

Texas Department of State Health Services

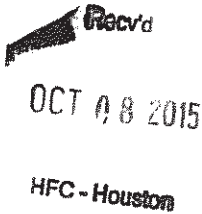
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 007326	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/23/2015
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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

HOUSTON WOMENS CLINIC

**4820 SAN JACINTO
HOUSTON, TX 77004**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	<p>TAC 139 Initial Comments</p> <p>Note: The State Form is an official, legal document. All information must remain unchanged except for entering the plan of correction, correction dates, and the signature space. Any discrepancy in the original deficiency citation(s) will be referred to the Office of the Texas Attorney General (OAG) for possible fraud. If information is inadvertently changed by the provider/supplier, the State Survey Agency (SA) should be notified immediately.</p> <p>An unannounced visit was made to the above named facility on 09/23/2015 to conduct a Re-Licensure Survey and complaint Investigation (TX 00221338), to determine compliance with 25 TAC (Texas Administrative Code) Chapter 139 State Licensing Rules for Abortion Facility.</p> <p>An Entrance Conference was conducted with the Facility's Administrator. The purpose of the visit and procedure for the inspection was discussed. The Facility's Administrator was provided information/ instruction on completing an acceptable plan of correction. Opportunities were provided for questions and answers about the survey process.</p> <p>An exit conference was conducted on the afternoon of 09/23/2015 with the Facility's Administrative staff. Findings and determination of the inspection was discussed. The complaint was unsubstantiated. Deficiencies were cited based on the visit. Information to complete and submit an acceptable plan of correction was given verbally and in writing.</p> <p>Glossary:</p> <p>Autoclave : An autoclave is a pressure chamber</p>	A 000	<div style="border: 1px solid black; padding: 10px; transform: rotate(-5deg); margin: 10px;"> <p>REVIEW POC'S</p> <p>REVIEWED <u>10/08/2015</u></p> <p><i>Reviewed</i></p> </div> <div style="text-align: center; margin-top: 20px;">  </div>	

NATURE

TITLE

(X6) DATE

Medical Director

10.8.15

6899

VRJY11

If continuation sheet 1 of 19

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A 000	Continued From page 1 used to sterilize equipment and supplies by subjecting them to high pressure saturated steam at 121 °C (249°F) for around 15-20 minutes depending on the size of the load and the contents. Nesacaine 2% : non pyrogenic local anesthetics Pathology: the science or the study of the origin, nature, and course of diseases Product of conception: Obstetrics: The aggregate of tissues present in a fertilized gestation; in a pregnancy that has been terminated or aborted Sterilizing: to destroy microorganisms in or on, usually by bringing to a high temperature with steam, dry heat, or boiling. Zithromax : antibiotic used to treat bacterial infections	A 000			
A 156	TAC 139.44(c) Orientation/Training/Demonstrated Competency (c) The facility shall ensure that staff responsible for sterilization of critical surgical instruments are trained by the facility to meet the requirements of §139.49(d) of this title (relating to Infection Control Standards) and demonstrate competency in performing the sterilization procedures at the facility. This Requirement is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure current documented competency and training for 2 of 2 staff responsible for sterilization of surgical	A 156	Administrator will be responsible for developing a specific training checklist for all staff responsible for sterilization of critical surgical instruments. This will include a review of facility policies regarding record keeping/logs for: 1. Sterilizer 2. Compliance disinfectant solution 3. Biological indicator This will also include an annual competency assessment	10/17/15	

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A 156	<p>Continued From page 2</p> <p>instruments (Staff M & Staff N).</p> <p>Findings include:</p> <p>Observation on 09-23-15 at 8:55 a.m. revealed a designated "clean" room with two (2) Midmark M11 autoclaves.</p> <p>Interview at this same time with Staff N she said she and Staff M were the staff who operated the autoclaves. She said Staff M was in charge of the autoclaves and did all of the autoclave testing and cleaning. Staff N went on to say she received on-the-job training to operate the autoclaves but did not complete a competency checklist that she could recall.</p> <p>Interview on 09-23-15 at 9:10 with Staff M she stated she was a medical assistant and the person responsible for the autoclaves. She had worked in the facility for over thirty years and had done many jobs. She said she had received on-the-job training over the years to operate the autoclaves. Staff M went on to say she did not have formal sterile processing training or a competency checklist for this area.</p> <p>Record review on 09-23-15 of the records/ logs maintained for both autoclaves failed to reveal documentation of sterilizer date/time; load number; duration & temperature; exposure; operator identification; results of biological tests, and time completed. The last entry in the facility "Steam Sterilizer Record/Log Book" was 01-29-15. [*please see A-245 and A-257 for further details].</p>	A 156			

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A 156	<p>Continued From page 3</p> <p>Observation on 09-23-15 at 9:15 a.m. in the designated "dirty" room revealed a large clear plastic unlabeled container 2/3 full of an unlabeled green liquid. The container was covered; on top of the lid was an electronic timer and a "sticky note" that read: "changed 01-30-15." Interview at this same time with Staff M she stated it was a disinfectant called "Compliance." Manufacturer's instructions read solution period "not to exceed 14 days." [*please see A-255 for details].</p> <p>Record review of the Personnel/Training Record of Staff M and Staff N failed to reveal specific competencies and / or training for sterile processing</p> <p>Interview on 09-23-15 at 2:15 p.m. with Consultant /Staff O she stated that staff job performance was documented on their annual evaluation.</p> <p>Review of current "Employee Evaluations" for Staff M and Staff N revealed they each last received evaluations on 06-15-13. There was an area labeled "Job Performance"and each received a score of 10. There was nothing specific documented related to competency in sterile processing.</p>	A 156			
A 197	<p>TAC 139.48(1)(A) Physical & Environmental Requirements</p> <p>The physical and environmental requirements for a licensed abortion facility are as follows. (1) A facility shall:</p>	A 197			

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A 197	<p>Continued From page 4</p> <p>(A) have a safe and sanitary environment, properly constructed, equipped, and maintained to protect the health and safety of patients and staff at all times;</p> <p>This Requirement is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure a safe and sanitary environment to protect the health of the patient, facility's direct care staff failed to store medication and administer medication in a safe manner.</p> <p>Findings:</p> <p>Findings include:</p> <p>Observation during initial tour of the facility on 09-23-15 between 8:45 a.m. & 9:30 a.m. revealed the following:</p> <p>Ripped, torn upholstery on exam tables :</p> <p>Procedure Rooms 1, 2, & 3: Each of the 3 rooms room had a padded exam table with several rips, tears and non-intact upholstery. Interview with Consultant/Staff O at the time of observation she said the pads could not be properly cleaned due to the ripped upholstery.</p> <p>In addition, each of the 3 exam tables had at least one roll of clear plastic tape stuck to the side of the table. Consultant/Staff O asked staff to remove the tape and discard it, as it was an infection control issue.</p> <p>Multiple cardboard boxes stored directly on the</p>	A 197	<p>Administrator will be responsible for repair or replacement of procedure room tables.</p> <p>Director of Nursing shall be responsible for ensuring procedure room tables are intact and nursing staff is advised of infection control issues.</p>	<p>11/15/15</p> <p>11/15/15</p>

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A 197	<p>Continued From page 5</p> <p>floor:</p> <p>Procedure Rooms 1, 2 , & 3 : Multiple cardboard boxes containing patient supplies located in corners of room and behind the exam tables-stored directly on the floor.</p> <p>Interview with Registered Nurse (RN) B at time of observation she acknowledged the floor could not be properly mopped under the boxes and the supplies could be contaminated if in contact with floor cleaning solutions.</p> <p>Dirty ultrasound machine:</p> <p>Procedure room 3: ultrasound machine located in the corner of the room had a large amount of dirt and dust, on the bottom and top of the machine.</p> <p>Interview with Registered Nurse (RN) B at time of observation she stated the facility did not use that ultrasound machine.</p> <p>Decontamination/"Dirty Room"</p> <p>Observation of a double door cabinet located under a sink revealed multiple bottles of cleaners, disinfectants, and various unknown liquid products. The bottom shelf of the cabinet had rings of dirt and a large amount of specks of gray/black dirt and grime.</p> <p>Interview at the time of observation with Staff M she stated cleaning under the sink was her responsibility, along with Staff N, who also did after-hours cleaning.</p> <p>Interview on 09-23-15 at 2:15 p.m. with Consultant /Staff O she stated the facility did not have specific policies that addressed general</p>	A 197	<p>Administrator shall be responsible for developing policies for storage of non sterile supplies to include use of plastic pallets for any supplies in exam areas.</p> <p>Administrator shall develop policies for daily cleaning of procedures rooms to include counters, all surfaces & floors.</p> <p>Administrator shall develop policies for daily cleaning of dirty & clean areas to include counters, all surfaces & floors.</p>	11/1/15

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A 197	<p>Continued From page 6</p> <p>cleaning of the facility.</p> <p>On 09/23/2015 at 12.10 p.m. during tour of the facility revealed patients' medications was observed stored in a drawer in the facility's staff breakroom. The drawer was unlocked and was accessible to all staff that uses the breakroom. The breakroom is located adjacent to the post-operative suite. The licensed nurse assigned to the room was observed leaving the breakroom to conduct post- surgical assessment on patients. Approximately 20 pre - poured large white tablets were observed in unlabeled cups stored in the unlocked drawer. The Director of Nursing who was present said the unlabeled medications in the cups were Zithromax.</p> <p>Interview with the Facility's Director of Nursing on 09/23/2015 at 12.12 p.m. revealed medications stored in the unlocked drawer are pre-poured in anticipation of administering it to patients who visits the facility for procedure during the day. She said medication pre- poured that is unused is returned to her at the end of the day and is locked away.</p> <p>Review of the Facility's current Policy and Procedure on Preparation and storage of Medication directs staff as follows: "Medication will be stored in locked cabinets. Medications will be stored in original containers. "</p>	A 197	<p>Director of Nursing shall be responsible for ensuring compliance with facility's policies for preparation and storage of medications. This will include in-service with all nursing staff and random checks by Director of Nursing to ensure on going compliance. This will also include purchase of more locked containers for all medications. This will be an on-going part of the facility's QA program.</p>	11/1/15
A 210	<p>TAC 139.49(a) Infection Control Standards</p> <p>(a) Written policies. A licensed abortion facility shall develop, implement, and enforce infection control policies and procedures to minimize the transmission of post-procedure infections. These</p>	A 210		

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A 210	<p>Continued From page 7</p> <p>policies shall include, but not be limited to, the prevention of the transmission of human immunodeficiency virus (HIV), hepatitis B virus (HBV), hepatitis C virus (HCV), Mycobacterium tuberculosis (TB), and Streptococcus species (S. spp.); educational course requirements; cleaning and laundry requirements; and decontamination, disinfection, sterilization, and storage of sterile supplies.</p> <p>This Requirement is not met as evidenced by: Based on observation and interview, the facility failed to enforce infection control policies to minimize the transmission of infection. The facility failed to ensure multi-dose vials (MDV) were dated when opened per facility policy.</p> <p>Findings include:</p> <p>Observation during initial tour of the facility on 09-23-15 between 8:45 a.m. & 9:30 a.m. revealed the following:</p> <p>Procedure Room # 2:</p> <p>two(2) thirty milliliter (ml) vials of sodium chloride, opened not dated</p> <p>two(2) thirty ml vials of Nescaine 2%, opened not dated</p> <p>Procedure Room # 3:</p> <p>one (1) thirty ml vial of Nescaine 2%, opened not dated</p> <p>Interview at time of observation with Registered Nurse (RN) B, she stated MDV should be dated when opened and were good for 30 days after</p>	A 210	<p>Director of Nursing shall be responsible for reviewing facility policies regarding preparation and storage of medications with all nursing staff. Director of Nursing will conduct random checks to determine compliance. This will also be an on going component of the facility's QA program.</p>	11/1/15

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A 210	Continued From page 8 opening. Review of facility policy titled "Policy for Preparation & Storage of Medications," dated 03-23-15, read: " ...1. Multidose vials will be labeled with date opened..."	A 210		
A 213	TAC 139.49(b)(1)(A)(i)(ii) Infection Control Standards (A) An abortion facility shall ensure that all staff comply with universal/standard precautions as defined in this paragraph. (i) Universal/standard precautions includes procedures for disinfection and sterilization of reusable medical devices and the appropriate use of infection control, including hand washing, the use of protective barriers, and the use and disposal of needles and other sharp instruments. (ii) Universal/standard precautions synthesize the major points of universal precautions with the points of body substance precautions and apply them to all patients receiving care in facilities, regardless of their diagnosis or presumed infection status. This Requirement is not met as evidenced by: Based on observation, interview and record review, the facility's staff failed to wash/ sanitize hands after removing contaminated gloves in 1 of 4 staff observed Staff (M) Findings: Observation on 09/23/2015 at 11:45 a.m revealed Technician (M) was observed in the facility's dirty utility room where (product of conception) are handled and discarded. The Technician was observed checking and floating the product of	A 213	Director of Nursing shall be responsible for conducting an in-service for all medical staff on appropriate use of infection control including glove use and hand-washing. Hand sanitizers will also be purchased and placed in clinic. Director of Nursing shall conduct random inspections to determine compliance. This will be an on-going part of the facility's QA program.	11/1/15

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A 213	Continued From page 9 conception in a clear dish after the procedure. The Technician donned a pair of gloves, poured the content of the product of conception through a strainer and rinsed it down the drain. The remaining content she placed in a clear dish with water and floated it. She then removed one hand of her gloves, and then used a forceps to examine the product of conception. After documenting on the pathology result form with her contaminated hands, Medical Technician (M) removed her contaminated gloves and walked from the room without washing or sanitizing her hands. She then rolled the contaminated cart which was used to transport the product of conception from the procedure room, into the clean supply room without sanitizing it. The Director of Nursing who was present during the observation directed her to clean/sanitize the cart. During an interview on 09/23/2015 at 11.55 a.m the Surveyor informed her that she did not wash/ sanitize her contaminated hands after removing her contaminated gloves. The Technician said she was sorry.	A 213			
A 234	TAC 139.49(d)(5)(B)(i)(ii) Infection Control Standards B) Environmental requirements. Where cleaning, preparation, and sterilization functions are performed in the same room or unit, the physical facilities, equipment, and the written policies and procedures for their use shall be such as to effectively separate soiled or contaminated supplies and equipment from the clean or sterilized supplies and equipment. (i) A facility shall have a sink for hand washing.	A 234	Administrator shall develop policy regarding separation of soiled or contaminated supplies from clean supplies. This will include a separate sink or hand sanitizer in the clean area. Director of Nursing shall conduct spot inspections to determine compliance with policy. This will be an on-going component of the facility's QA program.	11/1/15	

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A 234	<p>Continued From page 10</p> <p>This sink shall not be used for cleaning instruments or disposal of liquid waste. (ii) A facility shall have a separate sink for cleaning instruments and disposal of liquid waste. Hand washing shall only be performed at this sink after it has been disinfected.</p> <p>This Requirement is not met as evidenced by: Based on observation and interview, the facility failed to ensure clean supply utilized in the facility is separated from contaminated equipment and product of conception.</p> <p>Findings:</p> <p>Observation on 09/23/2015 at 11:50 a.m during tour of the Facility's dirty utility room where soiled instruments were observed being cleaned and product of conception were examined and floated, revealed clean supplies of syringes, Luer locks, boxes of gloves, packets of sanitary pads were stored on opened shelves above the dirty sink where contaminated equipment, blood and blood products are discarded. Subsequent observation on 09/23/2015 at 11.52 a.m revealed Medical Technician (M) was observed washing her hands over the dirty sink where contaminated equipment were washed.</p> <p>Interview on 09/23/2015 at 11: 52 a.m with Medical Technician (M) revealed the facility lacked storage space and so supplies are kept in the dirty utility room</p>	A 234		
A 245	<p>TAC 139.49(d)(5)(F)(iii)(iv)(v) Infection Control Standards</p> <p>(F) Biological indicators.</p>	A 245		

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A 245	<p>Continued From page 11</p> <p>(iii) A log shall be maintained with the load identification, biological indicator results, and identification of the contents of the load.</p> <p>(iv) If a test is positive, the sterilizer shall immediately be taken out of service. A malfunctioning sterilizer shall not be put back into use until it has been serviced and successfully tested according to the manufacturer's recommendations.</p> <p>(v) All available items shall be recalled and reprocessed if a sterilizer malfunction is found. A list of all items which were used after the last negative biological indicator test shall be submitted to the administrator.</p> <p>This Requirement is not met as evidenced by: Based on observation, interview, and record review, the facility failed to maintain a log for biological indicators (BI) that included date, time, load identification, BI results, and contents of the load.</p> <p>Findings include:</p> <p>Observation on 09-23-15 at 8:55 a.m. revealed a designated "clean" room with two (2) Midmark M11 autoclaves.</p> <p>Interview on 09-23-15 at 9:10 with Staff M she stated she was a medical assistant and the person responsible for the autoclaves. Staff M said she ran a biological indicator (BI) test every day.</p> <p>Record review on 09-23-15 of the records/ logs maintained for both autoclaves failed to reveal documentation of biological indicators that</p>	A 245	<p>Administrator will review facility's policy regarding Biological Indicators with staff working in sterilization area. Administrator will conduct random inspections to determine compliance. This will be an on-going component of the facility's QA program.</p>	10/17/15

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A 245	Continued From page 12 included load identification, BI results, and contents of the load. Review of facility binder titled "3M Steam Sterilization Record Keeping/Log Book" instructions read: " ..Routine Efficacy Testing : weekly, preferably daily, or every load to eliminate recalls and improve patient safety..."The instructions included 16 point details on how to complete each required component of the log; including, BI lot number, date, time, results, etc... The last complete entry in the "3M Steam Sterilization Record Keeping/Log Book" was dated 01-26-15. Continued interview with Staff M, she said she had not kept up with the record keeping on the autoclaves. Review of facility policy titled "Infection Control,dated 07-01-2005, read: " 3. Decontamination, Disinfection,Sterilization...3. Biological indicators will be used to determine the efficacy of the sterilization process. This shall be included in at least one run each day of use. A log will be kept with the load identification, results of the indicator and contents of the load..."	A 245		
A 255	TAC 139.49(d)(5)(K)(i)(ii)(iii) Infection Control Standards (K) Disinfection. (i) The manufacturer's written instructions for the use of disinfectants shall be followed. (ii) An expiration date, determined according to manufacturer's written recommendations, shall be marked on the container of disinfection solution currently in use.	A 255	Administrator will review facility policy's with staff working in sterilization area. Staff will be instructed on record keeping/logs. Administrator will conduct random inspections to determine compliance. This will be an on-going component of the facility's QA program.	10/17/15

Texas Department of State Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 007326	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/23/2015
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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

HOUSTON WOMENS CLINIC

**4820 SAN JACINTO
HOUSTON, TX 77004**

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A 255	<p>Continued From page 13</p> <p>(iii) Disinfectant solutions shall be kept covered and used in well-ventilated areas.</p> <p>This Requirement is not met as evidenced by: Based on observation, interview, and record review, the facility failed to follow the manufacturer's written instructions for the use of a disinfectant utilized on surgical instruments.</p> <p>Findings include:</p> <p>Observation on 09-23-15 at 8:55 a.m. revealed a designated "clean" room with two (2) Midmark M11 autoclaves.</p> <p>Interview on 09-23-15 at 9:10 with Staff M she stated she was a medical assistant and the person responsible for the autoclaves</p> <p>Further observation on 09-23-15 at 9:15 a.m. in the designated "dirty" room revealed a large clear plastic unlabeled container 2/3 full of an unlabeled green liquid. The container was covered; on top of the lid was an electronic timer and a "sticky note" that read: "changed 01-30-15."</p> <p>Interview at this same time with Staff M she stated it was a disinfectant called "Compliance." Staff M said the process was to wash the surgical instruments, then place them in the Compliance disinfectant, prior to being put into the autoclave.</p> <p>Review of Metrex Company instruction for use of Compliance Sterilizing and Disinfecting Solution, undated, read: " " high level disinfectant...sterilant...use period not to exceed 14 days..."</p>	A 255		

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A 255	Continued From page 14 Staff M went on to say she did not maintain a log that documented when the Compliance disinfectant solution was changed. She said "I am sure I changed the solution since 01-30-15..." , but could not state exactly when it had been changed.	A 255			
A 257	TAC 139.49(d)(5)(L)(ii)(I - V) Infection Control Standards (L) Performance records. (ii) Each sterilizer shall be monitored during operation for pressure, temperature, and time at desired temperature and pressure. A record shall be maintained either manually or machine generated and shall include: (I) the sterilizer identification; (II) sterilization date and time; (III) load number; (IV) duration and temperature of exposure phase (if not provided on sterilizer recording charts); (V) identification of operator(s); This Requirement is not met as evidenced by: Based on observation, interview, and record review, the facility failed to maintain performance records on two (2) autoclaves that included pressures, temperatures, and times at desired temperature and pressure. Findings include: Observation on 09-23-15 at 8:55 a.m. revealed a designated "clean" room with two (2) Midmark M11 autoclaves.	A 257	Administrator will review facility's policy with staff working in sterilization area. Staff will be instructed on record keeping/logs. Administrator will conduct random inspections to determine compliance. This will be an on-going component of the facility's QA program.	10/17/15	

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A 257	<p>Continued From page 15</p> <p>Interview on 09-23-15 at 9:10 with Staff M she stated she was a medical assistant and the person responsible for the autoclaves. Staff M was asked to produce all logs and records for the two(2) autoclaves.</p> <p>Staff M said she ran a biological indicator (BI) test every day.</p> <p>Record review on 09-23-15 of the records/ logs maintained for both autoclaves failed to reveal documentation of load identification, date, time, duration and temperature of exposure phase.</p> <p>Staff M produced a binder titled "3 M Steam Sterilization Record Keeping/Log Book" to record BI results. The last entry in this log book was dated 01-26-15.</p> <p>Continued interview with Staff M, she said she had not kept up with the record keeping on the autoclaves.</p> <p>Review of "Midmark M11 Manufacturer's Manual, "read: "...Physical monitors (temperature and pressure measuring devices) can help detect sterilizer malfunctions...The Printer Accessory should be used to create a record of each load's actual cycle time, temperature, and pressure..."</p>	A 257			
A 378	<p>TAC 139.59(d)(1)((2)(3)(4) Anesthesia Services</p> <p>(d) Only personnel who have been approved by the facility to provide anesthesia services shall administer anesthesia. All approvals or delegations of anesthesia services as authorized by law shall be documented and include the training, experience, and qualifications of the person who provided the service. A qualified</p>	A 378	<p>Medical Director shall develop training criteria for all RNs administering sedation. Medical Director will be responsible for training and authorizing RNs to administer sedation. Medical Director will ensure RNs are assessed annually for competency in sedation administration.</p>	11/1/15	

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A 378	<p>Continued From page 16</p> <p>registered nurse (RN) who is not a certified registered nurse anesthetist (CRNA), in accordance with the orders of the operating surgeon, anesthesiologist, or CRNA may administer topical anesthesia, local anesthesia, minimal sedation and moderate sedation, in accordance with all applicable rules, policies, directives and guidelines issued by the Texas Board of Nursing. When an RN who is not a CRNA administers sedation, as permitted in this paragraph, the facility shall:</p> <p>(1) verify that the registered nurse has the requisite training, education, and experience;</p> <p>(2) maintain documentation to support that the registered nurse has demonstrated competency in the administration of sedation;</p> <p>(3) with input from the facility's qualified anesthesia providers, develop, implement and enforce detailed, written policies and procedures to guide the registered nurse; and</p> <p>(4) ensure that, when administering moderate sedation during a procedure, the registered nurse has no other duties except to monitor the patient.</p> <p>This Requirement is not met as evidenced by: Based on record review and interview the facility failed to maintain documentation of demonstrated competency for 2 of 2 Registered Nurses (RN) who administered moderate sedation (RNs : B & P)</p> <p>Findings include:</p> <p>Record review of two sampled patient records (Patient # 4 & 12) revealed :</p> <p>RN B administered moderate sedation to Patient # 12 on 08-24-15.</p>	A 378		

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A 378	<p>Continued From page 17</p> <p>RN P administered moderate sedation to Patient 4 on 10-14-15.</p> <p>Record review on 09-23-15 of the personnel/training records of RN B and RN P failed to reveal documentation of demonstrated competency to administer moderate sedation.</p> <p>Interview on 09-23-15 at 3:15 p.m. with Consultant /Staff O she stated the RNs did not have specific documented competencies related to moderate sedation. Review of the facility policy for sedation revealed it did not address training/competency of RNs to administer moderate sedation.</p> <p>Observation on 09/23/2015 at 11.45 a.m revealed Registered Nurse (B) was observed in the procedure room assisting the physician with a procedure.</p> <p>Review on 09/23/2015 of Registered Nurse (B's) personnel and training file revealed she was hired to the facility on 01/10/2015.</p> <p>Review of Registered Nurse (B's) personnel and training record revealed no documentation of competency on administration of moderate sedation to patients.</p> <p>Interview on 09/23/2015 at 2.45 pm with the Facility's Director of Nursing revealed Registered Nurse (B) administers moderate sedation to patients during procedure in the facility.</p> <p>Interview on 09/23/2015 during the afternoon with</p>	A 378			

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A 378	Continued From page 18 Registered Nurse (B) revealed during her orientation period she shadowed several registered nurse in the facility but she had no documentation of competency.	A 378		