NAME OF FACILITY Omaha/ Winnebago I.H.S. Hospital	STREET ADDRESS. CITY, STATE, ZIP CODE P.O. Box HH, Hwy 75/77 Winnebago Ne. 68071			
ID PREFIX TAG	SUMMARY STATEMENT	ID PREFIX TAG	PLAN OF CORRECTION	COMPLETION DATE
A-0386	CFR 482.23 Condition of Participation: Nursing Services The hospital must have an organized nursing service that provides 24-hour nursing services. The nursing services must be furnished or supervised by a registered nurse. Patient #50, age 35, presented to the hospital emergency room (ED) on 4/14/14 with shortness of breath at rest and with exertion, obesity and massive peripheral edema (swelling caused by excess fluid trapped in the body's tissues). He had nasal flaring and grunting when breathing and had labored respirations with any exertion. A chest x-ray was done and showed limited diagnostic quality due to the patients large body mass and shallow inspirations. His respiratory rate was elevated at 40 per minute and his oxygen saturation level was as low as 78% in the ED (normal is 95-100%) but rose to 94% with 3.5 liters of oxygen per nasal cannula. Arterial blood gases (blood test from an artery that measures the acidity (pH) and the levels of oxygen and carbon dioxide in the blood) could not be obtained because the hospital laboratory is not equipped to perform this test. His admission weight was recorded at 590 pounds. He was admitted to the inpatient		Great Plains Area Office oversight: Ongoing Oversight will be provided until all deficiencies are corrected and monitored through the governing body and mock surveys.	4/23/14

	floor with the above diagnoses as well as a history of obstructive sleep apnea and hypertension. On 4/15/13 his physician prescribed the diuretic medication Lasix, 40 milligrams, once daily; he was to be weighed daily; was to have his intake and output measured every shift and was to have oxygen via nasal cannula to keep his blood oxygen saturations greater than 95%.		Admission criteria developed and approved by Medical staff on 4/30/14 and will be monitored for 30 days with reassessment for an additional 30 days by acting DON/acting CD/CEO for compliance. Monitoring is by review of admission criteria and agreement between acting DON and acting CD on all patients prior to admission, until we have established a pattern of criteria compliant admissions. Charge nurse will contact acting DON with potential admission; acting DON will assess capabilities of staff and equipment. Then contact acting CD with all data to review before a patient is admitted. The acting CD will contact the ER provider. All calls will be documented on shift report and identify if admission was approved or disapproved. **Training:** initial instructions on admission process are conducted by acting nursing educator with documentation showing staff received education. Repeated in nursing and medical staff meetings. These admission process instructions will be repeated in the medical staff and nursing meetings. (Attachment 1) (attachment 2)	4/30/14 4/30/14 5/8/14
	From 4/14/14-4/17/14 the patient's respiratory distress did not improve and his weight increased 26 pounds (from 590 to 616 pounds) without a concomitant change in his treatment plan. The patient often slept while sitting on the edge of the bed with his feet on the floor and told nursing staff he couldn't breathe unless he could lean forward at the edge		Multidisciplinary Bedside rounds by each attending physician in the morning. The multidisciplinary committee meeting will review UR and document discharge planning. Process was communicated to appropriate staff on 4/29/14 during the multidisciplinary committee meeting. Attending physician will round on their inpatients at the end of shift is implemented by 5/1/14. Medical staff instruction on end of shift rounds will be completed by 5/1/14. The end of shift rounding process instruction will be repeated in the medical staff and nursing meetings.	4/29/14 5/1/14

	of the bed. He was observed to hyperventilate while resting and at times would fall asleep while talking. Nursing staff infrequently assessed the patient's lung sounds (using a stethoscope, these are sounds heard coming from the lungs when you breathe in or breathe out. Breath sounds can indicate problems within the lungs such as obstructions, inflammation, or infection. An abnormal breath sound can indicate fluid in the lungs or asthma. Breath sounds are an important part of diagnosing many different medical conditions). The nursing staff failed to follow physician orders by not measuring the patient's intake and output each shift. At 10:00 AM on 4/17/14 the patient was found on the floor of his room. Over a 30 minute period he required 10 people to lift		(Attachment 3) Inpatient nursing supervisors will monitor the initial and daily nursing assessments. Nursing supervisors perform random real time review of assessments by nursing staff. Nursing supervisors will provide report to acting DON, the acting DON will provide a report to the acting CD, CEO monthly and Governing body quarterly. (Attachment 4) Implement hourly rounds to include fall precautions, utilizing "4 P's" (pain, position, potty, possession) assessment tool. Training on 4 P's assessment tool will be conducted by nurse educator and ACLS/BLS/PALS instructor completed by 5-8-14. The 4 P's assessment tool will be repeated in the medical staff and nursing meetings. (attachment 4) (attachment 5) Nursing supervisors will review Fall precaution policy at shift change with inpatient and ER nursing staff. Acting CD will communicate provider's responsibility after a fall with providers at shift change and morning rounds. Retraining for all nurses on Fall precautions policy will be conducted by acting nurse educator. (attachment 6)	5/1/14 5/8/14 5/1/14 5/8/14

	him into bed as the facility has no mechanical lifting equipment for a 600 pound patient. Once in bed, the patient's oxygen saturation level was found to be 56%. Nursing staff did not inform the patient's attending physician. A facility physician who had assisted with lifting the patient off the floor directed nursing staff to obtain an EKG (electrocardiogram is a recording of the heart's electrical activity), which showed an undetermined cardiac rhythm due to the patient's restlessness and inability to lie still during the test. The physician requested a repeat EKG which nursing staff did not obtain. At 12:40 PM on 4/17/14 the patient's blood pressure was 79/30, the patient became unresponsive and stopped breathing. A Code Blue (a hospital code announced over the intercom used to indicate a patient requiring immediate resuscitation) was announced at 12:44 PM from the nurse's station telephone because the nurse at the bedside was unfamiliar with accessing the hospital intercom system from the telephone in the patient's room.		Inpatient nursing supervisors will monitor the initial and daily nursing assessments. Nursing supervisors perform random real time review of assessments by nursing staff. Nursing supervisors will provide report to acting DON, the acting DON will provide a report to the acting CD, CEO monthly and Governing body quarterly. Admission criteria developed and approved by Medical staff on 4/30/14 and will be monitored for 30 days with reassessment for an additional 30 days by acting DON/acting CD/CEO for compliance. Nursing staff were instructed to inform provider of any change of status by GPAO staff and local nursing leadership on 4/25/14. Nursing supervisors notified all nursing shift on 4/25/14. Inpatient nursing supervisors will monitor the initial and daily nursing assessments. Mock code drills were conducted and continue to be conducted, including use of paging system from patient rooms.	5/1/14 4/30/14 4/25/14 5/1/14 4/24/14 4/25/14

	When the code team arrived, they could not locate any emergency airway resuscitation equipment on the crash cart (cabinet containing equipment that physicians and nurses need when a cardiac or respiratory arrest occurs). The physician responding to the emergency directed a code team ED nurse to go to the ED and get a combitube (an airway designed to establish a patient airway when placed into either the trachea or esophagus) but the nurse returned with the wrong equipment. Another nurse then went to the ED and returned with the correct combitube. The cardiac arrest record (a form for documenting all of the interventions that occur during a resuscitation) showed the patient's was not intubated with the combitube in order to provide airflow directly to the lungs until approximately 1:05 PM, which was 20 minutes after the initiation of the resuscitation efforts. In addition, no effort was made to place a backboard under the patient to facilitate effective heart compressions because staff said the patient was too big. Resuscitative efforts were discontinued at 1:14 PM and the patient expired. In an interview, the physician that responded to the code described the resuscitative efforts as "chaos".		Notice placed by phone on the wall in each patient room identifying how to page overhead. Paging assessed with every code blue and nurse instructed on how to page over head from room. Crash carts are standardized for medication and their location in the cart; checklists were updated to reflect supplies and equipment on carts. (Attachment 7) Staff trained on new crash cart list starting 4/25/14 and training will be completed on 5/7/14 (Attachment 8) The current supplies for the crash carts will be available in the supply stock on the units. The pharmacist and nursing responsible for restocking crash cart at the beginning of day shift is on the assignment sheets, the night shift will open and assess for outdates in supplies /medications weekly. If supplies are not available, the acting DON will be contacted to manage the situation. If medications are not available, the on call pharmacist is contacted to manage the situation. The nursing supervisor s will conduct direct observation of crash cart checks daily for the next 30 days until compliance is reached. After 30 days nursing supervisors will conduct random checks to ensure compliance and report to acting DON. Acting DON will provide report on crash cart checks to monthly Medical staff meeting and quarterly Governing body meeting beginning 4/30/14. A debriefing will be conducted right after the code blue, all code team staff will complete the code blue critique form right after the code. The	4/24/14 5/7/14 4/30/14 4/30/14 4/30/14

			code blue management review will be completed within 72 hours and discussed in the morning rounds. The direct line supervisor will ensure they are completed within the time frame. The acting nurse educator will provide instruction on the code blue critique form to pharmacy, medical providers, nursing, lab, radiology, and security by 5/8/14 (Attachment 9) Admission criteria developed and approved by Medical staff on 4/30/14 and will be monitored for 30 days with reassessment for an additional 30 days by acting DON/acting CD/CEO for compliance. (attachment 1) Retraining on Adverse incident reporting policy which uses the Joint Commission RCA tool will be conducted by IOP Director/ Risk Manager for all executive staff by 5/1/14. (Attachment 10) RCA conducted parallel to plan of correction with deficiencies identified and corrective actions implemented as developed. (Attachment 11) Crash carts are standardized for medication and their location in the cart; checklists were updated to reflect supplies and equipment on carts. (Attachment 7) Staff trained on new crash cart list starting 4/25/14 and training will be completed on 5/7/14 (Attachment 8)	5/8/14 4/30/14 5/1/14 5/1/14 4/30/14 4/30/14 4/30/14
	The Chief Medical Officer (CMO) from the Great Plains Area Office came to the hospital on 4/24/14 and reviewed the patient's medical record. He concurred with two hospital physicians that stated the patient should not have been admitted based on the hospital's admission criteria. On 4/25/14 the hospital had not yet completed a root cause analysis (a method of problem solving that tries to identify the root causes of faults or problems). During the survey on 4/22/14 the Regional Office surveyor requested nursing staff (RN AA and RN BB) perform a check of the inpatient floor adult and pediatric crash carts. Both nurses said they had never checked the crash carts before because the night shift			

	performed the checks. They also said the crash carts should be checked weekly. According to hospital policy, the patient care staff will check the integrity of the lock on the crash cart each shift and note the inspection on the crash cart checklist. The nurses' check of the crash carts was limited to verifying the crash carts were locked. The nurses were unfamiliar with how to operate the defibrillator/cardiac monitor and the procedure for using the crash cart checklist to determine if each item on the list was present and had not passed its expiration date. Surveyor comparison of the adult crash cart checklist with the contents of the cart showed a sterile tracheal cut down tray that was dated 4/26/06 and no combitube airway was found in the cart. The checklist showed that two-250 milliliter bags of 5% dextrose were to be in the cart but none were found. Sterile gloves in size 6 through size 8 ½ were not found in the cart. RN AA and RN BB were unfamiliar with the method for checking the laryngoscope (a medical device used to visualize a patient's airway during intubation) handle and blades to assure they were in proper working order. Review of the inpatient pediatric crash cart showed there was no Atropine (medication used to treat a low heart rate) as directed on the checklist. Nursing staff		The current supplies for the crash carts will be available in the supply stock on the units. The pharmacist and nursing responsible for restocking crash cart at the beginning of day shift is on the assignment sheets, the night shift will open and assess for outdates in supplies /medications weekly. If supplies are not available, the acting DON will be contacted to manage the situation. If medications are not available, the on call pharmacist is contacted to manage the situation. The nursing supervisor s will conduct direct observation of crash cart checks daily for the next 30 days until compliance is reached. After 30 days nursing supervisors will conduct random checks to ensure compliance and report to acting DON. Acting DON will provide report on crash cart checks to monthly Medical staff meeting and quarterly Governing body meeting beginning 4/30/14. 4/25/14 All pharmacy staff were retrained on the Loaning and borrowing policy. (Attachment 12) 4/30/14 For immediate notification: if medication is unavailable an email will be sent to a designated distribution list to include providers, nursing staff, and pharmacists. Notification of process will be completed by 4/30/14. 4/30/14 Agenda item added to P& T committee and reported to medical staff beginning on 4/30/14 (attachment 13)	

	did not know why the Atropine was not available. During a check of the ED adult and pediatric crash carts on 4/23/14, RN CC was unfamiliar with the procedure because another nurse working with her always checked the carts. She was unfamiliar with the operation of the defibrillator/cardiac monitor, the method for checking the laryngoscope/blades, and the procedure for using the crash cart checklists to determine if each item on the list was present and had not passed its expiration date. The ED pediatric crash cart showed there was no Atropine available on the cart as directed by the checklist. RN CC did not know why the Atropine was not available. The checklist in the pediatric crash carts on both the inpatient floor and the ED showed the notation, "back ordered" written next to the Atropine, with no date or signature of the individual making the entry. During interviews on 4/23/14 the department chief of inpatient pharmacy, the pharmacy director, the medical		Crash carts are standardized for medication and their location in the cart; checklists were updated to reflect supplies and equipment on carts. Staff trained on new crash cart list starting 4/25/14 and training will be completed on 5/7/14 The current supplies for the crash carts will be available in the supply stock on the units. The pharmacist and nursing responsible for restocking crash cart at the beginning of day shift is on the assignment sheets, the night shift will open and assess for outdates in supplies /medications weekly. If supplies are not available, the acting DON will be contacted to manage the situation. If medications are not available, the on call pharmacist is contacted to manage the situation. The nursing supervisor s will conduct direct observation of crash cart checks daily for the next 30 days until compliance is reached. After 30 days nursing supervisors will conduct random checks to ensure compliance and report to acting DON. Acting DON will provide report on crash cart checks to monthly Medical staff meeting and quarterly Governing body meeting beginning 4/30/14.	4/29/14 4/30/14 4/30/14 4/30/14

	director and another medical doctor on duty were unaware of the "back ordered" Atropine. The pharmacy staff later learned that the Atropine had been missing from the pediatric crash carts since October, 2013 because their pharmaceutical vendor was unable to provide the medication. Per interview, pharmacy staff had not made any attempt to acquire the Atropine from other sources until 4/24/14 when the Regional Office surveyor requested the Atropine be obtained as soon as possible. Review of the hospitals "Medical Emergency Response-Code Blue Team" policy, Medical Providers and nurses are required to take Basic Life Support, Advanced Cardiac Life Support and Pediatric Advanced Life Support every two years. Basic Life Support, or BLS, consists of essential procedures including CPR, artificial ventilation, and basic airway management. Advanced cardiac life support, or ACLS, refers to a set of clinical interventions for the urgent treatment of cardiac arrest, stroke and other life threatening medical emergencies, as well as the knowledge and skills to deploy those interventions for the adult patient. Pediatric Advanced Life Support, or PALS, is the assessment and maintenance of pulmonary and circulatory function in the period before,		All pharmacy staff were retrained on the Lend and loan policy. (Attachment 12) For immediate notification: if medication is unavailable an email will be sent to a designated distribution list to include providers, nursing staff, and pharmacists. Notification of process will be completed by 4/30/14. Agenda item added to P& T committee and reported to medical staff beginning on 4/30/14 (attachment 13) Training materials for ACLS retraining ordered on 4/30/14. Identified nurses /providers/ contractors who received ACLS conducted by I.H.S. employee will be scheduled for retraining. 2 day ACLS/BLS AHA curriculum based training conducted by ACLS/BLS certified instructor. Retraining will be completed by 5/8/14. (Attachment 14) Acting Nurse Educator was detailed on 4/29/14.	4/30/14 4/30/14 5/8/14 4/29/14

	during, and after an instance of cardiopulmonary arrest in a child. According to interviews with hospital management staff, the nurse educator taught the BLS, ACLS and PALS classes for staff until 1 ½ years ago when they found she was not teaching the courses based on the current approved American Heart Association curriculum. Another individual was hired to teach the classes. However, during an interview on 4/25/14 the CMO said this employee would immediately be removed as a trainer as he was not following the American Heart Association curriculum and instructor guidelines. On 4/25/14 the hospital provided a plan of correction to remove the Immediate Jeopardy situation. To verify implementation of the plan, the Regional Office surveyor requested Charge Nurse, RN AA, demonstrate how she would respond to an unresponsive, pulseless and breathless patient. RN AA omitted checking the patients pulse prior to performing chest compressions. She also said she would begin chest compressions for one or two minutes and then stop to call a Code Blue. RN AA could not demonstrate how to dial the bedside telephone to announce a Code Blue over		Mock drills are conducted and are assessed for competency by ACLS/BLS certified instructor. Staff that are found to not meet the AHA standards will be retrained by ACLS/BLS certified instructor.	ongoing

	the hospital's intercom system. The facility's failure to provide an organized nursing service for its patients posed an Immediate Jeopardy to patients that began on 4/17/14. The Administrator was notified on 4/25/14 at 12:30 PM that the Immediate Jeopardy was ongoing.			
REPRESENTATIVE Pat Medina			TITLE Chief Executive Officer 5-1-14	