylinder in room	M, Observed an unsecured 3809.		Secured tank, unit leaders conduct monitoring. (K-076.1)	daily 8/23/10
	These findings were obs Facility Maintenance Dir	served and confirmed by the ector.			
	At approximately 2:34PN oxygen cylinder in soiled	M, Observed an unsecured dutility room 3616.		Secured tank, unit leaders conduct monitoring. (K-076.2)	daily 8/23/10
	These findings were obs Facility Maintenance Dir	served and confirmed by the ector.			
	protection of medical gas	e facility failed to provide ses in accordance with NFPA ce could potentially affect All		2	
	Findings include:				
	On 06/21/10, the following	ng observations were made:			
	At approximately 1:10PN oxygen cylinders in the 4 Linen Room.	1, Observed two unsecured th floor Webber North Clean		Secured tank, unit leaders conduct of monitoring. (K-076.3)	daily 8/23/10
	These findings were obs Corporate Fire Safety Ins	erved and confirmed by the spector.			
K 147	NFPA 101 LIFE SAFETY	CODE STANDARD	K 147		
	Electrical wiring and equ	ipment is in accordance with			
LABORAT	ORY DIRECTOR'S OR PRO	VIDER/SUPPLIERS REPRESENTAT	IVE'S SIGN	ATURE TITLE	(X6) DATE
Any defici	ency statement anding with a	a seterick (*) denotes a deficiency			

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AND PLA	ENT OF DEFICIENCIES NO OF CORRECTION	(X1)PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULT	TIPLE CONSTRUCTION	(X3) DATE SURVEY
		22.000.000	B. WING	DING 01 – Harper University Hospital	COMPLETED
NAME OF	F PROVIDER OR SUPPLIER	230104	STREET	ADDRESS SIEV STATE	06/24/2010
	UNIVERSITY HOSPITAL			ADDRESS, CITY, STATE, ZIP CODE	
(X4) ID	-			N R STREET , MI. 48201	
PREFIX TAG	(EACH DEFICIENCY MUST E	EMENT OF DEFICIENCIES SE PRECEDED BY FULL REGULATORY TIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
K 147	Continued From page 2	E	T		
	NFPA 70, National Elec	trical Code 9.1.2.	K 147		
	This STANDARD is not	met as evidenced by:			
	electrical system in acco	ne facility failed to provide the ordance with the LSC section ctice could potentially affect All			
		ng observations were made:			
	At approximately 2:46PN junction box missing a c	M, Observed an electrical over plate at room 8702.		Replace junction box cover plate at room 8702 (K-147.1) WO #: 330538	
	These findings were obs Facility Maintenance Dir	served and confirmed by the ector.		To be installed by 8/31/10 Responsible: Director of Facility	
	electrical system in acco	e facility failed to provide the ordance with the LSC section ctice could potentially affect All		Engineering and Construction	
	Findings include:				
	1 200-4 Voca	ng observations were made:			
	At approximately 10:45A junction box, located in t missing a cover plate.	M, Observed an electrical he Weber South basement,		Replaced junction box cover plate in Webber South basement (K-147.2) WO #: 330538	8/19/10
	These findings were obs Corporate Fire Safety Ins	erved and confirmed by the spector.			
	electrical junction box loc above the smoke barrier Webber Building Radiolo	gy that is missing a cover		Replaced junction box cover plate above ceiling tile by room G207 (K-147.3) WO #: 328101	7/19/10
LABORAT	ORY DIRECTOR'S OR PRO	VIDER/SUPPLIERS REPRESENTAT	IVE'S SIGN	ATURE TITLE	(X6) DATE
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STATEMEN	T OF DEFICIENCIES				MB NO. 0938-0391
		(X1)PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE CONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		DING 01 - Harper University Hospital	COMPLETED
			B. WING		COMPLETED
		230104			00/04/0040
NAME OF P	ROVIDER OR SUPPLIER				06/24/2010
	NO VIDEN ON SUFFLIER	V	STREET	DDRESS, CITY, STATE, ZIP CODE	
HARPER UN	NIVERSITY HOSPITAL		3990 JOH	N R STREET	
(X4) ID	CUMMARYOTA	TELLELLE & C. C. C. C. C. C. C. C. C. C. C. C. C.	DETROIT,	MI. 48201	
		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N (X5)
		BE PRECEDED BY FULL REGULATORY	PREFIX	(EACH CORRECTIVE ACTION SHOULD	BE COMPLETE
TAG	OR LSC IDEN	ITIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR	
				DEFICIENCY)	NATE DATE
				DETIDIENT	

		L	DEFICIENCY)	
< 147	Continued From page 26	K 147		
	plate.			
	These findings were observed and confirmed by the			
	Corporate Fire Safety Inspector.		Replace junction box cover plate above	
	At approximately 11:25AM, observed by the Corporate		ceiling tile near room G234	
	Fire Safety Inspector that there is an electrical junction box located above the ceiling tile, above the smoke		(K-147.4) WO #: 330540	
	barrier doors by room G234 in Webber Radiology that is		To be installed by 8/31/10	
	missing a cover plate.		Responsible: Director of Facility Engineering and Construction	
	These findings were observed and confirmed by the		Linguisting and construction	
	Corporate Fire Safety Inspector.			
	At approximately 0.45AM, Ob., 188, 188		Replace junction box cover plate above	
	At approximately 9:45AM, Observed that there is an electrical junction box above the ceiling tile, above the		door to stairwell HUH-47 on 2 Brush (K-147.5)	
	door to the stairway marked HUH-47 on the 2 nd Floor of		WO #: 330541	
	the Brush Building that is missing a cover plate.		To be installed by 8/31/10 Responsible: Director of Facility	
	These findings were observed and confirmed by the Corporate Fire Safety Inspector.		Engineering and Construction	
	At approximately 10:03 AM, charged that there is		Adjust exposed wire above entrance to	
	At approximately 10:03AM, observed that there is exposed wiring to a construction light located above the		Surgical Lounge on 1 Brush (K-147.6)	
	ceiling tile, above the entrance to the Surgical Lounge		WO #: 330543	
	on the 2 nd Floor of the Brush Building.		To be installed by 8/31/10	
	These findings were observed and confirmed by the		Responsible: Director of Facility Engineering and Construction	
	Corporate Fire Safety Inspector.			
	At approximately 10:50AM, observed an electrical		Replace junction box cover plate in Brush Basement storage room next to	
	junction box in the Brush Building Basement storage		stairwell HUH-40 (K-147.7)	
	room next to stairway marked HUH-40 that is missing a		WO #: 330544	
	cover plate.		To be installed by 8/31/10	
	These findings were observed and confirmed by the		Responsible: Director of Facility Engineering and Construction	
	Corporate Fire Safety Inspector.		175	
	At approximately 10:50AM, Observed an electrical		Replace junction box cover plate above	
	junction box in the Brush Building Basement above the		smoke barrier doors at Pharmacy entrance in Brush Basement (K-147.8)	
	ceiling tile above the smoke barrier doors by the	(((WO #: 330545	

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

TITLE

(X6) DATE

PRINTED: 08/17/2010 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION (X1)PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 – Harper University Hospital B. WING		(X3) C	(X3) DATE SURVEY COMPLETED		
NAME OF	DDOVIDED OF OURDING	230104	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1			06/24/2010	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE				
	UNIVERSITY HOSPITAL			N R STREET MI. 48201			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST E	TEMENT OF DEFICIENCIES SE PRECEDED BY FULL REGULATORY TIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETE DATE	
K 147	Continued From page 2	7	16.4.47	T T			
K 147	Pharmacy Entrance tha	t is missing a cover plate.	K 147	To be installed by 8/31/10 Responsible: Director of Facility Engineering and Construction			
	Corporate Fire Safety Ir			Repaired damaged 220 volt outlet kitchen storage area (Brush Basen		8/19/10	
		AM, Observed that there is a rical outlet located in the Brush nen Storage Room.		(K-147.9) WO #: 330546			
	Corporate Fire Safety In	Addit Octobro Cada Calabact		Replaced junction box cover plate kitchen storage room (Brush Basel (K-147.10)	in ment)	8/18/10	
	junction box located in t	AM, observed an electrical he Brush Building Basement nat is missing a cover plate.		WO #: 330547			
	These findings were ob Corporate Fire Safety In	served and confirmed by the spector.					
	junction box located in t	AM, Observed an electrical he Fire Sprinkler Cabinet in the nt Grey Tunnel that is missing a		Replace junction box cover plate ir sprinkler cabinet in Brush Baseme grey tunnel (K-147.11) WO #: 330548 To be installed by 8/31/10			
	These findings were ob- Corporate Fire Safety Ir	served and confirmed by the spector.		Responsible: Director of Facility Engineering and Construction			
	junction box located in t	M, Observed an electrical he 3 rd floor Webber North n #3236 that is missing a cover		Replace junction box cover plate 3 electrical room #3236 (K-147.12) WO #: 330549 To be installed by 8/31/10 Responsible: Director of Facility	WN		
	These findings were obs Corporate Fire Safety In	served and confirmed by the spector.		Engineering and Construction			
	electrical system in acco	ne facility failed to provide the ordance with the LSC section actice could potentially affect all					
	Findings include:						
LABORAT	ORY DIRECTOR'S OR PRO	OVIDER/SUPPLIERS REPRESENTA	TIVE'S SIGN	ATURE TITLE		(X6) DATE	

PRINTED: 08/17/2010 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION DENTIFICATION NUMBER 230104 A BUILDING 01—Harper University Hospital B WIND STREET ADDRESS, CITY, STATE, ZIP CODE 2309 JOHN 8 STREET DETROIT, MI, 48201 DEROUGER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2309 JOHN 8 STREET DETROIT, MI, 48201 (#ACH DEFICIENCY MIST BE PRECEDED BY PULL REQULATORY TAG OR ISC IDENTIFYING INFORMATION) K 147 Continued From page 28 On 06/21/10, the following observations were made: At approximately 10-41AM, Observed an electrical junction box missing a cover plate, located in Substation 6 on the 11 Floor Penthouse North. These findings were observed and confirmed by the Plant Operations Manager. At approximately 10-10-10-10-10-10-10-10-10-10-10-10-10-1		ENT OF DEFICIENCIES	(X1)PROVIDER/SUPPLIER/CLIA	(X2) MULT	TIPLE CONSTRUCTION	(X3) DATE SURVEY
NAME OF PROVIDER OR SUPPLIER HARPER UNIVERSITY HOSPITAL 3990 JOHN R STREET DETROIT, MI. 48201 PREFIX TAG Continued From page 28 On 06/21/10, the following observations were made: At approximately 10.41AM, Observed an electrical junction box missing a cover plate, located in the Mechanical/Control Room, located on the 11 th Floor Penthouse North. These findings were observed and confirmed by the Plant Operations Manager. At approximately 11.01AM, Observed that there was an electrical junction box missing a cover plate, located in the Mechanical/Control Room, located on the 11 th Floor Penthouse North. These findings were observed and confirmed by the Plant Operations Manager. At approximately 11.01AM, Observed that there was an electrical junction box missing a cover plate, located in the Mechanical/Control Room, located on the 11 th Floor Penthouse (K-147, 13) These findings were observed and confirmed by the Plant Operations Manager. At approximately 11.20AM, Observed that there was an electrical junction box missing a cover plate, located in the Mechanical/Control Room, located on the 11 th Floor Penthouse (K-147, 16) Wo #: 330552 Replace junction box cover plate in substation 6 on 11 th floor penthouse (K-147, 16) Wo #: 330552 Replace junction box cover plate in mechanical/control room on 11 th floor penthouse (K-147, 16) Wo #: 330552 Replace junction box cover plate in mechanical/control room on 11 th floor penthouse (K-147, 16) Wo #: 330555 To be installed by 8/31/10 Responsible: Director of Facility Engineering and Construction Replace filler blanks in two electrical panels in room 10443 10WS (K-147-16) Wo #: 330555 To be installed by 8/31/10 Responsible: Director of Facility Engineering and Construction Replace filler blanks in two electrical panels in room 10443 10WS (K-147-16) Wo #: 330555 To be installed by 8/31/10 Responsible: Director of Facility Engineering and Construction Replace filler blanks in two electrical panels in room 10443 10WS (K-147-16) Wo #: 330	AND PLA	N OF CORRECTION	IDENTIFICATION NUMBER	A. BUIL	DING 01 – Harper University Hospital	
NAME OF PROVIDER OR SUPPLIER HARPER UNIVERSITY HOSPITAL SUMMAPY SYNTEMENT OF DEFICIENCIES PRETATOR (EACH DEFICIENCY MIST BE PRECEDED BY FULL REGULATORY DR LSC IDENTIFYING INFORMATION) K 147 Continued From page 28 On 06/21/10, the following observations were made: At approximately 10:41AM, Observed an electrical junction box missing a cover plate, located in Substation 6 on the 11 st Floor Penthouse North. These findings were observed and confirmed by the Plant Operations Manager. At approximately 11:01AM, Observed that there were two electrical panels missing iller blanks (Panels RP-112 and RP-113) located in the 11 st Floor Penthouse North. These findings were observed and confirmed by the Plant Operations Manager. At approximately 11:01AM, Observed that there was an electrical junction box missing a cover plate, located in the Mechanical/Control Room, located on the 11 st Floor Penthouse (K-147-15) WO #: 330552 To be installed by 8/31/10 Replace junction box cover plate in substation 6 on 11 st floor penthouse (K-147-14) WO #: 330552 Replace junction box cover plate in substation 6 on 11 st floor penthouse (K-147-15) WO #: 330555 To be installed by 8/31/10 Replace junction box cover plate in mechanical/control room on 11 st floor penthouse (K-147-15) WO #: 330555 To be installed by 8/31/10 Replace junction box cover plate in mechanical/control room on 11 st floor penthouse (K-147-15) WO #: 330555 To be installed by 8/31/10 Replace junction box cover plate in mechanical/control room on 11 st floor penthouse (K-147-16) WO #: 330555 To be installed by 8/31/10 Replace junction box cover plate in mechanical/control room on 11 st floor penthouse (K-147-16) WO #: 330555 To be installed by 8/31/10 Replace junction box cover plate in mechanical/control room on 11 st floor penthouse (K-147-16) WO #: 330555 To be installed by 8/31/10 Replace junction box cover plate in mechanical/control room on 11 st floor penthouse (K-147-16) WO #: 330555 To be installed by 8/31/10 Replace juncti			230104	B. WING	S	
HARPER UNIVERSITY HOSPITAL X40 ID SUMMARY STATEMENT OF DEFICIENCIES DETROIT, MIL, 48201 X41 CACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY (RAC) X42 CACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY (RAC) X42 CACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY (RAC) X42 CACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY (RAC) X43 CACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY (RAC) X44 CACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY (RAC) X44 CACH DEFICIENCY X44	NAME OF	PROVIDER OR SUPPLIER	230104	STREET	ADDRESS CITY STATE ZID CODE	06/24/2010
Continued From page 28				SINCE	ADDRESS, CITT, STATE, ZIP CODE	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIERS REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

PRINTED: 12/18/2012 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1)PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		230024	B. WING _		11/21/2012
NAME OF PROVIDER OR SUPPLIER SINAI-GRACE HOSPITAL		STREET ADDRESS, CITY, STATE, ZIP CODE 6071 W OUTER DRIVE DETROIT, MI 48235			
(X4) ID PREFIX TAG	(EACH DEFICIENCY N	EMENT OF DEFICIENCIES NUST BE PROCEEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE
A 000	facility and determine	urvey was for State artment has evaluated this d that it is not in compliance on requirements. See the	A 000	By submitting this plan of corresinal-Grace Hospital ("SGH" or "Hospital") is not waiving its rigamend the Plan of Correction necessary and/or to contest deficiencies, findings, conclusions actions of CMS and/or the State SAgency. SGH has taken immediations to ensure it is in complimited to ensure actions are more fully described by the seafter and is committed to on compliance.	r the pht to n as the s, and curvey ediate liance nents.
A 115 A hospital must protect and promote each patient's rights. This CONDITION is not met as evidenced by: Surveyor: 29313 Based on record review, policy review and interview, it was determined the facility failed to protect and promote the rights of patients as evidenced by: (A 117) failure to inform each patient, or when appropriate, the patient's representative (as allowed under State law), of the patient's rights; (A 144) failure to provide patient care in a safe setting; (A 168) failure to ensure that restraint orders were completed and authenticated by a physician; (A 170) failure to notify the patients attending physician as soon as possible after being placed in restraints when the attending did not originally give the order; (A 171) failure to provide complete restraint orders and (A 175) failure to monitor patients in restraints as ordered.		A 115	The Hospital has taken effective measures to protect and promote epatient's rights. Specifically, the Hospital has: Revised its processes to ensurth that each patient is provided nof his/her rights through provision of the initial and follow-up IMM (A117) and provided education staff regarding the provision of IMM, as more fully described herein; provided education to its staff ensure that patient care is reminal asafe setting, identifying the importance of maintaining operaccess to the lines (A144), as fully described herein; revised its processes for initial and continuing restraints and/outling seclusion (A170) and provided education to relevant staff regarding the initiation and continuation of restraints and/outling seclusion, as more fully describelow;	re otice sion I noto fithe to dered e en more ting or discorded to the dered to the more to the dered to the more to the dered to the	
LABORA	ORY DIRECTOR'S OR PROVI	DER/SUPPLIERS REPRESENTATIVE	S SIGNATUR	S	(X6) DATE
	\ \ 0 \ \ /			President	2/14/13

PRINTED: 12/18/2012 FORM APPROVED OMB NO. 0938-0391

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A 115	Continued from page	1	A 115	drafted and implemented guidelines and protocols for medical restraints at SGH to provide more definition on the notification of attending physical restraint orders entered by medical resident, other LIP, and to clarify the authenticat countersignature procedures (A171);	e icians / a or MLP ion /
				 implemented the measures fully described herein to ens that patients in restraint or seclusion are appropriately monitored by a physician, o LIP, and/or appropriately tra MLP's, the Hospital (A175). 	ther ined
	Li Control de la control de la			Monitoring The Hospital has implemented monitoring of the actions taken for A117, A144, A169, A170, A171, a A175, as described below in the I Correction for each referenced Ta	and Plan of
				Responsible Person(s) President	
A 117	RIGHTS A hospital must inform appropriate, the patie allowed under State la	RIGHTS: NOTICE OF n each patient, or when nt's representative (as aw), of the patient's rights, ng or discontinuing patient ble.	A 117	The Hospital has taken effective measures to inform the patient, o patient's representative, of the parights in advance of furnishing or discontinuing patient care whene possible. Specifically, as of 11/06 the Hospital provides the patient family and caregivers with a comprehensive care plan that encourages the patient, family an caretaker's/representative's input patient/family/caretaker/represent is provided education regarding the care plan that is clear and understandable. The patient/family/caretaker/represent is provided information and instrutor discharge planning post-hospicare placement; patient/family/caretaker/represent will be involved in the discharge planning process 100% of the tim (when applicable). Unit Social Woland/or Unit Case Mangers will document evidence of the plan in patient's medical record.	tient's ver 6/12, and d . The tative ne cative ctions tal ative e

A 117 Continued From page 2

This STANDARD is not met as evidenced by: Surveyor: 36164

Based on medical record review, interview, and policy review the facility failed to ensure 7 or 9 patients (#18, #27, #28, #34, #35, #38, and #39) received the Important Message from Medicare (IMM)

Findings include:

During medical record review on 11/19/12 at approximately 1400 it was revealed that patient #18's medical record failed to have the required IMM. During an interview with staff EE on 11/19/12 at approximately 1415 it was confirmed that the IMM was not in the medical record. Staff EE stated "I looked and it's not in there." During medical record review on 11/21/12 between the hours of 1000 – 1115 it was revealed that the medical record for patients #34, #35, #38, and #39 failed to have the required IMM. During an interview with staff FF on 11/21/12 at approximately 1100 it was confirmed that the IMM was not available for these patients. Staff FF stated "I can't find it."

Surveyor: 30988

During medical record review of patient #27 and #28 on 11/19/2012 at approximately 1330 (1:30 PM), it was revealed that the IMM had not been given to, or signed by the patient or his/her representative. Patient #27 had been admitted on 11/17/2012 and had signed consent for treatment, however, did not have signed IMM. Patient #28 was admitted on 11/05/12 and had signed consent for treatment, however, did not have signed IMM.

Review of the "Management Operating Directive-4 SGH MOD 001 001" revealed #3. If the patient or his/her representative refuses to sign the first IMM, the admitting staff member will notate "refused to sign" and add their name and date to the bottom of the form....#4. Patients who are unable to sign due to sedation, pain, mental status, or acuity, the admitting staff should contact the patient rep and the IMM should be read to the representative. The admitting staff should document who they spoke with including name and phone number even if the pt rep refused to listen to the IMM. Documentation that the attempt was made is important.

These findings were confirmed during interviews with staff FF at approximately 1330 (1:30 PM) on 11/19/12 and with staff S on 11/20/12 at approximately 0830 (8:30 AM).

To comply with Medicare regulations effective July 2, 2007, which require that the Important Message from Medicare (IMM) is provided to Medicare patients within the first 2 days of their admission and a follow-up copy of the IMM is provided within 2 days of the patient's discharge; to ensure that each Medicare patient is informed of the right to appeal his/her discharge; and to allow ample time for the patient's discharge appeal to be processed, the Hospital has implemented the following measures:

A 117

- Unit Clinical Social Workers and Case Managers review patient charts to verify if an initial IMM is present within 2 days after admission; if not, the Admitting Department is alerted and patient/family/representative is notified of their rights at that time.
- 2. Unit Clinical Social Workers and Case Managers discuss possible/confirmed discharges in the daily multidisciplinary rounds. Within 2 days prior to discharge Unit Clinical Social Workers or Case Managers present the IMM to Medicare patients (or family/representative, as appropriate) scheduled for discharge the second IMM.
- 3. Unit Clinical Social Workers and Case Managers will be alerted via pager from the Teletracking system that a discharge order has been entered and the patient is to be discharged; at which time the second ("follow-up") IMM will be provided to the patient/family /representative prior to actual discharge by the Unit Clinical Social Worker or Case Manager.
- On Fridays, for Medicare patients identified for weekend discharge, the Unit Clinical Social Workers or Case Managers reminds the patient of their Medicare rights by providing the follow-up IMM and having them resign the IMM.
- Competencies regarding the IMM and the patients' rights have been reviewed with all Unit Clinical Social Workers and Case Managers and will be reviewed annually hereafter.

Intensive education provided to the Clinical Resource Management department employees on 12/19/2012 regarding the new process and the implementation of daily chart reviews, which were initiated 12/20/2012.

Monitoring

The Hospital continues to track the compliance by completing a monthly audit of 20 cases to ensure patients/family/caregivers are informed of the care plan and post discharge placement.

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A 117	Continued from page 3	A 117	Lead Clinical Social Worker or Lead Case Manager audits patient charts daily to determine if a signed copy of the IMM is located in the patients chart and shares department compliance with staff.	
			The Lead Clinical Social Worker or Lead Case Manager is to be notified by unit Clinical Social Workers and Case Manager of all daily Medicare patients that have signed IMM and have been notified of their discharge rights; this is to be compared to the daily Medicare discharge list to ensure 100% compliance. The number of audits is based on the number of Medicare patients discharged daily. Responsible Person(s) Vice President, Medical Affairs ("VPMA")	12/20/12
A 144	482.13(c)(2) PATIENT RIGHTS: CARE IN SAFE SETTING The patient has the right to receive care in a safe setting. This STANDARD is not met as evidenced by: Surveyor: 29774 Based on observation, interview and document review, it was revealed that the facility failed to take steps to ensure patient safety in 1 out of 10 patient's hemodialysis stations observed. Findings include: On 11/19/12 at approximately 1100 during facility tour on 4-East, revealed in the in-patient hemodialysis unit, the patient at station #10 was dialyzing; lying in bed, covered from head to toe with a blanket, including the access site. Interview with Staff O, the unit's nursing manager on 11/19/12 at 1100 confirmed that the patient was covered from head to toe and said "he shouldn't be covered like that". On 11/19/12 at approximately 1530, during review of facility policy title "Hemodialysis – Initiation" dated 4/1/12 revealed "15. Keep lines and access visible to nursing staff".	A 144	To ensure the patient is receiving care in a safe setting, the Hospital has taken the following actions: 1. The issue was immediately corrected on 11/19/2012 by uncovering the access site of patient at Station #10. 2. Re-education of 4E staff on policy 2 PC 5105 Hemodialysis initiation, with emphasis on keeping lines and access site visible. Reeducation conducted by nurse educators, nurse specialists, and unit managers on 12-20-12. 3. Established a new process for the use of a Drape sheet around the dialysis access site in a manner that ensures lines are accessible and visible. Instituted 12/20/12. Monitoring Audits began on 12/20/12 and are conducted on a weekly basis with a goal of 100% compliance Responsible Person(s) Vice President, Patient Care	11/19/12 12/20/12 12/20/12
A 168	482.13(e)(5) PATIENT RIGHTS: RESTRAINT OR SECLUSION The use of restraint or seclusion must be in accordance with the order of a physician or other licensed independent practitioner who is responsible for the care of the patient as specified under §482.12(c) and authorized to order restraint or seclusion by hospital policy in accordance with State law.	A 168	To ensure the use of restraint and/or seclusion are in accordance with the order of a physician or other LIP on behalf of the physician, provided such is within the scope of the LIP's practice, who is responsible for the care of the patient and authorized to order restraint and/or seclusion by hospital policy in accordance with State law, the Hospital has taken the following actions:	Completed 12/19/12

Continued from page 4

This STANDARD is not met as evidenced by: Surveyor: 30988

On 11/19/12 at approximately 1330 (1:30 PM) during medical record review of patient #27 it was discovered that restraint orders were written on 11/16/12 at 18:17 (6:17 PM) by a medical resident and discontinued on 11/16/12 at 07:39 (7:39 AM) by a different medical resident. The orders have not been counter signed by the attending physician.

On 11/19/12 at approximately 1345 (1:45 PM) during medical record review of patient #28 it was discovered that restraint orders were written on 11/09/12 at 21:48 (9:48 PM) by a medical resident and discontinued on 11/12/12 at 21:41 (9:41 PM) by a PA-C, restraints were ordered again on 11/19/12 at 17:15 (5:15 PM) by the PA-C and then discontinued. The orders have not been counter signed by the attending physician. Surveyor: 29955

Based on medical record review, interview, and policy review the facility failed to ensure restraint orders were ordered or authenticated by the attending physician for six out of eight patients (#2,#3,#4,#27,and #28) resulting in the restraint of a patient without an order.

On 11/19/2012 at approximately 11:00 am during the medical record review of patient #2 it was revealed the patient #2 was in bilateral soft restraints for medical necessity were ordered by the medical resident on 11/10/2012 at 10:06 am and the order was rejected by the attending physician on 11/17/2012 at 06:26 am. The rejected order stated "wrong clinician". Staff #G was asked why the physician did not authenticate the orders and he stated "it was a misunderstanding between the intensivist and attending physician who would authenticate the order".

On 11/19/2012 at approximately 11:20 am during the medical record review of patient #3 it was revealed the patient #3 was in bilateral soft restraints for medical necessity were ordered by the medical resident on 11/5/2012 at 10:08 am and the order was rejected by the attending physician on 11/16/2012 at 04:42 am. The rejected order stated "wrong clinician". Staff #G was asked why the physician did not authenticate the orders and he stated "it was a misunderstanding between the intensivist and attending physician who would authenticate the order".

On 11/19/12 at approximately 11:35 am during the medical record review of patient #4 it was revealed the patient #2 was in bilateral soft restraints for medical necessity were ordered by the medical resident on 11/15/2012 at 12:33 pm and the order was rejected by the attending physician on 11/17/2012 at 14:21pm. The rejected ordered stated "wrong clinician". Staff

A 168

On 12/21/2012, SGH drafted and implemented guidelines and protocols for use of medical restraints and/or seclusion across all inpatient units at the Hospital, including ICU and specialty care units, to provide more definition on the notification of attending physicians of restraint and/or seclusion orders entered by a medical resident or other licensed independent practitioner and to clarify the authentication/countersignature procedures. These changes included:

- 1. The Initiate Restraint Protocol Order has been discontinued in the EMR as of 12/21/2012, and this electronic order has been de-activated in the EMR, which eliminates the order going to the inbox of a physician that did not order the restraints thereby eliminating the possibility of a "refusal to sign" the restraint order.
- 2. An EMR enhancement was also developed and is in the testing phase to capture the notification of the attending physician that the patient is in restraints for immediate physical safety.
- 3. An EMR report draft has been developed to alert the VPMA/VP of Quality & Safety on a daily basis (i) of all orders entered by an RN or licensed independent practitioner (LIP), (ii) that an order was sent to Message Center /Inbox of the attending physician, and (iii) the order was signed by the attending physician. VPMA/VP Quality & Safety will follow up with all physicians with unsigned orders to ensure orders are signed on time.

4. All orders are entered as initiate

- restraint orders by a physician or on behalf of a physician. When orders are entered by a medical resident or by a licensed independent practitioner (LIP) on behalf of a physician, the orders are now directed to the primary treating physician, who is defined as the "Attending Physician" for purposes of the protocol, for authentication/countersignature as appropriate. The medical resident or LIP ordering the restraints must notify the attending physician as soon as possible (and in every case within 1 hour) of the initial or renewal order for a patient requiring medical restraints for immediate physical safety. This notification shall be documented in the patient's medical record. These revised procedures were implemented as of 12/21/2012.
- During each shift or more often as appropriate, the nursing teams review a list of patients in restraints, and their current orders. The Nursing team communicates with the Floor Assigned

Continued from page 5

#G was asked why the physician did not authenticate the orders and he stated it was a misunderstanding between the intensivist and attending physician who would authenticate the order".

On 11/19/12 at approximately 11:35 am during the medical record review of patient #4 it was revealed the patient #2 was in bilateral soft restraints for medical necessity were ordered by the medical resident on 11/15/2012 at 12:33 pm and the order was rejected by the attending physician on 11/17/2012 at 14:21pm. The rejected ordered stated "wrong clinician". Staff #G was asked why the physician did not authenticate the orders and he stated it was a misunderstanding between the intensivist and attending physician who would authenticate the order".

According to Policy No. 1 CLN 008 "restraint us in the non-psychiatric, medical/surgical healthcare setting" (p. 12) "the physician must be contacted prior to the application of restraints, face to face assessment by physician required, order good for a maximum of one calendar day". The attending physician refused to sign the restraint order and did not evaluate the order per the facility's policy and rejected the order subsequently days later.

A 170

482.13(e)(7) PATIENT RIGHTS: RESTRAINT OR SECLUSION

The attending physician must be consulted as soon as possible if the attending physician did not order the restraint or seclusion.

This STANDARD is not met as evidenced by: Surveyor: 30988

Based on record review, interview, and policy review the facility failed to ensure that the attending physician who is responsible for the management and care of the patient was notified as soon as possible when the attending physician did not write the restraint order in 6 of 8 medical records of patients in restraints reviewed (#2, #3, #4, #27,). This has the potential to impact the care and safety of all patients in restraints. Findings include:

A 168

LIP a list of patients in restraints for review and assessments as to whether restraints should be continued.

- 6. The LIP team ensures that the Primary Treating Physician is aware of the present assessment of patient condition and discusses the need for a "continue" or "discontinue" restraint order and obtains order to continue or discontinue.
- 7. Orders entered by a LIP on behalf of the Primary Physician are countersigned by Primary Physician according to organizational policy on verbal/ telephone orders. VPMA or VP, Quality & Safety ensures that orders are placed in EMR and all countersignatures are completed on time.

Education: VPMA and/or VP, Quality & Safety shall provide education to all LIPs, RNs, and medical residents regarding the revised restraint protocols (i) initially, no later than January 31, 2013, (ii) prior to employ's first day of employment with Hospital, and (iii) on an annual basis thereafter.

Monitoring

Senior administration and informational technology staff developed a restraint audit tool for daily monitoring of restraint compliance to be conducted by VP Quality & Safety. Daily restraint monitoring was implemented on 12/19/12.

Responsible Person(s) Vice President, Medical Affairs

A 170

To ensure the attending physician is consulted as soon as possible if he/she did not order the restraint or seclusion, the Hospital revised its process to require RN, LIP, or other ordering physician to notify attending physician as soon as possible, and in all cases, within 1 hour, of initial or renewal order for patient requiring medical restraints (non-violent; non-self destructive) for immediate physical safety. This notification and consultation is documented in the medical record. Implemented 12/21/12.

 The nurse reassesses the patient according to policy and confers with the LIP team regarding the need for an order continuing or discontinuing the restraints. The LIP team ensures that the Attending Physician is aware of the present assessment of patient condition, the initiation of restraints and/or seclusion, and discusses the need for a "continued" or "discontinue" restraint order and obtains order 12/21/12

Continued from page 6

On 11/19/12 at approximately 1330 (1:30 PM) during medical record review of patient #27 it was discovered that restraint orders were written on 11/16/12 at 18:17 (6:17 PM) by a medical resident and discontinued on 11/18/12 at 07:38 (7:39 AM) by a different medical resident. The orders have not been counter signed by the attending physician and there is no documentation of the attending physician being notified.

On 11/19/12 at approximately 1345 (1:45 PM) during medical record review of patient #28 it was discovered that restraint orders were written on 11/09/12 at 21:48 (9:48 PM) by a medical resident and discontinued on 11/12/12 at 21:41 (09:41 PM) by a PA-C, restraints were ordered again on 11/19/12 at 17:15 (5:15 PM) by the PA-C and then discontinued. The orders have not been counter signed by the attending physician and there is no documentation of the attending physician being notified.

Review of policy# 1 CLN 008 titled "Restraint Use in the Non-Psychiatric, Medical/Surgical Healthcare Setting" states under Orders...#2 The ordering physician must consult the attending physician as son as possible (within 1 hour) of application if the attending physician did not order the restraint.

Interview of staff FF on 11/21/12 at approximately

Surveyor: 29955

On 11/19/2012 at approximately 11:00 am during the medical record review of patient #2 it was revealed the patient #2 was in bilateral soft restraints for medical necessity were ordered on 11/10/2012 at 10:06 am and the order was rejected by the attending physician on 11/17/2012 at 06:26 am. The rejected ordered stated "wrong clinician". Staff #G was asked why the physician did not authenticate the orders and he stated "it was a misunderstanding between the intensivist and attending physician who would authenticate the order". The attending physician was not notified within one hour according to the facility's policy.

On 11/19/2012 at approximately 11:20 am during the medical record review of patient #3 it was revealed that the patient #3 was in bilateral soft restraints for medical necessity were ordered by the medical resident on 11/5/2012 at 10:08 am and the order was rejected by the attending physician on 11/16/2012 at 04:42 am. The rejected ordered stated "wrong clinician". Staff #G was asked why the physician did not authenticate the orders and he stated "it was a misunderstanding between the intensivist and attending physician who would authenticate the order". The attending physician was not notified within one hour according to the facility's policy

A 170

to continue or discontinue.

- The LP team ensures that orders continuing or discontinuing restraints and/or seclusion are entered in EMR on behalf of the Attending Physician for his authentication/countersignature.
- Education has been provided to nursing unit staff and LIPs.
 Education of the Medical Staff and Medical Residents is ongoing.

Monitoring

VP, Quality & Safety will conduct 100% concurrent review of daily report against the medical record to ensure compliance.

Responsible Person(s)
Vice President, Patient Care
Vice President, Medical Affairs

A 170 Continued from page 7

On 11/19/2012 at approximately 11:35 am during the medical record review of patient #4 it was revealed the patient #2 was in bilateral soft restraints for medical necessity were ordered by the medical resident on 11/15/2012 at 12:33 pm and the order was rejected by the attending physician on 11/17/2012 at 14:21pm. The rejected ordered stated "wrong clinician". Staff #G was asked why the physician did not authenticate the orders and he stated it was a misunderstanding between the intensivist and attending physician who would authenticate the order". The attending physician was not notified within one hour according to the facility's policy.

A 171 482.13(e)(8) PATIENT RIGHTS: RESTRAINT OR SECLUSION

Unless superseded by State law that is more restrictive--

- (i) Each order for restraint or seclusion used for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, a staff member, or others may only be renewed in accordance with the following limits for up to a total of 24 hours: (A) 4 hours for adults 18 years of age or older;
- (B) 2 hours for children and adolescents 9 to 17 years of age; or
- (C) 1-hour for children under 9 years of age;

This STANDARD is not met as evidenced by: Surveyor: 29955

On 11/19/2012 at approximately 11:00 am during the medical record review of patient #2 it was revealed the patient #2 was in bilateral soft restraints for medical necessity were ordered by the medical resident on 11/10/2012 at 10:06 am

A 170

A 171

To the best of Hospital's knowledge, none of the patient records reviewed involved the use of restraints in the management of violent or selfdestructive behavior. To the extent the survey is addressing the use of restraint or seclusion for the management of such patients, the Hospital requires that each order for restraint or seclusion used for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, a staff member, or others may only be renewed in accordance with the following limits for up to a total of 24 hours: A) 4 hours for adults 18 years of age or older; (b) 2 hours for children and adolescents 9 t0 17 years of age; or (C) 1 hour for children under 9 years of age.

For purpose of medical restraints (for non-violent, non-self-destructive patients), the Hospital has implemented the following measures:

- The RN, LIP, or other ordering physician notifies attending physician as soon as possible, and in every case within 1 hour, of initial or renewal order for patient requiring medical restraints (nonviolent; non-self-destructive) for immediate physical safety. This notification is documented in the medical record.
- The Initiate Restraint Protocol
 Order has been discontinued in the
 EMR as of 12/21/2012, and this
 electronic order has been deactivated in the EMR, which
 eliminates the order going to the
 inbox of a physician that did not
 order the restraints thereby
 eliminating the possibility of a
 "refusal to sign" the restraint order.
- An EMR enhancement was also developed and is in the testing phase to capture the notification of the attending physician that the patient is in restraints for immediate physical safety.

Completed 12/21/12

		T	
A 171	Continued from page 8	A 171	4. An EMR report draft has been developed to alert the VPMA/VP of Quality & Safety on a daily basis (i) of all orders entered by an RN or licensed independent practitioner (LIP), (ii) that an order was sent to Message Center /Inbox of the attending physician, and (iii) the order was signed by the attending physician. VPMA/VP Quality & Safety will follow up with all physicians with unsigned orders to ensure orders are signed on time.
			5. All orders are entered as initiate restraint orders by a physician or on behalf of a physician. When orders are entered by a medical resident or by a licensed independent practitioner (LIP) on behalf of a physician, the orders are now directed to the primary treating physician, who is defined as the
			"Attending Physician" for purposes of the protocol, for authentication/countersignature as appropriate. The medical resident or LIP ordering the restraints must notify the attending physician as soon as possible (and in every case within 1 hour) of the initial or renewal order for a patient requiring medical restraints for immediate physical safety. This notification shall be documented in the
			patient's medical record. These revised procedures were implemented as of 12/21/2012.
			6. During each shift or more often as appropriate, the nursing teams review a list of patients in restraints, and their current orders. The Nursing team communicates with the Floor Assigned LIP a list of patients in restraints for review and assessments as to whether restraints should be continued.
			7. The LIP team ensures that the Primary Treating Physician is aware of the present assessment of patient condition and discusses the need for a "continue" or "discontinue" restraint order and obtains order to continue or discontinue.
			8. Orders entered by a LIP on behalf of the Primary Physician are countersigned by Primary Physician according to organizational policy on verbal/ telephone orders.
			9. VPMA or VP, Quality & Safety ensures that orders are placed in EMR and all countersignatures are completed on time.

Continued From page 9

And the order was rejected by the attending physician on 11/17/2012 at 06:26 am. The rejected ordered stated "wrong clinician". Staff #G was asked why the physician did not authenticate the orders and he stated it was a misunderstanding between the intensivist and attending physician who would authenticate the order". No renewal of orders occurred for the use of restraints from 11/10/2012 to 11/20/2012.

On 11/19/2012 at approximately 11:20 am during the medical record review of patient #3 it was revealed that the patient #3 was in bilateral soft restraints for medical necessity were ordered by the medical resident on 11/5/2012 at 10:08 am and the order was rejected by the attending physician on 11/16/2012 at 04:42 am. The rejected ordered stated "wrong clinician". Staff #G was asked why the physician did not authenticate the orders and he stated "it was a misunderstanding between the intensivist and attending physician who would authenticate the order". No renewal of orders occurred for the use of restraints from 11/15/2012 to 11/20/2012.

On 11/19/2012 at approximately 11:35 am during the medical record review of patient #4 it was revealed the patient #2 was in bilateral soft restraints for medical necessity were ordered by the medical resident on 11/15/2012 at 12:33 pm and the order was rejected by the attending physician on 11/17/2012 at 14:21pm. The rejected ordered stated "wrong clinician". Staff #G was asked why the physician did not authenticate the orders and he stated it was a misunderstanding between the intensivist and attending physician who would authenticate the order". No renewal of orders occurred for the use of restraints from 11/15/2012 to 11/20/2012.

Surveyor: 30988

Based on medical record review, interview, and policy review the facility failed to renew restraint orders no less than once every calendar day based on face to face assessment of the patient in 6 of 8 restrained patients records reviewed (#2, #3, #4, #27, and #28). Resulting in the potential for patients to be restrained longer than necessary and without a physician order.

Findings include:

On 11/19/12 at approximately 1330 (1:30 PM) during medical record review of patient #27 it was discovered that restraint orders were written on 11/16/12 at 18:17 (6:17 PM) by a medical resident and discontinued on 11/18/12 at 07:38 (7:39 AM) by a different medical resident.

A 171

Monitoring

Vice President, Quality & Safety is conducting 100% concurrent review of all patients in medical restraints.

Responsible Person(s)

Vice President, Patient Care Vice President, Medical Affairs

A 171 | Continued from page 10

The orders have not been counter signed by the attending physician and there is no documentation of the attending physician being notified. There are no orders to renew the restraints for 11/17/12, 11/18/12 and 11/19/12.

On 11/19/12 at approximately 1345 (1:45 PM) during medical record review of patient #28 it was discovered that restraint orders were written on 11/09/12 at 21:48 (9:48 PM) by a medical resident and discontinued on 11/12/12 at 21:41 (9:41 PM) by a PA-C, restraints were ordered again on 11/19/12 at 17:15 (5:15 PM) by the PA-C and then discontinued. The orders have not been counter signed by the attending physician and there is no documentation of the attending physician being notified. There are no orders to renew the restraints for 11/10/12, 11/11/12, and 11/12/12.

Review of policy# 1 CLN 008 titled "Restraints Use in the Non-Psychiatric, Medical/Surgical Healthcare Setting" states under Orders...#5 A restraint order is good for a maximum of one calendar day....B Continued use of restraint beyond the first day requires an order by the physician no less than nonce every calendar day based on face to face assessment of the patient.

Interview of staff FF on 11/21/12 at approximately 1000 (10:00 AM) confirmed there are no further restraint orders.

A 175 482.13(e)(10) PATIENT RIGHTS: RESTRAINT OR SECLUSION

The condition of the patient who is restrained or secluded must be monitored by a physician, other licensed independent practitioner or trained staff that have completed the training criteria specified in paragraph (f) of this section at an interval determined by hospital policy.

This STANDARD is not met as evidenced by: Surveyor 30988

Based on medical record review, interview, and policy review the facility failed to monitor restrained patients in 7 of 8 restrained patients records reviewed (#2, #3, #4, #5, #27, and #28). Resulting in the potential for physical harm to the patients. Findings include:

During medical record review on 11/19/12 at approximately 1330, it was revealed on the Electronic medical record (EMR) a shift

A175

A 171

To ensure that the condition of the patient who is restrained or secluded is monitored by a physician, other LIP, or trained staff the Hospital, SGH has taken the following measures:

- Educators and Unit Managers of the Non-Psychiatric, Medical/Surgical Units, including the ICUs, provided re-education to the RN staff on the requirement to complete the "Restraint Q2hr (every 2 hours) Check task" in the EMR, on every patient with an active Restraint order. Completed 12-21-12
- On a daily basis, Unit Managers or designee of the Non Psychiatric, Medical/Surgical Units, including the ICUs, monitor the "Restraint Q2hr (every 2 hours) Check task" in the EMR on every restraint patient. Implemented 12/21/12

Completed 12/21/12

PRINTED: 12/18/2012 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1)PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPI A. BUILDING	(X3) DATE SURVEY COMPLETED			
		230024	B. WING_		11/21/2012	
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 6071 W OUTER DRIVE DETROIT, MI 48235			
(X4) ID PREFIX TAG	(EACH DEFICIENCY N	EMENT OF DEFICIENCIES IUST BE PROCEEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
A 175	Continued From page 11 Assessment is completed and restraint is a yes or no question there is no documentation of patient care during restraint. Review of policy# 1 CLN 008 titled "Restraint Use in the Non-Psychiatric, Medical/Surgical Healthcare Setting" states under "Patient care during restraint#2 when restraint is in place, the patient is assessed, monitored and re-evaluated based on the patients care needs, at a minimum of every two (2) hours.		A 175	Monitoring Implemented 'Oversight' audit (12/19/12) by nursing quality staff Non Psychiatric, Medical/Surgical including the ICUs - to monitor the "Restraint Q2hr (every 2 hours) Cl task" in the EMR, on all patients v an active Restraint order. Schedu the oversight audit: daily x (1) mor weekly x (1) month; 2 times/month monthly ongoing. Target = 100% compliance. The result of the 'Oversight audit'	Units, eneck vith ele of hth;	
	#3 monitoring include A the proper applicati B. Skin integrity and of C Need to provide ac	s and determines:		reported to the VP of Patient Care Services, Unit Managers, and Unit (daily) and subsequently to Profes Nurse Council and site's High Reli Organization Committee(monthly) Implemented 12/19/12	t Staff sional ability	
1.0	E Patients behavior/a F Physical comfort/sa G Whether less restri- possible #4. Nutrition/Hydratio	fety		Non-compliance by staff is addres by Unit Managers in accordance to Policy on Progressive disciplinary actions. Reference: 1 HR 506 progressive discipline. Implement 12/21/12.	he HR	
	approximately 0900 (schecks and write on to not have an every 2 han interview with FF capproximately 1330 (scheduling)	1:00 PM) it was confirmed ation of reassessment every		Responsible Person(s) Vice President, Patient Care Vice President, Medical Affairs		
A 396		G CARE PLAN sure that the nursing staff current, a nursing care plan	A 396	To ensure that nursing staff develors and keeps current a nursing care for each patient, the Hospital has the following actions:	plan	
	for each patient. This STANDARD is n	o met as evidenced by:		Educators and Unit Manage all patient care Units re-education nursing staff regarding initial review and updating the path Plan of Care. Completed 12 12. A Tier 3 SGH policy on Plan.	cated tion, ient's -21-	
				Care developed and implem to guide the updating of the patient's Plan of Care – to ir 'admitting' nurse and 'subse nurses' responsibilities.	nclude	

Initiated development of an EMR A 396 Continued from page 12 A 396 enhancement for the addition of two fields - "Last reviewed" and "Last updated" that includes date and time (12/21/12). Monitoring Unit Managers monitor staff's compliance with updating plan of care. Target = 100% compliance. Surveyor: 29313 Non-compliance by staff is addressed Based on medical record review and interview the by Unit Managers in accordance with facility failed to ensure that nursing staff keeps a the HR Policy on Progressive disciplinary actions. Reference: 1 HR current care plan for each patient in 1 out of 2 506 -- progressive discipline. (#40) medical records reviewed. Implemented 'Oversight' audit Findings include: (12/20/12) by nursing quality Schedule During medical record review on 11/19/12 at of the oversight audit: daily x (1) month; approximately 1430 I was found that patient #40 weekly x (1) month; 2 times/month; had not had an updated plan of care since monthly ongoing. Target = 100% 11/12/12. During this time frame the patient had a compliance. change in his mental health status and no update to the plan of care was completed. Responsible Person(s) Vice President, Patient Care During the medical record review on 11/19/12 at Vice President, Medical Affairs approximately 1430 staff EE was the person explaining the chart content to this surveyor and confirmed the lack of an updated plan of care for this patient. A 469 A 469 482.24(c)(2)(viii) CONTENT OF RECORD -To ensure that medical record DISCHARGE DIAGNOSIS documents within 30 days following 12/21/12 discharge the Hospital has implemented [All records must document the following, as the following measures: appropriate:] Reminder to the Medical Staff regarding the Medical Staff By-Final diagnosis with completion of medical laws' guidelines for addressing records within 30 das following discharge Delinquent Medical Records are clearly communicated, and This STANDARD is not met as evidenced by: consistently and strictly enforced Surveyor: 29955 on a daily basis, such that any Based on document review and interview the physician with delinquent charts facility failed to ensure 100 medical records were greater than 25 days begins the suspension process. After the completed within 30 days. CMS-allowed 30 days, the physician is suspended: this On 11/19/2012 at approximately 3:00 pm during includes no boarding of surgical a meeting with medical records administration it cases, no admissions, and no other was revealed 100 records were not completed clinical activities until such time that within 30 days. Seventy four records were within the medical records are in full the 30 to 59 day range, 15 records within 60 to compliance. 89 days, 4 records within 90 to 119 days, 3 Creation of a SGH/Tier 3 Policy: records within 120 to 149 days, 1 record within Notification Process for Medical 150 to 179 days, 3 records within 200 plus days. Record Completion to support daily When asked if the physicians had been made enforcement of delinquent medical aware of the records were not completed it was records, effective 12/21/2012. stated "yes. Physicians are notified in writing and by fax that they have delinquent records. In cases where delays longer than Their offices are also notified. The department 45 days occur, despite suspension, heads are notified. We have done everything to the Specialist in Chief, Department

Chief, or the VPMA work together

"Administrative Physicians" and the case is to be closed according to new SGH/Tier 3 Policy: Notification Process for Medical Record Completion. Such will result in additional medical staff action

to complete the records as

try to get physicians to complete records, yet

some still do not fall in compliance".

A 469	Continued from page 13	A 469	pursuant to the Medical Staff Bylaws.	12/21/12
			Monitoring Monthly audits of 100 % of medical records by practitioner .	
			Responsible Person(s) Vice President, Medical Affairs	
A 700	482.41 PHYSICAL ENVIRONMENT	A 700	To ensure that the Hospital provides and maintains a safe environment for patients and staff, the Hospital has	
	The hospital must be constructed, arranged, and maintained to ensure the safety of the patient, and to provide facilities for diagnosis and treatment and for special hospital services appropriate to the needs of the community.		taken a number of immediate actions, as well as, other permanent actions, as more fully described in the Plan of Correction for the K Tags cited in CMS form 2567, dated November 20, 2012. The Plan of Correction for same is	eri Li
	This CONDITION is not met as evidenced by: Surveyor: 22182 The facility failed to provide and maintain a safe environment for patients and staff.		included herewith.	
	This is evidenced by the Life Safety Code deficiencies identified. See A-709			
A 701	482.14(a) MAINTENANCE OF PHYSICAL PLANT	A 701	Effective 12/17, 2012, the Hospital has prohibited patients waiting unattended on stretchers in the corridor near the	12/17/12
	The condition of the physical plant and the overall hospital environment must be developed and maintained in such a manner that the safety and well-being of patients are assured.		Nuclear Medicine Suite. All patients awaiting Nuclear Medicine studies will be held in the patient holding room in Nuclear Medicine and monitored as appropriate. This policy change has	
**	This STANDARD is not met as evidenced by: Surveyor: 22182		been communicated to appropriate staff members.	
	Based on interview and observation, the facility failed to provide an environment that ensures the safety and well being of patients. Findings include:		Monitoring Quality & Safety staff will conduct visual spot-checks of the patient holding area and the referenced corridor and report to the VP, Quality & Safety.	
	During the facility tour on the morning of November 19, 2012, three patients on stretchers were observed unattended in the corridor of the Nuclear Med Suite. Interview with the Nuclear Med Manager during the facility tour revealed that the patients either were waiting transport or waiting to enter a Nuclear Med Room. It was also stated during the interview that on average a		Responsible Person(s) Vice President, Quality & Safety	
	patient is waiting unattended in the corridor for about 20 or 30 minutes. During this time, the patient has no device to call for staff during an emergency unless they are physically able to yell loud enough that staff can hear the staff which is usually in a room off of the corridor.			
	During the facility tour on the morning of November 19, 2012, dead flies/insects were observed in the light fixtures throughout the radiology department located on the 6 th floor of the facility.		WO# 212277 Removed flies from light fixture and cleaned. Light fixture cleaning has been added to the routine cleaning checklist.	11/21/12
	During the facility tour on the morning of November 20, 2012, the floor in the Decon room in Central Sterile looked stained/soiled. Interview		WO# 213286 To be painted by Accurate Painting. Quote accepted. PO#2012 0201 620 579 SGS	Completed 12/23/12

A 701	Continued from page 14 with the Central Sterile Manager revealed that the floor is cleaned each night but some stains cannot be removed which makes the floor look dirty even after cleaning.	A 701		
A 709	482.41(b) LIFE SAFETY FROM FIRE	A 709	To ensure that the Hospital complies with the applicable	
	Life Safety from Fire		provisions of the 2000 Edition of the Life Safety Code, the Hospital has taken a number of immediate	
	This STANDARD is not met as evidenced by: Surveyor: 22182 Based upon on-site observation and document review by Life Safety Code (LSC) surveyors, the facility does not comply with the applicable provisions of the 2000 Edition of the Life Safety Code.		actions, as well as, other permanent actions, as more fully described in the Plan of Correction for the K Tags cited in CMS form 2567, dated November 20, 2012. The Plan of Correction for same is included herewith.	
	See the K-tags on the CMS-2567 dated November 20, 2012 for Life Safety Code.			
A 726	482.41 (c)(4) VENTILATION, LIGHT, TEMPERATURE CONTROLS	A 726	To provide proper ventilation to the inpatient dialysis unit, the Hospital has taken the following	
	There must be proper ventilation, light, and temperature controls in pharmaceutical, food preparation, and other appropriate areas.		action	
	This STANDARD is not met as evidenced by: Surveyor: 22182 Based on observation and interview, the facility failed to provide proper ventilation to the inpatient dialysis unit. Findings include:			
	During the facility tour on November 20, 2012 it was observed that two portable air conditioning units were within the inpatient dialysis unit. Interview with the Dialysis Manager revealed that these units had been installed a while back and are utilized year round. It was also stated that the unit was originally designed as an infusion unit and converted to dialysis. The existing ventilation was not designed to account for the dialysis machine heat load. The portable air conditioning units were connected to the plumbing under the hand wash sinks and one of the two air conditioning units was blocking access to the hand wash sink.		WO# 213287 Two portable AC units were removed from the Dialysis unit. They are being replaced with a recessed ceiling mounted DX AC system. To be completed by 02-08-13. Current units have been repositioned to not block sink access. PO#2012 0201 621 600 SGS	Estimated Completion 2/08/13
A 749	482.42(a)(1) INFECTION CONTROL OFFICER RESPONSIBILITIES The infection control officer or officers must develop a system for identifying, reporting, investigating, and controlling infections and communicable diseases of patients and	A 749	To ensure that the Hospital maintains a sanitary environment and ensures that staff are using personal protective equipment according to policy to protect again the potential for spread of infectious agents to patients, the Hospital has taken the following immediate actions:	
	personnel. This STANDARD is not met as evidenced by: Surveyor: 29313		miniculate actions.	

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A 749	Continued from page 15 Based on observation, policy and procedure review and interview the facility failed to, maintain a sanitary environment and ensure staff are using personal protective equipment according to policy, resulting in the potential for the spread of infectious agents to patients. Findings include: During the tour of the facility on 11/19/12 between the hours of 1130-1500 the following was observed: 1-West:	A 749	 The Hospital has reviewed and updated its housekeeping schedule for the entire facility, including, without limitation, all patient care areas, and those areas of the Hospital directly impacting patients and patient care. The Hospital has revised its housekeeping checklists for each area of the Hospital to ensure thorough cleaning and, as appropriate, disinfecting. 	12/12/12 01/01/13 01/04/13
	 In room 114-west the sink was dirty with debris The freezer in the nourishment room on 1-west was dirty with debris and had a large amount of ice build up. In room 106-west there was a lack of high dusting throughout the room, including the cabinets and closets. The front of the cabinets 		The Hospital is in the process of providing additional staff education regarding infection control procedures, including, without limitation, the use of gowns, gloves, and/or masks, as appropriate. 1-West	12/19/12
	were soiled and dirty from not being cleaned appropriately. This was all confirmed by staff CC at the time of the tour observations. 2-East		Patient room (114W) sink is cleaned twice daily. The manager of environmental services is in charge of this process. Implemented 12/19/12.	12/20/12
	 In room 107-E the inside the closets were dusty and high surfaces had dust build up. In room 110-E the bath tub and sink were dirty and high surfaces through out the room had dust build up. This was all confirmed by staff DD at the time of the tour observations. 		Dietary staff defrosted and cleaned the freezer on 1 West. Freezer placed on weekly cleaning schedule effective 12/20/12. Regular dusting and cleaning cabinet fronts (106W) are done once daily and high dusting is done weekly. The manager of	12/19/12
	 5-South The dietary room was unsanitary, it had debris on the counters, cabinets had dried material on it, Fingerprints could be seen. 		environmental services is in charge of this process. Implemented 12/19/12.	12/19/12
	 The seclusion rooms bathroom was unsanitary, it's toilet, shower and sink appeared to not have been cleaned after the last patient that occupied the room. The medication room had patient equipment and care items on the counter next to the sink with the risk of contamination by the splashing/dripping of water. The pill crusher had left over residue from the previous medication that was crushed on it. 		2-East 1. Regular dusting and cleaning cabinet fronts (107E) are done once daily and high dusting is done weekly. The manager of environmental services is in charge of this process. Implemented 12/19/12. 2. Patient room (110E) sink and tub are cleaned twice daily. The manager of environmental services	12/19/12
	This was all confirmed by staff EE at the time of the tour observations. During the tour of the facility on 11/20/12 between the hours of 1000-1200 the following was observed:		is in charge of this process. Implemented 12/19/12. 5-South 1. Dietary room cleaned, counters, cabinets and finger prints. Placed on daily cleaning schedule. Effective	12/20/12
			 12/20/12. As of 12/19/12, Seclusion rooms including toilet, shower, and sink are cleaned daily and upon discharge of patient. The director of Psychiatric Services is in charge of ensuring that this process occurs. Effective 12/19/12. (a) All patient equipment and care 	12/19/12
			items on the counter next to the sink were removed. Unit Manager is monitoring staff compliance.	12/19/12
			Effective 12/19/12. (b) Pill crusher was cleaned 11/21/12.	11/21/12

9 8 8		0		8 12
A 749	Continued from page 16 Rehabilitation Unit 1. The shower and tub on the rehabilitation unit was unsanitary, they had debris and dirt inside of them 2. The rehabilitation gym had dirty parallel bars and floor runner dirty with debris	A 749	1) Educators and Unit Managers of all patient care Units reeducated nursing staff regarding the cleaning of 'Pill Crusher' – upon every use – to ensure of no residue. Completed 12-21-12. 2) Unit Managers monitoring staff's	12/21/12
	3. The rehabilitation refrigerator was dirt with debris and dried on liquid.4. The rehabilitation kitchen was unsanitary, the cabinets and drawers had a lot of debris and dried		compliance regarding the cleaning of 'Pill Crusher' – upon every use – to ensure of no residue. Target = 100% compliance.	12/21/12
	on liquid that had not been cleaned. Finger prints were visible on the outside of the cabinets. This was all confirmed by staff CC at the time of the tour observations. When staff CC was asked how the unit ensured the equipment was disinfected between patient usage, he replied that the staff cleaned them between patients, but		3) Non-compliance by staff shall be addressed by Unit Managers with the HR Policy on Progressive disciplinary actions. Reference: 1 HR 506 progressive discipline.	12/21/12
	there was no type of check list or terminal cleaning list to ensure that it was being completed, housekeeping wiped down the equipment periodically.		Rehabilitation Unit 1. As of 12/19/12, Rehab unit is cleaned on a daily basis, including the shower, tubs, and floor runner. The director of environmental services is in charge of in- patient and the director of Rehab services is in charge of the out- patient areas.	12/19/12/
			Parallel bars are cleaned in between patient therapy daily by rehab staff. Parallel bars are cleaned weekly by EVS and included in their log. Effective 12/21/12.	12/21/12
			Refrigerator in the Rehab practice kitchen cleaned and maintained by therapy personnel. Cleaning is included on equipment weekly cleaning log. Implemented 12/21/12.	12/21/12
			4. Kitchen is utilized as a training tool and cleaned by rehab staff, special cleaning is also done upon request. Cabinets in the rehab practice kitchen are part of a weekly deep clean by EVS and documented in the EVS log. Effective 12/19/12, Equipment in Rehab gym is cleaned between patients and patient hand hygiene is observed per policy 2 IC 046 – Rehabilitation Services Guidelines for Infection Control and Equipment Cleaning Log was implemented to further document weekly cleaning. Effective 12/21/12.	12/21/12
	Surveyor: 29774 On 11/19/12 at approximately 1130 during observational tour of 4-East in-patient hemodialysis unit, observed Staff R, a hemodialysis nurse, in a private room, labeled Station #1, without gown or gloves. The private room was labeled with a sing "Contact Precautions Gown and gloves required upon room entry". Staff R was asked why she didn't have the required gown and gloves on to which she replied. "I was just taking his vital signs"		4-East Contact Precautions 1. Educators and Unit Managers of all patient care Units re-educated nursing staff regarding the Contact Precaution – Gown and gloves required upon room entry. Completed 12-21-12.	12/21/12

room entry". Staff R was asked why she didn't have the required gown and gloves on to which she replied, "I was just taking his vital signs".
Staff O confirmed on 11/19/12 at 1130, that Staff R "should have worn the personal protective equipment listed on the sign".

2. Unit Managers ongoing monitoring staff's compliance regarding the Contact Precaution – Gown and gloves required upon room entry.

3. Unit Managers ongoing monitoring staff's compliance regarding the Contact Precaution – Gown and gloves required upon room entry.

staff, as well as patient's family/visitors' compliance to the

A 749	Continued from page 17 On 11/19/12 at approximately 1540 a review of facility policy titled "DMC Isolation Policy" dated May 29, 2012 revealed "Contact Precautions Used to prevent transmission of infectious agents which are spread by direct or indirect contact with the patient or the patient's environment Gown and gloves required upon room entry. Discard PPE (personal protective equipment) before exiting room".	A 749	'Isolation Precaution' requirements. Schedule of the audit: Daily x 1 week, Weekly x (1) month; biweekly X (2) months; then monthly ongoing. Target = 100% compliance. 4. Non-compliance by staff shall be addressed by Unit Managers with the HR Policy on Progressive disciplinary actions. Reference: 1 HR 506 progressive discipline.	
	On 11/19/12 at approximately 1150 during observational tour of 4-East in-patient hemodialysis unit revealed one of two blood glucose testing machines with white paper-tape around the base of one of the two machines. Staff Q, the certified nurse educator was asked how the machine is cleaned with residual tape remaining on the unit to which she replied, "they really can't clean it. We are going to be replacing these (blood glucose testing) machines this month."		Glucose testing machine was removed from service and replaced with 2 new machines. Staff were re-educated regarding proper maintenance of glucose testing machine. If machine requires the use of tape, it will not be used and will be returned to the laboratory for repair or replacement. Machines replaced 12/21/12.	12/21/12
	On 11/19/12 at approximately 11:45, during the observational tour of 5-East revealed in the medication area a pill crusher soiled with residual white powder. Staff P, the charge nurse mentioned, "wow, look at that". Staff P was asked on 11/19/12 at 1145 what the cleaning policy was for using these pill crushers to which she replied, they should be cleaned between uses for each		Pill crusher was cleaned 11/21/12. 1. Educators and Unit Managers of all patient care Units re-educated nursing staff regarding the cleaning of 'Pill Crusher' – upon every use – to ensure of no residue. Completed 12-21-12.	11/21/12 12/21/12
	patient".		Unit Managers monitoring staff's compliance regarding the cleaning of 'Pill Crusher' – upon every use – to ensure of no residue. Target = 100% compliance.	12/21/12
			Non-compliance by staff shall be addressed by Unit Managers with the HR Policy on Progressive disciplinary actions. Reference: 1 HR 506 progressive discipline.	12/21/12
			Responsible Person(s) Vice President, Patient Care Unit Managers	
A 800	482.43(a) CRITERIA FOR DISCHARGE EVALUATIONS	A 800	Emergency Room Clinical Social Worker (when applicable – upon consultation or if patient has a health condition that requires a discharge	12/20/12
	The hospital must identify at an early stage of hospitalization all patients who are likely to suffer adverse health consequences upon discharge if there is no adequate discharge planning. This STANDARD is not met as evidenced by: Surveyor: 32164 Based on medical record review, interview, and policy review the facility failed to identify patients at an early stage of hospitalization in need of		plan assessment to be completed within 48 hours of admission per policy) completes an initial assessment for a patient with a full admit order and communicates daily with in-house Social Worker that assessment has been completed 2. The Hospital has revised its SGH MOD CRM 20, 22 and 24 policy to require that Unit Clinical Social	12/20/12
3	discharge planning according to their policy in four of six patients (#35, #36, #37, and #38,). Findings include: During medical record review on 11/21/12		Workers and Case Managers check daily for new patients to their unit, for new consultations or health conditions that would require a discharge plan	

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A 800	Continued from page 18 between the hours of 1000-1115 it was revealed that patient #35 was admitted on 8/14/12 and had a health condition that would require a discharge plan assessment to be completed within 48 hours of admission per hospital policy. The discharge plan was completed on 8/18/12, the day of discharge. During medical record review on 11/21/12 between the hours of 1000-1115 it was revealed that patient #36 was admitted on 6/15/12 and had a health condition that would require a discharge plan assessment to be completed within 48 hoursof admission per hospital policy. The discharge plan was completed on 6/19/12, the day of discharge. During medical record review on 11/21/12 between the hours of 1000-1115 it was revealed that patient #37 was admitted on 8/17/12 and had a health condition that would require a discharge plan assessment to be completed within 48 hours of admission per hospital policy. The discharge plan was completed on 8/20/12 with a discharge date of 8/21/12. During medical record review on 11/21/12 between the hours of 1000-1115 it was revealed that patient #38 was admitted on 8/16/12 and had a health condition that would require a discharge plan assessment to be completed within 48 hours of admission per hospital policy. The medical record did not contain a social work assessment or discharge plan. During the interview with Staff FF on 11/21/12 at approximately 1110 when asked if he could produce any further social work documentation he stated "No."	A 800	assessment within 48 hours of consultation or identification of a health condition that would require a discharge plan. 3. Unit Clinical Social Workers and Case Managers along with the bedside nurse review the patient needs daily in multidisciplinary rounds to discuss identified discharge needs or barriers, document these findings, and update the discharge plan as warranted. 4. Lead Unit Clinical Social Worker or Lead Case Manager audits patient charts daily to determine documentation compliance and shares with staff daily Intensive education provided to the Clinical Resource Management department employees on 12/19/2012 and the new process including daily chart review which was initiated 12/20/2012. Monitoring Lead Unit Clinical Social Worker or Lead Case Manager completes a total of 45 daily chart reviews to ensure assessment/d/c planning documentation with 48 hours of an admission to ensure compliance with new process and department policy. Responsible Person(s) Vice President, Patient Care Vice President, Medical Affairs	12/20/12
A 821	approximately 1110 when asked if he could produce any further social work documentation he stated "No." On 11/21/12 at approximately 1130 a review of the facility's policy title "Initial Social Work Assessment "dated 01/01/10 revealed "It is the policy of the Clinical Resource Management Department of Social Work staff to assess patient's needs for services, plans of discharge, and post acute setting health management services. Patients will be assessed based on the following trigger criteria for their need for services. The Social Work assessment form should be completed either after consultation or within 48 hours of admission. "Triggers include but are not limited to: Chronic disease/Complex needs with risk for readmission and history of falls, abnormal gait or unsteady gait. Each of the above listed patients had one or more triggers documented in their medical records. 482.43(c)(4) REASSESSMENT OF A	A821	Vice President, Patient Care	
W 5-37-25-03	DISCHARGE PLAN The hospital must reassess the patient's			12/20/12
	discharge plan if there are factors that may affect continuing care needs or the appropriateness of the discharge plan. This STANDARD is not met as evidenced by:		The Hospital has initiated the following actions to ensure that the discharge planning process commences with the patient's admission and continues throughout the patient's hospital stay:	
	Surveyor: 29313		Instituted a revised process whereby	

A 821	Continued from page 19 Based on medical record review, policy and procedure review and interview the facility failed to ensure that the discharge plan was being reassessed for the appropriateness of the discharge plan in 1 out of 2 (#40) medical records reviewed. Findings include: During medical record review on 11/19/12 at approximately 1430 it was found that patient #40 had not had an updated discharge plan completed since 11/14/12. During this time frame the patient had a change in his mental health status and no update to the discharge plan of care was completed. During the medical record review on 11/19/12 at approximately 1430 staff EE was the person explaining the chart content to this surveyor and confirmed the lack of an updated discharge plan for this patient. During policy and procedure review of 11/20/12 at approximately 1000 it was found in the policy titled, "Discharge Planning" states, "Discharge planning is initiated on patient presentation to the health care setting and is continuously assessed and updated throughout the hospital stay".	A 821	the Unit Clinical Social Workers and Case Managers along with the bedside nurse review the patient needs daily in multidisciplinary rounds to discuss identified discharge needs or barriers, and revise/update discharge plans and documents the updates. 2. Re-educated the Unit Clinical Social Workers and Case Managers regarding the required communication with the family/patient/representative regarding the updated plan or needs. 3. Intensive education provided to the Clinical Resource Management department employees on 12/19/2012 and the new process including daily chart review which was initiated 12/20/2012. Monitoring Lead Unit Clinical Social Worker or Lead Case Manager completes a total of 45 daily chart reviews to ensure assessment/d/c planning documentation with 48 hours of an admission to ensure we are complaint with our new process and department policy. Responsible Person(s) Vice President, Patient Care Vice President, Quality & Safety	12/20/12

PRINTED: 12/18/2012 FORM APPROVED OMB NO. 0938-0391

AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	.DING	01 - MAIN BUILDING 01	COMPL	
		230024	D. VVIIV	·		11/2	20/2012
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K 000		TS	К 0	00			
K 017	conducted by the Sire Services on N November 20, 201 AM and 5:00 PM. Hospital was found compliance with the in Medicare/	with a basement was If Construction Type II (222) Ited. The facility has a total Ids at the time of the survey. It 42 CFR Subpart 482.41(b) is Ince by: If AFETY CODE STANDARD Trated from use areas by walls Iteleast ½ hour fire resistance Ited buildings, partitions are only Iteleast ½ hour fire resistance Ited buildings, partitions are only Iteleast ½ hour fire resistance Ited buildings, walls properly extend Iteleast ½ hour fire resistance I	КО	17			
BORATORY	walls if the gift short 19.3.6.2.1	o is fully sprinklered.)	ATURE		TITLE		(X6) DAT

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.

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

Event ID:L45X21

Facility ID: 830450

PRINTED: 12/18/2012 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 700		E CONSTRUCTION	(X3) DATE S COMPL	
				LDING	01 - MAIN BUILDING 01	550.50100130	
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K 000	Surveyor. 13546 A Life Safety Code conducted by the Sire Services on November 20, 201 AM and 5:00 PM. Hospital was found compliance with the in Medicare/Medic 482.41(b), Life Safedition of the Natio (NFPA) 101, Life Sexisting Health Care	e Validation Survey was State of Michigan Bureau of Jovember 19, 2012 and 2 between the times of 9:00 At this survey, Sinai Grace d to be not in substantial le requirements for participation aid at 42 CFR Subpart fety from Fire, and the 2000 anal Fire Protection Association Safety Code (LSC), Chapter 19	K	000			
	determined to be of and partially sprink capacity of 383 between the requirement at NOT MET as evite NFPA 101 LIFE SA Corridors are separated to resist the non-sprinkler required to resist the non-sprinklered but above the ceiling, at the underside of permitted by Code waiting areas, dining area	of Construction Type II (222) sted. The facility has a total ds at the time of the survey. It 42 CFR Subpart 482.41(b) is nce by: AFETY CODE STANDARD Trated from use areas by walls t least ½ hour fire resistance ed buildings, partitions are only ne passage of smoke. In ildings, walls properly extend (Corridor walls may terminate ceilings where specifically Charting and clerical stations, ng rooms, and activity spaces corridor under certain d in the Code. Gift shops may corridors by non-fire rated p is fully sprinklered.)	K	017	TITLE		(X6) DATE

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.

CENTE	13 FOR MEDICARE	& MEDICAID SERVICES				OWR NO.	0938-039
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU		PLE CONSTRUCTION G 01 - MAIN BUILDING 01	(X3) DATE SU COMPLE	
		230024	B. WI	NG		11/2	0/2012
	ROVIDER OR SUPPLIER			60	EET ADDRESS, CITY, STATE, ZIP CODE 171 W OUTER DRIVE ETROIT, MI 48235		i A. Till Can Collingua con
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETIO DATE
K 017	Continued From pa	ge 1	K	017			ž.
	Surveyor. 13546 Based on observatifacility failed to provprovide at least 30 accordance with the 19.3.6.2.1. This depotentially affect all Findings include:	on it was determined that the vide corridor walls that could minute fire-resistance rating in a LSC section 19.3.6.1, ficient practice could occupants of the facility.		/	WO# 213245 Sealed holes in the docroom S683B Penetration prevention to be enforced above the ceiling work permit program through monthly Life Safety Assessme penetrations completed by Brooks Fire In addition, Environmental Rounds will monthly. Hospital representative responsible: Di Operations WO# 211592 Sealed multiple penetrativals and ceiling of M615C with HiltiSF Penetration prevention to be enforced a language and the ceiling work permit program, through monthly Life Safety Assessme penetrations completed by Brooks Fire in addition, Environmental Rounds will be progressed to the program of the	through . Correction nt for Stopping. monitor rector Plant	Completed 12/19/2013
	validation inspection 2012 and November		//	i	Operations	rector r lant	
перияли приводення верхня при верхня	door frame to room * Observed multiple	e unsealed wall and ceiling		- 11	NO# 212369 Seal penetration aroundox in ceiling and conduit coming out owall and 2 small holes above door. with energy and the ceiling work permit program. Correct the ceiling work permit program. Correct the ceiling work permit program for percompleted by Brooks Fire Stopping. In Environmental Rounds will monitor mo	around junction out of ceiling down 12/12/2 or. with HiltiSF1 rced through above Correction through for penetrations ng. In addition, or monthly	Completed 12/12/2012
***************************************	* Observed an unsuroom M615. * Observed that the repaired to meet the	ealed ceiling penetration in drywall patch needed to be a rating in the ceiling in closet		✓ V	Hospital representative responsible: Disperations NO# 213196 Patched hole with the a ated drywall sealed and fire stopped as enertation prevention to be enforced the ceiling work permit program. Correct monthly Life Safety Assessment for permit programs and the completed by Brooks Fire Stopping. In a completed by Brooks Fire Stopping.	rector Plant ppropriate s needed.	Completed 12/19/2012
1	W30E. NFPA 101 LIFE SAI	FETY CODE STANDARD	Ko		Environmental Rounds will monitor mor dospital representative responsible: Dir Operations		

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG 01 - MAIN BUILDING 01	(X3) DATE S COMPL	
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K 018	Doors protecting of required enclosure hazardous areas a those constructed wood, or capable of minutes. Doors in required to resist to impediment to are provided with a the door closed. It are permitted.	orridor openings in other than es of vertical openings, exits, or are substantial doors, such as of 1% inch solid-bonded core of resisting fire for at least 20 sprinklered buildings are only the passage of smoke. There is the closing of the doors. Doors a means suitable for keeping butch doors meeting 19.3.6.3.6 9.3.6.3	K 018			
	Surveyor: 13546 Based on observal corridor doors that passage of smoke positive latch in act 19.3.6.3. This defit affect all occupants include: The following violat validation inspectio 2012 and Novembe of 9:00 AM and 5:0	is not met as evidenced by: ion the facility failed to provide would close and resist the and/or able to provide a cordance with the LSC section cient practice could potentially s of the facility. Findings tions were noted during a n conduct on November 19, er 20, 2012 between the hours 0 PM. These findings were rmed by the facility	3	E E		

	to , or medicinic	A MILDIOAID OLIVIOLO				ONID NO.	0900-009
	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION G 01 - MAIN BUILDING 01	(X3) DATE SU COMPLE	
		230024	B. WIN	IG	1111 NA-T-1 R. Surfa (111 NA-T	11/2	0/2012
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K 018	Observed the c smoke tight when c	or during the inspection. loors to room E185 were not	K)18	WO# 213170 Installed 83 1/4" alumin ocut out notch to accommodate the strik repaired push/pull drilled & re-tapped b Door Deficiency prevention and correct accomplished through Life Safety Asse completed monthly by Jarvis Lock and Environmental Rounds will monitor mon Hospital representative responsible: Di Operations	um astragal te plate ottom hinge. ion to be ssments Door. nthly. ector Plant	Completed 12/19/2012
K 027	not close to a smok a coordinator to allo NFPA 101 LIFE SA Door openings in si 20-minute fire prote 1%-Inch thick solid protective plates the from the bottom of Horizontal sliding de Doors are self-closi accordance with 19 not required to swin	doors to the Rehab area did to the tight seal. The doors need ow the doors to close properly. FETY CODE STANDARD moke barriers have at least a retion rating or are at least bonded wood core. Non-rated at do not exceed 48 inches the door are permitted. Proof to comply with 7.2.1.14, and or automatic closing in .2.2.2.6. Swinging doors are greatly with egress and positive red. 19.3.7.5, 19.3.7.6,	K	27	WO# 213176 Installed 1 set of 831/8" Door Deficiency prevention and correcti accomplished through Life Safety Asset completed monthly by Jarvis Lock and I Environmental Rounds will monitor mor Hospital representative responsible: Dir Operations	brushes. on to be ssments Door. thly. ector Plant	Completed 12/19/2012
The second secon	Surveyor. 13546 Based on observati for the smoke barrie automatic closing in section 19.2.2.2.6.	on the facility failed to provide er doors to be self-closing or accordance with the LSC This deficient practice could occupants of the facility.		The second secon			
and the second second	validation inspection 2012 and Novembe	ons were noted during a n conduct on November 19, r 20, 2012 between the hours of PM. These findings were med by the facility		deministration at the second		d data	

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUI	LDING	5. III III II	(X3) DATE SI COMPLE	
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S Market S	ROVIDER OR SUPPLIER			60	EET ADDRESS, CITY, STATE, ZIP CODE 071 W OUTER DRIVE ETROIT, MI 48235		
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K 027	Observed the cont close to a smoken control of the control of	or during the inspection. cross corridor doors, WG36, do	K		WO# 213216 Installed only 1 4041 remount coordinating catch on door / installed 1 LCN 4041 closer. Door De prevention and correction to be accor through Life Safety Assessments com by Jarvis Lock and Door. Environmen monitor monthly. Hospital representat Director Plant Operations	ipieted montni tal Rounds wil	Completed 12/19/2012
	door 2G21F has be · Observed an u	the required smoke barrier een removed.		F	NO# 213207 Jarvis is measuring do eplacement. Quote being processed. PO#2012 0201 632 314 SGS. Door D prevention and correction to be accom- ife Safety Assessments completed marvis Lock and Door. Environmental monitor monthly. Hospital representation Director Plant Operations	eficiency oplished throug onthly by Rounds will	Door installed on 01/15/13 th
K 029	on the smoke barrie Care. NFPA 101 LIFE SA One hour fire rated fire-rated doors) or extinguishing syste and/or 19.3.5.4 pro- the approved auton option is used, the a other spaces by sm doors. Doors are s field-applied protect	construction (with ¾ hour an approved automatic fire m in accordance with 8.4.1 tects hazardous areas. When natic fire extinguishing system areas are separated from toke resisting partitions and elf-closing and non-rated or tive plates that do not exceed bottom of the door are	КО	29	WO# Shaw Fire received quote and removed unapproved hold open device Deficiency prevention and correction to accomplished through Life Safety Assign completed monthly by Jarvis Lock and Environmental Rounds will monitor methospital representative responsible: Experience of the province	PO and e. Door o be essments I Door. onthly.	Completed 01/07/13
	Surveyor: 13546 Based on observation of the protection of accordance with the deficient practice occupants of the factorial surveyors.	on the facility failed to provide hazardous areas in LSC section 19.3.2.1. This build potentially affect all bility. Findings include:		THE PROPERTY OF THE PROPERTY O			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION A BUILDING 01 - MAIN BUILDING 01 B. WING SINAI-GRACE HOSPITAL (X4) ID SINAI-GRACE HOSPITAL (X5) MULTIFLE CONSTRUCTION A BUILDING 01 - MAIN BUILDING 01 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 6071 W OUTER DRIVE DETROIT, MI 48235 D. PROVIDERS PLAN OF CORRECTION (X6) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) FREFIX TAG Continued From page 5 Validation inspection conduct on November 19, 2012 and November 20, 2012 between the hours of 9:00 AM and 5:00 PM. These findings were observed and confirmed by the facility maintenance director during the inspection. Observed the door to the storage area in the NICU needs a closer. This area is being used for storage which requires a closer on the door. Observed that the 2nd floor clean utility storage room is not sprinkled or properly rated. Observed a large ceilling and wall penetrations in janitor's closet located inside room M205. Observed a large unsealed wall penetration in mechanical room M245. Observed a large unsealed wall penetration in mechanical room M245.	01111111	NOT ON WEDIONINE	A MILDIOAID SLIVIOLS				OIVID IVO.	0930-0391	. 1
NAME OF PROVIDER OR SUPPLIER SINAI-GRACE HOSPITAL STREET ADDRESS, CITY, STATE, ZIP CODE 6071 W OUTER DRIVE DETROIT, MI 48235 DETROIT, MI 48235 I (AA) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) K 029 Continued From page 5 validation inspection conduct on November 19, 2012 and November 20, 2012 between the hours of 9:00 AM and 5:00 PM. These findings were observed and confirmed by the facility maintenance director during the inspection. Observed the door to the storage area in the NICU needs a closer. This area is being used for storage which requires a closer on the door. Observed that the 2nd floor clean utility storage room is not sprinkled or properly rated. Observed that the door to the storage room at elevator 11 does not self-close and latch. Observed a large celling and wall penetrations in janitor's closet located inside room M205. Observed a large unsealed wall penetration in genetical grown M245.			IDENTIFICATION NUMBER:	A. BUI	LDIN	G 01 - MAIN BUILDING 01	COMPLE	ETED	
SINAI-GRACE HOSPITAL SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) K 029 Continued From page 5 validation inspection conduct on November 19, 2012 and November 20, 2012 between the hours of 9:00 AM and 5:00 PM. These findings were observed and confirmed by the facility maintenance director during the inspection. Observed the door to the storage area in the NICU needs a closer. This area is being used for storage which requires a closer on the door. Observed that the 2nd floor clean utility storage room is not sprinkled or properly rated. Observed that the door to the storage aroa matelevator 11 does not self-close and latch. Observed a large ceiling and wall penetrations in janitor's closet located inside room M205. Observed a large unsealed wall penetration in mechanical room M245. Observed a large unsealed wall penetration in mechanical room M245. Observed a large unsealed wall penetration in mechanical room m249. Observed a large unsealed wall penetration in mechanical room m249. Observed a large unsealed wall penetration in mechanical room m249. Observed a large unsealed wall penetration in mechanical room m249. Observed a large unsealed wall penetration in mechanical room m249. Observed a large unsealed wall penetration in mechanical room m249. Observed a large unsealed wall penetration in mechanical room m249. Observed a large unsealed wall penetration in mechanical room m249. Observed a large unsealed wall penetration in mechanical room m249. Observed a large unsealed wall penetration in mechanical room m249. Observed a large unsealed wall penetration in mechanical room m249. Observed a large unsealed wall penetration in mechanical room m249. Observed a large unsealed wall penetration in the penetration of penetrations completed by Brooks Fire In addition. Environmental Rounds will monitor monthly. Hospital representative responsible: Director Plant Operations Observed a large unsealed wall penetration in the			230024				11/2	0/2012	
REGULATORY OR LSC IDENTIFYING INFORMATION PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION					6	071 W OUTER DRIVE			ero de constituit de la
K 029 Continued From page 5 validation inspection conduct on November 19, 2012 and November 20, 2012 between the hours of 9:00 AM and 5:00 PM. These findings were observed and confirmed by the facility maintenance director during the inspection. Observed the door to the storage area in the NICU needs a closer. This area is being used for storage which requires a closer on the door. Observed that the 2nd floor clean utility storage room is not sprinkled or properly rated. Observed that the door to the storage room at elevator 11 does not self-close and latch. Observed a large ceiling and wall penetrations in janitor's closet located inside room M205. K 029 room door. Door Deficiency prevention and correction to be accomplished through Life Safety Assessments completed monthly by Jarvis Lock and Door. Environmental Rounds will monitor monthly. Hospital representative responsible: Director Plant Operations WO# 213172 Door lock was repaired and closer was installed, Door Deficiency prevention to be accomplished through Life Safety Assessments completed monthly by Jarvis Lock and Door. Environmental Rounds will monitor monthly. Life Safety Assessments completed monthly by Jarvis Lock and Door Environmental Rounds will monitor monthly. Completed Penetration prevention to be enforced through above 12/18/2012 the ceiling work permit program. Correction through monthly Life Safety Assessment for penetrations completed by Brooks I Stopping. In addition, Environmental Rounds will monitor monthly. Hospital representative responsible: Director Plant Operations WO# 213188 Repaired wall. Penetration prevention to be enforced through above the ceiling vork permit program. Correction through monthly Life Safety Assessment for penetrations completed by Brooks I Stopping. In addition, Environmental Rounds will monitor monthly. Hospital representative responsible: Director Plant Operations Completed Penetration prevention to be enforced through above the ceiling vork permit program. Correction through monthly Life Sa	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR	ULD BE		
Observed wood pallets being stored in soiled utility room M249. Observed unsealed wall penetrations in electrical closet M243. Observed an unsealed ceiling penetration around pipes in janitor's closet JC W204. Observed an unsealed penetration above the door to the Joint Plus center. Observed unsealed penetrations and missing pieces of block, 2nd floor, in the 2- hour wall		validation inspection 2012 and November of 9:00 AM and 5:00 observed and confirmaintenance direct. Observed the confirmaintenance direct. Observed the confirmaintenance direct. Observed that is storage which required. Observed that is storage room is not. Observed that is at elevator 11 does. Observed a largue penetrations in janily room M205. Observed a largin mechanical room. Observed wood utility room M249. Observed unsee electrical closet M24. Observed an uraround pipes in janily observed an uraround pipes in janily observed unsee electrical closet M24. Observed an uraround pipes in janily observed unsee electrical closet M24.	n conduct on November 19, er 20, 2012 between the hours 0 PM. These findings were rmed by the facility or during the inspection. foor to the storage area in the er. This area is being used for ires a closer on the door. the 2nd floor clean utility sprinkled or properly rated. the door to the storage room not self-close and latch. ge ceiling and wall penetration was alled wall penetrations in 43. Insealed ceiling penetration alove the is center. aled penetrations and missing		029	room door. Door Deficiency prevention correction to be accomplished through Assessments completed monthly by Ja Door. Environmental Rounds will monit Hospital representative responsible: Director Plant Operation and correction to be accompatherence to building codes and AHJ it through Environmental rounds will mon responsible: Director Plant Operations WO# 213172 Door lock was repaired was installed. Door Deficiency preventic correction to be accomplished through Assessments completed monthly by Ja Door. Environmental Rounds will monit Hospital representative responsible: Dir WO# 213180 Ceiling & Wall penetration Penetration prevention to be enforced the ceiling work permit program. Corremonthly Life Safety Assessment for pe Stopping. In addition, Environmental Rounds will Hospital representative responsible: Dir WO# 213188 Repaired wall. Penetration addition, Environmental Rounds will Hospital representative responsible: Dir WO# 213242 removed pallet from roc Storage deficiency prevention and correenforced by Life Safety Assessments a Environmental rounds. Hospital representative responsible: Dir WO# 213186 Wall penetration in election and correenforced by Life Safety Assessments a Environmental rounds. Hospital representative responsible: Dir WO# 213186 Wall penetration in elections are provided with HilliSF1. Penetration pevenetrough monthly Life Safety Assessments a Environmental rounds. Hospital representative responsible: Dir WO# 213190 Penetrations around pip sealed with HilliSF1. Penetration preveneriorced through above the ceiling work monthly Life Safety Assessment for pen Stopping. In addition, Environmental Rohospital representative responsible: Dir WO# 213190 Penetrations around pip sealed with HilliSF1. Penetration preveneriorced through above the ceiling work monthly Life Safety Assessment for pen Stopping. In addition, Environmental Rohospital representative responsible: Dir WO# 213218 Wall penetrations were HilliSF1. Monitoring/Compliance: See V above.	and Life Safety rvis Lock and or monthly. rector Plant C intent to r deficiency olished through spections. L itor monthly. and closer on and Life Safety rvis Lock and or monthly. rector Plant C intent to r deficiency olished through spections. L itor monthly. rector Plant C intent to the celling gh monthly sector Plant C itor rector Plant C ito	installed on 12/24/12 Deparations Completed 1/13/2013 If Safety Ass Hospital representations Completed 12/18/2012 Deparations Completed 12/18/2012 Deparations Completed 12/18/2012 Deparations Completed 12/18/2012 Deparations Completed 12/19/2012 Deparations Completed by Brontor monthly. Deparations Completed 12/19/2012 Deparations Completed 12/19/2012 Deparations Completed 12/19/2012 Deparations Completed 12/19/2012	ooks Fire Stopping

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		IPLE CONSTRUCTION NG 01 - MAIN BUILDING 01	(X3) DATE SI COMPLE		
12		B. WI	NG _		11/20/2012		-	
	ROVIDER OR SUPPLIER			6	REET ADDRESS, CITY, STATE, ZIP CODE 8071 W OUTER DRIVE DETROIT, MI 48235			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF TAG		PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
K 029	M-1		K	029	WO# 213174 Repair latch on closet of Door Deficiency prevention and correct accomplished through Life Safety Asset Lock and Door. Environmental Rounds Hospital representative responsible: Dir	ion to be ssments con will monitor	Completed 12/19/2012 ppleted month monthly. Operations	y by Ja
	did not latch when o				WO# 213707 Installed manual flush b adjusted closer to ensure positive latch equipment storage room door. Door De be accomplished through Life Safety As Jarvis Lock and Door. Environmental R	olts and	Completed	rection
	 Observed the le storage room does upper jam. 	eaf door to the OR equipment not latch to the floor or the		_	Hospital representative responsible: Dir	ector Plant C	perations	
	being stored in the	d and other combustibles electrical room inside the			WO# 213205 Removed wood pallets items stored in room. Storage deficience and correction to be enforced by Life Sthrough monthly Environmental rounds. Hospital representative responsible: District Part 2007 Part 1997	ector, Materi	als Manageme	1
- Apontage - start de services	 Observed that t 	ss from elevator 11. the door to the janitor's closet			WO# 213172 Door lock was repaired was installed. Duplicate. Door Deficienc and correction to be accomplished thro completed monthly by Jarvis Lock and I monitor monthly. Hospital representative	y prevention ugh Life Safe Door. Enviror responsible	ty Assessment mental Round	ts s will
Annual decomposition of the second decomposition of the se		not self-close and latch.		•	WO# 213288 Patched and sealed per above ceiling with HiltiSF1. Penetration to be enforced through above the ceiling through monthly Life Safety Assessmen Fire Stopping. In addition, Environmenta Hospital representative responsible: Dire	netrations prevention work permit t for penetratal Rounds wit ector Plant C	Completed 12/19/2012 t program. Con tions complete Il monitor mont perations	ection d by Br hly.
***************************************	electrical closet MG	aled wall penetrations in 25D. he door to mechanical room			WO# 213213 Patched and sealed pen the walls and ceiling with HilliSF1. Penel prevention to be enforced through above Correction through monthly Life Safety A by Brooks Fire Stopping. In addition, En- monthly. Hospital representative response	etrations in	Completed	gram. s comp nitor
- The state of the	MG23 does not self	-close and latch.			WO# 213273 Installed door closer. Do prevention and correction to be accomp through Life Safety Assessments complete.	Door Deficiency Complete implished 12/19/20 mpleted monthly by Jarvis I monthly. Director Plant Operations		
	being stored in the f	s, solvents and combustibles 4 6-west mechanical room.			Environmental Rounds will monitor mon Hospital representative responsible: Dire			-
	 Observed missi utility room community 	ng ceiling tiles in the soiled nication closet M615C.	_		WO# 213265 Removed paint and solv mechanical room. Storage deficiency pro- correction to be enforced by Life Safety monthly Environmental rounds. Hospital representative responsible: Dire	ector, Materia	als Manageme	- N
		g tile missing in room M625.			NO# 213241 replaced missing ceiling Penetration prevention to be enforced the the ceiling work permit program. Correc Assessment for penetrations completed Environmental Rounds will monitor mon	tion through	monthly Life \$	afety ı additi
	NICU needs a close storage which requi	er. This area is being used for res a closer on the door.		\	Hospital Rounds will monitor mon Hospital representative responsible: Dire WO# 212353 replaced missing ceiling Management/Compliance: See WO# 21	ector Plant O tile in M625	perations Completed	THE PROPERTY OF THE PROPERTY O
1		FETY CODE STANDARD seproof towers used as exits	KO	134	WO# 203362 Jarvis installed closer for room door. Management/Compliance: S 213273 above.	r storage ee WO#	Door installed on 12/24/12	60-101-00 A-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1

	TO TOT THEOTOTIC	E & MEDICAID SEKVICES			OMB NO.	0930-039
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUII		(X3) DATE SU COMPLE	
		230024	B. WIN	G	11/2	0/2012
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 6071 W OUTER DRIVE DETROIT, MI 48235	DE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		SHOULD BE	(X5) COMPLETIO DATE
K 034	Continued From pare in accordance		КО	134		
	Surveyor: 13546 Based on observa approved means of the LSC section 19	is not met as evidenced by: tion the facility failed to provide of egress in accordance with 0.2.2.3, 19.2.2.4. This deficient entially affect all occupants of gs include:		WO# 213266 Removed cleaning Storage deficiency prevention and enforced by Life Safety Assessme through monthly Environmental ro Hospital representative responsible Environmental Services	is in working	Completed 12/21/2012
	validation inspection 2012 and Novemb of 9:00 AM and 5:0 observed and conf	tions were noted during a on conduct on November 19, er 20, 2012 between the hours to PM. These findings were irmed by the facility tor during the inspection.		order. Lighting deficiency preventic to be enforced by Life Safety Asse accomplished through monthly Enrounds. In addition, daily work order accomplished through Plant Opera Hospital representative responsible Operations. WO# 213271 4th floor stairwell p	anic bar was	Complete
	Observed clea stairwell SGH-07. Observed the	ning supplies being stored in ight in the stairwell, SCH07 5th	//	dogged down; loosened screw to a mechanism tightened screw on stri Door Deficiency prevention and co accomplished through Life Safety a completed monthly by Jarvis Lock Environmental Rounds will monitor Hospital representative responsible Operations.	ke plate. rrection to be Assessments and Door. monthly.	12/19/201
4		ot illuminated. ed that stairwell door SGH-16 did not		WO# Corrected during Inspection Lighting deficiency prevention and enforced by Life Safety Assessme through monthly Environmental row daily work order correction is accomplant Operation assignment. Hosp	correction to be nts accomplished unds. In addition, mplished through ital representative	
	not illuminated who	ight in stairwell SGH03 was en inspected. CORRECTED		responsible: Director Plant Operation WO# 213222 repaired door hand door. Door Deficiency prevention a be accomplished through Life Safe	e rubbing on nd correction to tv Assessments	Completed 12/19/2012
1/ 000	exit door was loose door.	door handle on the secondary		completed monthly by Jarvis Lock Environmental Rounds will moniton Hospital representative responsible Operations	and Door. monthly.	
K 038	NFPA 101 LIFE SA	AFETY CODE STANDARD	K0	38		
	Exit access is arra	nged so that exits are readily	1			

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUIL		(X3) DATE SI COMPLE	
****		230024	B. WIN	G	11/2	0/2012
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 6071 W OUTER DRIVE DETROIT, MI 48235	DDE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETIC DATE
K 038		ge 8 les in accordance with section	KO	38		
	Surveyor, 13546 Based on observati approved exit acces section 19.2.1. This	s not met as evidenced by: on the facility failed to provide es in accordance with the LSC es deficient practice could occupants of the facility.				
	validation inspection 2012 and November of 9:00 AM and 5:00 observed and confirmaintenance directors. Observed patie	or during the inspection. Int beds obstructing the door		with management and staff to rein awareness of egress requirement Storage deficiency prevention and enforced by Life Safety Assessmethrough monthly Environmental roll Hospital representative responsible Environmental Services. WO# 213268 Equipment remove department to reinforce awareness egress requirements. Storage defi	force staff s. I correction to be ints accomplished unds. e: Director, ed. Notified s of ingress and	Complete 11/20/201 Complete 12/19/201
K 045	was obstructed by e NFPA 101 LIFE SAI Illumination of mean	porridor at rehab stairs W20A cquipment. FETY CODE STANDARD as of egress, including exit	К 04	egress requirements. Storage def and correction to be enforced by Assessments accomplished throu Environmental rounds. Hospital representative responsible Environmental Services.		
	lighting fixture (bulb) darkness. (This doe	ed so that failure of any single will not leave the area in es not refer to emergency be with section 7.8.) 19.2.8				

	to r ort mediorate	A MEDICAID SERVICES			OIVID NO.	0938-039
	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 230024	A. BUILI	LTIPLE CONSTRUCTION DING 01 - MAIN BUILDING 01	(X3) DATE SU COMPLE	TED
		230024			11/2	0/2012
	RACE HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP COE 6071 W OUTER DRIVE DETROIT, MI 48235	E	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
K 045	This STANDARD Surveyor, 13546 Based on observat lighting in accordar 19.2.8. This deficie	age 9 is not met as evidenced by: ion the facility failed to provide nce with the LSC section ent practice could potentially s of the facility. Findings	K 04	25		
	validation inspection 2012 and November of 9:00 AM and 5:00 observed and confirmation of the confirmation	or during the inspection.	/	WO# 213169 Light bulb in E10F v Lighting deficiency prevention and c enforced by Life Safety Assessmen through monthly Environmental rou daily work order correction is accon	vas replaced. correction to be ts accomplished nds. In addition, nplished	Completed 12/18/2012
K 046	not working at time	ght in the electrical room was of inspection. FETY CODE STANDARD	K 04	daily work order correction is accon through Plant Operation assignmen Hospital representative responsible Operations	t. : Director Plant	
Annual An	Emergency lighting provided in accorda	of at least 1½ hour duration is ance with 7.9. 19.2.9.1.				
	Surveyor. 13546 Based on observati emergency lighting section 19.2.9.1. T	on the facility failed to provide in accordance with the LSC his deficient practice could occupants of the facility.				
and the second s	validation inspection 2012 and November of 9:00 AM and 5:00 observed and confir	ons were noted during a n conduct on November 19, r 20, 2012 between the hours DPM. These findings were med by the facility or during the inspection.				

		A MEDICAID SERVICES				OND NO.	0938-039
	TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ULTIPLE LDING	CONSTRUCTION 01 - MAIN BUILDING 01	(X3) DATE SI COMPLE	
		230024	B, WIN	IG		11/2	0/2012
	ROVIDER OR SUPPLIER	2		6071	ADDRESS, CITY, STATE, ZIP CODE W OUTER DRIVE ROIT, MI 48235		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE
K 046	have battery operat required where the and incapable of se	the catherization OR's don't led emergency lights as patient is under anesthesia	KO	Plai Hos Ope	# 213270 Lights in stock have be titing deficiency prevention and cor- proced by Life Safety Assessments bugh monthly Environmental round y work order correction is accompl nt Operation assignment. spital representative responsible: Derations	· ·	Completed 12/19/201
***************************************	accordance with se-	signs are displayed in ction 7.10 with continuous ved by the emergency lighting 1		AND THE REAL PROPERTY OF THE P			
	Surveyor: 13546 Based on observational sexit and directional s LSC section 19.2.10	on the facility failed to provide signs in accordance with the 0.1. This deficient practice ect all occupants of the facility.		And the second s			
No. of Control of Cont	validation inspection 2012 and November of 9:00 AM and 5:00 observed and confire	ons were noted during a conduct on November 19, r 20, 2012 between the hours PM. These findings were med by the facility or during the inspection.	/	assi	# 213274 Light replaced in exit sking order. Lighting deficiency prevection to be enforced by Life Safet essments accomplished through mironmental rounds. In addition, dail ection is accomplished through Plagnment. pital representative responsible: Dirations.	in Operation	Completed 12/19/201
	mechanical room no Observed that a	it sign in the 6-west t illuminated. n additional exit sign is -corridor smoke barrier door		enfo throu daily Plan Hosp	# 213275 Installed additional exit ting deficiency prevention and corr rced by Life Safety Assessments a ugh monthly Environmental rounds work order correction is accomplise t Operation assignment. oital representative responsible: Di rations.	ection to be accomplished . In addition, shed through	Completed 12/19/2012
K 052	NFPA 101 LIFE SAF	ETY CODE STANDARD	K 0	52			

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES				OMB NO.	0938-039
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	ULTIPLE LDING	CONSTRUCTION 01 - MAIN BUILDING 01	(X3) DATE SI COMPLE	
		230024	8. WN	IG	· · · · · · · · · · · · · · · · · · ·	11/2	0/2012
	PROVIDER OR SUPPLIER			6071	ADDRESS, CITY, STATE, ZIP CODE W OUTER DRIVE		
	·			DEI	ROIT, MI 48235		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SI- CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	COMPLETIO DATE
K 052	installed, tested, an with NFPA 70 Natio 72. The system has and testing program	ge 11 required for life safety is d maintained in accordance onal Electrical Code and NFPA s an approved maintenance n complying with applicable PA 70 and 72. 9.6.1.4	К	052			
	Surveyor: 13546 Based on observati a fire alarm system section 9.6.1.4. Thi potentially affect all Findings include:	on the facility failed to provide in accordance with the LSC is deficient practice could occupants of the facility.					
	validation inspection 2012 and November of 9:00 AM and 5:00 observed and confirmaintenance director	r conduct on November 19, r 20, 2012 between the hours DPM. These findings were		and defi by o the Hos	p# 213283 Fire strobe device insit is functioning according to design iciency prevention and correction daily response to monitor and troupanel and quarterly fire alarm equipital representative responsible: legisla representative r	n. Fire Alarm to be enforced ble alarms at sipment inspec	
The second secon	been converted into does not have a fire Observed that t E40B was in alarm	a 6-person office space and alarm audio/visual device. the smoke detector in room but was not showing on panel. FETY CODE STANDARD	/	prop corr mor qua Hos	# 213284 Panel repaired and fu perly. Fire Alarm deficiency prever ection to be enforced by daily res nitor and trouble alarms at the par rterly fire alarm equipment inspec pital representative responsible: I erations	nctioning htion and bonse to el and tions. Director Plant	Completed 12/19/2012

OLIVILI	10 LOW MICDIOVICE	& MEDICAID SERVICES				OND NO.	0938-039
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		E CONSTRUCTION 01 - MAIN BUILDING 01	(X3) DATE SU COMPLE	
		230024	B. WIN	G		11/20	0/2012
	ROVIDER OR SUPPLIER			607	ET ADDRESS, CITY, STATE, ZIP CODE 1 W OUTER DRIVE TROIT, MI 48235		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	QULD BE	(X5) COMPLETIO DATE
K 062	continuously mainta condition and are in	ige 12 c sprinkler systems are ained in reliable operating inspected and tested 6.6, 4.6.12, NFPA 13, NFPA	Κ¢	062			
BB the the and see properties the term of	Surveyor: 13546 Based on observati the facility failed to the automatic sprint and/or tested in acc sections 19.7.6, 4.6 practice could poter the facility. Findings	on and/or review of records provide documentation that kler system is maintained cordance with the LSC 5.12, 9.7.5. This deficient initially affect all occupants of s include:		to co As	O# 213187 Removed tape from s re Sprinkler deficiency prevention at be accomplished through adherence des and AHJ inspections. Life Safe ssessments through Environmental onitor monthly. Hospital representat rector Plant Operations	nd correction e to building by rounds will	Complete 12/19/201
	validation inspection 2012 and Novembe of 9:00 AM and 5:00 observed and confir maintenance director	n conduct on November 19, or 20, 2012 between the hours O PM. These findings were	//	Fin to co	O# 213276 One sprinkler head to over the lower ceiling area. Letter of as been received. PO#2013 0301 66 re Sprinkler deficiency prevention at be accomplished through adherence and AHJ inspections. Life Safe ssessments through Environmental onitor monthly. Hospital representat rector Plant Operations	intent to repair 66 430 SGS. nd correction te to building ty rounds will	1/13/13
	 Observed that t cross-corridor smok 	he sprinkler head at the se barrier doors SGC26 is sy-in ceiling and doesn't		re Sp ac ar thi Ho	O# 213289 One sprinkler head to over the room. Letter of intent to represented PO#2013 0301 666 430 SG prinkler deficiency prevention and complished through adherence to be AHJ inspections. Life Safety Asserough Environmental rounds will mospital representative responsible: Experations	S. Fire prection to be suilding codes essments into monthly.	Complete 1/13/13
	sprinkler protected.	mechanical room MG23 is not alled wall penetrations in 25D.		wi thi Co for In mo	O# 213213 Penetrations patched th HiltiSF1. Penetration prevention trough above the ceiling work permit orrection through monthly Life Safet r penetrations completed by Brooks addition, Environmental Rounds will onthly. ospital representative responsible: E perations.	o be enforced program. y Assessment Fire Stopping I monitor	Completed 12/19/201:

		& MEDICAID SERVICES				OMB NO.	0938-039
STATEMEN AND PLAN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ULTIP LDING		(X3) DATE SU COMPLE	
		230024	B. WI	IG		11/2	0/2012
	PROVIDER OR SUPPLIER RACE HOSPITAL			60	EET ADDRESS, CITY, STATE, ZIP CODE 71 W OUTER DRIVE ETROIT, MI 48235	1175	0/2012
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	x	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETIO DATE
K 062	protected.	ge 13 MG25G is not sprinkler FETY CODE STANDARD)62 r	VO# 213290 Sprinkler heads to be insover the room. Letter of intent to repair eceived. PO#2013 0301 666 430 SGS. Sprinkler deficiency prevention and correccomplished through adherence to built and AHJ inspections. Life Safety Assess prough Environmental rounds will monit dospital representative responsible: Directors	has been Fire ection to be ding codes ments or monthly.	Completion 1/13/13
	with 9.2.3. 19.3.2 This STANDARD is Surveyor. 13546 Based on observation the facility failed to paccordance with the deficient practice occupants of the facility failed to paccordance with the deficient practice occupants.	on and/or review of records provide cooking facilities in ELSC section 19.3.2.6. This build potentially affect all cility. Findings include:					
	The following violations were noted during a validation inspection conduct on November 19, 2012 and November 20, 2012 between the hours of 9:00 AM and 5:00 PM. These findings were observed and confirmed by the facility maintenance director during the inspection. Upon review of records the following deficiencies were noted on the Fire Defense kitchen hood				/O# 213201 Elite Eire Safety conducte		Complete
K 135	 Ducts not welde Hood missing file Nozzles out of a Tanks rusted Incorrectly sized Not all systems 	d ter djustment	K 1:	in co	70# 213291 Elite Fire Safety conducted spection on 12/20/12. Documented repusts, hood filter, adjustment of nozzles, is spection and UL compliance were review rections completed where necessary. The Defense replaced rusted tanks. Specific Specifi	wed and ial Hazard id herence to Safety	Completed 12/20/12
	Flammable and com from and stored in a	bustible liquids are used oproved containers in					

		A MILDICAID SERVICES				OIVID IVC	0.0938-03
STATEMEN AND PLAN (T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUIL	DING	ONSTRUCTION 01 - MAIN BUILDING 01	(X3) DATE S COMPL	
		230024	B. WIN	s		111	20/2012
	PROVIDER OR SUPPLIER			6071 W	DDRESS, CITY, STATE, ZIP CODE OUTER DRIVE DIT, MI 48235	1 11/2	JOILUIL
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIC DATE
K 135	Combustible Liquid Standard on Fire P Using Chemicals. flammable and con constructed in according Company Co	FPA 30, Flammable and is Code, and NFPA 45, rotection for Laboratories Storage cabinets for abustible liquids are ordance with NFPA 30, mbustible Liquids Code, NFPA	K1	35			
K 147	Surveyor: 13546 Based on observation protection of flammatin accordance with practice could potent the facility. Finding: The following violation validation inspection 2012 and November of 9:00 AM and 5:00 observed and confirmatintenance director observed flammating flammati	ons were noted during a conduct on November 19, r 20, 2012 between the hours PM. These findings were med by the facility or during the inspection. These findings were med by the facility or during the inspection. The property stored.	K 14	a flam flamm flamm deficie by Life month Hospit WO# have b Storage enforce through Hospita and Dir	213277 All flammables have be mable cabinet. Department was able liquid storage requirements ency prevention and correction to a Safety Assessments accomplisely Environmental rounds. The safety Assessments accomplisely en compressed on compressed of the safety Assessments at monthly Environmental rounds. The representative responsible: Safety Assessments all representative responsible: Safector Respiratory Therapy.	informed of . Storage be enforced hed through afety Officer ed and staff gas safety. ection to be ccomplished	10/01/001

STATEMEN AND PLAN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	TIPLE CONSTRUCTION	(X3) DATE S	. 0938-039
	z. Johncorlon	IDENTIFICATION NUMBER:	A. BUILDII		COMPL	
	919	230024	B. WNG_	•	14/0	0/2012
NAME OF I	PROVIDER OR SUPPLIER		STI	REET ADDRESS, CITY, STATE, ZIP CO		0/2012
	RACE HOSPITAL		1	0071 W OUTER DRIVE DETROIT, MI 48235		
(X4) ID PREFIX TAG	EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE APPROPRIATE	(X5) COMPLETIO DATE
K 147	Surveyor, 13546	s not met as evidenced by:	K 147	WO# 213279 Junction cover plates deficiency plates deficiency plates deficiency plates deficiency plates deficiency plates deficiency plates are correction to be enforced by Life Season and the correction is accomplished throug assignment. Hospital representation of the correction of the corrections are considered as a complete the correction of the corrections.	ate replaced. prevention and Safety Igh monthly Igh daily work order In Plant Operation we responsible:	Completed 12/18/2012
	section 9.1.2. This	on the facility failed to provide in accordance with the LSC deficient practice could occupants of the facility.	//	WO# 213217 Removed extensio outlet accessible. Rounding to rem compliant extension cords has bee In addition, Environmental rounds monthly basis. Hospital represental Manager, Psychiatric Unit.	on cord and made nove non-code en completed, will monitor on a ative responsible:	Completed 12/18/2012
The following validation insp 2012 and Nove of 9:00 AM and observed and maintenance of the core of the	The following violati validation inspection 2012 and Novembe	ons were noted during a n conduct on November 19, r 20, 2012 between the hours DPM. These findings were med by the facility		WO# 213198 Junction box cover Junction cover plates deficiency procurection to be enforced by Life S Assessments accomplished throug Environmental rounds. In addition, correction is accomplished through assignment. Hospital representative Director Plant Operations.	evention and afety ih monthly daily work order i Plant Operation e responsible:	Completed 12/18/2012
	 Observed a junc protective cover plat 	or during the inspection of the control of the cont	//	WO# 213199 Junction box cover Junction cover plates deficiency procorrection to be enforced by Life Sa Assessments accomplished throug Environmental rounds. In addition, correction is accomplished through assignment. Hospital representative Director Plant Operations.	plate replaced. evention and afety h monthly daily work order Plant Operation e responsible:	Completed 12/18/2012
	cord in use on a fan Psych ward. - Observed an op West doors, entry do		1 0	NO# 213194 put covers on e electroxes and made 12" x 8" cover for lounction cover plates deficiency precorrection to be enforced by Life Satssessments accomplished through invertion in a complished through correction is accomplished through basignment. Hospital representative Director Plant Operations.	ctrical junction	Completed 12/18/2012
	wall by the West pas Observed an ope E30D.	en junction box in room	PS E ci a D	VO# 213280 Installed cover on or inction box. Junction cover plates of revention and correction to be enfo afety Assessments accomplished to invironmental rounds. In addition, do orrection is accomplished through F ssignment. Hospital representative irector Plant Operations.	pen electric deficiency irced by Life hrough monthly aily work order Plant Operation responsible:	Completed 12/19/2012
	able box in room E1	nt in the electrical room was	U Li ei th di di P	VO# 213169 Light bulb was replating deficiency prevention and conforced by Life Safety Assessment irrough monthly Environmental rounally work order correction is accomplant Operation assignment. Hospitalsponsible: Director Plant Operation	ced. orrection to be s accomplished ds. In addition, plished through all representative	Completed 12/18/2012

DEPAR CENTE	RTMENT OF HEALTH	AND HUMAN SERVICES MEDICAID SERVICES			FORM	12/18/2012 APPROVED 0938-0391
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION ING 01 - MAIN BUILDING 01	(X3) DATE S COMPLI	URVEY
		230024	B. WING	No.	1110	0/2012
SINAI-G	PROVIDER OR SUPPLIER RACE HOSPITAL		s	TREET ADDRESS, CITY, STATE, ZIP CODE 6071 W OUTER DRIVE DETROIT, MI 48235	1 11/2	0)2012
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	LIDBE	COMPLETION DATE
K 147	Continued From pa	ge 16	K 14	7		
	the doors within the the wall. Observed an or	nagnetic hold open device on ICU unit was not secured to		WO# 213282 Magnetic hold secured in working order. Door Deficiency preve correction to be accomplished through Assessments completed monthly by Ja and Door. Environmental Rounds will n monthly. Hospital representative responding to Director Plant Operations	to wall and ention and Life Safety rvis Lock nonitor nsible:	Completed 12/19/2012
The second secon	cross corridor doors	Observed an open junction box above the cross corridor doors by office WG36.		WO# 213214 Put cover on open junct Junction cover plates deficiency prevention and correction to be enforce Safety Assessments accomplished thro Environmental rounds. In addition, daily correction is accomplished through Plar assignment. Hospital representative res Director Plant Operations.	ion box.	Completed 12/18/2012
					OCCUPATION OF THE PROPERTY OF	
Administrative properties (A) (Albanda p. 1711).					1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	
			The control of the co		The state of the s	