PRINTED: 02/18/2020 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION NG		TE SURVEY MPLETED
		22C0001041	B. WING _		01.	/06/2016
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 150 EMORY STREET ATTLEBORO, MA 02703	·	
(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 SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
Q 000	INITIAL COMMEN	ΓS	Q 00	00		
		re Recertification survey was our Women Health Services 6.				
	The Condition(s) of					
	The Standard(s)of:					
	 Performance Im Emergency Pers Other Practition Administration of Laboratory Serv Infection Controwere not met. 	ers (416.45) if drugs (416.48) ices (416.49)				
Q 040	Ambulatory Surger	Conditions of Coverage for y Centers at 42 CFR, 416.00 Y AND MANAGEMENT	Q 04	40		2/1/16
	assumes full legal r implementing, and r the ASC's total ope has oversight and a assessment and pe program, ensures t programs are admi quality health care	e a governing body that responsibility for determining, monitoring policies governing ration. The governing body accountability for the quality erformance improvement hat facility policies and nistered so as to provide in a safe environment, and tains a disaster preparedness			_	Sicans
LABORATORY	I Y DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE	Ten di	X6 DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined to the safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are discloss following the date of survey whether or not a plan of correction is provided. For pursing homes, the above findings required to the safety of the 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.

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION		E SURVEY IPLETED
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NAME OF F	PROVIDER OR SUPPLIER		150	REET ADDRESS, CITY, STATE, ZIP CODE DEMORY STREET TLEBORO, MA 02703	,	
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Q 040	Continued From pa	ge 1	Q 040			
	Based on observar staff interview, the cassume full legal reimplementing and reference the Ambulatory Suroperation. The Govan effective, data defective, data deference Improfailed to provide ov ASC's pharmaceutimedication practices.	is not met as evidenced by: tion, document review and Governing Body failed to esponsibility for determining, monitoring policies governing gical Center's (ASC) total rerning Body failed to provide riven Quality Assessment and evement (QAPI) program, ersight and direction to the fical services to insure safe es consistent with standards of to implement a formal ogram.				
	1. During an interview on 1/5/16 at 10:10 A.M., the Administrator/Nurse Practitioner said the ASC is owned by the Medical Director and she provides the oversight to insure that the day-to-day operational functioning of the ASC was consistent with facility policies. The ASC does surgical procedures 2 days a week and she sees patients one day a week. The Administrator/Nurse Practitioner said that in addition to providing patient care she performs the day to day functions of: - Human Resources; - Management of Nursing Services; - Management of contracted services; - Management of the physical plant;			A	S. meri	Sicans
	- Infection Control F			_	_	
ORM CMS-25	567(02-99) Previous Versions	s Obsolete Event ID: NY8W	/11 Facili			Life

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	CONSTRUCTION		E SURVEY PLETED
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FOR STATE OF	ongoing training for staff competencies infection control and personnel files of the reviewed, all 3 were The facility /persona procedure for the Mono information includescription for the tability to perform the were opening and comulti-dose medicationable rubber septum and the vials. Additionally, the ASCPR mock code yes policies and process policies po	e and Performance I); el files had no evidence of staff and no evaluation of for assigned tasks related to d QA/PI activities. For 3 of 3 in Medical Assistants (MA) is performing venipuncture's. It is all files had no policy and land land land land land land land				

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Q 040	supporting docume tracked. During interview or Administrator/Nurse information or docume infection control properties of the properties of the control properties of the cont	dentify infections and had no entation that infections were a 1/5/16 at 3:00 P.M. the e Practitioner, could offer no imentation of an on-going ogram.	Q 04			2/9/16
	1. Review of the A Assessment/Perfor program indicated to utilize data to meas provided by the AS	SC's Quality mance Improvement (QAPI) the ASC failed to collect and sure all aspects of care C and use this data to assess I address problems and		. A	Amer	Sicans
FORM CMS-2	567(02-99) Previous Version:	s Obsolete Event ID: NY8W	11			ted: Life

TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION		E SURVEY PLETED
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NAME OF PROVIDER OR SUPPLIER FOUR WOMEN	150	REET ADDRESS, CITY, STATE, ZIP CO DEMORY STREET TLEBORO, MA 02703	•	00/2010
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
Continued From page 4 improve performance. Review of the Quality Assurance/Patient Care Assessment Committee/Board (QAPI/CAC) meeting minutes, complication reports, incident reports and staff interviews, indicated that the Ambulatory Surgical Center (ASC) failed to consistently measure, analyze, and track quality indicators. The Administrator/Nurse Practitioner was identified as the Continuous Quality Improveme (CQI) Coordinator responsible for the monthly coordination and implementation of QA/PI activities. On 1/6/16 at 2:30 P.M., the Administrator/Nurse Practitioner said that the facility identified screening criteria of surgical occurrences as part of the Quality Assurance monitoring and evaluation process. The Administrator was unable to explain how the screening process resulted in data that could be used to evaluate care, identify facility problems and provide opportunities for improvement. The Administrator said the ASC had no infections but had no tracking of infections and not incorporate infections into the facility's QA/PI program scope and activities. Please refer to Q - 0083 and Q - 0245 2. Review of existing QAPI documentation and interview on 1/6/16 at 2:30 P.M. the Administrator indicated that a quality improvement project on "Patient Wait Times", "non-surgical time studies" and "patient satisfaction" had not had data analyzed since	nt ed		Ameri	S

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED	
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NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 150 EMORY STREET ATTLEBORO, MA 02703	•		
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Q 080	Continued From pathe projects had be committee for overs no new performance identified for 2015. Please refer to Q - 3. Review of ASC review and staff into (GB) failed to provice Assessment and Perogram (QAPI) are effectiveness of the Please refer to Q - PERFORMANCE I CFR(s): 416.43(d) (1) The number and improvement project the scope are services and operation (2) The ASC must obeing conducted. In minimum, must incompared to the scope and conducted.	ege 5 een presented to the QA sight and action. There were be improvement projects 0083 meeting minutes, document erview, the Governing Body de oversight of the Quality erformance Improvement and failed to ensure the exprogram was evaluated. 0083 MPROVEMENT PROJECTS d scope of distinct cts conducted annually must and complexity of the ASC's	Q 0	DEFICIENCY)	J. IVALE	1/20/16	
	Based on docume the facility failed to Continuous Quality identified and imple	s not met as evidenced by: nt review and staff interviews, ensure that the facility's Improvement (CQI) program emented specific quality cts on an annual basis.		A	S/ mer	Sicans	
	This STANDARD i Based on docume the facility failed to Continuous Quality identified and imple improvement project	nt review and staff interviews, ensure that the facility's Improvement (CQI) program emented specific quality		A	me	CA Seri	



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Q 083	no quality improver planned for or identical calendar year 2015 the QI projects of p for non-surgical pair reports acted on in analyzed and not rein 2015. 2. According to the Practitioner, at the 5/29/15 and 9/22/1 meetings. A review 9/22/15 Goverening indicated there was QAPI program special control of the QI of	QI program data indicated that ment projects had been tified by the QA committee for 5. Further review indicated that attent wait times, time study tients and patient satisfaction 2014 had not had it's data eported to the Governing Body e Administrator/Nurse Governing Body meetings of 5, they also have the QAPI of both the 5/29/15 and the g Body minutes/QAPI minutes, a no information listed for the cific improvement projects. 20 A.M., the NP said there in place to monitor sharps cks, breaks in the skin by a refore, there were no results committee. The facility policy arps injury log would be in the been implemented. In 2015 in injuries that had occurred out track and trend these	Q0			1/23/16
	equipment and in c	n the use of emergency cardiopulmonary resuscitation whenever there is a patient in		Aı	S. mer	Sicans
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Q 106	Based on staff inter Ambulatory Surgical their policy and pro Cardiopulmonary Residual Findings included: A review of the Carl (CPR) Mock Drill point point point point approach that to en and respond approach common documentation of the ASC document mock drill was control to documentation of the ASC document point p	rotiopulmonary Resuscitation olicy, last approved 12/2015, sure that the staff are trained priately in case of emergency e conducted yearly. Itation indicated the last CPR ducted 8/14/14 and there was of having one in 2015. In 1/6/16 at 2:30 P.M., the e Practitioner said there was otted in 2015. ONERS patient care responsibilities to than physicians, it must have and procedures, approved ody, for overseeing and dical activities.	Q 1			1/20/16
	the Certified Registered the Ambulatory Sur	e Nurse Practioner (NP) and d Nurse Anesthetist (CRNA) gical Center(ASC) failed to es for the oversight and			Amer	cans
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Q 123	evaluation of the Pr 2 of 2 CRNA's file. Findings include: Review of the person M. indicated that the oversight/evaluation according to their strequired by law. When a ASC uses provide patient care ASC's governing be policies and proceed for overseeing and clinical services proceed The ASC's policies type of clinical activity practioner, e.g. NP'CRNA, will be eligited. The ASC may not practioner's permitted applicable State Later On 1/6/16 at 2:45 Figure 1.	onal files on 1/6/16 at 10:00 A. ere was no documentation of n of the physician extenders cope of practice and as a licensed practioner to e, other than nursing care, the ody must approve written dures that establish a system evaluation the quality of the ovided by other practioner's. must address the specific vities that each class of 's, Physician's Assistants or ole to perform. Deermit performance of any utside the licensed ted scope of practice under	Q 1	23		
Q 180	documentation to s PHARMACEUTICA CFR(s): 416.48 The ASC must prov safe and effective r	vide drugs and biologicals in a manner, in accordance with	Q 1	80	S	1/20/16
		nal practice, and under the vidual designated responsible		A	meri	cans
FORM CMS-2	567(02-99) Previous Versions	s Obsolete Event ID: NY8W	11		tinuation shee	ted [®] Life

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Q 180	for pharmaceutical This CONDITION i Based on observat	services. Is not met as evidenced by: tion and staff interviews the	Q 1	80			
	ensure that drugs a	y Center (ASC) failed to and biological's were provided ive manner, in accordance essional practice.					
	Findings include:						
	the Medical Assista expired medications dated when opened policy when using r	r at 8:30 A.M. on 1/5/16 with ont, the Surveyors noted s, medications not being d as required by the ASC' multiply doses vials and equipment in Operating in the stock room.					
	Please refer to Q-1	81.					
	the Surveyors the p for the procedure the anesthetic, Lidocain went to explain that opened by removin top of the vial and r The multi-dose vial accessed with a ste	a.M., MA #1 was explaining to process for preparing the OR's nat included the local ne. The explanation further is the vial of Lidocaine was g the metal ring around the removing the rubber stopper. is manufactured to be erile needle and sterile ce compromises the integrity al.				S	
Q 181	Please refer to Q-1 ADMINISTRATION CFR(s): 416.48(a)		Q 1	81	Ar	neri	2/20/16 cans



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Q 181		pared and administered ished policies and acceptable	Q 1	81			
	Based on observation Ambulatory Surgery dispose of expired equipment in a time multi-dose vials (a vial)	s not met as evidenced by: tion and staff interviews, the y Center (ASC) failed to medications and anesthesia ely manner and failed to date vial of medication that can be tients) when opened 6C"s policy.					
	Findings include:						
	1/5/16 with the Med Surveyors noted ex medications not be required by the ASO doses vials, potenti contents by removing rubber stopper and	r of the ASC at 8:30 A.M. on dical Assistant (MA) #1, the spired medications, ing dated when opened as C's policy when using multiple ally contaminating the vials ng the metal ring and the vial's expired anesthesia ating Room (OR) #2. and the					
	1/5/16 at 8:30 A.M. that there were nun were expired. These	ne initial environmental tour on with MA#1, it was observed nerous vials of medication that se medications were kept in a e following medications had				Si	S
		use vials of Rocuronium skeletal muscle relaxation			Aı	meri	cans



NAME OF PROVIDER OR SUPPLIER FOUR WOMEN SUMMARY STATEMENT OF DEPICIENCIES (EACH DEPICIENCY MUST BE PRECEDED BY AULL (MA) ID (OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		CONSTRUCTION		E SURVEY PLETED
The companies Summary stratement of Deficiencies Summary stratement of Deficiencies PREFIX REGULATORY OR ISE IDENTIFYING INFORMATION PREFIX REGULATORY OR ISE IDENTIFYING INFORMATION PREFIX TAG PR			22C0001041	B. WING			01/	06/2016
PREETX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) Q 181 Continued From page 11 during surgery) with an expiration date of 11/2015 b. 4 ampule's of single use vials of Methogen (used to prevent/control post partum hemorrhage) with 4 ampule's having having an expiration date of 11/2015. C. One liter Inter venous (IV) of Normal Saline with an expiration date of 11/2015. The expired surgical/anesthesia equipment observed is as follows: a. Single use Endotracheal Tubes (a flexible plastic tube that is put into the mouth and then down into the trachea airway. The purpose of using an enforceable tube is to ventilate the lungs). Three ET tubes had expirations dates of 10/28/13, 3/28/15 and 3/28/12. b. A shilley tracheal tube (a tube placed through an opening in the neck to provide an airway), that had an expiration date 4/20/2010. OR#1 was then toured with MA#1 and it was observed that the following had expired: a. An ET tube with an expiration date of 11/28/14. b. A trachea tube with an expiration date of 1/2003. c. 2 IV tubing sets with an expiration dates of 7/2015. On 1/5/15 at 9:30 A.M., MA#1 said that the					150	EMORY STREET		
during surgery) with an expiration date of 11/2015 b. 4 ampule's of single use vials of Methogen (used to prevent/control post partum hemorrhage) with 4 ampule's having having an expiration date of 11/2015. c. One liter Inter venous (IV) of Normal Saline with an expiration date of 11/2015. The expired surgical/anesthesia equipment observed is as follows: a. Single use Endotracheal Tubes (a flexible plastic tube that is put into the mouth and then down into the trachea airway. The purpose of using an enforceable tube is to ventilate the lungs). Three ET tubes had expirations dates of 10/28/13, 3/28/15 and 3/28/12. b. A shiley tracheal tube (a tube placed through an opening in the neck to provide an airway), that had an expiration date 4/20/2010. OR#1 was then toured with MA#1 and it was observed that the following had expired: a. An ET tube with an expiration date of 11/28/14. b. A trachea tube with an expiration date of 1/2003. c. 2 IV tubing sets with an expiration dates of 7/2015. On 1/5/15 at 9:30 A.M., MA#1 said that the	PRÉFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFI		(EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF) BE	COMPLETION
		during surgery) with 11/2015 b. 4 ampule's of si (used to prevent/cohemorrhage) with 4 expiration date of 12 c. One liter Inter with an expiration of the e	Ingle use vials of Methogen control post partum 4 ampule's having having an 11/2015. Henous (IV) of Normal Saline date of 11/2015. Help and the mouth and then help a airway. The purpose of collectube is to ventilate the lubes had expirations dates of and 3/28/12. Help the mouth and then help are airway, that date 4/20/2010. Help the mouth and then help are airway, that date 4/20/2010. Help the mouth and it was following had expired: Help the mouth and it was following had expired: Help the mouth and it was following had expired: Help the mouth and the mouth and it was following had expired: Help the mouth and the mouth and it was following had expired: Help the mouth and the mouth and it was following had expired: Help the mouth and the mouth and it was following had expired: Help the mouth and the mouth and the mouth and it was following had expired: Help the mouth and th					

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FOUR W	PROVIDER OR SUPPLIER			150	EET ADDRESS, CITY, STATE, ZIP CODE EMORY STREET FLEBORO, MA 02703	_	
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Q 181	expiration dates. The stock room/sup with MA#1 and it wo catheter (a tube insurine) had an expirate. 2. During the initial that in OR#2 there Lidocaine (a medic this ASC, to numb to when is had been of Lactated Ringers so on the set. The last procedure was perful/2/16., At this time also observed that Lidocaine had been to the MA#1 said that the metal ring off the septum and pour a surgeon who is perful to Disinfect the via 1. The vial cap septum is sterile 2. Use at least 3. Use friction (4. The septum allow to air dry for 15 b). Do not leave no vial between use as vials contents.	oply room was then toured as observed that a Foley serted into the bladder to drain ation date of 7/2015. I tour is was also observed was an open bottle of cation used for the purpose, in the cervix) with no date as to opened, and an IV setup of colution with no date and time t date that any type of formed in OR#2 was on e. 1/5/15 at 9:30 A.M., is was the metal ring on the vial of a removed. If the procedure is to take off the vial, remove the rubber certain amount for the forming the surgery.	Q 1	81	An	Sineri	Scans



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Q 181	Surveyor that the bopened with a can indicated that the dand proceeded to the door jam of the to remove the meta. On 1/6/15 at 12:30 demonstration of so the procedure for p	inistrator again told the ottles of Lidocaine were opener. The NP then oor jam could also be used open a bottle of Lidocaine in ASC's narcotic storage area al ring. P.M., the MA#1 performed a cetting up the surgical field and ouring the Lidocaine into a	Q 1	81			
Q 201	told the Surveyors vial was removed. On 1/6/16 at 2:30 F did not have a polic metal ring should n comprise the vial.	P.M., the NP said that the ASC by for this procedure and the ot be removed, as it could The ASC's policy for use of a not address the removing of RVICES	Q 2	201		1/20/16	
	meet the requirement chapter. If the ASC laboratory services obtaining routine at services from a cerwith Part 493 of this laboratory must be specialties and subperform the referra requirements of Part 1930 chapter in the referra requirements of Part 1930 chapter in the requirements of Part 1930 chapter in the referra requirements of Part 1930 chapter in the requirement in the	s laboratory services, it must ents of Part 493 of this does not provide its own, it must have procedures for and emergency laboratory tified laboratory in accordance schapter. The referral certified in the appropriate especialties of services to I test in accordance with the rt 493 of this chapter.			Amer	Some	
	This STANDARD i	s not met as evidenced by:			Amer	ICALIS	
ORM CMS-2	567(02-99) Previous Version:	s Obsolete Event ID: NY8W	11		for l		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPI A. BUILDING	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		22C0001041	B. WING		01/	06/2016
NAME OF I	PROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP CODE 150 EMORY STREET ATTLEBORO, MA 02703	,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
Q 201	records and policy Ambulatory Surgical ensure that for 3 of performing phleboth were trained and condraws. Findings include: During the initial tool 8:30 A.M 10:00 A provided the Surve facility. The MA poil brought to the paties survey team observe the room. The MA 7/2015 with a new (hemaglobin), that if factor) status and retest tubes to determ (positive or negative). A review of the ASC blood collection, has this task to the Medical Review of 3 of 3 per Assistants (MA), incliniformation that the draw task and there ASC having evaluative venipunctures. During interview on Administrator/Nurse no information in the	ur of the ASC on 1/5/16 from M.M., Medical Assistant #1 y team with a tour of the nted out that all patients are ent changing area and the ved phlebotomy supplies in said that the ASC started in machine, the Hemacue HGB tests patients Rh (Rhesus equires the patient's Rh typing.	Q 201	A	S. meri	Sicans
ORM CMS-2	567(02-99) Previous Versions	s Obsolete Event ID: NY8W	 11 Fa	cility ID: AO52 If continu	ation shapi	Pace 16 of 16
	(* 11)	2.3.(.2.)				
				I	ori	Life

PRINTED: 02/18/2020 FORM APPROVED OMB NO. 0938-0391
(X3) DATE SURVEY

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED			
		22C0001041 B. W		WING			01/06/2016	
NAME OF F	PROVIDER OR SUPPLIER		1	15	TREET ADDRESS, CITY, STATE, ZIP CODE 50 EMORY STREET TTLEBORO, MA 02703	<u> </u>	00/2010	
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Q 201	Continued From pa evaluation of the M the blood draws.	ge 15 As' competency to perform	Q 2	201				
Q 245	INFECTION CONT CFR(s): 416.51(b)(Q 2	245			1/20/16	
	preventing, identify and communicable	providing a plan of action for ing, and managing infections diseases and for immediately active and preventive alt in improvement.						
	This STANDARD is not met as evidenced by: Based on staff interview, the Ambulatory Surgical Center (ASC) failed to have a plan of action for preventing, identifying, and managing infections and communicable disease. The ASC had no active surveillance and no plan to identify infection control issues.							
	Findings include:							
	describe any plan of control program we corrective measure infection control ou infection control po	provide documentation or of action of how the infection ould take preventive or its to improve the ASC's tcomes. There was no licy to review for active or plan of identify infection						
		at 3:00 P.M. the Nurse there was no system and no infections.				Sy	Ŝ	
					Ar	neri	cans	
ORM CMS-2	567(02-99) Previous Versions	s Obsolete Event ID: NY8W	11	Fac			tege Life	

MA DPF	I/Division of Health (Care Facility Licensure				
	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	LE CONSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:	:	COMPL	-ETED
		44H1	B. WING		07/3	1/2019
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, §	STATE, ZIP CODE		
				GROUND FLOOR		
FOUR W	OMEN		RO, MA 027			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ON	(X5)
PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL	.D BE	COMPLETE
TAG	REGULATORY OR L	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROI DEFICIENCY)	PRIATE	DATE
				22.16.2.16.7		
C 000	INITIAL COMMENT	TS	C 000			
		e renewal survey was				1
		Clinic on 7/31/19 for the				1
	provision of medica	al and surgical services.				1
	Deficiencies were	cited				
	Deliciencies were (sited.				
C 380	140 201(D)(5) Adm	ninistrativo Basarda - Balisias	C 380			
C 360	& Procedure	ninistrative Records - Policies	C 360			1
	& Frocedure	I				
	(B) Administrative	records shall include:				
	(5) Written policies	s and procedures designed to				
		th and safety of patients and				
	staff. These policie	es and procedures shall be				
	reviewed and upda	ited annually.				
		I				
		I				
	This ELEMENT is	not met as evidenced by:				1
		ntation review and interview,				1
	the Clinic failed to r	review their policies and				1
	procedures on an a	annual basis.				
	Findings include:					
		of the Clinic's policy and				
		found that the policies and				1
	procedures were la	ast reviewed on 2/21/17.				
	During an interview	v on 7/31/19 at 11:52 A.M., the				
		d that the policies and			C\1	
		ot been reviewed on an annual			300	5
	basis.)
				A .		
C1320		Without Pharmacies -	C1320	Aı	meri	cans
	Outdated Drugs					+

MA Division of Health Care Facility Licensure and Certification
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

XZBF11

MA DPF	1/Division of Health (Care Facility Licensure			FURIVI	AFFROVED
STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		44H1	B. WING		07/3	31/2019
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
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C1320	Continued From page 1		C1320			
	clinic's stock in acc	all be eliminated from the cordance with clinic policies. lestroyed in accordance with d federal laws.				
	Based on observat failed to date a mul	not met as evidenced by: ion and interview, the Clinic Itiple dose bottle of medication d, to ensure product stability.				
	Findings include:					
	7/31/19 at 12:06 P. Administrator, the S bottle of lidocaine (dated when opened said that the bottle	on of the medication closet on .M., accompanied by the Clinic Surveyor observed an open (an anesthetic) which was not d. The Clinic Administrator was likely opened last week, have been dated when it was				
	(CDC) recommend	isease Control and Prevention Is that multi-dose vials be after being opened to prevent				
C3430	140.1201(D) End o	of Life - Policies	C3430		A 4	
	attending health ca	ave a policy to guide its are practitioners for identifying as and ensuring that they tional pamphlet.		A	meri	Sicans
	Such policies shall	be made available to the		_	Tan .	

MA DPF	1/Division of Health	Care Facility Licensure				71110122
STATEMEN	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		E SURVEY PLETED
l		44H1	B. WING		07/3	31/2019
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, S	STATE, ZIP CODE		
FOUR W	/OMEN			GROUND FLOOR		
			ORO, MA 027		SECTION	(X5)
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C3430	Continued From pa	age 2	C3430			
	Department upon	request.				
	by: Based on docume the Clinic failed to attending health ca appropriate patien care and ensuring informational pamp Findings include: Surveyor's review procedure binders procedure regardir During an interview Clinic Manager sai	ent review and staff interview, develop a policy to guide its are practitioners in identifying its for palliative and end of life that they receive an phlet. of the Clinic's policies and identifying and a did not find a policy or an apalliative or end of life care. w on 7/31/19 at 11:50 A.M., the identify that she could not locate formational pamphlet.			S. Amer	Sicans

(X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES

PRINTED: 02/18/2020 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY

AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 01 - ASC CENTER (01) 22C0001041 B. WING 01/12/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **150 EMORY STREET FOUR WOMEN** ATTLEBORO, MA 02703 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** PRÉFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG **DEFICIENCY**) K 000 **INITIAL COMMENTS** K 000 LIFE SAFETY CODE 42 CFR 416.44(b) The facility must meet the applicable provisions of the 2000 edition of the "LIFE SAFETY CODE" (LSC) of the "National Fire Protection Association" (NFPA) #101 for an Existing Ambulatory Health Care Occupancy surveyed under chapter 21. Form CMS-2786U was completed. K 020 LIFE SAFETY CODE STANDARD K 020 2/26/16 CFR(s): 416.44(b)(1) Vertical openings such as stairways, elevator shaftways, escalators, and building service shaftways are enclosed in accordance with section 8.2.5. 8.2.5.2, 38.3.1, 39.3.1 This STANDARD is not met as evidenced by: Based on observations and confirmed by staff, the facility failed to ensure stairwells are properly maintained. Section 21.3.1 states protection of vertical openings shall comply with section 39.3.1. Section 39.3.1 states any vertical opening shall be enclosed or protected in accordance with section 8.2.5. Section 8.2.5.1 states every floor that separates stories in a building shall be constructed as a smoke barrier to provide a basic degree of compartmentation. Section 8.2.5.2 states openings through floors, such as stairways, hoistways for elevators, dumbwaiters, and inclined and vertical conveyors; shaftways used for light, ventilation, LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE

(X2) MULTIPLE CONSTRUCTION

other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above following the date of survey whether or not a plan of correction is provided. Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting pro 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.

(X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES

PRINTED: 02/18/2020 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY

COMPLETED AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING 01 - ASC CENTER (01) 22C0001041 B. WING 01/12/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 150 EMORY STREET **FOUR WOMEN** ATTLEBORO, MA 02703 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PRÉFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG **DEFICIENCY**) K 020 | Continued From page 1 K 020 or building services; or expansion joints and seismic joints used to allow structural movements shall be enclosed with fire barrier walls. Such enclosures shall be continuous from floor to floor or floor to roof. Openings shall be protected as appropriate for the fire resistance rating of the barrier. THE FINDINGS INCLUDE: During the morning hours of 1/12/16 at approximately 10:30 A.M., the rear stairwell door was tested for proper operation. Although the door opens and closes as required, the door is lacking a self closing device as required. As a result, the facility failed to comply with Section 21.3.1. This was acknowledged by the Medical Assistant during the exit interview process. K 029 LIFE SAFETY CODE STANDARD K 029 2/26/16 CFR(s): 416.44(b)(1) Hazardous areas separated from other parts of the building by fire barriers have at least one hour fire resistance rating or such areas are enclosed with partitions and doors and the area is provided with an automatic sprinkler system. High hazard areas are provided with both fire barriers and sprinkler systems 38.3.2, 39.3.2 This STANDARD is not met as evidenced by: Based on observations and confirmed by staff. the facility failed to ensure that hazardous areas are separated and maintained as required. Section 21.3.2 states protection from hazards Event ID: NY8W21

(X2) MULTIPLE CONSTRUCTION

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

Facility ID: AO52



	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION ING 01 - ASC CENTER (01)		E SURVEY IPLETED	
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NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COI 150 EMORY STREET ATTLEBORO, MA 02703			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	PROVIDER'S PLAN OF CORF X (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
	but not limited to, a boiler or furnace ro that include woodw shall be protected i 8.4. Section 8.4.1.1 star having a degree of normal to the gene or structure shall be following means: (1) Enclose the are windows that has a in accordance with (2) Protect the area systems in accorda (3) Apply both 8.4. hazard is severe or Chapters 12 through THE FINDINGS INDURING THE FINDINGS INDURING THE WOOD	tes hazardous areas including, treas used for general storage, toms, and maintenance shops working and painting areas in accordance with Section tes protection from any area hazard greater than that ral occupancy of the building e provided by one of the as with a fire barrier without a 1-hour fire resistance rating Section 8.2. As with automatic extinguishing ance with Section 9.7. 1.1(1) and (2) where the rewhere otherwise specified by 19th 42. CLUDE: If hours of 1/12/16 at 10 A.M., the following items arding hazardous locations: If the furnace room were non-rated hollow core is also observed that the doors with any self closing device as alled penetrations were list to the boiler room, these limited to the following its in the wall adjacent to the	KO	Eacility ID: AO52	Ameri	Sicans	



(X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES

PRINTED: 02/18/2020 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY

COMPLETED AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING 01 - ASC CENTER (01) 22C0001041 B. WING 01/12/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 150 EMORY STREET **FOUR WOMEN** ATTLEBORO, MA 02703 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PRÉFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG **DEFICIENCY**) K 029 | Continued From page 3 K 029 medical records room, b) Two old exhaust ducts in the wall adjacent to the old operating room, c) An approximate 8" x 18" non sealed penetration in the wall adjacent to the office area. NOTE: The facility in non-sprinklered and requires a 1-hour separation of hazardous areas. As a result, the facility failed to comply with Section 21.3.2. This was acknowledged by the Medical Assistant during the exit interview process. K 046 LIFE SAFETY CODE STANDARD K 046 2/1/16 CFR(s): 416.44(b)(1) Emergency illumination is provided in accordance with section 7.9. 20.2.9.1, 21.2.9.1 This STANDARD is not met as evidenced by: Based on observations and confirmed by staff, the facility failed to ensure that emergency lighting is tested as required. Section 21.2.9.1 states emergency lighting shall be provided in accordance with Section 7.9. Section 7.9.3 states a functional test shall be conducted on every required emergency lighting system at 30-day intervals for not less than 30 seconds. An annual test shall be conducted on every required battery-powered emergency lighting system for not less than 11/2 hours. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. Event ID: NY8W21 Facility ID: AO52

(X2) MULTIPLE CONSTRUCTION

(X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES

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(X3) DATE SURVEY

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(X2) MULTIPLE CONSTRUCTION

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 01 - ASC CENTER (01) 22C0001041 B. WING 01/12/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 150 EMORY STREET **FOUR WOMEN** ATTLEBORO, MA 02703 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PRÉFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG **DEFICIENCY**) K 047 Continued From page 5 K 047 be arranged so that it is not necessary to pass through any area identified under Protection from Hazards in Chapters 11 through 42. Section 39.3.2.1 states hazardous areas including, but not limited to, areas used for general storage, boiler or furnace rooms, and maintenance shops that include woodworking and painting areas shall be protected in accordance with Section 8.4. THE FINDINGS INCLUDE: During the morning hours of 1/12/16 at 10:00 A.M., an exit sign was observed above the furnace room door. Although the furnace room has a door leading to the exterior of the facility, exiting through a hazardous area is not permitted per 7.5.1.7. Note: The facility has the required amount of egress routes without utilizing the designated exit through the furnace room. As a result, the facility failed to comply with Section 21.2.5. This was acknowledged by the Medical Assistant during the exit interview process. K 050 LIFE SAFETY CODE STANDARD K 050 2/1/16 CFR(s): 416.44(b)(1) Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. 20.7.1.2. 21.7.1.2

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 01 - ASC CENTER (01) 22C0001041 B. WING 01/12/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 150 EMORY STREET **FOUR WOMEN** ATTLEBORO, MA 02703 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PRÉFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG **DEFICIENCY**) K 050 Continued From page 6 K 050 This STANDARD is not met as evidenced by: Based on observation, record review, and confirmed by staff, the facility failed to ensure that fire drills are conducted as required. Section 21.7.1.2 states fire drills in ambulatory health care facilities shall include the transmission of a fire alarm signal and simulation of emergency fire conditions. Drills shall be conducted quarterly on each shift to familiarize facility personnel (nurses, interns, maintenance engineers, and administrative staff) with the signals and emergency action required under varied conditions. When drills are conducted between 9:00 p.m. (2100 hours) and 6:00 a.m. (0600 hours), a coded announcement shall be permitted to be used instead of audible alarms. THE FINDINGS INCLUDE: During the morning hours of 1/12/16 at approximately 8:30 A.M. while reviewing the provided fire drills, it was observed that drills are not performed as required. The documented drills are dated, 12/9/15; 9/5/15; 2/20/15 and 11/15/14. A time period of over 6-1/2 months passed between the February and September fire drills, exceeding the 3-month allowance. As a result, the facility failed to comply with section 21.7.1.2. This was acknowledged by the Medical Assistant during the exit interview process. K 051 LIFE SAFETY CODE STANDARD K 051 CFR(s): 416.44(b)(1) A manual fire alarm system, not a pre-signal type, is provided to automatically warn the building FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: NY8W21 Facility ID: AO52

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 01 - ASC CENTER (01) 22C0001041 B. WING 01/12/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 150 EMORY STREET **FOUR WOMEN** ATTLEBORO, MA 02703 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PRÉFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG **DEFICIENCY**) K 051 Continued From page 7 K 051 occupants. Fire alarm system has initiation notification and control function. The fire alarm system is arranged to automatically transmit an alarm to summon the fire department. 20.3.4.1. 21.3.4.1 This STANDARD is not met as evidenced by: Based on observations, record review, and confirmed by staff, the facility failed to ensure the fire alarm system is tested and maintained as Section 21.3.4.1 states ambulatory health care facilities shall be provided with fire alarm systems in accordance with Section 9.6, except as modified by 21.3.4.2 through 21.3.4.5. Section 9.6.1.4 states a fire alarm system required for life safety shall be installed, tested, and maintained in accordance with the applicable requirements of NFPA 70, National Electrical Code, and NFPA 72, National Fire Alarm Code, unless an existing installation, which shall be permitted to be continued in use, subject to the approval of the authority having jurisdiction. NFPA 72. Table 7-3.2 #20 states Off-Premises Transmission Equipment shall be tested on a quarterly basis. Section 7.3.2 and Table 7.3.2 require systems with sealed batteries to have the battery charger tested annually, replace the battery every 4 years, to conduct a 30 minute battery discharge test annually, and to conduct a load voltage test semi-annually. Section 7-3.2.1 states smoke detector sensitivity shall be checked within 1 year after installation and every alternate year thereafter. After the second required calibration test, if sensitivity tests indicate that the detector has remained within its listed and marked sensitivity range (or 4

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ASC CENTER (01)		E SURVEY IPLETED
		22C0001041	B. WING		01/	12/2016
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 150 EMORY STREET ATTLEBORO, MA 02703		
(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 CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
K 051	marked), the length tests shall be perm maximum of 5 year extended, records alarms and subsequent shall be maintained nuisance alarms shall be maintained nuisance alarms shall be performed. Section 21.3.4.3 states a upon operation of a upon oper	in light gray smoke, if not in of time between calibration itted to be extended to a res. If the frequency is of detector-caused nuisance quent trends of these alarms in a cocupant notification shall be attested on the state of the provided by any fire alarm activating device ernal audible alarm in 6.3. Cation shall be provided by signals in accordance with a signals in accordance with a signals in accordance with a signal be provided by signal by signal by signal by signal by sig	KO		Amer	Sicans



(X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES

PRINTED: 02/18/2020 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY

AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 01 - ASC CENTER (01) 22C0001041 B. WING 01/12/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 150 EMORY STREET **FOUR WOMEN** ATTLEBORO, MA 02703 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PRÉFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG **DEFICIENCY**) K 051 | Continued From page 9 K 051 during the past 4-year period. 4) There is no line item on the inspection reports documenting the 30-minute annual discharge test of the batteries has been performed. 5) There is no line item on the inspection reports documenting the semi-annual load voltage battery testing has been performed. 6) There is no line item on the inspection reports documenting the smoke detectors have had a sensitivity test performed during the past 5-year 7) There are no audio/visual alarm devices located on the administrative side of the smoke barrier wall. This area houses both office space as well as patient counseling rooms. As a result, the facility failed to comply with Section 21.3.4.1. This was acknowledged by the Medical Assistant during the exit interview process. K 115 K 115 LIFE SAFETY CODE STANDARD 2/26/16 CFR(s): 416.44(b)(1) Ambulatory health care facilities are divided into at least two smoke compartments with smoke barriers having at least 1 hour fire resistance rating. Doors in smoke barriers are equipped with positive latcher. Doors are constructed of not less than 13/4 inch thick solid bonded core wood or equivalent. Vision panels are provided and are of fixed wire glass limited to 1,296 sq. inch per 20.3.7.1, 20.3.7.2, 20.3.7.3, 21.3.7.1, 21.3.7.2, 21.3.7.3 This STANDARD is not met as evidenced by: Based on observations and confirmed by staff. Event ID: NY8W21 Facility ID: AO52

(X2) MULTIPLE CONSTRUCTION

PRINTED: 02/18/2020 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 01 - ASC CENTER (01) 22C0001041 B. WING 01/12/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 150 EMORY STREET **FOUR WOMEN** ATTLEBORO, MA 02703 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PRÉFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG **DEFICIENCY**) K 115 Continued From page 10 K 115 the facility failed to ensure that smoke barrier walls and doors are properly maintained. Section 21.3.7.2 states the ambulatory health care facility shall be divided into not less than two smoke compartments. Section 21.3.7.4 states vision panels in the smoke barrier shall be of fixed fire window assemblies in accordance with 8.2.3.2.2. Section 21.3.7.6 states doors in smoke barriers shall be not less than 13/4-in. (4.4-cm) thick, solid-bonded wood core or the equivalent and shall be self-closing. A vision panel shall be required. THE FINDINGS INCLUDE: During the morning hours of 1/12/16 at approximately 11:45 A.M. while performing the facility tour, the following items were observed regarding smoke barrier walls and doors: 1) The smoke barrier door by the front entrance is not equipped with a self closing device. 2) The smoke barrier door by the rear of the waiting room is not equipped with a self closing device. In addition, this door is not equipped with a vision panel as required. 3) Each of the two smoke barrier doors have unsealed voids around the entire door perimeter where the drywall meets the original block walls. 4) The piping penetrating the smoke barrier wall by the front entrance has numerous unsealed penetrations. As a result, the facility failed to comply with Section 21.3.7.2. This was acknowledged by the Medical Assistant



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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 01 - ASC CENTER (01) 22C0001041 B. WING 01/12/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 150 EMORY STREET **FOUR WOMEN** ATTLEBORO, MA 02703 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PRÉFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG **DEFICIENCY**) K 115 | Continued From page 11 K 115 during the exit interview process. K 144 LIFE SAFETY CODE STANDARD K 144 2/1/16 CFR(s): 416.44(b)(1) Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1, NFPA 110, 8.4.2 This STANDARD is not met as evidenced by: Based on observation, record review, and confirmed by staff, the facility failed to ensure that the emergency generator is maintained and tested as required. NFPA 110 section 6-4.1 states level 1 and level 2 Emergency Power Supply Systems (EPSSs), including all appurtenant components, shall be inspected weekly and shall be exercised under load at least monthly. NFPA 99 3-4.4.1.1 states generator sets shall be tested twelve (12) times a year with testing intervals not less than 20 days or exceeding 40 days. NFPA 110 section 6-4.2 states generator sets in Level 1 and Level 2 service shall be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods: (a) Under operating temperature conditions or at not less than 30 percent of the EPS nameplate rating (b) Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer The date and time of day for required testing shall be decided by the owner, based on facility operations. Section 6-4.3 states load tests of generator sets shall include complete cold starts.



(X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES

PRINTED: 02/18/2020 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY

AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 01 - ASC CENTER (01) 22C0001041 B. WING 01/12/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 150 EMORY STREET **FOUR WOMEN** ATTLEBORO, MA 02703 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PRÉFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG **DEFICIENCY**) K 144 Continued From page 12 K 144 THE FINDINGS INCLUDE: During the morning hours of 1/12/16 at approximately 9:30 A.M., it was observed that monthly load testing of the emergency generator is not performed as required. There is no documentation available to substantiate that testing was performed during the following months: August 2015; July 2015; March 2015; February 2015; January 2015; and December 2014. In addition to not performing monthly load tests, there is no documentation to substantiate that the generator is inspected on a weekly basis as required. As a result, the facility failed to comply with NFPA 110 section 6-4.2 for both monthly and weekly testing. This was acknowledged by the Medical Assistant during the exit interview process. K 211 LIFE SAFETY CODE STANDARD K 211 2/26/16 CFR(s): 416.44(b)(1) o Where Alcohol Based Hand Rub (ABHR) dispensers are installed in a corridor, the corridor is at least 6 feet wide o The maximum individual fluid dispenser capacity shall be 1.2 liters (2 liters in suites of rooms) o The dispensers have a minimum spacing of 4 ft from each other o Not more than 10 gallons are used in a single smoke compartment outside a storage cabinet.

(X2) MULTIPLE CONSTRUCTION



PRINTED: 02/18/2020 FORM APPROVED OMB NO. 0938-0391

(X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 01 - ASC CENTER (01) 22C0001041 B. WING 01/12/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **150 EMORY STREET FOUR WOMEN** ATTLEBORO, MA 02703 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PRÉFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG **DEFICIENCY**) K 211 | Continued From page 13 K 211 o Dispensers are not installed over or adjacent to an ignition source. o If the floor is carpeted, the building is fully 19.3.2.7, CFR 403.744, 418.100, sprinklered. 460.72, 482.41, 483.70, 483.623, 485.623 This STANDARD is not met as evidenced by: Based on observations and confirmed by staff, the facility failed to ensure that alcohol based hand rub (ABHR) dispensers are installed as required. THE FINDINGS INCLUDE: During the morning hours of 1/12/16 at approximately 11:30 A.M., an ABHR was observed in the corridor by the patient counseling office. This area is equipped with carpeted floors and the facility is not protected by an automatic sprinkler system. This was acknowledged by the Medical Assistant during the exit interview process.

MA DPH/Division of Health Care Facility Licensure

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		4WSC	B. WING		05/06/2015	
	PROVIDER OR SUPPLIER			STATE, ZIP CODE TER, SUITE 131-Q		
HEALIH	QUARTERS, INC	BEVERLY	, MA 01915			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETE	
C 000	INITIAL COMMENT	rs	C 000			
	relocation of the pa Cummings Center,	Suite 126-R Beverly, to 100 Suite 131-Q, Beverly. for the				
	Parent:					
	Health Quarters 100 Cummings Cer Beverly, MA 01915					
	Satellite:					
	Health Quarters 101 Amesbury Stre Lawrence, MA 0184					
	Satellite:					
	Health Quarters 215 Summer Stree Haverhill, MA 0183					
	Services: medical					
	The clinic was not i clinic licensure requ	n compliance with applicable uirements.				
C 056	140.105(A) - (C) Tr Change in Location	ansfer of Ownership & า	C 056		CO	
	Transfer of Owners	ship and Change in Location			SVR	
	name or location of	ent shall be notified ng of any proposed change in f a facility. A license shall not one person or entity to		A ₁	mericans	
	of Health Care Facility Lic	ensure and Certification	NATURE	TITLE	HILEG	

MA DPH/Division of Health Care Facility Licensure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		4WSC	B. WING		05/0	06/2015
NAME OF F	PROVIDER OR SUPPLIER		, ,	STATE, ZIP CODE		
HEALTH	QUARTERS, INC		MINGS CENT , MA 01915	TER, SUITE 131-Q		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
C 056	(B) The proposed I of Intent to acquire least 30 calendar dof ownership. (C) Any person application for licentransfer or such lon Commissioner shall Intent was not time! Commissioner, an aresult of a transfer of considered as filed longer period as the designate, after such that the same of t	e location to another. icensee shall submit a Notice a clinic to the Department at ays in advance of any transfer plying for a license as a result wnership shall file an sure within 48 hours of the ger period in advance as the I prescribe. If the Notice of ly filed, at the discretion of the application received as a of ownership will not be for 30 calendar days, or such a Commissioner shall ch application is received.	C 056			
	2/5/15, the clinic m Center, Suite 126-F Center, Suite 131-F to the Department 2 relocated to anothe	oved from 900 Cummings R, Beverly to 100 Cummings R, Beverly. The letter was sent 27 days after the clinic		A	eri meri	Sicans
	clinic had to relocat	e to another building in a		T	Ini	tod
MA Division of STATE FOR!	of Health Care Facility Lic VI		6899	K5OS11	or I	ation hesp2 of 3

MA DEL	Mulvision of Health C	are Facility Licensure					
	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE COMP	(X3) DATE SURVEY COMPLETED	
		4WSC	B. WING		05/0	6/2015	
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE			
HEALTH	QUARTERS, INC		MMINGS CEN .Y, MA 01915	TER, SUITE 131-Q			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TON SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
C 056	Continued From pa	age 2	C 056				
C 056	short period of time 01/2015, the buildir Cummings Center I vacate the building Director said she no	e. During the last week in ng's landlord for 900 had requested that the clinic as soon as possible. The otified the Department after to another location.	C 056				
					Ameri	cans	
MA Division	of Health Care Facility Lic	ensure and Certification			-Un1 1	lea	
STATE FOR			6899	X5OS11	for I	tion here 3 of 3	

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		4174	B. WING		07/1	2/2019
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
PLANNE	D PRNTHD/PRETRM	HI TH SRV-GT B	MA 02215	TH AVENUE		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
C 000	INITIAL COMMENT	TS	C 000			
	conducted of the C	renewal survey was linic on 7/3/19 for the al and surgical services.				
		newal surveys were ollowing satellite clinics:				
	7/3/19 Planned Parenthoo Center 470 Pleasant Stree Worcester, MA 016 services: medical a	609				
	7/10/19 Planned Parenthoo 91 Main Street suit Marlborough, MA 0 services: medical					
	7/12/19 Planned Parenthoo Center 3550 Main Street s Springfield, MA 011 services: medical a	107				
	Deficiencies were of	cited.				
C 030	140.103(C)(1) Lice Approvals	nsing Requirements - Prior	C 030			
	(C) Prior Approvals	S.			Sy	Ś
	must obtain and su	or a license, all applicants bmit the following documents oplication for licensure:		Aı	meri In i	cans

MA Division of Health Care Facility Licensure and Certification LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

If continuation sheet 1 of 7

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		4174	B. WING		07/12/2019
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE	
PLANNE	D PRNTHD/PRETRM	HITH SRV-GTB	MMONWEAL I, MA 02215	TH AVENUE	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETE
C 030	pursuant to M.G.L. inspector of the De stating that the clini premises comply w requirements gover	ertificate of inspection issues c. 111 s. 51 by a building partment of Public Safety ic and any satellite clinic ith the Department's	C 030		
C 070	Based on document the Clinic failed to offrom the Department Findings include: During review of donoted that the DPS Clinic expired on 5/for the satellite in Market End of the Satellite	not met as evidenced by: Intation review and interview, Dobtain current inspections Int of Public Safety (DPS). Documentation, Surveyor #1 Certificate for the parent 6/19, and the DPS certificate Plariborough expired 6/28/19. To on 7/3/19 at 10:50 A.M., the Cer confirmed that both DPS Dired, and said that they were cons to be completed for both License and DPS Certificate Infrom the Department, and The current Department of Certificate, where relevant, Tensure and Certification	C 070	A	SS mericans Inited
STATE FORM		ensure and Certification	6899	IFCV11	If continuation cheep 2 of LITE

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		4174	B. WING		07/12/2019
NAME OF F	PROVIDER OR SUPPLIER		DRESS, CITY,	STATE, ZIP CODE	1 01/12/2010
PLANNE	D PRNTHD/PRETRM	HITH SRV-GT B	MONWEAL MA 02215	TH AVENUE	
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE COMPLETE
C 070	Continued From pa	age 2	C 070		
	shall be posted in a clinic, and in any of	a conspicuous place in the fits satellite clinics.			
	Based on observat	not met as evidenced by: ion and interview, the Clinic epartment of Public Safety inspection.			
	Findings include:				
	Clinic on 7/3/19 at the Health Center N	mental tour of the parent 10:00 A.M., accompanied by Manager, Surveyors #1 and #2 posted DPS certificate.			
	The Health Center DPS certificate was	Manager confirmed that the s not posted.			
C 130	140.206 Janitor's C	Closet	C 130		
	located janitor's clo sink or floor recepta	ovide one or more suitably sets equipped with a service acle with hot and cold water leaning housekeeping			
	premises of anothe a janitor's closet or provided by that en	clinic that is located on the er entity may store supplies in other designated space atity provided that the janitor's ignated space is suitably			
	Each janitor's close	et must have a door that locks.			SP
	properly and clearly closet or other lock			A	mericans Initod
MA Division of STATE FORM	of Health Care Facility Lic M	censure and Certification	6899	IFCV11	If continuation here 3 of
				I (or Life

MA DPH/Division of Health Care Facility Licensure

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION 5:	(X3) DATE SURVEY COMPLETED
		4174	B. WING		07/12/2019
NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY,	STATE, ZIP CODE	,
PLANNE	D PRNTHD/PRETRM	HITH SRV-GT R	MONWEAL MA 02215	TH AVENUE	
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETE
C 130	Continued From pa	age 3	C 130		
C 250	This ELEMENT is Based on observat failed to ensure that in a locked cabinet Findings include: During the environing clinic, accompanie at 10:05 A.M., Survicleaning products is under the sinks (in unnumbered room Virex Tb 946 ml bo Alconox powered puring the environing the environing the environing the door was not looked and acce During the environing the door was not looked and acce During the environing the door was not looked and acce During the environing the door was not looked and acce During the environing the door was not looked and acce During the environing the door was not looked and acce During the environing the door was not looked and acce During the environing the door was not looked and acce During the environing the environing the environing the environing the door was not looked and acce	not met as evidenced by: ion and interview, the Clinic it cleaning products were kept or closet. mental tour of the parent d by the Manager, on 7/3/19 reyor #1 and #2 observed stored in unlocked cabinets rooms #1, H and in an across from room #1): ttle precision cleaner 4 lbs ne tour by the Health Center irmed the chemicals were ssible. mental tour of the Worcester at 11:10 A.M., accompanied urveyor #4 observed that the tained cleaning products, and icked. The Manager had the ock the door, and said that it	C 250		
	adequate to the ne	eds of the clinic, for the ng equipment and supplies as		A	mericans
MA Division (STATE FORI	□ of Health Care Facility Lic M	ensure and Certification	6899	IFCV11	If continuation sheets 4 of 7
7.				f	or Life

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1055 COMMONWEALTH AVENUE BOSTON, MA 02215 (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) C 250 Continued From page 4 required or shall have an arrangement to obtain such services from a source approved by the Commissioner.	(X5) COMPLETE DATE
PLANNED PRNTHD/PRETRM HLTH SRV-GT B 1055 COMMONWEALTH AVENUE BOSTON, MA 02215 (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) C 250 Continued From page 4 required or shall have an arrangement to obtain such services from a source approved by the	COMPLETE
PLANNED PRNTHD/PRETRM HLTH SRV-GT B BOSTON, MA 02215 (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) C 250 Continued From page 4 required or shall have an arrangement to obtain such services from a source approved by the	COMPLETE
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) C 250 Continued From page 4 required or shall have an arrangement to obtain such services from a source approved by the	COMPLETE
required or shall have an arrangement to obtain such services from a source approved by the	
such services from a source approved by the	
A recognized method of checking clinic sterilizer performance shall be in effect. This ELEMENT is not met as evidenced by: Based on documentation review and interview, the Clinic failed to provide staff with the equipment required to perform quality control testing on the autoclave machine (used to sterilize instruments).	
Findings include:	
During the environmental tour of the parent Clinic on 7/10/19 at 10:00 A.M., Surveyor #1 reviewed the sterility testing log for the autoclave. The last documented test had been run on 6/4/19. On 6/11/19, a staff member had documented that they ran out of supplies and were unable to run the test. For the week of 6/17/19, a staff member had documented that they ran out of supplies, were unable to run the test, testing supplies were ordered and expected to arrive on 6/19/19. For the week of 6/19/19, a staff member had documented that they ran out of supplies and were unable to run the test. For the week of 6/24/19, a staff member had documented that they ran out of supplies and were unable to run the test. For the week of 7/1/19, a staff member had documented that they ran out of supplies and were unable to run the test. For the week of 7/1/19, a staff member had documented that they ran out of supplies and were unable to run the test.	S cans
STATE FORM 6899 IFCV11 IFCV11	ncheen 5 of 7

	NT OF DEFICIENCIES OF CORRECTION			(X3) DATE S COMPL		
		4174	B. WING		07/12	2/2019
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
PLANNE	D PRNTHD/PRETRM	HLTH SRV-GT B	OMMONWEAL N, MA 02215	TH AVENUE		
(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)	ULD BE	(X5) COMPLETE DATE
C 250	Surveyor #1's revied directions for the au was to be conducted. During an interview Associate Health C staff member who presting was no long She confirmed that not been performed. During a follow up to 7/10/19 at 12:02 P. Center Manager information had expedited the twas working on get During a follow up to 7/10/19 at 12:03 P. Center Manager information staff member had to testing and was more compliance. During a telephone on 7/10/19 at 12:49 Assurance said that autoclave until staff.	w of the quality control testing at on a weekly basis. on 7/10/19 at 10:27 A.M., the enter Manager said that the performed the quality control are employed by the Clinic. The quality control testing had on a weekly basis. discussion by email on M., the Associate Health formed Surveyor #1 that she order for testing supplies, and the time that day. discussion by email on M., the Associate Health formed Surveyor #1 that she order for testing supplies, and the time that day. discussion by email on M., the Associate Health formed Surveyor #1 that a taken over the quality control on the control on the time that the control on the time that the control on the c	e d			
C 320	Each separate clini fire drill at least twic and such drills shal	c premises shall conduct a ce a year in each work shift, I include the entire staff.	C 320		S. meri	S
	the Commissioner	such drills shall be available to for review.		T	In	
MA Division of STATE FOR!	of Health Care Facility Lic M	ensure and Certification	6899	IFCV11	or L	on here 6 of 7

IVIA DPF	1/Division of Health C	Jare Facility Licensure			
	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPI	LE CONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	<u> </u>	COMPLETED
		4174	B. WING		07/12/2019
		4174			07/12/2019
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY,	STATE, ZIP CODE	
DI ANNE	D DONTHO/DDETOM	1055 COI	MMONWEAL	TH AVENUE	
PLANNE	D PRNTHD/PRETRM	BOSTON	, MA 02215		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORREC	TION (X5)
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHO	ULD BE COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPR DEFICIENCY)	OPRIATE DATE
C 320	Continued From pa	age 6	C 320		
	-				
	This FI FMFNT is	not met as evidenced by:			
		ntation review and interview,			
		conduct 2 fire drills per year at			
	the parent and sate				
	and paronicand date	sinto rocationo.			
	Findings include:				
	3				
	Surveyor #1's revie	ew of fire drill documentation			
		nic, found that only 1 fire drill			
	was conducted at e	each Clinic location per year.			
		on 7/3/19 at 10:50 A.M., the			
		icer confirmed with the			
		tor by email, that the parent			
		s only conduct 1 fire drill per			
	year.				
					Chro
					CMS
				A	
					mericans
					Initad

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		4174	B. WING		06/28/2017
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE	
PLANNE	D PRNTHD/PRETRM	HI TH SRV-GT B	MMONWEALT I, MA 02215	H AVENUE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE COMPLÉTE
C 000	An onsite licensure conducted for the p June 20, 2017 Planned Parenthoo 1055 Commonwea Boston, MA. Services: Medical, Onsite Licensure reconducted for the formula of June 21, 2017 Planned Parenthoo 91 Main Street Marlborough, MA. Services: Medical, June 21, 2017 Planned Parenthoo 470 Pleasant Stree	renewal survey was parent clinic: od Ith Avenue Surgical enewal surveys were also collowing satellite clinics: od Surgical	C 000		
	Worcester, MA 016 Services: Medical, June 22, 2017 Planned Parenthoo 391 Main Street Fitchburg, MA 0142 Services: Medical June 28, 2017 Planned Parenthoo 3550 Main Street, S Springfield, MA 011 Services: Medical, A site survey was n Parenthood: Milford Suite 101, Milford M December 27, 2016 of Health Care Facility Lice	Surgical Surgical od Suite 201 O7 Surgical ot conducted for Planned d Health Center 208 Main St, MA due to site closure on S.		TITLE	SS Americans Jnited

If continuation sheet 1 of 6

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	PLE CONSTRUCTION G:	(X3) DATE SURVEY COMPLETED	
		4174	B. WING		06/28/2017
NAME OF I	PROVIDER OR SUPPLIER	STREE	TADDRESS, CITY,	STATE, ZIP CODE	
PLANNE	D PRNTHD/PRETRM	HITH SRV-GT B	COMMONWEA ON, MA 02215		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETE
	The current license copies thereof, and Public Safety (DPS shall be posted in a clinic, and in any of This ELEMENT is Based on observatifailed to obtain a cu Department of Pub Findings include: The Surveyor observation of the Surveyor observation of the Fitch Boston sites expire questioned, the Ce	not met as evidenced by: ion and interview, the Clinic urrent inspection from the lic Safety, (DPS). erved that the DPS certificate burg, Marlborough, and ed on 4/24/17. When inter Manager said that DPS arrive coincidentally with the			
	safe,sanitary and ir necessary for the s	ep supplies and equipment n good working condition as ervices offered by the clinic			
	Based on observati	not met as evidenced by: ion and interview, the Clinic lies (specula), in a safe,			
	During the environr	mental tour of the Boston sit	e,	A	Americans
MA Division (STATE FORI	of Health Care Facility Lic M	ensure and Certification	6899	HKIN11	or Life

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVE COMPLETED	(X3) DATE SURVEY COMPLETED		
		4174	B. WING		06/28/201	7	
	PROVIDER OR SUPPLIER D PRNTHD/PRETRM	HI TH SRV-GT B	DDRESS, CITY, S' MMONWEALT I, MA 02215				
(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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE COM	X5) PLETE ATE	
MA Division	on 6/20/17 at 1:30 that the specula we drawer and were now was no material be bottom of the draw. When interviewed, the specula were streatment cart draws aid that the specula Cooper Medical. Surveyor review of for care of these specula with partitions. - Thoroughly dried individually in a motray with partitions. - Protect with cloth During the environs site, on 6/21/17, be P.M., attended by the Surveyor observed in warming drawers covered. There was specula and the bointerior of the draw. When asked by the Manager said that brought in to each placed into the draw. Surveyor about the drawers, she said to nightly. The Center Manager of Health Care Facility Lice.	P.M., the Surveyor observed ere stored in a treatment cart of wrapped or covered. There tween the specula and the ers. the Center Manager said that terilized and placed into the wers. The Center Manager la were purchased from the Manufacturer's guidelines becula indicates that: specula should be stored disture-free area in a protective or gauze if stored in drawers. mental tour of the Worcester etween 11:30 A.M., and 12:20 the Center Manager, the that: the specula were stored is, and were not wrapped or is no material between the ottom of the drawers. The ers appeared lightly soiled. Surveyor, the Center the specula were sterilized, exam room, unwrapped and wers. When asked by the ecleaning of the storage that the drawers were cleaned er said that the specula were			SS merica Juite If continuation the	d	
				I I	UI LII	IC	

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	LE CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		4174	B. WING		06/2	28/2017
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	,	
PLANNE	D PRNTHD/PRETRM	HITH SRV-GT B	MMONWEAL , MA 02215	TH AVENUE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUT CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
C 210	Continued From pa	ge 3	C 210			
	purchased from Co Review of the Manu of these specula in	ufacturer's guidelines for care				
		specula should be stored isture-free area in a protective				
	-Protect with cloth of	or gauze if stored in drawers.				
	Center Manager, w	wed these guidelines with the ho said that the specula being reviewed by the Clinic.				
	the Surveyor obser the Center Manage were stored in cove lined with a disposa bins were on top of #2, specula were si	P.M., at the Fitchburg site, ved the specula storage with er. In exam room #1, specula ered plastic bins, which were able under pad. The plastic a heating pad. In exam room tored in a warming drawer, th a disposable underpad, in				
		tored individually, as is nufacturer's guidelines.				
	the surveyors obse the Center Manage warming drawers, v disposable under p	O A.M., at the Springfield site, rved the specula storage with er. The specula were stored in which were lined with ads, in the exam tables. They ividually, as is specified in the delines.			Si	
C 300	140.212(C) Linen 8	Laundry - Storage	C 300		<i>-</i> U,	
		e clean linen in a closed cart away from soiled areas.		A	mer	cans
MA Division of STATE FORM	of Health Care Facility Lic M	ensure and Certification	6899	HKIN11	If continue	ation here 4 of 6

	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		4174	B. WING		06/2	8/2017
	PROVIDER OR SUPPLIER D PRNTHD/PRETRM	HITH SRV-GT B		STATE, ZIP CODE TH AVENUE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
C 300	μ.		C 300			
	Based on observati	not met as evidenced by: on and interview, the ed to store soiled linen an linen.				
	Findings include:					
	attended by the Nu observed an open, stand, in the supply said that dirty linen Surveyor observed uniforms were hung When questioned by	the environmental tour, rse Practitioner, the surveyor red cloth bag in a metal room. The Nurse Practitioner was stored in the bag. The that a was a rack on which g, next to the red cloth bag. y the Surveyor, the Nurse at the hanging uniforms were				
C 320	140.221 Fire Drills		C 320			
	fire drill at least twice	c premises shall conduct a ce a year in each work shift, I include the entire staff.				
	Documentation of s the Commissioner t	uch drills shall be available to for review.				
	Based on documen	not met as evidenced by: t review, and interview, the ed to perform fire drills twice a			CV.	S
	Findings include:				S.	3
	conducted once in	cated that a fire drill had been 2015, on 10/19/15 and once in		A	meri In i	cans
MA Division (STATE FORM	of Health Care Facility Lic VI	ensure and Certification	6899	HKIN11	If continue	tion here 5 of 6

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		4174	B. WING		06/28/2017
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE	
PLANNE	D PRNTHD/PRETRM	HITH SRV-GT B	MMONWEAL , MA 02215	TH AVENUE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETE
C 320	Continued From pa	ige 5	C 320		
	2016, on 6/14/16. Manager said that a 6/28/17. The Center	During interview, the Center a fire drill is scheduled for er Manager said that the Clinic cy regarding fire drills.			
				A	mericans
MA Division of STATE FORI	 of Health Care Facility Lic M	ensure and Certification	6899	HKIN11 f	If continuation here 6 of 6

PRINTED: 02/14/2020 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		LE CONSTRUCTION		E SURVEY IPLETED
		220110	B. WING				C 12/2019
NAME OF F	PROVIDER OR SUPPLIER			-;	STREET ADDRESS, CITY, STATE, ZIP CODE	077	12/2019
BRIGHAI	M AND WOMEN'S HO	SPITAL		75 FRANCIS STREET BOSTON, MA 02115			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
A 000	INITIAL COMMEN	TS	Α0	000			
	was conducted (AC	Substantial Allegation Survey CTS Reference #: 7/11/19 & 7/12/19 at:					
	Brigham & Women 75 Francis Street Boston, MA 02115	•					
		litions of Participation were ample of ten patients.					
A 283	42 CFR 482.21: Qu Performance Impro	EMENT ACTIVITIES	A 2	283	3		8/31/19
	(ii) Identify oppo	nust use the data collected to - portunities for improvement and and to improvement.					
	performance impro (i) Focus on high problem-prone area (ii) Consider the severity of problem	ust set priorities for its vement activities that h-risk, high-volume, or				SV.	(C)
	performance impro implementing those	ust take actions aimed at vement and, after e actions, the hospital must es, and track performance to			An	neri	cans
LABORATOR\	/ DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIGN	IATURE		TITLE	10 11	X6 DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it in determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are discloss play 50 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.

NAME OF PROVIDER OR SUPPLIER RIGHAM AND WOMEN'S HOSPITAL STREAMORS STREET BOSTON, MA 02115 SUMMAND'S TATEMENT OF DEFICIENCIES (PACI) IN STREAMOR'S PLAN OF CORRECTION EACH OF MAN OF CORRECTION TO MAN OF CORRECTION EACH OF CORRECTION EACH OF MAN OF CORRECTION EACH OF CORRECTION EACH		OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION NG		E SURVEY PLETED
STREET ADDRESS, CITY, STATE, ZIP CODE 75 FRANCIS STREET 76 PROVIDER OR SUPPLIER BRIGHAM AND WOMEN'S HOSPITAL SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PULL (EACH DEFICIENCY) A 283 Continued From page 1 ensure that improvements are sustained. A 283 This STANDARD is not met as evidenced by: Based on records reviewed and interviews the Hospital falled for three (Patients #1, #Patient 6 & Patient #7) patients of ten sampled patients to implement opportunities for improvement regarding patient falls after Patient #1's, Patient #6's and Patient #7's adverse events. The Hospital falled to implement opportunities for improvement regarding: 1.) Physician evaluation documentation after a patient fall. 2.) Clear staff instructions of Hospital expectations regarding Physician (or Licensed Independent Provider) notification to evaluate a patient after a fall and 3.) Coordinated instructions between nursing services and transport services for monitoring patients at risk for falls when the patient is off the patient care unit for testing. Findings included: The document titled, Quality Improvement Plan, dated 2019, indicated the Hospital had a process for improvement. The Quality Improvement Plan indicated the Hospital monitored performance by collecting data that allowed the Hospital to decide on improvements. STANDARD 2815 SATINDARD 2915 A 283 Facility To 2341 STANDARD 2915 Facility ID. 2341 STANDARD 2915 Facility ID. 2341 STANDARD 2915 Facility ID. 2341 Indicated the Hospital monitored performance by collecting data that allowed the Hospital to decide on improvements.			220110	B. WING			
PRÉETIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) A 283 Continued From page 1 ensure that improvements are sustained. This STANDARD is not met as evidenced by: Based on records reviewed and interviews the Hospital failed for three (Patients #1, #Patient 6 & Patient #7) patients of ten sampled patients to implement opportunities for improvement regarding patient falls after Patient #1's, Patient #6's and Patient #7's adverse events. The Hospital failed to implement opportunities for improvement regarding: 1.) Physician evaluation documentation after a patient fall, 2.) Clear staff instructions of Hospital expectations regarding Physician (or Licensed Independent Provider) notification to evaluate a patient after a fall and 3.) Coordinated instructions between nursing services and transport services for monitoring patients at risk for falls when the patient is off the patient care unit for testing. Findings included: The document titled, Quality Improvement Plan, dated 2019, indicated the Hospital had a process for improvement. The Quality Improvement Plan indicated the Hospital monitored performance by collecting data that allowed the Hospital to decide on improvements.					75 FRANCIS STREET	1 011	12/2019
ensure that improvements are sustained. This STANDARD is not met as evidenced by: Based on records reviewed and interviews the Hospital failed for three (Patients #1, #Patient 6 & Patient #7) patients of ten sampled patients to implement opportunities for improvement regarding patient falls after Patient #1's, Patient #6's and Patient #7's adverse events. The Hospital failed to implement opportunities for improvement regarding: 1.) Physician evaluation documentation after a patient fall. 2.) Clear staff instructions of Hospital expectations regarding Physician (or Licensed Independent Provider) notification to evaluate a patient after a fall and 3.) Coordinated instructions between nursing services and transport services for monitoring patients at risk for falls when the patient is off the patient care unit for testing. Findings included: The document titled. Quality Improvement Plan, dated 2019, indicated the Hospital had a process for improvement. The Quality Improvement Plan indicated the Hospital monitored performance by collecting data that allowed the Hospital to decide on improvements.	PRÉFIX	(EACH DEFICIENCY	/ MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	D BE	COMPLÉTION
Based on records reviewed and interviews the Hospital failed for three (Patients #1, #Patient 6 & Patient #7) patients of ten sampled patients to implement opportunities for improvement regarding patient falls after Patient #1's, Patient #6's and Patient #7's adverse events. The Hospital failed to implement opportunities for improvement regarding: 1.) Physician evaluation documentation after a patient fall, 2.) Clear staff instructions of Hospital expectations regarding Physician (or Licensed Independent Provider) notification to evaluate a patient after a fall and 3.) Coordinated instructions between nursing services and transport services for monitoring patients at risk for falls when the patient is off the patient care unit for testing. Findings included: The document titled, Quality Improvement Plan, dated 2019, indicated the Hospital had a process for improvement. The Quality Improvement Plan indicated the Hospital monitored performance by collecting data that allowed the Hospital to decide on improvements.	A 283		•	A 28	33		
improvement regarding: 1.) Physician evaluation documentation after a patient fall, 2.) Clear staff instructions of Hospital expectations regarding Physician (or Licensed Independent Provider) notification to evaluate a patient after a fall and 3.) Coordinated instructions between nursing services and transport services for monitoring patients at risk for falls when the patient is off the patient care unit for testing. Findings included: The document titled, Quality Improvement Plan, dated 2019, indicated the Hospital had a process for improvement. The Quality Improvement Plan indicated the Hospital monitored performance by collecting data that allowed the Hospital to decide on improvements. FORM CMS-2567(02-99) Previous Versions Obsolete Event ID:27W711 Facility ID:2341 If dantid the face 2.1		Based on records Hospital failed for the Patient #7) patients implement opportunates regarding patient fa	reviewed and interviews the nree (Patients #1, #Patient 6 & s of ten sampled patients to nities for improvement after Patient #1's, Patient				
patient fall, 2.) Clear staff instructions of Hospital expectations regarding Physician (or Licensed Independent Provider) notification to evaluate a patient after a fall and 3.) Coordinated instructions between nursing services and transport services for monitoring patients at risk for falls when the patient is off the patient care unit for testing. Findings included: The document titled, Quality Improvement Plan, dated 2019, indicated the Hospital had a process for improvement. The Quality Improvement Plan indicated the Hospital monitored performance by collecting data that allowed the Hospital to decide on improvements. FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 27W711 Facility ID: 2341 If ontiful that the Carterian Plan indicated the Hospital Security Indicated the Hospital Indicated the Hospital Indicated In							
expectations regarding Physician (or Licensed Independent Provider) notification to evaluate a patient after a fall and 3.) Coordinated instructions between nursing services and transport services for monitoring patients at risk for falls when the patient is off the patient care unit for testing. Findings included: The document titled, Quality Improvement Plan, dated 2019, indicated the Hospital had a process for improvement. The Quality Improvement Plan indicated the Hospital monitored performance by collecting data that allowed the Hospital to decide on improvements. **GRM CMS-2567(02-99) Previous Versions Obsolete** Event ID: 27W711 Facility ID: 2341 If a niting fact and a patient and patients and patients are patients. The document titled, Quality Improvement Plan indicated the Hospital monitored performance by collecting data that allowed the Hospital to decide on improvements.			uation documentation after a				
services and transport services for monitoring patients at risk for falls when the patient is off the patient care unit for testing. Findings included: The document titled, Quality Improvement Plan, dated 2019, indicated the Hospital had a process for improvement. The Quality Improvement Plan indicated the Hospital monitored performance by collecting data that allowed the Hospital to decide on improvements. Americans FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 27W711 Facility ID: 2341 If cantiful fighther and 2019		expectations regard Independent Provide	ding Physician (or Licensed der) notification to evaluate a				
The document titled, Quality Improvement Plan, dated 2019, indicated the Hospital had a process for improvement. The Quality Improvement Plan indicated the Hospital monitored performance by collecting data that allowed the Hospital to decide on improvements. **CORM CMS-2567(02-99) Previous Versions Obsolete** Event ID: 27W711 Facility ID: 2341 If continuation the tale of the continuation the tale of the continuation that the continuation the tale of the continuation that the c		services and transp patients at risk for f	port services for monitoring falls when the patient is off the				
dated 2019, indicated the Hospital had a process for improvement. The Quality Improvement Plan indicated the Hospital monitored performance by collecting data that allowed the Hospital to decide on improvements. FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 27W711 Facility ID: 2341 If continuation that allowed the Hospital to decide and indicated the Hospital monitored performance by collecting data that allowed the Hospital to decide and indicated the Hospital monitored performance by collecting data that allowed the Hospital to decide and indicated the Hospital monitored performance by collecting data that allowed the Hospital to decide and indicated the Hospital monitored performance by collecting data that allowed the Hospital to decide and indicated the Hospital monitored performance by collecting data that allowed the Hospital to decide and indicated the Hospital monitored performance by collecting data that allowed the Hospital to decide and indicated the Hospital monitored performance by collecting data that allowed the Hospital to decide and indicated the Hospital monitored performance by collecting data that allowed the Hospital to decide and indicated the Hospital monitored performance by collecting data that allowed the Hospital to decide and indicated the Hospital monitored performance by collecting data that allowed the Hospital to decide and indicated the Hospital monitored performance by collecting data that allowed the Hospital to decide and indicated the Hospital monitored performance by collecting data that allowed the Hospital monitored performance by collecting data that allowed the Hospital monitored performance by collecting data that allowed the Hospital monitored performance by collecting data that allowed the Hospital monitored performance by collecting data that allowed the Hospital monitored performance by collecting data that allowed the Hospital monitored p		Findings included:					
FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 27W711 Facility ID: 2341 If continuation the et al. 201		dated 2019, indicat for improvement. I indicated the Hospi collecting data that	ed the Hospital had a process The Quality Improvement Plan tal monitored performance by				3
	ORM CMS-2!	567(02-99) Previous Versions	s Obsolete Event ID: 27W71	1			

BRIGHAM AND WOMEN'S HOSPITAL	PREET ADDRESS, CITY, STATE, ZIP CODE FRANCIS STREET DSTON, MA 02115 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIDEFICIENCY)	3E	2/2019 (X5)
BRIGHAM AND WOMEN'S HOSPITAL (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) A 283 Continued From page 2 A 283	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI	3E	(X5)
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG PREFIX TAG PREFIX TAG A 283 Continued From page 2 A 283	(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPR	3E	(X5)
7.250			COMPLETION DATE
undated, indicated that a staff nurse, nurse leader or Department Manager was responsible to complete a review of the event, talking to the patient witnesses or staff members who were in proximity and had knowledge of the event. The Surveyor interviewed the Quality Director at 1:30 P.M. on 7/11/19. The Quality Director said that the Falls Committee reviewed falls; however, the Falls Committee had not met after 4/2018. The Hospital policy titled, Fall Risk Assessment, dated 9/28/18, indicated that the Hospital called a Rapid Response (emergency response personnel) when a patient fell and struck the head. The Fall Risk Assessment policy did not indicate clear instructions for when staff were expected to contact a Physician (or Licensed Independent Provider) to evaluate a patient after a fall. The Hospital Fall Risk Assessment policy did not indicate instructions for monitoring patients at risk for falls when off the patient care unit for testing. The Hospital policy titled, Observer, dated 5/31/18, indicated the Hospital implemented either a constant observer (person) or a visual monitor (device) to monitor patients evaluated to have a high risk for fall. The policy did not indicate instructions for monitoring Patients at risk for falls when off the patient care unit for testing. The Hospital Policy titled, Central Transport Services Stretcher Procedure, dated 7/16/15, indicated that floor (patient care unit) staff accompanied patients on fall precautions (at risk			cans

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION		E SURVEY IPLETED
		220110	B. WING				C
NAME OF F	PROVIDER OR SUPPLIER	220110	B. WING		STREET ADDRESS. CITY. STATE. ZIP CODE	07/	12/2019
NAIVIE OF F	PROVIDER OR SUPPLIER				75 FRANCIS STREET		
BRIGHA	M AND WOMEN'S HO	SPITAL			BOSTON, MA 02115		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTIO	N	(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP		COMPLETION DATE
IAG			1710		DEFICIENCY)		
4.000		_					
A 283		ige 3	A 2	283	3		
	for fall).						
	Regarding Patient	#1's fall:					
	The History & Phys	sical, dated 10/11/18, indicated					
	that Patient #1 was	admitted from a cardiac clinic					
	for a syncopal (fain falls.	ting) episode and a history of					
	A Nurse's Note da	ted at 10:04 P.M. on 10/11/18,					
		assessed Patient #1 on					
	admission to the Hospital to be at a high risk of						
	falling.						
	A Nurse's Note, da	se's Note, dated at 9:42 P.M. on 10/12/18,					
	indicated Patient #1 fell from a stretcher today at						
	approximately 2:30	P.M. while at cardiology.					
	A.) The Surveyor i	nterviewed the Senior					
		at 11:15 A.M. on 7/11/19.					
		ort Manager said the nursing					
		care unit documented the a document called a Ticket to					
		of communication between					
		rsing staff and transport					
		lior Transport Manager said use the Ticket to Ride for the					
	patients fall status.	ase the Hovet to Ivide to title					
	•	ladaa daar (CC CC					
	The Hospital provide Patient #1's fall risk	ded no documentation that					
		n the nursing staff to the					
	Transport Staff on					CC.	
						3	K
	B.) Medical Record	d review indicated no) -
	documentation by	a physician that evaluated					
	Patient #1 in cardio	ology after Patient #1's fall.			An	neri	cans
FORM CMS-25	1 567(02-99) Previous Version:	s Obsolete Event ID: 27W71	1	Fa	acility ID: 2341 If continu	lation she	et age 4 of 6
					fr	rl	Life

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION NG		E SURVEY IPLETED
		220110	B. WING _			C 12/2019
	PROVIDER OR SUPPLIER	SPITAL		STREET ADDRESS, CITY, STATE, ZIP CODE 75 FRANCIS STREET BOSTON, MA 02115	<u> </u>	12/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y 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)	ULD BE	(X5) COMPLETION DATE
A 283	at 11:53 A.M. on 10 fall. The Surveyor inter 7:30 A.M. on 7/12/physician did not d Patient #1 after the #1's medical record Regarding Patient A Hospital Report, Patient #6 was four between the bed singular out of the bed and Medical Record incan Emergency Resord The Resident Progon 3/15/19, approximation of the head and spoundicated a Computof the head and spoundicated a Record Resheet documentation Regarding Patient #7 had a fact A Nurse's Note, daindicated Patient #7 Medical Record Redocumentation on the street documentation	view indicated a physician note 0/13/18 regarding Patient #1's viewed the Quality Director at 19. The Quality Director said a ocument an evaluation of a fall in cardiology in Patient d. #6's fall: dated 3/15/18, indicated and dangling out of bed in derails, with the torso (chest) head noted on the floor. The dicated no documentation that apponse Team was notified. ress Note, dated at 7:44 P.M. imately 12 hours after the fall, terized Tomography (CT) scan ine showed no acute findings. eview indicated no nursing flow on regarding Patient #6's fall. #7's fall: dated 6/22/19, indicated	A 28	A	S. mer	Sicans
ORM CMS-2	 567(02-99) Previous Version	s Obsolete Event ID: 27W71	1		ntirustion she	Life

STATEMENT O AND PLAN OF	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION IG	COM	E SURVEY PLETED C
		220110	B. WING _			12/2019
	OVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE 75 FRANCIS STREET BOSTON, MA 02115		12/2013
(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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
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PRINTED: 02/14/2020 FORM APPROVED OMB NO. 0938-0391

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS. CITY, STATE, 2IP CODE TS FRANCIS STREET BOSTON, MA. 02115		OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	COM	E SURVEY IPLETED
STREET ADDRESS, CITY, STATE, ZIP CODE THE PROVIDER OR SUPPLIER BRIGHAM AND WOMEN'S HOSPITAL STREET BOSTON, MA 02115 SPANICIS STREET BOSTON, MA 02115 DEPRETER TAG REGULATORY OR LSC IDENTIFYING INFORMATION) A 000 INITIAL COMMENTS A CMS authorized Substantial Allegation Survey was conducted (ACTS Reference Number: MA00031021) on 5/2/19 and 5/3/19 at: Brigham and Women's Hospital 75 Francis Street Boston, MA 02115 The following Condition of Participation was reviewed using a sample of ten patients: 42 CFR 482.51: Surgical Services The following Condition of Participation was out of compliance. 42 CFR 482.51: Surgical Services The following Condition of Participation was out of compliance. 42 CFR 482.51: Surgical Services The following Condition of Participation was out of compliance. 42 CFR 482.51: Surgical Services SURGICAL SERVICES CFR(s): 482.51 If the hospital provides surgical services, the services must be well organized and provided in accordance with acceptable standards of practice. If outpatient surgical services are offered the services must be consistent in quality with inpatient care in accordance with the complexity of services offered. This CONDITION is not met as evidenced by: The Hospital vas out of compliance with the Condition of Surgical Services. Findings included: The Hospital failed to assure that policies			220110	B. WING	i			
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) A 000 INITIAL COMMENTS A CMS authorized Substantial Allegation Survey was conducted (ACTS Reference Number: MA00031021) on 5/2/19 and 5/3/19 at: Brigham and Women's Hospital 75 Francis Street Boston, MA 02115 The following Condition of Participation was reviewed using a sample of ten patients: 42 CFR 482.51: Surgical Services The following Condition of Participation was out of compliance. 42 CFR 482.51: Surgical Services The following Condition of Participation was out of compliance. 49 CFR (8): 482.51 If the hospital provides surgical services, the services must be well organized and provided in accordance with acceptable standards of practice. If outpatient surgical services are offered the services must be consistent in quality with inpatient care in accordance with the complexity of services offered. This CONDITION is not met as evidenced by: The Hospital was out of compliance with the Condition of Surgical Services. Findings included: The Hospital failed to assure that policies			SPITAL			75 FRANCIS STREET	•	
A CMS authorized Substantial Allegation Survey was conducted (ACTS Reference Number: MA00031021) on 5/2/19 and 5/3/19 at: Brigham and Women's Hospital 75 Francis Street Boston, MA 02115 The following Condition of Participation was reviewed using a sample of ten patients: 42 CFR 482.51: Surgical Services The following Condition of Participation was out of compliance. 42 CFR 482.51: Surgical Services SURGICAL SERVICES A 940 6/7/19 If the hospital provides surgical services, the services must be well organized and provided in accordance with acceptable standards of practice. If outpatient surgical services are offered the services must be consistent in quality with inpatient care in accordance with the complexity of services offered. This CONDITION is not met as evidenced by: The Hospital was out of compliance with the Condition of Surgical Services. Findings included: The Hospital failed to assure that policies	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFI		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP) BE	COMPLETION
Brigham and Women's Hospital 75 Francis Street Boston, MA 02115 The following Condition of Participation was reviewed using a sample of ten patients: 42 CFR 482.51: Surgical Services The following Condition of Participation was out of compliance. 42 CFR 482.51: Surgical Services SurGiCAL SERVICES CFR(s): 482.51 If the hospital provides surgical services, the services must be well organized and provided in accordance with acceptable standards of practice. If outpatient surgical services are offered the services must be consistent in quality with inpatient care in accordance with the complexity of services offered. This CONDITION is not met as evidenced by: The Hospital was out of compliance with the Condition of Surgical Services. Findings included: The Hospital failed to assure that policies	A 000	A CMS authorized	Substantial Allegation Survey	A	000			
services must be well organized and provided in accordance with acceptable standards of practice. If outpatient surgical services are offered the services must be consistent in quality with inpatient care in accordance with the complexity of services offered. This CONDITION is not met as evidenced by: The Hospital was out of compliance with the Condition of Surgical Services. Findings included: The Hospital failed to assure that policies	A 940	Brigham and Wome 75 Francis Street Boston, MA 02115 The following Concreviewed using a set 42 CFR 482.51: Set The following Concord compliance. 42 CFR 482.51: Set SURGICAL SERVI	en's Hospital dition of Participation was ample of ten patients: urgical Services dition of Participation was out urgical Services	AS	940			6/7/19
		services must be waccordance with ac practice. If outpatic offered the services with inpatient care complexity of service. This CONDITION The Hospital was a Condition of Surgic	rell organized and provided in acceptable standards of sent surgical services are so must be consistent in quality in accordance with the ces offered.				S	S
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE		regarding surgical	counts were effective and			Ar	ner	cans

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 disclossible 10 lay 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

(X1) PROVIDER/SUPPLIER/CLIA

PRINTED: 02/14/2020 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY

AND PLAN C	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING	COM	IPLETED
		220110	B. WING			C 03/2019
	PROVIDER OR SUPPLIER M AND WOMEN'S HO			STREET ADDRESS, CITY, STATE, ZIP CODE 75 FRANCIS STREET BOSTON, MA 02115	•	03/2019
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE	OULD BE	(X5) COMPLETION DATE
A 940	ensured all surgica	ge 1 I items were accounted for patients after surgery.	Α9	40		
A 951	and resources. Po must be designed to maintenance of hig practice and patien. This STANDARD is Based on record resurgical failed to ensurgical counts were surgical items were retained in patients. Findings include:	M POLICIES Thust be consistent with needs licies governing surgical care to assure the achievement and the standards of medical to care. It care. It is not met as evidenced by: eview and interview the insure that policies regarding the effective and that all the accounted for and not after surgery.	A 9	51		6/7/19
	splenectomy on 2/1 splenectomy was counts were perform reported as correct was transferred to t (PACU) where he/s blood pressure)req (medications used bedside ultrasound waves to produce p was performed sho Patient #1 was brook Room (OR) where a (from the previous statement was to produce p was performed sho patient #1 was brook Room (OR) where a county was to produce p was performed sho patient #1 was brook Room (OR) where statement was the previous statement was the previou	ompleted and the surgical med two times and were. After the surgery Patient #1 the Post Anesthesia Care Unit he became hypotensive (low uiring vasopressors to treat hypotension). A (imaging which uses sound pictures of inside the body) wing signs of bleeding. Uight back to the Operating a retained malleable retractor surgery) was discovered		_	S. Ameri	
ORM CMS-25	567(02-99) Previous Versions	Obsolete Event ID: I9BZ11				100 5
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(X2) MULTIPLE CONSTRUCTION

CACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG		OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION		E SURVEY IPLETED
RAME OF PROVIDER OR SUPPLIER BRIGHAM AND WOMEN'S HOSPITAL CALP DEPOSITION SUMMARY STATEMENT OF DEFICIENCIES TO STANCIS STREET BOSTON, MA 02115 CALP DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG TAG PROVIDERS PLAN OF CORRECTION DEFICIENCY			220110	B. WING			
EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) A 951 Continued From page 2 inside the patient. 2. Patient #2 underwent a bilateral lung transplant on 3/12/19. From 3/12/19 to 3/21/19, Patient #2 returned to the OR multiple times to have the vacuum dressing (a negative pressure dressing for wounds) changed along with multiple surgical sponges being removed and replaced. Patient #2's Operative Note, dated 3/21/19, indicated that all surgical sponges were removed and the chest was closed. On 3/22/19, Patient #2 received an x-ray revealing a retained surgical sponge. On 3/26/19, Patient #2 returned to the OR for removal of the retained sponge. The Surveyor interviewed the Risk Manager on 5/2/19 at 8:30 A.M. The Risk Manager said that Patient #1's case was reviewed by a multidisciplinary group on 2/18/19. The Risk Manager said that, in Patient #1's case, the Surgical Scrub counted a retractor that was still in use during the surgery and the Circulating Nurse acknowledged the count. The Risk Manager said that, at some point after the count was completed, the retractor was retained in Patient #1's abdomen. The Risk Manager said that the count process was reviewed and it was determined that the Count Policy needed to be changed. The Risk Manager said patient #2 required multiple wound packing procedures in the OR where multiple sponges were being removed and replaced over several days. The			SPITAL	7	5 FRANCIS STREET	1 00/	00/2013
inside the patient. 2. Patient #2 underwent a bilateral lung transplant on 3/12/19. From 3/12/19 to 3/21/19, Patient #2 returned to the OR multiple times to have the vacuum dressing (a negative pressure dressing for wounds) changed along with multiple surgical sponges being removed and replaced. Patient #2's Operative Note, dated 3/21/19, indicated that all surgical sponges were removed and the chest was closed. On 3/22/19, Patient #2 received an x-ray revealing a retained surgical sponge. On 3/26/19, Patient #2 returned to the OR for removal of the retained sponge. The Surveyor interviewed the Risk Manager on 5/2/19 at 8:30 A.M. The Risk Manager said that Patient #1's case was reviewed by a multidisciplinary group on 2/18/19. The Risk Manager said that, in Patient #1's case, the Surgical Scrub counted a retractor that was still in use during the surgery and the Circulating Nurse acknowledged the count. The Risk Manager said that, at some point after the count was completed, the retractor was retained in Patient #1's abdomen. The Risk Manager said that the count process was reviewed and it was determined that the Count Policy needed to be changed. The Risk Manager said Patient #2 required multiple wound packing procedures in the OR where multiple sponges were being removed and replaced over several days. The	PRÉFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	D BE	(X5) COMPLETION DATE
Risk Manager said that, on 3/21/19, the Operative Note indicated that all sponges were removed before the wound was closed. The Risk Manager said that the Count Policy did not address this type of scenario (where a patient received multiple surgical dressing changes) and FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: I9BZ11 Facility ID: 2341 If continuation sheet Age		inside the patient. 2. Patient #2 under transplant on 3/12/Patient #2 returned have the vacuum d dressing for wound surgical sponges b Patient #2's Operatindicated that all su and the chest was received an x-ray responge. On 3/26/19 OR for removal of to The Surveyor interpolation of the Surveyor interpol	went a bilateral lung 19. From 3/12/19 to 3/21/19, 1 to the OR multiple times to ressing (a negative pressure s) changed along with multiple eing removed and replaced. tive Note, dated 3/21/19, prigical sponges were removed closed. On 3/22/19, Patient #2 evealing a retained surgical p. Patient #2 returned to the the retained sponge. viewed the Risk Manager on The Risk Manager said that vas reviewed by a pup on 2/18/19. The Risk in Patient #1's case, the nted a retractor that was still turgery and the Circulating ed the count. The Risk at some point after the count eretractor was retained in then. The Risk Manager said theses was reviewed and it was the Count Policy needed to be Manager said Patient #2 ound packing procedures in tiple sponges were being ced over several days. The that, on 3/21/19, the ticated that all sponges were the wound was closed. The Risk the Count Policy did not f scenario (where a patient turgical dressing changes) and				

NAME OF PROVIDER OR SUPPLIER BRIGHAM AND WOMEN'S HOSPITAL SUMMARY STATEMENT OF DEPICIENCIES RECHARD RECOVERY WASTER PROCESS IN TALL (XA) ID RECHARD RECIPION ON LIST BE PRECEDED BY TALL RECULATORY OR LIST DEPICIENCY WASTER PROCESS IN TALL RECULATORY OR LIST DEPICIENCY WASTER PROCESS IN TALL REVIEW OF the document titled "Collaborative Case Review", dated 4/24/19, indicated that the Hospital determined the surgical instrument count policy was ambiguous and the review group discussed recommendations for changing the current policy. The Surveyor interviewed the Nurse Manager of the OR on \$2/19 at 10:00 A M. The Nurse Manager said that the Count Policy was vague and was not clear about counting instruments that were in use and could be visualized by staff. The Nurse Manager said that a new policy was developed that corrected his with an added second step/count that would prevent this event from re-occurring. The Nurse Manager said that the new policy was yet to be approved and it needed to be reviewed by two or three more committees. The Nurse manager acknowledged that the Count Policy change. The Nurse Manager said that a staff meetings of that all staff would be aware of the policy change. The Nurse Manager said that staff meetings of attending the staff meeting as a prossible that some OR staff were aware of the changes prior to the policy being approved. The Nurse Manager said that staff meetings of a staff. The Nurse Manager said there was no process in place to ensure all OR staff were aware of the changes prior to the policy being approved. The Nurse Manager said that was possible that some OR staff were unaware of the changes prior to the policy being approved. The Nurse Manager acknowledged that it was possible that some OR staff were unaware of the changes prior to the policy being approved. The Nurse Manager acknowledged that it was possible that some OR staff were unaware of the changes prior to the policy being approved. The Nurse Manager said there was no process in place to ensure all OR staf		OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION	COM	E SURVEY PLETED
BRIGHAM AND WOMEN'S HOSPITAL (PA) ID			220110	B. WING				
A 951 A 951 Continued From page 3 that corrective measures were being reviewed. Review of the document titled "Collaborative Case Review", dated 4/24/19, indicated that the Hospital determined the surgical instrument court policy was ambiguous and the review group discussed recommendations for changing the current policy. The Surveyor interviewed the Nurse Manager of the OR on 5/2/19 at 10:00 A.M. The Nurse Manager said that the Count Policy was vague and was not clear about counting instruments that were in use and could be visualized by staff. The Nurse Manager said that a new policy was developed that corrected this with an added second step/count that would prevent this event from re-occurring. The Nurse Manager said that the new policy was yet to be approved and it needed to be reviewed by two or three more committees. The Nurse Manager said that the Count Policy changes were discussed in the April 2019 staff meetings are available to be reviewed by staff meetings are available to be reviewed by staff where more committees. The Nurse Manager said then the April 2019 staff meetings are available to be reviewed by staff where were aware of the place of the policy changes. The Nurse Manager said thrend. The Nurse Manager as available to be reviewed by staff where aware of the changes prior to the policy being approved. The Nurse Manager acknowledged that staff would be aware of the policy being approved. The Nurse Manager acknowledged that it was possible that some OR staff were unaware of the practice/policy changes. The Hospital provided the Surveyors with an updated draft policy titled "Surgical Counts and Prevention of Retained Surgical Items (RSI)" on			SPITAL		75	FRANCIS STREET		
that corrective measures were being reviewed. Review of the document titled "Collaborative Case Review", dated 4/24/19, indicated that the Hospital determined the surgical instrument count policy was ambiguous and the review group discussed recommendations for changing the current policy. The Surveyor interviewed the Nurse Manager of the OR on 5/2/19 at 10:00 A.M. The Nurse Manager said that the Count Policy was vague and was not clear about counting instruments that were in use and could be visualized by staff. The Nurse Manager said that a new policy was developed that corrected this with an added second step/count that would prevent this event from re-occurring. The Nurse Manager said that the new policy was yet to be approved and it needed to be reviewed by two or three more committees. The Nurse manager acknowledged that the Count Policy hand not been updated with changes as of 5/2/19. The Nurse Manager said that the Count Policy changes were discussed in the April 2019 staff meeting ser available to be reviewed by staff who were unable to attend. The Nurse Manager said that staff meetings are available to be reviewed by staff who were unable to attend. The Nurse Manager said that staff meetings are available to be reviewed by staff who were unable to attend. The Nurse Manager said three was no process in place to ensure all OR staff were aware of the changes prior to the policy being approved. The Nurse Manager acknowledged that it was possible that some OR staff were unaware of the changes prior to the policy being approved. The Nurse Manager acknowledged that it was possible that some OR staff were unaware of the practice/policy changes. The Hospital provided the Surveyors with an updated draft policy titled "Surgical Counts and Prevention of Retained Surgical Items (RSI)" on	PRÉFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFI		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE	COMPLETION
		Review of the docu Case Review", date Hospital determine count policy was an group discussed rethe current policy. The Surveyor intent the OR on 5/2/19 a Manager said that and was not clear at that were in use and The Nurse Managed developed that corns second step/count from re-occurring. The new policy was needed to be review committees. The Norman that the Count Policy changes as of 5/2/2 that the Count Policy t	iment titled "Collaborative ed 4/24/19, indicated that the d the surgical instrument imbiguous and the review ecommendations for changing viewed the Nurse Manager of at 10:00 A.M. The Nurse the Count Policy was vague about counting instruments ad could be visualized by staff. For said that a new policy was rected this with an added that would prevent this event were manager acknowledged by two or three more urse manager acknowledged by had not been updated with 19. The Nurse Manager said by changes were discussed in meeting so that all staff would licy change. The Nurse staff meetings are available to ff who were unable to attend. For said there was no process in OR staff were aware of the epolicy being approved. The knowledged that it was OR staff were unaware of the neges. Ided the Surveyors with an attitude the Surveyors					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		E SURVEY IPLETED
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	PROVIDER OR SUPPLIER	R	J 2	STRI 75 F	EET ADDRESS, CITY, STATE, ZIP CODE RANCIS STREET STON, MA 02115		03/2019
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A 951	for counting instruverified upon final counting sponges taken upon permapacking has been acknowledged that been approved.	policy addresses a new process aments including "a count of closure" and a new process for that includes "an X-ray being anent closure to assure all a removed". The Risk Manager at the draft policy had not yet	AS	951		Amer	
ORM CMS-2	567(02-99) Previous Versio	ons Obsolete Event ID: I9BZ11		Facility			5
						Orl	Life

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		220110	B. WING		03/0	06/2019
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
BRIGHA	M AND WOMEN'S HO	SPITAI	CIS STREET , MA 02115			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
P 000	INITIAL COMMENT	ΓS	P 000			
	and ACTS #MA000 3/5/19 and 3/6/19 a Brigham and Wome 75 Francis Street					
	Boston Ma 02115					
	Deficiencies related	d to MA00030883 were cited.				
P 024	130.200 INCORPO CONDITIONS OF F	PRATION OF M'CARE PARTIC	P 024			3/18/19
	of the Medicare Co Hospitals, 42 C.F.R (hereinafter Conditi they may be amend the requirement for specified in 42 C.F. review specified in requirement for cor Code specified in 4 requirement that co	meet all of the requirements nditions of Participation for 8, 482.11 through 482.62 cons of Participation), and as ded from time to time, except institutional plan and budget R. 482.12(d), for utilization 42 C.F.R. 482.30, the inpliance with the Life Safety 2 C.F.R. 482.41(b), and any onflicts with the supplementary MR 130.000 Subparts C and				
	This REQUIREMENT by: A-0450	NT is not met as evidenced				33
		patient medical record entries mplete, dated, timed, and		Aı	mer	cans
MA Division	 of Health Care Facility Lic	ensure and Certification			mi	tea

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

TITLE

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		220110	B. WING		03/06/2019	
					1 03/0	10/2019
NAME OF I	PROVIDER OR SUPPLIER		DRESS, CITY, S CIS STREET	TATE, ZIP CODE		
BRIGHA	M AND WOMEN'S HO	SPITAL	MA 02115			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
P 024	Continued From pa	ge 1	P 024			
1 024	authenticated in wriperson responsible service provided, coand procedures. Based on records reprocedure for Information (Patient #1) The Hospital Policy dated 4/2018, indicated 4/2018, indicated the nepatient and the patient and the patient and the patient and time the coan.) The Surveyor reconsent for a cardion 3/5/19. The Information aleft unsigned beautiful both the Surveyor full formed Consent for procedure. Under the procedure planned three hand-written of the Surveyor. The Formatical procedure in the Surveyor. The Formatical procedures and the Surveyor. The Formatical procedure in the Surveyor. The Formatical procedures planned the Surveyor.	itten or electronic form by the for providing or evaluating the onsistent with hospital policies eviewed and interview the dhere to its' policy and med Consent for one of two requiring Informed Consent. It titled Informed Consent, ated that after the physician ecessary information to the ent agrees to the procedure, dethe physician must sign, consent. Eviewed Patient #1's Informed ac catheterization procedure rmed Consent, dated 1/29/19, by the physician. Earther reviewed Patient #1's for a cardiac catheterization he section titled additional dor comments there were entries that were illegible to Risk Manager was asked to and was only able to	1 02-7		Si	S
				A	meri I 1	tod
	of Health Care Facility Lic		6899	-	JA A A	
STATE FORI	vi			FTH11 f	ortinua	tion sheep 2 of 2

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		220110	B. WING				C 17/2017
	PROVIDER OR SUPPLIER	SPITAL		7	STREET ADDRESS, CITY, STATE, ZIP CODE 75 FRANCIS STREET BOSTON, MA 02115	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFII TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
A 000	INITIAL COMMENT	TS I Allegation Complaint Survey	Α0	000			
	(ACTS Reference #	# MA00026121) was 5/10, 5/15, 5/17/17 at:					
	Brigham and Wome 75 Francis Street Boston, MA 02115	en's Hospital					
	•	litions of Participation were ample of ten patients:					
A 049	482.22 Medical Sta 482.23 Nursing Set 482.27 Laboratory MEDICAL STAFF - CFR(s): 482.12(a)(rvices Services ACCOUNTABILITY	Α0)49			7/10/17
	medical staff is acc	dy must] ensure that the countable to the governing of care provided to patients.					
	Based on docume the Medical Staff fa care provided to pa #4, and #9) of 7 Ne (NICU) patients in a	s not met as evidenced by: nts reviewed and interviews illed to ensure the quality of atients for 4 (Patients #2, #3, conatal Intensive Care Unit a total sample of 10 patients es, diagnostic studies or heart at Hospital #2.					
	Findings included:					cC/	
	Products at Hospita staff administered by	itled, Use of Hospital Blood al B, dated 3/20/17, indicated blood products issued by bital #2. The policy indicated			A	8	5
I ARODATORY	that a Blood Transf	usion Record was available in	NATURE		TITLE	neri	cans

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing the determined has other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above rediscloss play 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.

			(X3) DATE SURVEY COMPLETED		
	220110 B. W	/ING			C 17/2017
NAME OF PROVIDER OR SUPPLIER BRIGHAM AND WOMEN'S HOSPITAL		75	REET ADDRESS, CITY, STATE, ZIP CODE FRANCIS STREET OSTON, MA 02115	1 03/	1112011
(X4) ID SUMMARY STATEMENT OF D PREFIX (EACH DEFICIENCY MUST BE PRI TAG REGULATORY OR LSC IDENTIFYIN	ECEDED BY FULL P	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETION DATE
A 049 Continued From page 1 Hospital #2's operating room for The policy indicated that operation documented other information operating room notes. The policy indicated blood products is Hospital #1 and administered if operating room. The policy indicated the Hospital #2 reported to Hospital product transfusion reactions of from Hospital #1 and administer. The reference book titled Stan Banks and Transfusion Serviced dated 4/21/16 page 45 and Staindicated the patient's medical the date and time of transfusion and post-transfusion vital signs blood transfused, the transfusion applicable, transfusion-related. The Surveyor interviewed NIC #1, at 9:15 A.M. on 5/8/17. NI #1 said that patients (NICU bagastrointestinal procedures, imcardiac surgery for Patent Duck (PDA, heart defect) conducted the NICU babies returned to Hispocedure, diagnostic study or surgery. NICU Charge Nurse #1 said thand #4 had a jejunostomy feed placed into the infant's intestin conducted at Hospital #2.	ating room staff in Hospital #2's icy indicated that Registered Nurses sued by the in Hospital #2's dicated that all #1, blood of blood issued ered at Hospital #2. dards for Blood es, 30th Edition, andard # 5.29, record included on, pre-transfusion s, the volume of onist and, if adverse events. U Charge Nurse CU Charge Nurse bies) had haging studies, and ctus Arteriosus lat Hospital #2 and lospital #1 after the PDA heart mat Patients #2, #3 ding tube (tube	A 049		S. meri	

RAME OF PROVIDER OR SUPPLIER BRIGHAM AND WOMEN'S HOSPITAL (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	AND DLAN OF CODDECTION INDENTIFICATION NUMBER:		E CONSTRUCTION	COM	E SURVEY IPLETED		
NAME OF PROVIDER OR SUPPLIER BRIGHAM AND WOMEN'S HOSPITAL (X4) ID REETX (SAMPREY TO PEFICIENCIES TAG T			220110	B. WING			C 17/2017
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG Continued From page 2 feeding tube. Medical records of Patients #2, #3 and #4 indicated no documentation by the providers at Hospital #2 of the jejunostomy feeding tube procedure placement. The Physician Note, dated 5/28/17 at 10:25 A.M., indicated Patient #9 had heart surgery for a PDA ligation. The medical record did not indicate any documentation by the surgeon, care provided, monitoring and medications administered by the anesthesiologist or operating room staff at Hospital #2, or documentation of blood product administration by staff caring for Patient #9 during surgery performed at Hospital #2. A 582 A 582 A DEQUACY OF LABORATORY SERVICES CFR(s): 482.27(a) The hospital must have laboratory services available, either directly or through a contractual agreement with a certified laboratory that meets the requirements of part 493 of this chapter. This STANDARD is not met as evidenced by: Based on interviewes and documentation review for one (Patient #9) for a total sample of ten patients, Hospital #1 failed to have in their Transfusion Medicine policies and procedures a procedure to ensure Hospital #2 reported to			SPITAL	75	FRANCIS STREET		
feeding tube. Medical records of Patients #2, #3 and #4 indicated no documentation by the providers at Hospital #2 of the jejunostomy feeding tube procedure placement or the response of Patients #2, #3 and #4 to the jejunostomy feeding tube placement. The Physician Note, dated 5/28/17 at 10:25 A.M., indicated Patient #9 had heart surgery for a PDA ligation. The medical record did not indicate any documentation regarding the procedure performed by the surgeon, care provided, monitoring and medications administered by the anesthesiologist or operating room staff at Hospital #2, or documentation of blood product administration by staff caring for Patient #9 during surgery performed at Hospital #2. A 5822 A DEQUACY OF LABORATORY SERVICES CFR(s): 482.27(a) The hospital must have laboratory services available, either directly or through a contractual agreement with a certified laboratory that meets the requirements of part 493 of this chapter. This STANDARD is not met as evidenced by: Based on interviews and documentation review for one (Patient #9) for a total sample of ten patients, Hospital #1 failed to have in their Transfusion Medicine policies and procedures a procedure to ensure Hospital #2 reported to	RÉFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	D BE	(X5) COMPLETION DATE
was to occur in Hospital #2.	A 582	feeding tube. Medical records of indicated no docum. Hospital #2 of the j procedure placeme #2, #3 and #4 to th placement. The Physician Note indicated Patient # ligation. The medicated Patient # ligation. The medicated patient # ligation in the monitoring and me anesthesiologist or Hospital #2, or documentation by surgery performed by the smonitoring and me anesthesiologist or Hospital #2, or documentation by surgery performed by the smonitoring and me anesthesiologist or Hospital #2, or documentation by surgery performed by the smonitoring and me anesthesiologist or Hospital #2, or documentation by surgery performed by the smonitoring and me anesthesiologist or Hospital #2. The hospital must be available, either directly available, either directly available, either directly available, either directly patients, Hospital #1 a blood was to occur in Hospital #1 a blood was to occu	Patients #2, #3 and #4 nentation by the providers at ejunostomy feeding tube ent or the response of Patients e jejunostomy feeding tube e., dated 5/28/17 at 10:25 A.M., 9 had heart surgery for a PDA cal record did not indicate any arding the procedure urgeon, care provided, dications administered by the operating room staff at umentation of blood product taff caring for Patient #9 formed at Hospital #2. ABORATORY SERVICES have laboratory services ectly or through a contractual certified laboratory that meets f part 493 of this chapter. s not met as evidenced by: vs and documentation review of for a total sample of ten en epolicies and procedures a fee Hospital #2 reported to for transfusion reaction, if one				8/1/17
Findings include: Americ		Findings include.			Aı	meri	cans
ORM CMS-2567(02-99) Previous Versions Obsolete Event ID: ENYK11 Facility ID: 2341 If centification sheet	M CMS-256	567(02-99) Previous Version	s Obsolete Event ID: ENYK1	1 Faci	lity ID: 2341 If conti	uation she	et age 30 /
for L					f	or I	ife

STATEMENT OF AND PLAN OF C		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING			COMPLETED	
		220110	B. WING				C 1 7/2017
	VIDER OR SUPPLIER	SPITAL		75 F	EET ADDRESS, CITY, STATE, ZIP CODE FRANCIS STREET STON, MA 02115		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
The Calon sulfred here is the state of the s	are Unit (NICU) No. 5/8/17. The NICurgery was indicated the compital #2 and if now staff at Hospital #2 will be compital #1. Memo, dated 5/10 patients do an obspital #1. Memo, dated 5/10 patients do an obspital #1's NICU patients do an obspital #1's NICU packed red blood it's Blood Bank. If cour while at Hospital #1.	viewed the Neonatal Intensive urse Director on at 9:15 AM CU Nurse Director said when ed for a NICU patient, blood ould be brought over to eeded would be administered #2. ven Hospital #1 and Hospital #2, 2016 regarding laboratory that both Hospital #1 and compliant with regulatory vas not an individual Hospital #2 to report and sion reaction (if one was to #1 so that this information for the care of patients at 20/17, indicated Hospital #1's times go to Hospital #2's certain cardiac procedures nediately to Hospital #1. patients do travel with a unit if cells released from Hospital #2 a transfusion reaction was to both the information back to	A 5				Cans
·URM CMS-2567((02-99) Previous Versions	: Obsolete Event ID: ENYK1	1	Facilit			ed ⁴

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 7	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		220110	B. WING		08/3	1/2016
	PROVIDER OR SUPPLIER	SPITAI 75 FRAN	DDRESS, CITY, S CIS STREET , MA 02115	TATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
P 000		omplaint investigation was Reference Number /31/16 at: 's Hospital	P 000			
P 024	CONDITIONS OF F Each hospital shall of the Medicare Co Hospitals, 42 C.F.R (hereinafter Conditi they may be amend the requirement for specified in 42 C.F. review specified in 4 requirement for cor Code specified in 4 requirement that co	meet all of the requirements nditions of Participation for a 482.11 through 482.62 ons of Participation), and as ded from time to time, except institutional plan and budget R. 482.12(d), for utilization 42 C.F.R. 482.30, the anpliance with the Life Safety 2 C.F.R. 482.41(b), and any onflicts with the supplementary MR 130.000 Subparts C and	P 024			9/14/16
	by: A-0144	NT is not met as evidenced NT RIGHTS: CARE IN SAFE		A	S. meri	cans
		right to receive care in a safe		T.	Inii	tod
	of Health Care Facility Lic	ensure and Certification	NATURE	TITLE		(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		220110	B. WING		08/3	31/2016
	PROVIDER OR SUPPLIER M AND WOMEN'S HO	SPITAI 75 FRANC	DRESS, CITY, S CIS STREET , MA 02115	TATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
MA Division STATE FOR	setting. This STANDARD is Based on records r Hospital failed to el Care Unit (NICU) s 4 of 4 Code (Emergements, consistent) Findings included: Hospital policy title Emergency Equipments the assigned Fiverify that the neon minimum of every 2 Hospital policy title Inspection and Maindicated the Nursifor checking and docode cart lock at a Hospital Policy title 3/2016, indicated the for checking and docode cart at minimum The following 16 of Code Cart Checklis & document the int NICU: Dated 3/2016, located days; Dated 3/2016, located 3/2016, locate	eviewed and interview the nsure that Neonatal Intensive taff checked and documented gency) Carts in 16 of 30 with Hospital policy. d Checking Neonatal nent, dated 9/21/15, indicated Registered Nurse (RN) would ratal code cart was intact at a 24 hours. d Code Cart Control, ntenance, dated 1/2013, ng Services was responsible ocumenting the integrity of the minimum of once a day. d Code Cart Exchange, dated ne unit staff was responsible ocumenting the integrity of the unit staff was responsible ocumenting the integrity of the unit of once a day. 30 documents titled Neonatal st; indicated staff did not check egrity of the Code Carts in the tion not documented, 1 of 31 tion not documented, 1 of 31 tion not documented, 1 of 31		/B8I11	meri If continue	cans ted tion-here 2 of 3
				1	UI I	

IVIA DPF	//Division of Health C	Jare Facility Licensure			
	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	LE CONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:	:	COMPLETED
		000440	B. WING		00/04/0040
		220110	D. WING		08/31/2016
NAME OF F	PROVIDER OR SUPPLIER	STREET AC	DRESS, CITY, S	STATE, ZIP CODE	
		75 FRAN	CIS STREET		
BRIGHA	M AND WOMEN'S HO)SPITAI	, MA 02115		
 			-		
(X4) ID	= = =	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU	
PREFIX TAG		SC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPR	
				DEFICIENCY)	
D 004	0 " d F		D 004		
P 024	Continued From pa	age 2	P 024		
	days;				
	days,				
	Dated 4/2016, NICI	LLA 1 of 30 days:			
	Dated 5/2016, NICU A, 1 of 31 days;				
	Dated 3/2016, NICI	IIR 10 of 31 days:			
	Dated 3/2016, NICI				
	Dated 5/2016, NICI				
	Dated 6/2016, NICI				
	Dateu 0/2010, NIO	OB, 1 of 30 days,			
	Dated 4/2016, NICI	IIC 2 of 30 days.			
	Dated 5/2016, NICI				
	Dated 5/2010, NIC	0 C, 2 01 31 days,			
	Dated 8/2016 Grov	wth & Development Unit			
	(GDU), 1 or 31 day				
	(GDO), I of 31 day	78,			
	Dated 9/2016 Neic	ghborhood 2, 1 of 31 days;			
	Dated 0/2010, Neig	JIDOITIOOU Z, TOTSTUAYS,			
	Dated 4/2016 Adu	Ilt Code Cart, 3 of 30 days;			
		ilt Code Cart, 3 of 30 days; ilt Code Cart, 1 of 30 days;			
		ilt Code Cart, 1 of 30 days,			
	Dated 6/2010, Addi	Il Code Cart, Tor 5 ruays.			
	The Surveyor inter	viewed the Clinical Nurse			
		M. on 8/311/16. The Clinical			
		id that the NICU had an Adult			
		rgencies of parents and			
	visitors of NICU bal	DIES.			
					Clarin
					8.8
				^	mericans
					illel lealis
					Initad

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		E CONSTRUCTION	COM	E SURVEY PLETED
		220110	B. WING				C 16/2016
	PROVIDER OR SUPPLIER	DSPITAL		75	REET ADDRESS, CITY, STATE, ZIP CODE FRANCIS STREET OSTON, MA 02115	1 02	10/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
A 000	INITIAL COMMEN	TS	Α 0	000			
		ation survey (ACTS # conducted on 2/11/16 and					
	Brigham and Wom 75 Francis Street Boston, MA 02115	en's Hospital					
		articipation of Patient Rights wed using a sample of 10					
A 131	A deficiency was control PATIENT RIGHTS: CFR(s): 482.13(b)(INFORMED CONSENT	A 1	31			3/28/16
	allowed under Stat	or her representative (as le law) has the right to make regarding his or her care.					
	or her health status planning and treatr request or refuse to be construed as a provision of treatm	s include being informed of his s, being involved in care ment, and being able to reatment. This right must not mechanism to demand the ent or services deemed sary or inappropriate.					
	Based on record r Hospital failed to fo policy and procedu Care Proxy (HCP) (Patient #1, Patien	is not met as evidenced by: eviewed and interview the bllow the Hospital's internal are for activating the Health in three of five patients t #5 and Patient #6) who to make health care					5
	decisions. Findings included:	DER/SUPPLIER REPRESENTATIVE'S SIG			An TITLE	ner	cans

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing the determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclossible 90 day 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.

(X4) ID PREFIX TAG R A 131 Cont	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	75	TREET ADDRESS, CITY, STATE, ZIP CODE 5 FRANCIS STREET OSTON, MA 02115 PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL	02 /	C 16/2016
(X4) ID PREFIX TAG R A 131 Cont	SUMMARY STA (EACH DEFICIENCY REGULATORY OR L	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX	FRANCIS STREET OSTON, MA 02115 PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL	ON	
A 131 Cont The and I	(EACH DEFICIENC) REGULATORY OR L	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOUL		
The and I	tinued From pa			CROSS-REFERENCED TO THE APPRO DEFICIENCY)		(X5) COMPLETION DATE
and I		ige 1	A 131			
to ma surror Prox Patie and venti proce (visu centrolooc (a ca proce signe Medi deter make the h	Living Wills, da sician was to do determination of ake health care ogate decision by, Legal Guard ent #1 was diagrams treated wirelation. Patient redures on 2/7/ualization of the ral line (an intradovessel) and to atheter inserted ed by Patient #1 ical Record lactormination of Patient Care Agree de Health Care Agree	titled Health Care Proxies ated 9/13, indicated the ocument in the medical record of the patient's lack of capacity e decisions and indicate the maker (i.e. the Health Care dian or Next of Kin). Ignosed with respiratory failure th sedation and mechanical #1 underwent three invasive 16; a bronchoscopy e lungs), the insertion of a avenous line into a major the insertion of an arterial line d informed consent and were est's family member. The exked the physician's atient #1's lack of capacity to decisions and the activation of ent was not written until the 30 A.M. on 2/11/16.				
surge mech multi (i.e. s trans were Medi deter make	ery. Patient #5 hanical ventilat iple procedures surgery, the instruction and an e signed by Patical Record lacomination of Patical Patient #50.	t-operative from an abdominal was treated with sedation and tion. Patient #5 required a requiring informed consent sertion of a central line, blood invasive heart tracing) that tient #5's family member. The exed the physician's attent #5's lack of capacity to lecisions and the activation of ent.				3
The	Surveyor interv	viewed one of Patient #5's		Aı	meri	cans

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			TIPLE CONSTRUCTION DING	COM	(X3) DATE SURVEY COMPLETED	
		220110	B. WING			C (4.0)204.0
	PROVIDER OR SUPPLIER	l	B. WING	STREET ADDRESS, CITY, STATE, ZIP CODI 75 FRANCIS STREET BOSTON, MA 02115		16/2016
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		OULD BE	(X5) COMPLETION DATE
A 131	physician said she process to activate Patient #6 was diag status and respirate with sedation and redical Record lace determination of Page 2015.	P.M. on 2/11/16. The was not familiar with the the surrogate decision maker. gnosed with altered mental ory failure and was treated mechanical ventilation. The cked the physician's atient #6's lack of capacity to decisions and the activation of sion maker.	A 1		Ameri	
	, ,	2.52]	forl	Life

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-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		CONSTRUCTION		E SURVEY IPLETED
		220110	B. WING				C 20/2015
NAME OF F	PROVIDER OR SUPPLIER	220110			REET ADDRESS, CITY, STATE, ZIP CODE	01/	20/2015
BRIGHA	M AND WOMEN'S HO	SPITAL			FRANCIS STREET DSTON, MA 02115		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
A 000	INITIAL COMMEN	TS	Α0	000			
A 131	was conducted (AC MA00022806) on 1 1/20/15 at: Brigham and Wome 75 Francis Street Boston, MA 02115 The following Concreviewed using a set 482.12 Governing I 482.13 Patient Right 482.22 Medical State 482.23 Nursing Set 482.25 Pharmaceut 482.42 Infection Copatient Right 182.42 Infection Copatient or his callowed under State informed decisions The patient or his callowed under State informed decisions The patient's rights or her health status planning and treatmeduest or refuse trequest or refuse trequest or refuse treduction of treatmeducally unnecess This STANDARD is Based on records the Hospital failed to 11/20/20/20/20/20/20/20/20/20/20/20/20/20/	ditions of Participation were ample of 10 patients. Body hts aff rvices tical Services ontrol	Α1	31	An	S. neri	Sicans
APODATOD	V DIDECTOR'S OR DROVIE	ER/SUPPLIER REPRESENTATIVE'S SIGI	NATURE		TITLE	10 11	VENTATE

Any deticiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting provide other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated about red following the date of survey whether or not a plan of correction is provided. For purple, the state of survey whether or not a plan of correction is provided. 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.

A 131 Continued From page 1 informed consent for invasive procedures in two of two incapacitated patients. The Health Care Proxy was not activated by the attending physician in the medical record as required by Hospital policy titled Health Care Proxies and Living Willis, dated August 2013, indicated the attending physician in the medical record as required by Hospital policy titled Health Care Proxies and Living Willis, dated August 2013, indicated the attending physician makes the determination that a patient tacks the capacity to make healthcare decisions. The attending physician must document the determination of incapacity and the surrogate decision maker in the patient's medical record. The medical record for Patient #6 indicated he/she had respiratory failure, was ventilator dependent and sedated. Informed consent forms for Patient #6 indicated the Health Care Proxy signed the informed consent for sorrogate the informed consent of a tractal line (a thin catheter inserted into an artery.) The medical record did not indicate the Health Care Proxy was activated by the attending physician as required by Hospital policy. The medical record for Patient #7 indicated he/she had dementia. The informed consent form for Patient #7 indicated the Health Care Proxy signed the informed consent form for Patient #7 indicated Patient #7's informed consent form indicated Patient #7's indicated Patient #		OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION		E SURVEY PLETED
RIGHAM AND WOMEN'S HOSPITAL PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES FRANCIS STREET BOSTON, MA 02115 SUMMARY STATEMENT OF DEFICIENCIES FREETY TAG SUMMARY STATEMENT OF DEFICIENCIES FREETY TAG Continued From page 1 Informed consent for invasive procedures in two of two incapacitated patients (Patient #6 and #7) in a total sample of ten patients. The Health Care Proxy was not activated by the attending physician in the medical record as required by Hospistal policies and procedures. Findings include: The Hospital policy titled Health Care Proxies and Living Wills, dated August 2013, indicated the attending physician makes the determination that a patient lacks the capacity to make healthcare decisions. The attending physician must document the determination of incapacity and the surrogate decision maker in the patient's medical record for Patient #6 indicated he/she had respiratory failure, was ventilator dependent and sedated. Informed consent forms for Patient #6 indicated the Health Care Proxy signed the informed consents for bronchoscopy (a medical test to level the airways and lungs) and the placement of an arterial line (a thin catheter inserted into a ratery.) The medical record did not indicate the Health Care Proxy was activated by the attending physician as required by Hospital policy. The medical record for Patient #7 indicated he/she had dementia. The informed consent form for Patient #7 indicated the Health Care Proxy signed the informed consent form for Patient #7 indicated the Health Care Proxy signed the informed consent form (a surgical procedure to create an opening through the neck.) Review of Patient #7's informed consent form indicated Patient #7's informed consent form indicated the Health Care Proxy signed the informed consent for a tracheostomy (a surgical procedure to create an opening through the neck.) Review of Patient #7's informed consent form indicated the Health Care Proxy signed the informed consent for a tracheostomy (a surgical procedure to create an o			220110	B. WING			
A 131 Continued From page 1 informed consent for invasive procedures in two of two incapacitated patients. The Health Care Proxy was not activated by the attending physician must document the determination that a patient lacks the capacity to make healthcare decisions. The Health Care Proxy signed the informed consent for invasive procedures in two of two incapacitations. The Health Care Proxy was not activated by the attending physician in the medical record as required by Hospital policy titled Health Care Proxies and Living Wills, dated August 2013, indicated the attending physician makes the determination that a patient lacks the capacity to make healthcare decisions. The attending physician must document the determination of incapacity and the surrogate decision maker in the patient's medical record. The medical record for Patient #6 indicated he/she had respiratory failure, was ventilator dependent and sedated. Informed consent forms for Patient #6 indicated the Health Care Proxy signed the informed consents for bronchoscopy (a medical test to view the ainways and lungs) and the placement of an arterial line (a thin catheter inserted into an artery.) The medical record did not indicate the Health Care Proxy was activated by the attending physician as required by Hospital policy. The medical record for Patient #7 indicated he/she had dementia. The informed consent form for Patient #7 indicated the Health Care Proxy signed the informed consent for a tracheostomy (a surgical procedure to create an opening through the neck.) Review of Patient #7's informed consent form indicated Patient #7's Health Care Proxy signed the informed consent form indicated Patient #7's Health Care Proxy signed the informed consent form indicated Patient #7's Health Care Proxy signed the informed consent form indicated Patient #7's Health Care Proxy signed the informed consent form indicated Patient #7's Health Care Proxy signed the informed consent form indicated Patient #7's Health Care Proxy signed the informed consent form f			SPITAL	75	5 FRANCIS STREET	,	
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A 347	record did not indic was activated by the required by Hospital The Surveyor intended the Medical Intensity P.M. on 1/14/15. The MICU said that the required to enter a when a Health Care MEDICAL STAFF (ACCOUNTABILITY CFR(s): 482.22(b)() The medical staff maccountable to the of the medical care (1) The medical staff maccountable to the of the medical staff manner approved by the medical staff manner approved by (2) If the medical staff manner approved by (3) The responsibility conduct of the medical staff maccountable to the office of the medical staff manner approved by (3) The responsibility conduct of the medical staff manner approved by (3) The responsibility conduct of the medical staff medical staff manner approved by the medical staff maccountable to the office of the office of the	ate the Health Care Proxy e attending physician as al policy. Viewed the Medical Director of we Care Unit (MICU) at 1:00 ne Medical Director of the Attending Physician is note into the Progress Notes e Proxy is activated. ORGANIZATION & 1), (2), (3) nust be well organized and governing body for the quality provided to the patients. aff must be organized in a by the governing body. taff has an executive ity of the members of the doctors of medicine or ty for organization and ical staff must be assigned bllowing: doctor of medicine or ental surgery or dental rmitted by State law of the	A 1		S. mer	Sicans



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A 347	Continued From pa	nge 3	A 347			
	Based on record re Hospital failed to en adhered to the Hos Prevention of Intrav	s not met as evidenced by: eview and interview, the nsure that the Medical Staff epital's Guidelines for the vascular Catheter Related of ten sampled patients				
	Guidelines for Prev Catheter Related Ir indicated that a Per Catheter (a PICC is can be used for a p	rection Control Policy titled rention of Intravascular rections, approved 10/12/11, ripherally Inserted Central an intravenous access that prolonged period of time) was ere was clinical evidence of a				
	indicated Patient #4 sudden feeling of c	dated, 10/7/14 at 5:00 A.M., 4 experienced rigors (a old with shivering) and n of general bodily weakness).				
	10/7/14 and signed Physician, indicated in white blood cells (normal is 4500 to	y Progress Note, dated by Patient #4's Attending d Patient #4 had an increase (WBC s) from 7000 to 11,000 10,000; an increase may and reported chills. The				
	Attending Physician	n Note indicated a concern for and that the PICC line would			Syl	Ŝ
		ers, at 8:15 A.M. on 10/7/14, cin (an antibiotic) 1000		Ar	neri	cans
ORM CMS-2	567(02-99) Previous Versions	s Obsolete Event ID: 0T5Z1	1 Fa		ation shee	
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PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) A 347 Continued From page 4 milligrams (mg) to be administered every twelve hours (no duration indicated in the order) for Patient #4. The medication administration record indicated Vancomycin 1000 mg was administered to Patient #4 beginning at 8:48 A.M. on 10/7/14. The Physician Progress Note, dated 10/8/14 at 3:20 A.M., indicated Patient #4 had a temperature of 100.8 degrees Fahrenheit (normal is 97.8 to 99 Fahrenheit) and had a low blood pressure. The Surveyor interviewed Hospital Physician #1 at 7:20 A.M. on 1/20/15. Hospital Physician #1 said Patient #4's PICC line was not discontinued. Hospital Physician #1 said he believed there was a team discussion about asking for an Infectious Disease consult, but Hospital Physician #1 said it was decided that Patient #4's symptoms of infection were related to the series of injections into his/her knees. Patient #4's medical record entries from 10/7/14 through 10/25/14 did not indicate the knee injections as a possible cause for the symptoms of chills, malaise, fever or increase in WBC count. The Hospital policy Guidelines for Prevention of	STATEMENT OF AND PLAN OF C	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION		E SURVEY PLETED
RECETADDRESS, CITY, STATE, ZIP CODE TO FRANCIS STREET BOSTON, MA 02115 CALID CALID CALID CALID CRACK DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) A 347 Continued From page 4 milligrams (mg) to be administered every twelve hours (no duration indicated in the order) for Patient #4. The medication administration record indicated Vancomycin 1000 mg was administered to Patient #4 beginning at 8:48 A.M. on 10/7/14. The Physician Progress Note, dated 10/8/14 at 3:20 A.M., indicated Patient #4 had a temperature of 100.8 degrees Fahrenheit (normal is 97.8 to 99 Fahrenheit) and had a low blood pressure. The Surveyor interviewed Hospital Physician #1 at 7:20 A.M. on 1/20/15. Hospital Physician #1 said Patient #4's PiCC line was not discontinued. Hospital Physician #1 said ream disconsion about asking for an Infectious Disease consult, but Hospital Physician #1 did not believe this happened. Hospital Physician #1 said it was decided that Patient #4's symptoms of infection were related to the series of injections into his/her knees. Patient #4's medical record entries from 10/7/14 through 10/25/14 did not indicate the knee injections as a possible cause for the symptoms of chills, malaise, fever or increase in WBC count. The Hospital policy Guidelines for Prevention of			220110	B. WING			
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Intravascular Catheter Related Infections, a patient with a PICC line and clinical signs of infection i.e. rigors, malaise, temperature and elevated WBCs would require careful assessment of the insertion site for erythema (redness), induration (swelling) or purulence (pus). The Guideline also indicated the biopatch and transparent dressing were to be changed FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 0T5Z11 Facility ID: 2341 If continuations led Page	m ho P in to Ti 3: tes is properties and the same in t	nilligrams (mg) to be ours (no duration is attent #4. The mendicated Vancomy of Patient #4 begins the Physician Programmer of 100 is 97.8 to 99 Fahren ressure. The Surveyor intervative of 100 is 97.8 to 99 Fahren ressure. The Surveyor intervative of 100 is 97.8 to 99 Fahren ressure. The Surveyor intervative of 100 is 97.8 to 99 Fahren ressure. The Surveyor intervative of 100 is 97.8 to 99 Fahren ressure. The Surveyor intervation of Patient #4's Place of Patient #4's Place of Patient Was decided affection were related to his/her knees. The Hospital policy of the interval of the	be administered every twelve indicated in the order) for dication administration record cin 1000 mg was administered ning at 8:48 A.M. on 10/7/14. The seast Note, dated 10/8/14 at department #4 had a seast a look and heit) and had a low blood wiewed Hospital Physician #1 CC line was not discontinued. #1 said he believed there was about asking for an Infectious at Hospital Physician #1 that Patient #4's symptoms of the terms of injections and record entries from 10/7/14 and not indicate the knee sible cause for the symptoms ever or increase in WBC. Guidelines for Prevention of the Related Infections, a line and clinical signs of malaise, temperature and uld require careful insertion site for erythema on (swelling) or purulence e also indicated the biopatch essing were to be changed			-	

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A 347	every 7 days or wh loosened or soiled. The Nurses Notes, Patient #4 was due change. The Nurse postponed the dres of an insertion site Patient 4's medical The Physician Orde A.M., indicated Pat was to be changed it was " ok to go lowas contradictory to change policy and a silver in the property of th	dated 10/8/14, indicated for a PICC line dressing s Notes indicated, Patient #4 sing change and no evidence assessment was present in record through 10/25/14. ers, dated 10/7/14 at 8:15 ient #4's PICC line dressing by Registered Nurse #7 and nger than seven days." This of the PICC catheter dressing accepted standards of care.	A 347			
A 405	3:00 P.M. on 1/14/ named in the Physi the Registered Nur to change his/her F Nurse #7 said Patie something happeni not allow just any F the dressing. ADMINISTRATION CFR(s): 482.23(c)((1) Drugs and biolo administered in acc State laws, the orde practitioners respon	15. Registered Nurse #7 was cian Order dated 10/8/14 as see that Patient #4 would allow PICC line dressing. Registered ent #4 was fixated on ng to the PICC line and would Registered Nurse to change OF DRUGS 1), (c)(1)(i) & (c)(2) gicals must be prepared and cordance with Federal and ers of the practitioner or nsible for the patient's care as 32.12(c), and accepted	A 405			
	(i) Drugs and biolog	gicals may be prepared and e orders of other practitioners		Ar	neri	cans
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A 405 Continued From page 6 not specified under \$482.12(c) only if such practitioners are acting in accordance with State law, including scope of practice laws, hospital policies, and medical staff bylaws, rules, and regulations. (2) All drugs and biologicals must be administered by, or under supervision of, nursing or other personnel in accordance with Federal and State laws and regulations, including applicable licensing requirements, and in accordance with the approved medical staff policies and procedures. This STANDARD is not met as evidenced by; Based on record review and staff interview, for one of ten sampled patients (Patient #4), the Hospital failed to ensure that nursing staff documented from 6/6/14 to 12/19/14 that Patient #4's routine daily medications were self-administered and 2) reported to nursing leadership that personal private staff were practicing nursing by accessing a peripherally inserted central catheter (PICC). Findings include: The Hospital's policies and procedures related to Nursing Medication Administration indicated that only a registered nurse, licensed practical nurse or student nurse will administrate medications to ensure safe medication administration of medicateds. Hospital policies and procedures related to Patient Self-Administration of Medications indicated that the physician will write an order for a patient to store medication at the bedside and			SPITAL		75 FRANCIS STREET	1 017	20/2010
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FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 0T5Z11 Facility ID: 2341 If continual on islated P G2 1011		not specified under practitioners are ad law, including scop policies, and medic regulations. (2) All drugs and bi administered by, or or other personnel and State laws and applicable licensing accordance with the policies and proced. This STANDARD is Based on record reone of ten sampled Hospital failed to endocumented from 6 #4's routine daily m self-administered a leadership that perspracticing nursing beinserted central cate. The Hospital's policines are patient Self-Administered in or student nurse with ensure safe medical Hospital policies are patient Self-Administered that the paragraph patient to store medical to self-administer the self-administer	§482.12(c) only if such sting in accordance with State e of practice laws, hospital sal staff bylaws, rules, and cologicals must be under supervision of, nursing in accordance with Federal regulations, including grequirements, and in e approved medical staff dures. Is not met as evidenced by: eview and staff interview, for patients (Patient #4), the neure that nursing staff 6/6/14 to 12/19/14 that Patient nedications were and 2) reported to nursing sonal private staff were by accessing a peripherally theter (PICC). Cies and procedures related to a Administration indicated that curse, licensed practical nurse and procedures related to a stration of Medications to estion administration practices. In the procedures related to estration of Medications hysician will write an order for redication at the bedside and the medication. The policy		A	_	

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i i i i i i i i i i i i i i i i i i i	ability to self-admin and the nurse will reself-administered. The Hospital policy Duty Nursing Personal may and the care is limit activities of daily live measures. The Physician Order indicated that it was be administered by according to their secontrary to Hospital because private duredications to patimas transcribed by The Physician Order indicated that Patier routine medications must be administer The Surveyor interest. 3 of Patient #4's personal patie	will assess the patient's hister the ordered medications ecord the medication as and procedure titled Private onnel indicated that private y assist in the care of patients ted to the provisions of ring and companionship and companionship are, dated 6/7/14 at 3:53 P.M., so okay for the medications to a Patient #4's personal staff chedule. The Order was I policy and procedure ty nurses may not administer ents. The Physician's Order a hospital registered nurse. For the date of the date of the provision of the prov		05	Am		

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	PROVIDER OR SUPPLIER M AND WOMEN'S HO		B. Wille	S ⁻	TREET ADDRESS, CITY, STATE, ZIP CODE 5 FRANCIS STREET 6 OSTON, MA 02115	01/	20/2015
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A 405	then hand her a pictime Patient #4 too medications. Regi would then enter the electronic medicati (eMAR). The Surveyor inter 7:45 A.M. on 1/14/she never witnesse medications. Reg #4's personal staff paper that indicate took his/her medications would the Patient #4's eMAR The Surveyor inter 8:00 A.M. on 1/15/Patient #4's persor #4 received routine Nurse #5 said she information into Patient #4's persor his/her routine daily medications. Patient #4's persor his/her routine daily Nurse #6 said Patient #4 resident #4 received #4 received routine saw Patient #4's persor his/her routine daily medications. Patient #4's patient #4's persor his/her routine daily Nurse #6 said Patient #4 received Patient Patient #4 received Patient Patient #4 received Patient Patient Patient Patient Patient Patient Patie	ece of paper with the date and k his/her routine daily stered Nurse #3 said she he information into Patient #4's on administration record viewed Registered Nurse #4 at 15. Registered Nurse #4 said ed Patient #4 taking his routine istered Nurse #4 said Patient provided her with a piece of d the date and time Patient #4 ations. Registered Nurse #4 n enter the administration into viewed Registered Nurse #5 said hal staff told her when Patient e medications. Registered would then enter the tient #4's eMAR. viewed Registered Nurse #6 at 15. Registered Nurse #6 at 15. Registered Nurse #6 said hel staff would give Patient #4 take his/her routine Registered Nurse #6 said hal staff would give Patient #4 y medications. Registered ent #4's personal staff told her ceived his/her medications rse #6 would enter the		105		<u>Ç</u> N	
	12/19/14, indicated	eMARs, dated 6/6/14 to Registered Nurse #1, #3, Registered Nurse #4,			Aı	meri	cans
FORM CMS-25	Registered Nurse 7			Fac	ility ID: 2341 If continu	ation shee	ted Life

The Surveyor interviewed Hospital Physician #1 at 7:30 A.M. on 1/12/15. Physician #1 at 7:30 A.M. on 1/12/15. Physician #1 at 7:30 A.M. on 1/12/15. Physician #1 at 12:50 P.M. on 1/12/15. Nurse Director #1 said she did not thinks he reported to executive nursing leadership that nursing staff were recording medications administered by Patient #4's personal staff flush Potient #4's PICC. The Surveyor interviewed Nursing Director #1 at 12:50 P.M. on 1/12/15. Nurse Director #1 said she did not thinks he reported to executive nursing leadership that nursing staff were recording medications administered by Patient #4's personal staff flush patient #4's personal staff were recording medications administered patient #4's personal staff were not authorized to practice nursing in the Hospital.		OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION NG		E SURVEY PLETED
BRIGHAM AND WOMEN'S HOSPITAL PRAYID PREFIX TAG A 405 Continued From page 9 Registered Nurse #3 and Registered Nurse #6 documented that they administered by Patient #4's PICC. Registered Nurse #3 said Patient #4's PICC. Registered Nurse #3 said Patient #4's PICC. Registered Nurse #4 said Said henever provided the flush medication to the personal staff flushed Patient #4's PICC. The Surveyor interviewed Hospital Physician #1 at 7:30 A.M. on 1/21/15. Physician #1 said he saw Patient #4's personal staff flush Patient #4's PICC. The Surveyor interviewed Nursing Director #1 at 12:50 P.M. on 1/12/16. Nurse Director #1 at 12:50 P.M. on 1/12/15. Nurse P.M. on 1/12/15			220110	B. WING _			
A 405 A 405 Continued From page 9 Registered Nurse #5 and Registered Nurse #6 documented that they administered routine daily medications to Patient #4. The eMARs did not indicate the medications were self-administered by Patient #4. PICC following fentanyl administration by Hospital registered Nurse #3 said She observed Patient #4's PICC. Registered Nurse #4 said Patient #4's personal staff flushing Patient #4's PICC. Registered Nurse #4 said Patient #4's PICC. The Surveyor interviewed Hospital Physician #1 at 7:30 A.M. on 1/21/15. Nurse Director #1 at 12:50 P.M. on 1/12/15. Nurse Director #1 said she did not think she reported to executive nursing leadership that nursing staff were recording medications administered by Patient #4's PICC. The Surveyor interviewed Associate Chief Nurse #1 at 10:00 A.M. on 1/13/15. Associate Chief Nurse #1 at 10:00 A.M. on 1/13/15. Associate Chief Nurse #1 at 10:00 A.M. on 1/13/15. Associate Chief Nurse #1 at 10:00 A.M. on 1/13/15. Associate Chief Nurse #1 at 10:00 A.M. on 1/13/15. Associate Chief Nurse #1 at 10:00 A.M. on 1/13/15. Associate Chief Nurse #1 at 10:00 A.M. on 1/13/15. Associate Chief Nurse #1 at 10:00 A.M. on 1/13/15. Associate Chief Nurse #1 at 10:00 A.M. on 1/13/15. Associate Chief Nurse #1 at 10:00 A.M. on 1/13/15. Associate Chief Nurse #1 at 10:00 A.M. on 1/13/15. Associate Chief Nurse #1 at 10:00 A.M. on 1/13/15. Associate Chief Nurse #1 at 10:00 A.M. on 1/13/15. Associate Chief			SPITAL		75 FRANCIS STREET	1 01/	20/2010
Registered Nurse #5 and Registered Nurse #6 documented that they administered routine daily medications to Patient #4. The eMARs did not indicate the medications were self-administered by Patient #4 or his/her personal staff. Registered Nurse #1 said Patient #4's personal staff flushed Patient #4's PICC following fentanyl administration by Hospital registered nurses. Registered Nurse #3 said she observed Patient #4's personal staff flushed Patient #4's PICC. Registered Nurse #4 said Patient #4's PICC. Registered Nurse #4 said Patient #4's PICC. Registered Nurse #4 said her self-self-self-self-self-self-self-self-	PRÉFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR	ULD BE	COMPLÉTION
VINE ORDERON DESCRIPTION OF STREET AND		Registered Nurse # documented that the medications to Patient indicate the medications to Patient indicate the medication by Patient #4 or his Registered Nurse # staff flushed Patient administration by H Registered Nurse # #4's personal staff Registered Nurse # staff flushed Patient Nurse #4 said she medication to the personal staff had to The Surveyor intervat 7:30 A.M. on 1/2 saw Patient #4's per PICC. The Surveyor intervat 2:50 P.M. on 1/12 she did not think shoursing leadership recording medication #4's personal staff were accessing The Surveyor intervating the staff were accessing the staff were accessing the staff were nursing in the Hospital staff were nursing in t	#5 and Registered Nurse #6 rey administered routine daily ent #4. The eMARs did not ations were self-administered s/her personal staff. #1 said Patient #4's personal tt #4's PICC following fentanyl lospital registered nurses. #3 said she observed Patient flushing Patient #4's PICC. #4 said Patient #4's personal tt #4's PICC. Registered never provided the flush ersonal staff because the their own supply. #4 wiewed Hospital Physician #1 1/15. Physician #1 said he ersonal staff flush Patient #4's #4 wiewed Nursing Director #1 at /15. Nurse Director #1 said he reported to executive that nursing staff were ons administered by Patient or that Patient #4's private g Patient #4's PICC. #4 wiewed Associate Chief Nurse in 1/13/15. Associate Chief ent #4's visitors, guests and not authorized to practice oital.			_	

PRINTED: 02/18/2020 FORM APPROVED OMB NO. 0938-0391
(X3) DATE SURVEY

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION ING		E SURVEY IPLETED
						С
		220110	B. WING			20/2015
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL	ÞΕ	
BRIGHAI	M AND WOMEN'S HO	SPITAL		75 FRANCIS STREET		
				BOSTON, MA 02115		
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A 405	Continued From parthe Surveyor interv#2 at 10:30 A.M. or Nurse #2 said she was nursing staff were administration of Partient #4's person personal staff were SECURE STORAGE (CFR(s): 482.25(b)). All drugs and biologarea, and locked with the standard procedures, and locked with the self-administration froom, as required by procedures, for one (Patient #4). Findings include: The Hospital's policing Nursing Medication ordered be stored in a locked bedside. The Surveyor intervent	ge 10 viewed Associate Chief Nurse in 1/14/15. Associate Chief was not aware the Hospital documenting the atient #4's routine daily on information provided by al staff or that Patient #4's accessing Patient #4's PICC. iE 2)(i) gicals must be kept in a secure	A 4	DEFICIENCY)	PROPRIATE	DATE
	Patient #4's routine a locked place in Page 19	medications were not kept in attent #4's room.			Si	8
	•				V.	ש
		viewed Registered Nurse #3 at /15. Registered Nurse #3 said			Amer	cans
EODM CMS 3	567(02 00) Provious Versions	Obsoloto Event ID: 075744	<u> </u>	Facility ID: 2341		
-URIVI CIVIS-28	567(02-99) Previous Versions	s Obsolete Event ID: 0T5Z11		Facility ID: 2341 If co	ntinuation sheet	are 1 01 16
					for I	

NAME OF PROVIDER OR SUPPLIER **RIGHAM AND WOMEN'S HOSPITAL** **BRIGHAM AND WOMEN'S HOSPITAL** **PREFIX FRANCIS STREET BOSTON, MA 02115* **STREET ADDRESS, CITY, STATE, ZIP CODE 75 FRANCIS STREET BOSTON, MA 02115* **STREET ADDRESS, CITY, STATE, ZIP CODE 75 FRANCIS STREET BOSTON, MA 02115* **STREET ADDRESS, CITY, STATE, ZIP CODE 75 FRANCIS STREET BOSTON, MA 02115* **STREET ADDRESS, CITY, STATE, ZIP CODE 75 FRANCIS STREET BOSTON, MA 02115* **STREET ADDRESS, CITY, STATE, ZIP CODE 75 FRANCIS STREET BOSTON, MA 02115* **STREET ADDRESS, CITY, STATE, ZIP CODE 75 FRANCIS STREET BOSTON, MA 02115* **STREET ADDRESS, CITY, STATE, ZIP CODE 75 FRANCIS STREET BOSTON, MA 02115* **STREET ADDRESS, CITY, STATE, ZIP CODE 75 FRANCIS STREET BOSTON, MA 02115* **STREET ADDRESS, CITY, STATE, ZIP CODE 75 FRANCIS STREET BOSTON, MA 02115* **STREET ADDRESS, CITY, STATE, ZIP CODE 75 FRANCIS STREET BOSTON, MA 02115* **STREET ADDRESS, CITY, STATE, ZIP CODE 75 FRANCIS STREET BOSTON, MA 02115* **STREET ADDRESS, CITY, STATE, ZIP CODE 75 FRANCIS STREET BOSTON, MA 02115* **STREET ADDRESS, CITY, STATE, ZIP CODE 75 FRANCIS STREET BOSTON, MA 02115* **STREET ADDRESS, CITY, STATE, ZIP CODE 75 FRANCIS STREET BOSTON, MA 02115* **STREET ADDRESS, CITY, STATE, ZIP CODE 75 FRANCIS STREET BOSTON, MA 02115* **STREET ADDRESS, CITY, STATE, ZIP CODE 75 FRANCIS STREET BOSTON, MA 02115* **STREET ADDRESS, CITY, STATE, ZIP CODE 75 FRANCIS STREET BOSTON, MA 02115* **STREET ADDRESS, CITY, STATE, ZIP CODE 75 FRANCIS STREET BOSTON, MA 02115* **PREFIX TAGE TO THE TAGE TO	NAME OF PROVIDER OR SUPPLIER BRIGHAM AND WOMEN'S HOSPITAL CAL) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG) TAG		OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		ONSTRUCTION		E SURVEY PLETED
RIGHAM AND WOMEN'S HOSPITAL PRIGHAM AND WOMEN'S HOSPITAL (A) D (XA) ID (XA) ID (XA) C (A) C (A	STREET ADDRESS. CITY, STATE, ZIP CODE TS FRANCIS STREET BOSTON, MA 02115 SUMMARY STATEMENT OF DEFICIENCIES TAG SUMMARY STATEMENT OF DEFICIENCIES RECOLLATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG A 502 Continued From page 11 Patient #4's routine medications were kept in Patient #4's routine medications were kept in Patient #4's routine medications ordered for self-administration. The Surveyor interviewed Registered Nurse #5 at 8:00 A.M. on 1/15/15. Registered Nurse #5 said she did not know where in Patient #4's roun his/her routine daily medications were kept. A ssociate Chief Nurse #1 was interviewed at 12:00 P.M. on 1/14/15. Associate Chief Nurse #1 said the bedside tables on Patient #4's nursing unit, unlike the bedside tables on the other nursing unit, did not contain a drawer with a lock to secure medications ordered for self-administration. A 749 CFR(s): 482.42(a)(1) The infection control officer or officers must develop a system for identifying, reporting, investigating, and controlling infections and communicable diseases of patients and personnel. This STANDARD is not met as evidenced by: Based on record review and interview, for 6 of 6 sampled employees (Registered Nurse #3, #4, #7, #8, #9 and Hospital Physician #1) the Hospital failed to ensure that staff consistently adhered to Infection Control practices including Hospital policies for precautions and respiratory protection requirements. Findings include: STANDARD services Registered Nurse #3, #4, #7, #8, #9 and Hospital Physician #1) the Hospital failed to ensure that staff consistently adhered to Infection Control practices including Hospital policies for precautions and respiratory protection requirements. Findings include: Event ID:015211 Facility ID:2541			220110	B. WING				
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) A 502 Continued From page 11 Patient #4's routine medications were kept in Patient #4's routine medications were kept in Patient #4's routine medications were kept in Patient #4's routine medications ordered for self-administration. The Surveyor interviewed Registered Nurse #5 at 8:00 A.M. on 1/15/15. Registered Nurse #5 said she had nothing to do with the medications ordered for self-administration. The Surveyor interviewed Registered Nurse #5 said she did not know where in Patient #4's roum his/her routine daily medications were kept. Associate Chief Nurse #1 was interviewed at 12:00 P.M. on 1/14/15. Associate Chief Nurse #1 said the bedside tables on Patient #4's nursing unit, unlike the bedside tables on the other nursing unit, unlike the bedside tables on the other nursing unit, unlike the bedside tables on the other nursing unit, sid not contain a drawer with a lock to secure medications ordered for self-administration. A 749 INFECTION CONTROL PROGRAM CFR(s): 482.42(a)(1) The infection control officer or officers must develop a system for identifying, reporting, investigating, and controlling infections and communicable diseases of patients and personnel. This STANDARD is not met as evidenced by: Based on record review and interview, for 6 of 6 sampled employees (Registered Nurse #3, #4, #7, #8, #9 and Hospital Physician #1) the Hospital failed to ensure that staff consistently adhered to Infection Control practices including Hospital policies for precautions and respiratory protection requirements. Findings include:	REGULATORY OR US CIDENTIFYING INFORMATION) A 502 Continued From page 11 Patient #4's routine medications were kept in Patient #4's routine medications were kept in Patient #4's routine medications were kept in Patient #4's routine medications ordered for self-administration. The Surveyor interviewed Registered Nurse #5 at 8.00 A.M. on 11/51/5. Registered Nurse #5 said she did not know where in Patient #4's room his/her routine daily medications were kept. Associate Chief Nurse #1 was interviewed at 12:00 P.M. on 11/41/5. Associate Chief Nurse #5 and 12:00 P.M. on 11/41/5. Associate Chief Nurse #1 said the bedside tables on Patient #4's nursing unit, unlike the bedside tables on the other nursing units, did not contain a drawer with a lock to secure medications ordered for self-administration. A 749 INFECTION CONTROL PROGRAM CFR(s): 482.42(a)(1) The infection control officer or officers must develop a system for identifying, reporting, investigating, and controlling infections and communicable diseases of patients and personnel. This STANDARD is not met as evidenced by: Based on record review and interview, for 6 of 6 sampled employees (Registered Nurse #3, #4, #7, #8, #9 and Hospital Flayistan #1) the Hospital failed to ensure that staff consistently adhered to infection Control practices including Hospital policies for precautions and respiratory protection requirements. Findings include: DEMCMS-2687(02-99) Previous Versions Obsolete Event ID-075211 Facility ID-2341 If confurtified Infections A for a facility in the Associate Chief Nurse #3, #4, #7, #8, #9 and Hospital Failed to ensure that staff consistently adhered to Infection Control practices including Hospital policies for precautions and respiratory protection requirements. Findings include: EVENT ID-075211 Facility ID-2341 If confurtified Infections A for a facility in the Associate Chief Nurse #3 and The Associate Chief Nurse #3 and The Associate Chief Nurse #4 and The Associate Chief Nurse #4 and The Associate Chief Nurse #4 and The			SPITAL		75 FR	RANCIS STREET		
Patient #4's routine medications were kept in Patient #4's room and Patient #4 took his/her own medications. Registered Nurse #3 said she had nothing to do with the medications ordered for self-administration. The Surveyor interviewed Registered Nurse #5 at 8:00 A.M. on 1/15/15. Registered Nurse #5 said she did not know where in Patient #4's room his/her routine daily medications were kept. Associate Chief Nurse #1 was interviewed at 12:00 P.M. on 1/14/15. Associate Chief Nurse #1 said the bedside tables on Patient #4's nursing unit, unlike the bedside tables on the other nursing units, did not contain a drawer with a lock to secure medications ordered for self-administration. A749 INFECTION CONTROL PROGRAM CFR(s): 482.42(a)(1) The infection control officer or officers must develop a system for identifying, reporting, investigating, and controlling infections and communicable diseases of patients and personnel. This STANDARD is not met as evidenced by: Based on record review and interview, for 6 of 6 sampled employees (Registered Nurse #3, #4, #7, #8, #9 and Hospital Physician #1) the Hospital Failed to ensure that staff consistently adhered to Infection Control practices including Hospital policies for precautions and respiratory protection requirements. Findings include:	Patient #4's routine medications were kept in Patient #4's room and Patient #4 so how his/her own medications. Registered Nurse #3 said she had nothing to do with the medications ordered for self-administration. The Surveyor interviewed Registered Nurse #5 at 8:00 A.M. on 1/15/15. Registered Nurse #5 said she did not know where in Patient #4's room his/her routine daily medications were kept. Associate Chief Nurse #1 was interviewed at 12:00 P.M. on 1/14/15. Associate Chief Nurse #1 said the bedside tables on Patient #4's nursing unit, unlike the bedside tables on the other nursing units, did not contain a drawer with a lock to secure medications ordered for self-administration. A749 INFECTION CONTROL PROGRAM CPR(s): 482.42(a)(11) The infection control officer or officers must develop a system for identifying, reporting, investigating, and controlling infections and communicable diseases of patients and personnel. This STANDARD is not met as evidenced by: Based on record review and interview, for 6 of 6 sampled employees (Registered Nurse #3, #4, #7, #8, #9 and Hospital Physician #1) the Hospital Failed to ensure that staff consistently adhered to Infection Control practices including Hospital policies for precautions and respiratory protection requirements. Findings include: Findings include: Event ID:015211 Facility ID:2341 If control in the Indian	PRÉFIX	(EACH DEFICIENC)	/ MUST BE PRECEDED BY FULL	PREFIX	х	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE	COMPLETION
	Cilitea	A 749	Patient #4's routine Patient #4's room a own medications. had nothing to do w for self-administration. The Surveyor interes:00 A.M. on 1/15/s she did not know whis/her routine daily. Associate Chief Nutle:00 P.M. on 1/14 #1 said the bedside nursing unit, unlike other nursing units, a lock to secure meself-administration. INFECTION CONT CFR(s): 482.42(a)(The infection controdevelop a system frinvestigating, and communicable disepersonnel. This STANDARD is Based on record resampled employee #7, #8, #9 and Hos Hospital failed to enadhered to Infection Hospital policies for protection requirem.	e medications were kept in and Patient #4 took his/her Registered Nurse #3 said she with the medications ordered on. Viewed Registered Nurse #5 at 15. Registered Nurse #5 said there in Patient #4's room v medications were kept. It is a sociate Chief Nurse tables on Patient #4's the bedside tables on the did not contain a drawer with edications ordered for transport or identifying, reporting, controlling infections and eases of patients and the same same as a soft patient with the process of patients and the same same as a soft patient with the same that staff consistently in Control practices including in precautions and respiratory tents.	Α7	749	An Inc. 2341 If community	neri	cans

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		220110	B. WING			C 20/2015
	PROVIDER OR SUPPLIER	SPITAL	75	TREET ADDRESS, CITY, STATE, ZIP CODE 5 FRANCIS STREET OSTON, MA 02115	<u>, </u>	20/2010
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A 749	Continued From pa	nge 12	A 749			
	Fact Sheet, dated 8 resistant organisms Precautions. The Honon-sterile isolation entering the room of Precautions. Patient #4's Progres indicated he/she was resistant organism Precautions. The Surveyor interval 12:50 P.M. on 1/12 the use of precaution interpreted by Patien Nurse Director #1 services.	licy titled Contact Precaution 8/2013, indicated multi-drug is required Contact dospital policy indicated clean in gowns must be worn upon of a patient who is on Contact as Note, dated 6/10/14, as diagnosed with a multi-drug and placed on Contact wiewed Nurse Director #1 at 1/15. Nurse Director #1 said on gowns by staff was ent #4 as if he/she was dirty, said staff were expected to of personal protective				
	11:10 A.M. on 1/13 she did not wear powhen entering Patin #4 requested that it Nurse #3 said she caregivers using powhen caring for Pathe Surveyor intered 7:45 A.M. on 1/14/2	viewed Registered Nurse #3 at /15. Registered Nurse #3 said ersonal protective equipment ent #4's room because Patient to not be worn. Registered did not observe other ersonal protective equipment tient #4. viewed Registered Nurse #4 at 15. Registered Nurse #4 said mant about staff not using			SV.	
		egistered Nurse #4 said she on gowns when caring for			3	3
	· · · · · · · · · · · · · · · · · · ·			Aı	meri	cans
ORM CMS-25	567(02-99) Previous Versions	s Obsolete Event ID: 0T5Z1	1 Fac			ted [®] Life

AND PLAN OF CORRECTION	NT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: A. BUILDING			(X3) DATE SURVEY COMPLETED			
		220110	B. WING				C 20/2015
NAME OF PROVIDER OR SUPPLIER BRIGHAM AND WOMEN'S HOSPITAL				7	STREET ADDRESS, CITY, STATE, ZIP CODE 75 FRANCIS STREET BOSTON, MA 02115	, , , , , ,	
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3:00 P.M. o she often ch Inserted Ce intravenous prolonged p aware Patie Registered any signage not wear an Patient #4. The Survey A.M. on 1/2 Patient #4 fi #1 said he obecause Pa The Survey Preventionis unit 1:30 P.I Preventionis personal pre according to approached The Survey 12:50 P.M. Patient #4 to personal phe attendant st The Nurse I continuously his/her six (in Director #1 personal sta	or internal 1/14/ langed ontral Calaccess eriod on the work indicate isolation or internal 1/15. Played to solid not with tient #4 or internal 1/12 or internal	viewed Registered Nurse #7 at 15. Registered Nurse #7 said Patient #4's Peripherally atheter (a PICC is an atheter (a PICC is an atheter) dressing and was not as on Contact Precautions. #7 said she did not remember ting precautions and she did on gown when caring for viewed Physician #1 at 7:20 hysician #1 said he visited even times weekly. Physician wear an isolation gown at found it offensive. Viewed the Infection need to monitor Patient #4's /14/15. The Infection she had no knowledge of equipment not being used ospital policy and staff had not out Patient #4. Viewed Nurse Director #1 at /15. The Nurse Director said with a private cook, a gaproximately six (6) sons, and a cleaner/helper. It said Patient #4's staff were endance of Patient #4's for the hospitalization. The Nurse attent #4 referred to his/her curses and the staff would rect care of Patient #4.	A 7		An		cans
2 2 2007 (02 00) 1 10000				. u			Life

NAME OF PROVIDER OR SUPPLIER BRIGHAM AND WOMEN'S HOSPITAL STREET ADDRESS, CITY, STATE. ZIP CODE 75 FRANCIS STREET BOSTON, MA 02115 SUMMARY STATEMENT OF DEFICIENCIES (PACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) A 749 Continued From page 14 The Surveyor interviewed Registered Nurse #1 at 9:45 A.M. on 1/13/15. Registered Nurse #3 at 10:35 A.M. on 1/13/15. Registered Nurse #3 at 10:36 A.M. on 1/13/15. Registered Nurse #3 at 10:36 A.M. on 1/13/15. Registered Nurse #3 at 10:37 A.M. on 1/13/15. Registered Nurse #3 at 10:36 A.M. on 1/13/15. Registered Nurse #3 at 10:37 A.M. on 1/13/15. Registered Nurse #3 at 10:37 A.M. on 1/13/15. Registered Nurse #3 at 10:38 A.M. on 1/13/15. Registered Nurse #3 at 10:39 A.M. on 1/13/15. Registered Nurse #3 at 10:36 A.M. on 1/13/15. Registered Nurse #3 at 10:37 A.M. on 1/13/15. Registered Nurse #3 at 10:37 A.M. on 1/13/15. Registered Nurse #3 at 10:38 A.M. on 1/13/15. Registered Nurse #3 at 10:39 A.M. on 1/13/15. Registered Nurse #3 at 10:39 A.M. on 1/13/15. Registered Nurse #3 at 10:30 A.M. on 1/13/15. Registered Nurse #3 at 10:37 A.M. on 1/13/15. Registered Nurse #3 at 10:38 A.M. on 1/13/15. Registered Nurse #3 at 10:39 A.M. on 1/13/15. Registered Nurse #3 at 10:39 A.M. on 1/13/15. Registered Nurse #3 at 10:30 A.M. o	EMENT OF DEFICIENCE PLAN OF CORRECTION	(X3) DATE SURVEY COMPLETED	
REIGHAM AND WOMEN'S HOSPITAL X(4) D PREFIX TAG TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG TAG TAG TAG Continued From page 14 The Surveyor interviewed Registered Nurse #1 at 9:45 A.M. on 1/13/15. Registered Nurse #1 at 10:35 A.M. on 1/13/15. Registered Nurse #3 at 10:35 A.M. on 1/13/15. The Hospital Epidemiologist, Infectious Disease Physician, Infection Preventionists and Occupational Health Director) at 1:30 P.M. on 1/14/15. The Hospital Epidemiologist said the Hospital did not have any policies or procedures in place relating to infection control or immunization that addressed these personal staff. 3.) The Occupational Health Director said the Hospital policy follows the requirements for annual fit testing of Hospital staff who wear an N-95 (a tight-fitting facepiece respirator). The Surveyor interviewed Registered Nurse #8		C 01/20/2015	
### REGULATORY OR LSC IDENTIFYING INFORMATION A 749 Continued From page 14 The Surveyor interviewed Registered Nurse #1 at 9:45 A.M. on 1/13/15. Registered Nurse #1 at 10:35 A.M. on 1/13/15. Registered Nurse #3 said Patient #4's personal staff provided all of Patient #4's care including routine medication administration. The Surveyor interviewed the Infection Prevention Team (Hospital Epidemiologist, Infectious Disease Physician, Infection Preventionists and Occupational Health Director) at 1:30 P.M. on 1/14/15. The Hospital Epidemiologist said the Hospital did not have any policies or procedures in place relating to infection control or immunization that addressed these personal staff. 3.) The Occupational Health Director said the Hospital policy follows the requirements for annual fit testing of Hospital staff who wear an N-95 (a tight-fitting facepiece respirator). The Surveyor interviewed Registered Nurse #8	NAME OF PROVIDER OR SUPPLIER		
The Surveyor interviewed Registered Nurse #1 at 9:45 A.M. on 1/13/15. Registered Nurse #1 said Patient #4's personal staff would assist with activities of daily living care. The Surveyor interviewed Registered Nurse #3 at 10:35 A.M. on 1/13/15. Registered Nurse #3 said Patient #4's personal staff provided all of Patient #4's care including routine medication administration. The Surveyor interviewed the Infection Prevention Team (Hospital Epidemiologist, Infectious Disease Physician, Infection Preventionists and Occupational Health Director) at 1:30 P.M. on 1/14/15. The Hospital Epidemiologist said the Hospital did not have any policies or procedures in place relating to infection control or immunization that addressed these personal staff. 3.) The Occupational Health Director said the Hospital policy follows the requirements for annual fit testing of Hospital staff who wear an N-95 (a tight-fitting facepiece respirator). The Surveyor interviewed Registered Nurse #8	REFIX (EACH DI	OULD BE COMPLÉTION	
and #9 at approximately 11:00 A.M. on 1/15/15. Registered Nurses #8 and #9 said they could care for a patient requiring them to use an N-95 respirator. The Surveyor reviewed the health files of Registered Nurse #8 and #9 on 1/20/15. Registered Nurse #8 and #9, who said they would be able to immediately don an N-95 particulate respirator as needed, did not undergo fit testing since 2000 and not annually as American	The Survey 9:45 A.M. of Patient #4's activities of The Survey 10:35 A.M. Patient #4's #4's care in administration. The Survey Prevention Infectious Engineering Prevention at 1:30 P.M. Epidemiolo policies or prevention in the servey and #9 at a Registered care for a prespirator. The Survey Registered Registered would be all particulate in the survey and #9 at a respirator.	Samericans	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
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NAME OF PROVIDER OR SUPPLIER BRIGHAM AND WOMEN'S HOSPITAL				STREET ADDRESS, CITY, STATE, ZIP C 75 FRANCIS STREET BOSTON, MA 02115		20/2015
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