RON DESANTIS
GOVERNOR

MARY C. MAYHEW
SECRETARY

September 9, 2019

Ms. Priscilla Roberts, Chief Executive Officer
Reception And Medical Center Hospital
7765 S. County Rd. 231
Lake Butler, FL 32054

Dear Ms. Roberts:

This letter reports the findings of a state licensure survey that was completed on August 14, 2019 by representatives of this office.

Attached is the provider's copy of the State (3020) Form, which indicates the deficiencies that were identified on the day of the visit.

Please provide a plan of correction to this Field Office, in accordance with enclosed instructions, for the identified deficiencies **within ten calendar days of receipt of this faxed report**. You will not receive a copy of this report in the mail; you will only receive this faxed report. **All deficiencies shall be corrected no later than October 9, 2019.**

The plan of correction must include the following:

1. Identify how corrective action will be accomplished for those residents found to have been affected by the deficient practice.
2. Describe how the facility will identify other residents having the potential to be affected by the same deficient practice.
3. Explain measures to be put into place or systemic changes made to ensure that the deficient practice will not recur.
4. Identify how the facility will monitor its corrective action to ensure the deficient practice is being corrected and will not recur; i.e., what program will be put into place to monitor the continued effectiveness of the systemic change.
5. Ensure that no protected or other confidential information (i.e., resident or staff names) are included in the plan.
6. State the completed date; the date that the facility identifies compliance can be achieved, which must be after the exit date.
7. You must sign the bottom of page 1 of the statement of deficiencies; include your title and date.

The Quality Assurance Questionnaire has long been employed to obtain your feedback following survey activity. This form has been placed on the Agency's website at http://ahca.myflorida.com/Publications/Forms.shtml as a first step in providing a web-based interactive consumer satisfaction survey system. You may access the questionnaire through

the link under Health Facilities and Providers on this page. Your feedback is encouraged and valued, as our goal is to ensure the professional and consistent application of the survey process.

Thank you for the assistance provided to the surveyors. Should you have any questions please call this office at (386) 462-6201.

Sincerely,

Aleta Garner, RN

Aleta Garner
Field Office Manager

AEG/pcp
Enclosures

TBB2

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Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HL110183	A. BUILDING: _____ B. WING _____	08/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RECEPTION AND MEDICAL CENTER HOSPITA	7765 S COUNTY RD 231 LAKE BUTLER, FL 32054

(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
H 000	INITIAL COMMENTS A State Health Biennial survey was conducted at Reception and Medical Center Hospital on August 12, 2019 to August 14, 2019. The provider had deficiencies at the time of the visit.	H 000		
H 076	59A-3.240(10-16), FAC NUTRITIONAL CARE - Environment & Equipment (10) The dietetic department shall be designed and equipped to facilitate the safe, sanitary, and timely provision of food service to meet the nutritional needs of patients. (11) The dietetic department shall have adequate equipment and facilities to prepare and distribute food, protect food from contamination and spoilage, to store foods under sanitary and secure conditions, and to provide adequate lighting, ventilation and humidity control. (12) The dietetic department shall thoroughly cleanse and sanitize food contact surfaces, utensils, dishes and equipment between periods of use, shall ensure that toilet, hand-washing and hand-drying facilities are conveniently available, and provide for dishwashing and utensil washing equipment that prevent recontamination and are apart from food preparation areas. (13) The dietetic department shall ensure that all walk-in refrigerators and freezers can be opened from inside and that all food and nonfood supplies are clearly labeled. Where stored in the same refrigerator, all nonfood supplies and specimens shall be stored on separate shelves from food supplies. (14) The dietetic department shall implement methods to prevent contamination in the making, storage, and dispensing of ice. (15) The dietetic department shall ensure that disposable containers and utensils are discarded after one use, and that worn or damaged dishes	H 076		

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H 076	Continued From page 1 and glassware are discarded. (16) The dietetic department shall hold, transfer, and dispose of garbage in a manner which does not create a nuisance or breeding place for pests or otherwise permit the transmission of disease. This Statute or Rule is not met as evidenced by: Based on observation, interview and Food Service Operations Manual review the facility failed to prevent the possible spread of infection for failing to ensure the kitchen was free of pests, the walk-in freezer was clean, failed to equipment the kitchen with proper hand hygiene solution, and failed to sanitize the thermometer prior to inserting into food items. Findings: Tour of the dietary department/kitchen with the Administrator, Food Service Director, and the Administrative Lieutenant on 8/13/2019 beginning at 9:37 AM through 10:30 AM revealed the following observations: # 1. Upon entry to the kitchen, at the tray dump station, revealed several live small insects crawling on the sink. The Food Service Director (FSD) confirmed the presence of the pests. # 2. The walk-in freezer air curtain was observed to have a sticky substance on the curtain, was stained with an orange-red discoloration, and visible food particles. # 3. Observed several staff performing hand washing in the sink using a small bar of soap as their hand washing solution. # 4. At 9:55 AM, the Food Service Director (FSD)	H 076		

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H 076	Continued From page 2 obtained a thermometer. The FSD removed the cover of the thermometer and checked the temperature of macaroni. The FSD failed to sanitize the thermometer before inserting it into the cooked macaroni. After removing the thermometer from the macaroni, the FSD did not sanitize the thermometer, and checked the temperature of the cooked carrots. The FSD failed to sanitize the thermometer before checking the food temperatures. During an interview on 08/13/2019 at 10:30 AM, the Food Service Director (FSD) confirmed the observations made while conducting the tour. Review of the Food Service Operations Manual with a revised date of 6/25/2018. On Page 26 of the manual, item #5 read: Wash, rinse and sanitize food contact surfaces of sinks, tables, utensils, thermometers, carts and equipment: a. before each use, b. between uses when preparing different types of foods or, c. anytime contamination occurs or is suspected. Page 25 of the policy read: The FSD will be responsible for implementation and compliance with food preparation and comply with State Health Department requirements.	H 076		
H 084	59A-3.241(3), FAC PHARMACY - Preparing & Storing (3) All drugs shall be prepared and stored under proper conditions of sanitation, temperature, light, moisture, ventilation, security and segregation to promote patient safety and proper utilization and efficacy. This Statute or Rule is not met as evidenced by: Based on observation, interview and policy	H 084		

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H 084	Continued From page 3 review, the facility failed to ensure the pharmacy department maintained a sanitary environment for the storage and preparation of drugs and biologicals. Findings: During an initial tour of the pharmacy department on 8/12/2019 at 1:43 PM with the Pharmacy Manager revealed several wall units filled with prescription medications and over the counter medications. There were some medications observed on top of the counter in the preparation room. The preparation room was carpeted. The carpet was visibly stained with a dark black to brownish colored substances over 80% of the carpeted floor. There was debris on the floor, and a two foot by two foot section of carpet was missing exposing the wood floor. During an interview the Pharmacy Manager on 8/12/2019 at 1:47 PM, stated "The carpets are stained and unclean. There was some kind of leak in the past and that is why a part of the carpet is missing, there was a pipe that burst in the pharmacy and it flooded the area." During an interview on 08/12/2019 at 2:45 PM the Housekeeping Sergeant stated, "The carpeting is stained, the carpet needs to be replaced. The housekeeping staff is not allowed to enter the pharmacy department." When asked who is responsible for housekeeping services in the pharmacy department, the Housekeeping Sergeant replied, "I guess they are." Review of the Pharmacy Scope of Services policy on page 1 read: The RMC (Reception and Medical Center) Pharmacy department provides a complete range of pharmacy services to	H 084		

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H 084	Continued From page 4 hospitalized inmates with the primary responsibilities including: Maintaining a safe, sanitary environment and efficient system for dispensing medications. Review of the Hospital/Maintenance General Post Order #01 policy dated January 2010 and revised on June 2013. Page 1 of 6 of the policy read: Purpose: To ensure a clean and dustfree environment, and to minimize infections. Page 5 of 6 of the policy read: The Hospital/Sanitation/Maintenance Officers will maintain a continual check of orderlies to ensure their assigned work areas are properly cleaned. All work areas should be checked by the Correctional Officer Sergeant (Housekeeping Supervisor) daily to make sure they are cleaned to his/her specifications prior to allowing the assigned inmates to return to their housing areas.	H 084		
H 124	59A-3.247(1)(a-j) , FAC HOUSEKEEPING SERVICE - Staffing/Contract/Plan Each hospital shall have an organized housekeeping department with a qualified person designated as responsible for all housekeeping functions. The designated supervisor of housekeeping shall be responsible for developing written policies and procedures for coordinating housekeeping services with other departments, developing a work plan and assignments for housekeeping staff, and developing a plan for obtaining relief housekeeping personnel. (1) A sufficient number of housekeeping personnel shall be employed to fulfill the responsibilities of the housekeeping department seven days a week. (2) When housekeeping services are provided by a third party, the hospital shall have a formal	H 124		

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H 124	Continued From page 5 written agreement with the third party provider on file. (3) The designated supervisor of housekeeping shall develop, implement, and maintain an effective housekeeping plan to ensure that the facility is maintained in compliance with the following: (a) The facility and its contents shall be kept free from dust, dirt, debris, and noxious odors; (b) All rooms and corridors shall be maintained in a clean, safe, and orderly condition, and shall be properly ventilated to prevent condensation, mold growth, and noxious odors; (c) All walls and ceilings, including doors, windows, skylights, screens, and similar closures shall be kept clean; (d) All mattresses, pillows, and other bedding; window coverings, including curtains, blinds, and shades, cubicle curtains and privacy screens; and furniture shall be kept clean; (e) Floors shall be kept clean and free from spillage, and non-skid wax shall be used on all waxed floors; (f) Articles in storage shall be elevated from the floor; (g) Aisles in storage areas shall be kept unobstructed; (h) All garbage and refuse from patient areas shall be collected daily and stored in a manner to make it inaccessible to insects and rodents; (i) Garbage or refuse storage rooms, if used, shall be kept clean, shall be vermin-proof, and shall be large enough to store the garbage and refuse containers that accumulate. Outside garbage or refuse storage areas or enclosures shall be large enough to store the garbage and refuse containers that accumulate, and shall be kept clean. Outside storage of unprotected plastic bags, wet strength paper bags, or baled units	H 124		

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H 124	Continued From page 6 containing garbage or refuse is prohibited. Garbage and refuse containers, dumpsters, and compactor systems located outside shall be stored on or above a smooth surface of non-absorbent material, such as concrete or machine-laid asphalt, that is kept clean and maintained in good repair; and (j) Garbage and refuse shall be removed from both interior and outside storage areas as often as necessary to prevent sanitary nuisance conditions. If garbage and refuse are disposed of on the facility premises, the method of disposal shall not create a sanitary nuisance. This Statute or Rule is not met as evidenced by: Based on observation, interview and policy review, the facility failed to ensure an effective housekeeping program for a safe and clean environment. Findings: During a tour of the in-patient area (East wing) with the Housekeeping Sergeant and the Director of Nursing (DON) on 8/12/2019 beginning at 2:52 PM revealed the following observations: #1. Room 22111 - 22118 at 3:15 PM, it was observed the entire baseboard in the bathroom floor was missing. #2. Room 22101 - 22108 the floor next to the bathroom was unclean with dust build up, a sticky substance was on the floor and in the corners of the bathroom. The privacy curtain of the bathroom/toilet had several areas of dark colored, black colored stains/spots on the curtain. #3. The main elevator wall had an area where paint was peeling off. Review of the Hospital/Maintenance General Post	H 124		

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H 124	Continued From page 7 Order #01 policy dated January 2010 and revised on June 2013. Page 1 of 6 of the policy read: Purpose: To ensure a clean and dustfree environment, and to minimize infections. Page 5 of 6 of the policy read: The Hospital/Sanitation/Maintenance Officers will maintain a continual check of orderlies to ensure their assigned work areas are properly cleaned. All work areas should be checked by the Correctional Officer Sergeant (Housekeeping Supervisor) daily to make sure they are cleaned to his/her specifications prior to allowing the assigned inmates to return to their housing areas.	H 124		
H 402	395.0197(1)(a), F.S. RM Prog - Investigation & Analysis The investigation and analysis of the frequency and causes of general categories and specific types of adverse incidents to patients. This Statute or Rule is not met as evidenced by: Based on facility documentation, interview and, policy review the facility failed to ensure Risk Management investigations were conducted or complete for 8 of 10 sampled incidents, Incident #1, #2, #5, #6, #7, #8, #9 and #10. Findings: A review of incident report #1 dated 01/10/2019 indicated an Intravenous pump with the medication Milrinone (used to make the heart beat stronger so the amount of blood pumped by the heart is increased) was found with the medication bag empty set at a rate of 100 milliliters per hour instead of the ordered rate of 11.16 milliliters per hour. There was no	H 402		

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H 402	Continued From page 8 documentation of the patient or any staff involved being interviewed, the Intravenous (IV) pump was not removed and checked for any malfunction, and no follow up education or training provided. A review of incident report #2 dated 07/02/2019 indicated an intravenous antibiotic was administered to a patient with no orders for antibiotics and a documented penicillin allergy, the incident report did not indicate what antibiotic was administered or how much of the medication was administered. There was no documentation of staff interviews. No investigation was conducted by the Risk Manager. A review of incident reports #5, #6, #7, #8, #9 and #10 failed to ensure all staff involved were interviewed and failed to indicate a thorough investigation had been conducted. During an interview on 08/13/2019 at 1:00 PM the Regional Director she stated, "Eight out of the ten of these incident reports are not filled out correctly and not investigated thoroughly. It seems that they are rubber stamped with no further action or no need for further evaluation by the Risk Manager. There is no follow up to determine how these errors occurred and if any further education or training was necessary. We should have removed the IV (Intravenous) pump from service, to ensure that it did not malfunction, we should have determined if our IV pumps have a lock out feature that would prevent patients from adjusting the rate and provide education to all staff regarding the IV Pump features. We should have involved pharmacy in a Root Cause Analysis of the incident. We should have determined the exact time that the Milrinone was hung to be able to determine the exact amount of the medication that was infused." The Regional	H 402		

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H 402	Continued From page 9 Director reviewed the antibiotic incident report that an inmate was administered an IV antibiotic when they had no IV antibiotics ordered and there was no documentation of the IV antibiotic that was administered to a patient that had a Penicillin allergy. She stated, "That incident report was incompletely filled out and that there was no Risk Manager investigation into the events." She verified there was no documentation of the antibiotic that was administered in the incident report, nurses note or physician note. She verified that there was no documentation of the amount of medication that was infused, no follow up investigation by the Risk Manager, no employee statements, no pharmacy involvement to determine the cause of this and prevent the errors from occurring again. She stated, "Unfortunately, these incidents do impact patient safety. We cannot assume that the patient adjusted the IV pump rate, we should have investigated further. This incident could have, really should have changed the way we work with the IV pumps based on that incident alone, our lack of investigation cost us the opportunity to improve our practice and prevent other IV pump related incidences." During an Interview with the Administrator on 08/13/2019 at 12:25 PM she stated, I expect the Risk Manager to do a thorough investigation of all incident reports to promote patient safety and increase the staff's knowledge. If we do incomplete investigations, we impact patient safety. I am not sure why they were not completely investigated. I was not aware of the incident in January with the IV pump and Milrinone. There seems to be an opportunity there that was missed for education and to determine if our pumps have features that we are not aware of. That alone would impact patient	H 402		

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H 402	Continued From page 10 safely. As we review these incident reports it appears that the risk manager had a rubber stamp and did not do a thorough job on the ones that you reviewed. This was not presented to the board at the April 23, 2019 meeting by the last Risk Manager. During an interview 08/12/2019 at 3:55 PM with the Executive Nursing Director she stated, "It is apparent no investigations have been completed on the 8 out of the 10 incident reports we reviewed, as acting Risk Manager, there needs to be employee statements, patient statements if necessary, the reports need to include the basic facts of the amounts and types of medications, if it's a fall that the injuries were addressed, and if tests are ordered the results should be included as part of the investigation. It is my expectation that all incident reports are filled out appropriately and that the Risk Manager investigates fully. It appears that little if any investigations were completed. The IV pump Milrinone investigation was not complete, we have no time the medication was hung, no amount that was infused, no statements from the patient or nurses involved in the incident. The IV pump was not removed from service or checked to make sure it was running properly because there is no investigation of the incident. I think that everyone assumed that the patient changed the rate, but even if that did happen, we did not investigate and have no documentation to support that idea. Had we done an investigation we may have provided education, found out how to lock out patients from changing the rates on the pumps. We could have done education on how to fill out reports, the necessary information needed to complete an incident report, and getting statements from the staff and patient. It is my expectation that if we see an error in a high risk,	H 402		

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H 402	Continued From page 11 low volume medication that we provide education to the staff about any precautions to be aware of. During an interview with the Pharmacy Director on 08/13/2019 at 09:08 AM she stated, "I was not made aware that a patient had been administered Milrinone at 100 cc/hr when it was ordered at 11.16 cc/hr. When we are notified of any errors we do a Quality Related Event report which really drills down to find the cause, correct any practice related issues and provide education to prevent any reoccurrences. Milrinone is a very low volume medication that is administered here, so it could be problem prone if the staff are not aware of the uses and side effects. This should have been reported to me. I was also unaware that an inmate received an antibiotic that was not ordered and he had a penicillin allergy. If we are proactive we minimize any potential adverse reactions and increase patient safety. All major medication errors should be thoroughly investigated and be evaluated quarterly in the patient safety committee. I expect to be notified with any major medication error." A review of the Policy and Procedure titled, "Investigation Guidelines for Incident Reports #15.007" last revised on 04/2018 policy read: All adverse incidents/occurrences shall be investigated by the Department Manager and Risk Manager by utilizing the following guidelines to ascertain that appropriate management of the event has been completed and documented. b. Medication Errors: note the type of medication error, note the total doses omitted or given incorrectly, review the medication sheet and doctors orders sheet to ascertain what type of medication was made, research the side effects and possible reactions, if needed notify the clinical pharmacist to ascertain if there is any	H 402		

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H 402	Continued From page 12 additional side effects or adverse reactions that could occur. Medication errors should be followed for several days to ascertain that there was no adverse reactions, note the patient is aware, note if the primary physician is aware that the error occurred. If an incident involves any IV fluids ascertain immediately the amount of solution received, time discontinued, if any questionable contaminants. If there was an electrical malfunction of any piece of equipment notify the electrical safety officer. Also, note if the equipment was routinely checked for malfunctions.	H 402		
H 404	395.0197(1)(b)1, F.S.; 59A-10.0055(1) FS Approp Measure - Education & Training 395.0197(1)(b)1, F.S. 1. Risk management and risk prevention education and training of all nonphysician personnel as follows: a. Such education and training of all nonphysician personnel as part of their initial orientation; and b. At least 1 hour of such education and training annually for all personnel of the licensed facility working in clinical areas and providing patient care, except those persons licensed as health care practitioners who are required to complete continuing education coursework pursuant to chapter 456 or the respective practice act. 59A-10.0055(1) FAC (1) INCIDENT REPORTING. An incident reporting system shall be established for each facility. Procedures shall be detailed in writing and disseminated to all employees of the facility. All new employees, within 30 days of employment, shall be instructed about the operation of the system and responsibilities of it. At least annually all	H 404		

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	HL110183	A. BUILDING: _____ B. WING _____	08/14/2019

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H 404	Continued From page 13 nonphysician personnel of the facility working in clinical areas and providing patient care shall receive 1 hour risk management and risk prevention education and training including the importance of accurate and timely incident reporting. This Statute or Rule is not met as evidenced by: Based on Interview and record review the facility failed to provide yearly one-hour risk management training for 7 of 15 personnel records reviewed, Staff A, B, M, N, O, T and Q. Findings: Review of the personnel file for Staff A, Registered Nurse (RN) revealed a hire date of 08/11/2015. The last documented risk management annual one-hour training was completed on 04/17/2017. Review of the personnel file for staff B, Certified Nursing Assistant (CNA), revealed a hire date of 03/26/2018. Initial Risk Management training was completed on 3/27/2018. There was no documentation of annual Risk Management training having been completed. Review of the personnel file for Staff M, RN revealed a hire date of 10/3/2016. The most recent Risk Management annual training documented revealed 04/17/2017. Review of the personnel file for Staff N, RN revealed a hire date of 06/2017. Initial Risk Management training was documented as 06/27/2017. The most recent Risk Management annual training documented revealed 04/18/2018.	H 404		

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H 404	Continued From page 14 Review of the personnel record for Staff O, Respiratory Therapist (RT) revealed a hire date of 05/2016. Initial Risk Management training was completed on 05/16/2016. The most recent Risk Management annual training documented revealed 04/28/2017. During an interview on 08/13/2019 at 10:33 AM Staff O, RT stated, "I have not done any risk management training in a couple of years." Review of the personnel file for Staff Q, RN revealed a hire date of 05/2016. Initial Risk Management training was completed on 05/14/2016. The most recent Risk Management annual training documented revealed on 04/19/2018. During an interview on 08/14/2019 at 3:30 PM Staff Q, RN stated, "I did not do the annual Risk Management training, I'm not sure why." Review of the personnel file for Staff T, RT revealed a hire date of 03/2018. Initial Risk Management training was completed on 03/19/2018. There was no documentation of annual Risk Management training having been completed. During an interview with the Executive Nursing Director on 08/13/2019 at 02:45 PM she reviewed the personnel records and verified no required annual one-hour risk management training was documented as being completed for Staff A, B, M, N, O, T and Q. "We do annual training in April each year. This should have captured all of the staff at the same time and prevent any employee from missing the training." Review of the policy and procedure titled, "Risk	H 404		

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H 404	Continued From page 15 Management Training Policy #15.035" read: Annually each non-physician employee must receive at least one hour of risk management training and risk management prevention in April to include the importance of accurate and timely incident reporting.	H 404		
H 419	59A-10.0055(3), FAC RISK MANAGER REVIEW OF INCIDENT REPORTS (3) INCIDENT REPORT REVIEW AND ANALYSIS. The risk manager shall be responsible for the regular and systematic reviewing of all incident reports including 15-day incident reports for the purpose of identifying trends or patterns as to time, place or persons: and upon emergence of any trend or pattern in incident occurrence shall develop recommendations for corrective actions and risk management prevention education and training. Summary data thus accumulated shall be systematically maintained for 3 years. This Statute or Rule is not met as evidenced by: Based on observation record review and interview the facility failed to review incident reports for trends and patterns and develop corrective actions and education based on the trends and patterns for 8 of 10 incident reports reviewed. Findings: Review of incident report #1 dated 01/10/2019 read an Intravenous (IV) pump with the medication Milrinone (used to make the heart beat stronger so the amount of blood pumped by the heart is increased) was found with the medication bag empty was set at a rate of 100	H 419		

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H 419	Continued From page 16 milliliters per hour; the physician ordered 11.16 milliliters per hour. There was no documentation of the patient or any staff involved having been interviewed. the IV pump was not removed and checked for malfunction, and no follow up education or training provided. Review of incident report 2 dated 07/02/2019 read an intravenous antibiotic was administered to a patient with no orders for antibiotics. The Patient had a documented penicillin allergy. The incident report did not indicate what antibiotic was administered or how much of the medication was administered. There was no documentation of staff interviews. No investigation was conducted by the risk manager. A review of incident reports #5, #6, #7, #8, #9 and #10 failed to ensure all staff involved were interviewed and follow up indicating a thorough investigation had been conducted. During an interview on 08/13/2019 at 1:00 PM the Regional Director she stated, "Eight out of the ten of these incident reports are not filled out correctly and not investigated thoroughly. It seems that they are rubber stamped with no further action or no need for further evaluation by the Risk Manager. There is no follow up to determine how these errors occurred and if any further education or training was necessary. We should have removed the IV (Intravenous) pump from service, to ensure that it did not malfunction, we should have determined if our IV pumps have a lock out feature that would prevent patients from adjusting the rate and provide education to all staff regarding the IV Pump features. We should have involved pharmacy in a Root Cause Analysis of the incident. We should have determined the exact time that the Milrinone was	H 419		

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H 419	Continued From page 17	H 419		

hung to be able to determine the exact amount of the medication that was infused." The Regional Director reviewed the antibiotic incident report that an inmate was administered an IV antibiotic when they had no IV antibiotics ordered and there was no documentation of the IV antibiotic that was administered to a patient that had a Penicillin allergy. She stated, "That incident report was incompletely filled out and that there was no Risk Manager investigation into the events." She verified there was no documentation of the antibiotic that was administered in the incident report, nurses note or physician note. She verified that there was no documentation of the amount of medication that was infused, no follow up investigation by the Risk Manager, no employee statements, no pharmacy involvement to determine the cause of this and prevent the errors from occurring again. She stated, "Unfortunately, these incidents do impact patient safety. We cannot assume that the patient adjusted the IV pump rate, we should have investigated further. This incident could have, really should have changed the way we work with the IV pumps based on that incident alone, our lack of investigation cost us the opportunity to improve our practice and prevent other IV pump related incidences."

During an interview 08/12/2019 at 3:55 PM with the Executive Nursing Director she stated, "It is apparent that no investigations have been completed on the 8 out of the 10 incident reports we reviewed, as acting Risk Manager, there needs to be employee statements, patient statements if necessary, the reports need to include the basic facts of the amounts and types of medications, if it's a fall that the injuries were addressed, and if tests are ordered the results should be included as part of the investigation. It

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H 419	Continued From page 18 is my expectation that all incident reports are filled out appropriately and that the Risk Manager investigates fully. It appears that little if any investigations were completed. The IV pump Milrinone investigation was not complete, we have no time the medication was hung, no amount that was infused, no statements from the patient or nurses involved in the incident. The IV pump was not removed from service or checked to make sure it was running properly because there is no investigation of the incident. I think that everyone assumed that the patient changed the rate, but even if that did happen, we did not investigate, and have no documentation to support that idea. Had we done an investigation we may have provided education, found out how to lock out patients from changing the rates on the pumps. We could have done education on how to fill out reports, the necessary information needed to complete an incident report, and getting statements from the staff and patient. It is my expectation that if we see an error in a high risk, low volume medication that we provide education to the staff about any precautions to be aware of. A review of the Policy and Procedure titled, "Investigation Guidelines for Incident Reports #15.007" last revised on 04/2018 policy read: All adverse incidents/occurrences shall be investigated by the Department Manager and Risk Manager by utilizing the following guidelines to ascertain that appropriate management of the event has been completed and documented. b. Medication Errors: note the type of medication error, note the total doses omitted or given incorrectly, review the medication sheet and doctors orders sheet to ascertain what type of medication was made, research the side effects and possible reactions, if needed notify the	H 419		

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H 419	Continued From page 19 clinical pharmacist to ascertain if there is any additional side effects or adverse reactions that could occur. Medication errors should be followed for several days to ascertain that there was no adverse reactions, note the patient is aware, note if the primary physician is aware that the error occurred. If an incident involves any IV fluids ascertain immediately the amount of solution received, time discontinued, if any questionable contaminants. If there was an electrical malfunction of any piece of equipment notify the electrical safety officer. Also, note if the equipment was routinely checked for malfunctions.	H 419		