STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	71	A. BUILDING: _____ B. WING _____	C 04/22/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARYS HOSPITAL	**700 SOUTH PARK ST MADISON, WI 53715**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Z 001	Initial Comments An unannounced Validation survey was conducted at St. Mary's Hospital in Madison, WI on 4/20/2015 through 4/22/2015. St. Mary's Hospital was found to be in compliance with WI Caregiver Regulations.	Z 001		
Y3000	INITIAL COMMENTS An unannounced Validation survey was conducted at St. Mary's Hospital in Madison, WI on 4/20/2015 through 4/22/2015 using State of Wisconsin Chapter 50, regulations for Emergency Contraception. St. Mary's Hospital was found not to be in compliance with Chapter 50 for Emergency Contraception.	Y3000		
Y3121	50.375(2)(a) Hospital - Emergency Contraception (2) A hospital that provides emergency services to a victim shall do all of the following: (a) Provide to the victim medical and factually accurate and unbiased written and oral information about emergency contraception and its use and efficacy.	Y3121		6/19/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 06/05/15

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Y3121	Continued From page 1	Y3121		

This Rule is not met as evidenced by:
Based on record review and interview the facility failed to provide 3 of 3 sexual assault patients (#14, 15, 16) written and oral information regarding emergency contraception. This deficiency has the potential to affect all sexual assault patients treated at this hospital.

Findings include:

Per review on 4/21/2015 at 4:30 PM of facility policy "Sexual Assault" dated 9/2005 states "1. Emergency Services (ES) personnel will provide...comprehensive medical care with cooperation of the SANE (Sexual Assault Nurse Examiner) Staff in order to address the woman's physical, psychosocial and spiritual needs...Referral to the SANE Staff is accomplished by: a. Transfer of the patient to a hospital with on-site SANE Staff. All transfers shall comply with hospital policy on Transfer of Patients--Interhospital...2. If the patient remains at [facility] for care, the following procedures will apply: a. ES personnel will provide the patient with written and verbal information about emergency contraception that is medically and factually unbiased..." The policy does not address offering patients information about emergency contraceptives if discharged or transferred to another facility.

Per pt. #14's MR, reviewed on 4/21/2015 at 11:15 AM, Pt. #14 presented to the ED on 7/9/2014 at 9:16 PM with a chief complaint of alleged sexual

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Y3121	Continued From page 2	Y3121		

assault. Per ED RN notes, "Pt. states she was raped roughly 20 minutes ago..."MD notes document "Pt. will be transferred...They will address STD's and pregnancy prophylaxis there." ED disposition is listed as "transfer". Pt. #14 was transferred from the facility at 10:00 PM. There is no evidence that pt. #14 was given any verbal information about emergency contraceptives while receiving care in the ED. Pt. #14's discharge instructions include patient education for the topic "Sexual Assault, Rape." The instructions state "Emergency contraceptive medications are also available to help prevent pregnancy, if this is desired. All of these options can be discussed with your caregiver." There is no evidence that pt. #14 was provided any written information about emergency contraceptives prior to the time of discharge. There is no evidence that the facility provided pt. #14 information about the medication's use and efficacy.

Per pt. #15's MR, reviewed on 4/21/2015 at 11:25 AM, pt. #15 presented to the ED on 12/21/2014 at 7:58 PM with a chief complaint of alleged sexual assault. Pt. #15 was discharged from the ED on 12/21/2014 at 9:02 PM with the instructions "Go directly to [facility] ER." Pt. #15's discharge instructions include patient education for the topic "Sexual Assault, Rape". The instructions state "Emergency contraceptive medications are also available to help prevent pregnancy, if this is desired. All of these options can be discussed with your caregiver." There is no evidence that Pt. #15 was provided any written information about emergency contraceptives prior to the time of discharge. There is no evidence that the facility provided pt. #15 information about the medication's use and efficacy.

Pt. #16's MR, reviewed on 4/21/2015 at 11:40

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Y3121	Continued From page 3 AM, reveals pt. #16 presented to the ED on 6/23/2014 at 3:42 AM with a chief complaint of alleged sexual assault. Pt. #16 was discharged from the ED on 6/23/2014 at 4:46 AM with instructions "Go to [facility] for SANE. Return for new concerns." There is no documentation that Pt. #16 was given any verbal or written information about emergency contraceptives, its use or efficacy. During an interview on 4/20/2015 at 11:40 AM, ED Dir I stated it is the facility's process to medically clear sexual assault patients for transfer to another ED for SANE examination. The facility does not provide patients with information about emergency contraceptives due to its religious affiliation. Dir I stated on 4/21/2015 at 1:45 PM that ED staff has not had any training specific to emergency contraceptives.	Y3121		
Y3122	50.375(2)(b) Hospital - Emergency Contraception (2) A hospital that provides emergency services to a victim shall do all of the following: (b) Orally inform the victim of all of the following: 1. Her option to receive emergency contraception at the hospital. 2. Her option to report the sexual assault to a law enforcement agency. 3. Any available options for her to receive an examination to gather evidence regarding the sexual assault.	Y3122		6/19/15

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Y3122	Continued From page 4 This Rule is not met as evidenced by: Based on record review and interview the facility failed to provide 3 of 3 sexual assault patients (#14, 15, 16) the option to receive emergency contraception at the facility. This deficiency has the potential to affect all sexual assault patient receiving treatment at this hospital. Findings: Per review on 4/21/2015 at 4:30 PM of facility policy "Sexual Assault" dated 9/2005 states "1. Emergency Services (ES) personnel will provide...comprehensive medical care with cooperation of the SANE (Sexual Assault Nurse Examiner) Staff in order to address the woman's physical, psychosocial and spiritual needs...Referral to the SANE Staff is accomplished by: a. Transfer of the patient to a hospital with on-site SANE Staff. All transfers shall comply with hospital policy on Transfer of Patients--Interhospital...2. If the patient remains at [facility] for care, the following procedures will apply: ...b. ES personnel will verbally inform the patient of her option to receive emergency contraception at the hospital..." The policy does not address offering patients the option to receive emergency contraceptives if discharged or transferred to another facility. Per pt. #14's MR, reviewed on 4/21/2015 at 11:15 AM, pt. #14 presented to the ED on 7/9/2014 at 9:16 PM with a chief complaint of alleged sexual assault. Per ED RN notes, "Pt. states she was raped roughly 20 minutes ago..." MD notes document "Pt. will be transferred...They will	Y3122		

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Y3122	Continued From page 5 address STD's and pregnancy prophylaxis there." ED disposition is listed as "transfer." Pt. #14 was transferred from the facility at 10:00 PM. There is no evidence that pt. #14 was offered the option to receive emergency contraception at the facility prior to transfer. Per pt. #15's MR, reviewed on 4/21/2015 at 11:25 AM, pt. #15 presented to the ED on 12/21/2014 at 7:58 PM with a chief complaint of alleged sexual assault. Pt. #15 was discharged from the ED on 12/21/2014 at 9:02 PM. with the instructions "Go directly to [facility] ER." There is no documentation that pt. #15 was offered the option to receive emergency contraception at the facility prior to discharge. Pt. #16's MR, reviewed on 4/21/2015 at 11:40 AM, reveals pt. #16 presented to the ED on 6/23/2014 at 3:42 AM with a chief complaint of alleged sexual assault. Pt. #16 was discharged from the ED on 6/23/2014 at 4:46 AM with instructions "Go to [facility] for SANE. Return for new concerns." There is no documentation that Pt. #16 was offered the option to receive emergency contraception at the facility prior to discharge. During an interview on 4/20/2015 at 11:40 AM, ED Dir I stated it is the facility's process to medically clear sexual assault patients for transfer to another ED for SANE examination. The facility does not offer emergency contraceptives due to its religious affiliation. Dir I stated on 4/21/2015 at 1:45 PM. that ED staff has not had any training specific to emergency contraceptives.	Y3122		

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Y3124	Continued From page 6	Y3124		
Y3124	50.375(3) Hospital - Emergency Contraception (3) A hospital that provides emergency care shall ensure that each hospital employee who provides care to a victim has available medical and factually accurate and unbiased information about emergency contraception. This Rule is not met as evidenced by: Based on record review and interview the facility failed to provide staff with information regarding emergency contraception in 1 of 1 departments (ED). This deficiency has the potential to affect all sexual assault patient receiving treatment at this hospital. Findings Include: Per review on 4/21/2015 at 4:40 PM of facility policy "Sexual Assault" dated 9/2005 states "...2. If the patient remains at [facility] for care, the following procedures will apply: a. ES personnel will provide the patient with written and verbal information about emergency contraception that is medically and factually unbiased..." Review of literature provided to sexual assault victims does not include information specific to emergency contraceptives. Dir I stated on 4/21/2015 at 1:45 PM that ED staff	Y3124		6/19/15

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Y3124	Continued From page 7 has not had any training specific to emergency contraceptives.	Y3124		
R 000	INITIAL COMMENTS An unannounced on-site Validation survey was conducted at St. Mary's Hospital in Madison, WI on 4/20/2015 through 4/22/2015. St. Mary's Hospital was found to be out of compliance with WI Administrative Code for Hospitals, DHS 124. The off-site stand alone Emergency Department located in Sun Prairie, WI was included in the survey. The following abbreviations may be used throughout this document: IMM-Important Message from Medicare, MR-Medical Record, Dir-Director, MD-Medical Doctor, Pt./pt.-Patient, Mgr-Manager, RN-Registered Nurse, ED-Emergency Department, ES-Emergency Services, SANE-Sexual Assault Nurse Examiner, EVS-Environmental Services, OB-Obstetrics, NB-Newborn, HIM-Health Information Management, PHI-Protected Health Information, PS-Product Specialist, NI-Nurse Informaticist, ADMS-Administrator Director Medical/Surgical, ADO-Administrator Director of Operations, NICU-Neonatal Intensive Care Unit, AM-Morning, PM-afternoon, MPA-Manager Patient Access, MRSA-Methicillin Resistant Staph Aureus, CNO-Cheif Nursing Officer, CRC-Coordinator of Regulatory Compliance, SW-southwest, MSDS-Material Safety Data Sheet, ICU-Intensive Care Unit, PICC-Peripherally inserted central catheter, and OT-Occupational Therapy.	R 000		

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R 252	124.05(3)(a)2. GOVERNING BODY - POLICIES Patient rights and responsibilities. A patient who receives treatment for mental illness, a developmental disability, alcohol abuse or drug abuse shall be recognized as having, in addition, the rights listed under s. 51.61, Stats., and ch. HFS 94. This Rule is not met as evidenced by: Based on record review and interview, this facility failed to identify all security measures to be used when secluding or restraining patients. In 1 of 1 policy reviewed (Restraint Utilization) the facility failed to identify all measures used to protect patients during violent episodes requiring staff intervention. This deficient practice could affects all inpatients requiring restraints at this facility. Findings include: Facility policy entitled, "Restraint Utilization (Violent, Self Destructive)" dated 9/29/2012 was reviewed on 4/21/15 at 1:00 PM, it states under outcome statements; "a. Patient will be protected from harm in the least restrictive environment possible with the intent to prevent, reduce and work to eliminate the use of restraints." "b. Patient will be restrained only when necessary to provide and promote safety and when the least restrictive interventions have been determined to be ineffective."	R 252		6/19/15

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R 252	Continued From page 9 This policy fails to define a continuum of least to most restrictive measures used to protect a violent patient from themselves as well as providing a safe environment for all patients. Less restrictive measures are not defined nor is their use delineated in the policy. Per interview with Unit Manager J on 4/20/15 at 2:30 PM the policy on Restraint utilization is in the process of being revised to more clearly define the use of security interventions by staff when dealing with violent patients.	R 252		
R 294	124.08(1) INFECTION CONTROL - PROGRAM The hospital shall provide a sanitary environment to avoid sources and transmission of infections and communicable diseases. There shall be an active program for the prevention, control and investigation of infections and communicable diseases. This Rule is not met as evidenced by: Based on observation, record review, and interview, the facility failed to complete hand hygiene and wear proper protective equipment to prevent potential spread of infection during 3 of 11 staff observations (RN F, G, and GG). These deficiencies potentially affect all patients, staff, and visitors at this hospital. Findings Include: Observations of care: Review on 4/20/15 at 3:00 PM of "Mosby's Skills	R 294		6/19/15

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R 294	Continued From page 10 Peripherally Inserted Central Lines (Neonatal) Quicksheet" provided by staff "A" states the following: Perform hand hygiene and don gloves, open equipment maintaining sterility of contents and prepare sterile field using aseptic technique; remove gloves perform hand hygiene, and don sterile gloves. On 4/20/15 at 1:50 PM observed RN F and RN G attempting to place pt. #1's PICC (peripherally inserted central catheter) line. RN F performed hand hygiene then proceeded to open supplies sitting on keyboard, move supply cart, and move chair; RN F then donned sterile gloves, gown, and mask without first performing hand hygiene. RN G assisted RN F in performing pt. #1's PICC insertion, with gloved hands RN G silenced Vocera in scrub pocket sitting on chair, then proceeded to obtain normal saline syringe remove cap and connect syringe to a sterile syringe being held by RN F; RN G then injected normal saline into sterile syringe held by RN F allowing for potential cross contamination of sterile saline syringe used for pt. #1. RN G did not remove potentially contaminated gloves, perform hand hygiene and apply "clean" gloves prior to obtaining and opening normal saline syringe. RN G donned sterile gloves to help hold light for RN F, RN G then touched light switch near computer potentially contaminating sterile gloves. RN G then proceeded to open clean supplies, hold pt. #1's leg under sterile field, and suction Pt. #1 without first removing gloves, performing hand hygiene, and applying new pair of gloves. Isolation: Review on 4/21/15 at 3:00 PM of policy titled, "Isolation/Transmission-Based Precautions" Infection Control Hospital Wide, dated 10/92 states when a patient is admitted with a known or suspected communicable disease appropriate	R 294		

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R 294	Continued From page 11 isolation precautions will be implemented. Per the Contact Precautions signage placed outside the door of patients on contact precautions provided by Staff "A" on 4/21/15 at 3:30 PM, All staff must use isolation gowns and gloves for contact with the patient, equipment, and/or the environment. On 4/21/15 beginning at 10:45 AM, observed pt. #33 and pt. #34 receiving dialysis in the Dialysis unit. Per interview with RN GG at the time of observations, pt. #33 and pt. #34 are on contact isolation precautions for MRSA (methicillin resistant staph aureus). Per Interview, RN GG stated staff only wear isolation gowns and gloves when touching patient or patient dialysis machine. Observations showed RN HH don gloves, sit in chair, and roll directly next to pt. #34's bed to check dialysis machine without wearing an isolation gown, allowing RN HH potential exposure to infectious contaminates.	R 294		
R 313	124.08(4)(b) GENERAL INFECTION CONTROL PROVISIONS Sanitary environment. A sanitary environment shall be maintained to avoid sources and transmission of infection. This STANDARD is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure a safe and	R 313		6/19/15

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R 313	Continued From page 12 sanitary environment to prevent and control the potential spread of infection in 10 of 24 areas toured (3SW, 4SW, 5SW, 8SW, NICU, EVS, ED, Off site ED, 2SW, and Kitchen). These deficiencies potentially affect all patients and visitors at this hospital. Findings Include: Nursing Units: Per tour on 4/22/15 at 9:40 AM, accompanied by Chief Nursing Officer (CNO) D noted the following: 3SW, room #3656, labeled staff, contained clean supplies including walkers and commodes. The room also contained a chute for the disposal of dirty laundry. There is no defined separation between clean and dirty supplies. 4SW, room #4656, labeled staff, contained clean supplies including geri-chairs, mechanical lifts and Christmas decorations. This room also contained a chute for the disposal of dirty laundry with no defined separation between clean and dirty supplies. 5SW, room unlabeled, contained clean supplies including mattresses, computers, chairs, sleeping cots and Christmas decorations. This room also contained a chute for the disposal of dirty laundry with no defined separation between clean and dirty supplies. On 4/20/2015 at 11:40 AM observation of of the 8SW floor kitchenette revealed a microwave with dry, food on all walls inside the microwave. Director of Critical Care CC observed the microwave and stated uncertainty regarding what department was responsible for cleaning the microwave.	R 313		

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R 313	Continued From page 13 Laundry: Per review on 4/22/2015 at 4:30 PM of the facility's "Washer and Dryer Guidelines" reviewed 6/2014 state in part: "The washer and dryer are used for: Individual patient clothing...2) Disinfection of the washer will be done after contaminated load...and at least monthly." Per the CDC guidelines for Environmental Infection Control in Health Care Facilities, "Laundry equipment should be used and maintained according to the manufacturer's instructions to prevent microbial contamination of the system." The guideline goes on to state, "The antimicrobial action of the laundering process results from a combination of mechanical, thermal and chemical factors." Dir N stated during interview on 4/21/2015 at 9:00 AM the facility uses residential-grade washer, dryer and detergent for internal laundering of patient personal clothing only. The facility uses one set of washer and dryer in the EVS department (room B520) and one set of washer and dryer in the NICU. The EVS laundry facilities were observed on 4/21/2015 at 9:45 AM accompanied by Dir M and Dir N. The dryer contained the following items: 2 dry dust mops; 2 floor cleaning pads; 1 washcloth. Dir N stated the facility staff uses Tide detergent for laundering. No detergent was found in room B520. Dir N was unable to confirm what type of detergent the items in the dryer had been washed with or why hospital linens and not patient linens were observed in the dryer. The washer and dryer in the NICU were observed on 4/21/2015 at 10:00 AM per NICU Assistant II, the facility launders infant clothing for patient use.	R 313		

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R 313	Continued From page 14 NICU Assistant II stated laundry is done "almost daily" using 7th Generation Natural Laundry Detergent and Green Works Chlorine Free Bleach with each load. NICU Assistant II wipes the interior of the washing machine with a germicidal sani-cloth after each load and runs the machine empty with bleach monthly for disinfection. The interior of the dryer is wiped with a germicidal sani-cloth monthly. When asked about a written policy for the use and disinfection of the washer and dryer, NICU Assistant II stated "I have no idea where that would be." Dir N stated "we don't have in place" a policy or procedure on how the equipment is used or disinfected between use. There was no evidence that the detergent used was adequate to kill microbes or was reviewed and approved by the infection control committee. There is no system in place to ensure that the mechanical, thermal and chemical mechanisms used are adequate to ensure an antimicrobial effect on linens laundered within the facility. Emergency Department: During a tour of the ED on 4/20/2015 at 11:25 AM, 3 of 3 clean rooms observed contained single-use patient equipment that was out of it's packaging. ED room #2 contained open oxygen tubing connected to the wall oxygen unit. ED rooms #27 and #28 contained suction tubing including Yankauer (oral suctioning tool) that was opened and not protected by packaging. These findings were verified at the time of the observation with ED Dir I. Dir I stated staff will "sometimes" open oxygen tubing and suction tubing in preparation for patients coming in. Dir I was unable to state how long the equipment had been open in the rooms or how long it would be	R 313		

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R 313	Continued From page 15 before a patient would be roomed into any of the 3 rooms. Off-site Emergency Department: A tour was completed on 4/21/15 at 9:50 AM, accompanied by Director of Critical Care Services CC, the following was observed: - In room #1143 stains and sharps containers were stored under the sink allowing for contamination by plumbing leaks. - In room #1141 a cooler and a partially used bottle of distilled water were stored under the sink. Behavioral Health Unit 2SW: A tour of the behavioral health unit was completed on 04/20/2015 at 12:15 PM, accompanied by Manager J and Administrator W, the following was observed: - In the Occupational Therapy (OT) kitchen (room #2650) the top of the refrigerator was covered in a layer of dust. - In the medication room off the Nursing station hand sanitizers, plastic bags and a plastic basin were stored under the sink allowing contamination by potential plumbing leaks. Examples of observations: Per tour on 4/21/15 at 2:15 PM, accompanied by Food Services Manager Z and Dir of Food Services U, noted the following: -Noted stainless steel rack cart containing a blender, blender parts and a toaster touching the hand washing sink allowing for contamination. Per Food Service Manager Z, the items on the	R 313		

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R 313	Continued From page 16 cart were clean and Z stated it should be moved. -Noted towels and aprons on the lower shelf of a stainless steel cart with splash and debris on and around the linens. A waste receptacle was noted right next to the cart. Per Food Manager Z, the towels and lines were clean stock. -Noted thick dust and debris on rack where clean baking pans are stored. -Noted dust and debris on shelving and tables in beverage area. -Noted dust and debris coving shelves in the dry storage area. Per interview on 4/22/15 at 10:30 AM, with Dir of Food Services U, the facility does not currently have a daily cleaning schedule or checklist for the kitchen. The employee assigned to each area is expected to clean as needed. They facility does a "deep clean" of the kitchen quarterly. Per U the facility is working on a checklist/cleaning schedule but it has not been implemented as of yet.	R 313		
R 314	124.08(4)(c) GENERAL INFECTION CONTROL PROVISIONS Disposal of wastes. Proper facilities shall be maintained and techniques used for incineration or sterilization of infectious wastes, and sanitary disposal of all other wastes. This Rule is not met as evidenced by: Based on observation, interview, and policy review the hospital failed to ensure availability of spill kits for hazardous waste in 1 of 1 area (Respiratory equipment storage room #6539).	R 314		6/19/15

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R 314	Continued From page 17 The facility failed to secure biohazard waste in soiled utility rooms on 5 of the 8 floors of the southwest wing of the hospital (NICU, Ortho, Oncology, Neurosceince and Cardiac). This deficiency could potentially affects all personnel, visitors and patients. Findings include: Per review on 4/21/15 at 2:00 PM of facility policy entitled; "Formaldehyde Safety" dated 4/26/2013 states its purpose: "All employees working with, or having the potential exposure to, formaldehyde will be knowledgeable in the health risks associated with it and understand appropriate safe handling procedures." The MSDS (material safety data sheet) for 10% Neutral Buffered formalin states; "EMERGENCY OVERVIEW-Warning! May cause respiratory tract irritation. Harmful if inhaled. Harmful if absorbed through the skin. May cause lung damage. May cause pulmonary edema. May cause eye irritation and transient injury. May cause severe skin irritation. May cause reproductive and fetal effects. Contains formaldehyde which can cause cancer. May cause allergic respiratory and skin reaction." Per observation, while touring room 6539 with Vice President K on 4/20/15 at 2:30 PM, approximately 30 specimen containers containing 120 ml of 10% Neutral Buffered formalin were found kept in a drawer next to the sink. VP K was interviewed at the time of the tour, K stated there was no spill kit available for a formalin spill in the area. Review on 4/21/15 at 3:50 PM, of document titled "St. Mary's Hospital Exposure Control Plan for	R 314		

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R 314	Continued From page 18	R 314		

Bloodborne Pathogens", dated 5/92, states "Biohazard labels are used to identify refrigerators, freezers, and other containers used to store or transport blood, or other potentially infectious fluids." This document does not address the securing of biohazard materials.

On 4/21/15 at 10:15 AM observed, during a tour of 2nd floor Intensive Care Unit (ICU) accompanied by Dir of ICU UU, a soiled utility room containing biohazard materials in a red bin. This utility room was not labeled as containing biohazard materials.

On 4/21/15 at 10:30 AM observed, during a tour of 5th floor ICU accompanied by Dir of ICU UU, a scolded utility room containing biohazard materials in a red bin and a sharps container full of needles. This utility room was not locked or secured and was not labeled as containing biohazard materials.

On 4/20/15 at 11:40 AM observed, during a tour of 3rd floor Orthopedic Unit accompanied by Administrator of Director of Operations (ADO) V, a soiled utility room containing biohazard materials in a large uncovered red bin and a small rectangular plastic bin. This utility room was not locked or secured and was not labeled as containing biohazard material.

On 4/20/15 at 1:40 PM observed, during a tour of 5th floor Oncology Unit accompanied by Administrator Director of Medical/Surgical Services (ADMS) W, a soiled utility room containing biohazard materials in large red bin. This utility room was not locked or secured and was not labeled as containing biohazard material.

On 4/20/15 at 1:55 PM observed, during a tour of

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R 314	Continued From page 19 7th floor Neuroscience Unit accompanied by Administrator Director of Medical/Surgical Services (ADMS) W, a soiled utility room containing biohazard materials in large red bin. This utility room was not locked or secured and was not labeled as containing biohazard material. On 4/20/15 at 11:55 AM observation of the 8th floor dirty utility room revealed no signage for biohazard material and the two doors for access to the room were not locked. The room contained biohazardous materials and cleaning chemicals.	R 314		
R 430	124.13(6)(b) DOCUMENTATION,STAFF MEETINGS\EVALUATION There shall be a written nursing care plan for each patient which shall include the elements of assessment, planning, intervention and evaluation. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure care plans were individualized to patient in 5 of 22 medical records (MR) reviewed (pt. # 25, 26, 27, 5, and 33) who would have required a care plan with a total of 30 MR	R 430		6/19/15

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R 430	Continued From page 20 reviewed. This deficiency has the potential to affect all patients served at the facility. Findings include: Per review on 4/22/201 at 11:30 AM of facility policy titled Care Planning, revised June 2014, states in part under Procedure: Select appropriate goals for the patient based on assessment/reassessment and involvement with patient and family. Select appropriate interventions to assist the patient with reaching the individualized goals. Modify the problem, goals and interventions as needed to ensure they are specific, individualized and measurable. Pt. #25's medical record was reviewed on 04/21/15 at 10:50 AM, the record contains a care plan for the problem of Alteration in mood which does not define its manifestations. Goals and interventions are not individualized and do not offer concrete examples of expected outcomes or specific patient driven plans. Pt. #26's medical record was reviewed on 04/22/15 at 9:25 AM, the record contains a care plan for the problem of Altered Thought Processes which does not define its manifestations. Goals and interventions are not individualized and do not offer concrete examples of expected outcomes or specific patient driven plans. Pt. #27's medical record was reviewed on 04/22/15 at 9:50 AM, the record contains a care plan for the problem of Alteration in mood which does not define its manifestations. Goals and interventions are not individualized and do not offer concrete examples of expected outcomes or specific patient driven plans.	R 430		

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R 430	Continued From page 21 Per interview with Product Specialist O on 04/21/15 at 11:30 AM, PS O stated the care plan does not define problems that are specific to patient's diagnosis. Per review of pt. #5's record on 4/21/15 at 1:50 PM with Product Specialist O, pt. #5 was admitted on 4/19/15 with acute chronic diastolic congestive heart failure. The Plan of Care dated 4/19/15 lists heart failure as a problem which does not define its manifestations. Goals and interventions are not individualized and do not offer concrete examples of expected outcomes or specific patient driven plans. Per interview with Product Specialist O on 4/21/15 at 2:00 PM, the plan of care is not individualized and complete. PS O stated staff are expected to include patient specific information and interventions and goals need to be individualized to meet the needs of the patient. Per review of pt. #33's MR on 4/22/15 at 10:20 AM, showed pt. #33 was admitted on 4/13/15 at 7:05 PM on Contact Isolation for MRSA (Methicillin Resistant Staph Aureus). Review of nursing care plans and assessments from 4/13/15 to 4/21/15 revealed no evidence of staff developing a plan of care for pt. #33 being in contact isolation.	R 430		
R 446	124.14(2)(b)2. MEDICAL RECORD SERVICES - SERVICE Confidentiality. Original medical records may not be removed from the hospital except by authorized persons who are acting in accordance with a court order, a subpoena issued under s.	R 446		6/19/15

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R 446	Continued From page 22 908.03(6m), Stats., or in accordance with contracted services, and where measures are taken to protect the record from loss, defacement, tampering and unauthorized access. This Rule is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure patient records are secure and protected from unauthorized access in 1 of 1 departments in which medical records are stored (HIM). Findings Include: Per review on 4/21/2014 at 4:30 PM of facility policy "Privacy Safeguards" Number P2-v1.4 dated 9/12/2013 states in part: "9. Limit Unauthorized Access to PHI [Protected Health Information]: Limit unauthorized access to PHI by...staff members without need to know." The HIM department was observed to contain patient medical record files on 4/21/2015 at 12:55 PM Per HIM Dir SS, the facility scans patient records and maintains the records for 90 days. HIM Dir SS stated all clinical staff have access to the HIM department 24/7, but the department is only staffed from 6:30 PM. to 7:00 PM. Monday through Friday and from 8:00 AM to 4:30 PM on weekends. HIM Dir SS stated EVS staff comes in the evening to clean the department and HIM staff is not always present during the cleaning. During an interview on 4/21/2015 at 9:00 AM, EVS Dir N stated HIM staff "are not present" when EVS staff cleans the HIM department.	R 446		
R 517	124.15(4)(a) PHARMACEUTICAL SERVICES - FACILITIES	R 517		6/19/15

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R 517	Continued From page 23 Storage and equipment. Drugs shall be stored under proper conditions of sanitation, temperature, light, moisture, ventilation, segregation and security. In a pharmacy, current reference materials and equipment shall be provided for the compounding and dispensing of drugs. Hospitals utilizing automated dispensing systems must meet the requirements under Phar 7.09. This Rule is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure all medications are secured from unauthorized access in 1 of 2 procedure rooms (Stress Lab) and 4 of 4 crash carts (3SW, 5SW, Birthing Suites, and Family Suites) that staff were not able to monitor. This deficiency potentially affects all patients at this facility. Findings include: Review on 4/21/15 at 2:30 PM, facility policy titled "Medication Distribution, storage inspections and security" dated 1/15, states "2)d) On patient care units, medications are stored in automated dispensing cabinets or in secure medications	R 517		

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R 517	Continued From page 24 carts and/or cabinets." On 4/21/15 at 11:05 AM, observed a box containing medications in a cabinet in the stress lab room. The cabinet was not secured by the keypad and the door to the room was not closed or locked by the keypad. The waiting area is located right outside this room and at the time of observation two people were within the waiting area and had potential access to the unsecured medication. Per interview with Cardio diagnostic procedure manager AA at the time of discovery, the cabinet should have been locked. On 4/20/15 at 11:45 AM, during tour of 3SW, observed a crash cart containing medications being stored in a pass through hallway, not in view of nurses station, secured with a break away plastic lock. On 4/20/15 at 1:40 PM, during a tour of 5SW, observed a crash cart containing medications being stored in the hallway, not in view of nurses station, secured with a break away plastic lock. Per interview on 4/20/15 at 11:45 AM, Administrator Director of Operations V confirmed the crash cart contained medications and that is was stored in an area that was not in view of the staff. Per interview on 4/21/15 at 11:00 AM, Coordinator of Regulatory Compliance (CRC) A stated the facility placed the carts in that area trying to balance accessibility and safety (as it is located in the center of the unit but out of the	R 517		

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R 517	Continued From page 25 way). Per observation on 4/20/15 at 1:30 PM, while touring 2nd floor Birthing Suites with RN E and Chief Nursing Officer (CNO) D, observed 1 Neonatal and 1 Adult crash cart in an area unattended by staff; crash carts were not locked to prevent unauthorized access. Per interview with RN E at the time of tour, crash carts are not always in view of staff. Per observation on 4/20/15 at 3:00 PM, while touring 3rd floor Family Suites and Pediatric unit with RN H, observed 1 Adult crash cart and 1 Pediatric crash cart in an area unattended by staff; crash carts were not locked to prevent unauthorized access.	R 517		
R 569	124.16(6)(a)1. DIETARY SERVICES - SANITATION Kitchen sanitation. Equipment and work areas shall be clean and orderly. Surfaces with which food or beverages come into contact shall be of smooth, impervious material free of open seams not readily corrodible and easily accessible for cleaning. This Rule is not met as evidenced by: Based on observation and interview, the facility failed to ensure a sanitary environment in the kitchen to prevent and control the potential spread of infection in 1 of 1 kitchen observed. This has the potential to affect all patients, staff and visitors who eat at this facility.	R 569		6/19/15

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R 569	Continued From page 26 Findings include: Per tour on 4/21/15 at 2:15 PM, accompanied by Food Services Manager Z and Dir of Food Services U, noted the following: -Noted stainless steel rack cart containing a blender, blender parts and a toaster touching the hand washing sink allowing for contamination. Per Food Service Manager Z, the items on the cart were clean and Z stated it should be moved. -Noted towels and aprons on the lower shelf of a stainless steel cart with splash and debris on and around the linens. A waste receptacle was noted right next to the cart. Per Food Manager Z, the towels and lines were clean stock. -Noted thick dust and debris on rack where clean baking pans are stored. -Noted dust and debris on shelving and tables in beverage area. -Noted dust and debris covering shelves in the dry storage area. Per interview on 4/22/15 at 10:30 AM, with Dir of Food Services U, the facility does not currently have a daily cleaning schedule or checklist for the kitchen. The employee assigned to each area is expected to clean as needed. They facility does a "deep clean" of the kitchen quarterly. Per U the facility is working on a checklist/cleaning schedule but it has not been implemented as of yet.	R 569		
R 576	124.16(6)(d) DIETARY SERVICES - SANITATION Cooks and food handlers. Cooks and food handlers shall wear clean outer garments and hair nets or caps, and shall keep their hands	R 576		6/19/15

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R 576	Continued From page 27 clean at all times when engaged in handling food, drink, utensils or equipment.	R 576		

This Rule is not met as evidenced by:
Based on record review, interview, and observation, this facility failed to ensure all staff keep hair covered when working in the kitchen in 7 of 10 employees in the kitchen (P, Q, R, S, T, X, and Y). This deficiency has the potential to affect all patient, visitors and staff who eat at this facility.

Findings include:

Per interview of 4/21/15 at 2:00 PM, Food Services Manager Z stated this facility follows Wisconsin Food Code.

Wisconsin Food Code states:
"FOOD EMPLOYEES shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting exposed FOOD; clean EQUIPMENT, UTENSILS, and LINENS; and unwrapped SINGLE-SERVICE and SINGLE-USE ARTICLES."

Per review on 4/21/15 at 3:30 PM of facility policy titled "Food and Nutrition Services", #B-1, dated 8/1/1988, it states "All employees must restrain

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R 576	Continued From page 28 their hair appropriately when they are in a food work area or the dish room. Employees with very short hair may wear a disposable hat providing that it is worn to cover the majority of the hair. Hair nets or bonnets must be worn to effectively cover hair which is longer. Longer hair may need to be confined in a band or braid under a hair restraint... Hair, moustaches, and beards must be clean, neatly-combed, and trimmed." This policy does not reference which standard of practice was used and has not been updated in the past 3 years. During a tour of the kitchen on 4/21/15 at 2:15 PM, accompanied by Food Services Manager Z and Dir of Food Services U, noted the following employees in the kitchen without proper hair coverings: Ambassador P, Ambassador Q, Ambassador R, FSA S, FSA T, FSA X, and Cook Y. Also noted cook Y did not have beard covered. Per interview with Cook Y at the time of discovery, Cook Y stated "I have never been required to cover my beard." Per interview with Dir of Food Services U, this facility does not require hair nets and staff could used bonnets or hats with hair tied back.	R 576		

DEPARTMENT OF HEALTH SERVICES
STATE OF WISCONSIN
Division of Quality Assurance
F-00344 (12/10)

PLAN OF CORRECTION

Name - Provider/Supplier:	
St Marys Hospital	
Street Address/City/Zip Code:	
700 South Park St, Madison, WI 53715	
License/Certification/ID Number (X1):	**520083**
Survey Date (X3):	**04/22/2015**
Survey Event ID Number:	**ODVX11**

ID Prefix Tag (X4)	Provider's Plan of Correction (Each corrective action must be cross-referenced to the appropriate deficiency.)	Completion Date (X5)
Y3121	**The hospital attorney will revise facility policy "Sexual Assault" to state that Emergency Services personnel will provide the patient with written and verbal information about emergency contraception that is medically and factually unbiased, and addresses the medication's use and efficacy - whether they are treated on-site or transferred to another facility. 100% of Emergency Services Staff and Providers will then be educated to the requirements and policy. Staff and Providers who are on Leaves of Absence and miss the completion timeline will be educated "just in time" by the Director of the ED or designee upon return to duty. Auditing of all sexual assault charts will be completed until 100% compliance is demonstrated for 3 consecutive months. Results will be reported monthly to Patient Safety and Quality Committee.**	**6/19/2015**
Y3122	**The hospital attorney will revise facility policy "Sexual Assault" to state that Emergency contraceptives are to be offered and provided on site if patient wishes to receive them – and prior to transfer to another facility for SANE examination. 100% of Emergency Services staff and providers will be educated regarding this requirement, the fact that we do have emergency contraceptives on site for dispensing, and that we do dispense emergency contraceptives to victims of sexual assault that wish to receive them. Staff and Providers who are on Leaves of Absence and miss the completion timeline will be educated "just in time" by the Director of the ED or designee upon return to duty. Auditing of all sexual assault charts will be completed until 100% compliance is demonstrated for 3 consecutive months. Results will be reported monthly to Patient Safety and Quality Committee.**	**6/19/2015**
Y3124	**Director of Emergency Services or designee, will obtain written material that is compliant with State requirements to provide to victims of sexual assault that is specific to emergency contraceptives, their use and efficacy, that is factually and medically unbiased. This literature will be given to all sexual assault victims that present for treatment. 100% of Emergency Services staff and providers will be educated regarding this requirement. Emergency services staff and providers who are on Leaves of Absence and miss the completion timeline will be educated "just in time" by the Director of the ED or designee upon return to duty. Auditing of all sexual assault charts will be completed until 100% compliance is demonstrated for 3 consecutive months. Results will be reported monthly to Patient Safety and Quality Committee.**	**6/19/2015**

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The individual signing the first page of the SOD (CMS-2567) is indicating their approval of the plan of correction being submitted on this form.