

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/30/2019
FORM APPROVED
OMB NO. 0938-0391

| | | | | | |
|--|---|---|---|----------------------|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 450076 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED C 05/17/2019 |
| NAME OF PROVIDER OR SUPPLIER UNIVERSITY OF TEXAS M D ANDERSON CANCER CENTER, THE | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1515 HOLCOMBE BLVD HOUSTON, TX 77030 | | |
| (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) COMPLETION DATE | |
| A 000 | <p>INITIAL COMMENTS</p> <p>Note: The CMS-2567 (Statement of Deficiencies) 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 reported to the Dallas Regional Office (RO) for referral to the Office of the Inspector General (OIG) for possible fraud. If information is inadvertently changed by the provider/supplier, the State Survey Agency (SA) should be notified immediately.</p> <p>An onsite unannounced complaint investigation survey was conducted to determine the facility's compliance with the federal requirements set forth in the Medicare Conditions of Participation at 42 CFR Part 482. An entrance conference was conducted on May 13, 2019, at 8:45 am, in the Administrative Board Room with the facility's Administrative Staff. A brief introduction and explanation of the survey process was provided with an opportunity for questions and discussion.</p> <p>An exit conference was conducted on May 17, 2019 at 8:30 am with hospital leadership and staff in the Administrative Board Room. The preliminary findings were explained and an opportunity was given for questions and discussion. The next steps in the survey process were explained. An opportunity was given for the facility to provide evidence of compliance with those requirements for which non-compliance had been found during the survey. No further</p> | A 000 | | | |

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

TITLE

(X6) DATE

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 disclosable 90 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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/30/2019
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 450076 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED C 05/17/2019 |
|--|---|---|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER UNIVERSITY OF TEXAS M D ANDERSON CANCER CENTER, THE | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1515 HOLCOMBE BLVD HOUSTON, TX 77030 | | |
| (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) COMPLETION DATE | |
| A 000 | Continued From page 1 evidence was provided. Complaint #TX00311802 - Substantiated, deficiencies cited The following Conditions of Participation were found to be out of compliance: CFR 482.12 Governing Body CFR 482.13 Patient Rights CFR 482.21 QAPI CFR 482.23 Nursing Services CFR 482.27 Laboratory Services | A 000 | | | |
| A 043 | GOVERNING BODY CFR(s): 482.12 There must be an effective governing body that is legally responsible for the conduct of the hospital. If a hospital does not have an organized governing body, the persons legally responsible for the conduct of the hospital must carry out the functions specified in this part that pertain to the governing body ... This CONDITION is not met as evidenced by: Based on record review and interview, the facility failed to: A. have written governing bylaws. Review of the Presidents job description revealed, "MD Anderson is an independent, free-standing component of the University of Texas System, and the President reports to the Board of Regents via the university's Chancellor and Executive Vice Chancellor for Health Affairs. | A 043 | | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/30/2019
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 450076 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED C 05/17/2019 |
|--|---|---|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER UNIVERSITY OF TEXAS M D ANDERSON CANCER CENTER, THE | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1515 HOLCOMBE BLVD HOUSTON, TX 77030 | | |
| (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) COMPLETION DATE | |
| A 043 | Continued From page 2 The University of Texas System is governed by a board of nine regents appointed for overlapping six-year terms by the governor and one non-voting student regent selected annually by the board itself. The presidents of UT's health institutions report to the Chancellor via the Executive Vice Chancellor for Health Affairs." Review of the Medical Staff bylaws page 1 under, "Definitions: "Board of Regents or Board" means the Board of Regents of the University of Texas System. The Texas Legislature, in Article VII, Section 10 of the Texas Constitution, has delegated the power and authority to administer The University of Texas System to the Board of Regents. The Board has broad authority to delegate powers. The Board has delegated the authority to perform the duties and responsibilities of the governing body of The University of Texas MD Anderson Cancer Center Medical Staff, as those duties and functions are described by The Joint Commission, the Centers for Medicare and Medicaid Services, and these Medical Staff Bylaws, to the President of The University of Texas MD Anderson Cancer Center. The President, and/or his or her designees appointed by him or her, shall perform the duties and responsibilities of the governing body of The University of Texas MD Anderson Cancer Center that are set forth in these Medical Staff Bylaws." However, there is no governing bylaws that direct the medical staff and ensure medical staff is effectively functioning by direction of the Governing Board. The facility executive staff was unable to provide any written information on how the Governing | A 043 | | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/30/2019
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 450076 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED C 05/17/2019 |
|--|--|---|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER UNIVERSITY OF TEXAS M D ANDERSON CANCER CENTER, THE | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1515 HOLCOMBE BLVD HOUSTON, TX 77030 | | |
| (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) COMPLETION DATE | |
| A 043 | <p>Continued From page 3</p> <p>Board effectively functions or dictates how committees will report to the Governing Board.</p> <p>An interview was conducted with Staff #16 and Staff #27 in the afternoon of 5-16-19. Staff #16 and #27 confirmed, there was no written governing bylaws that addressed the organized governing body or how it identifies the authority and structure of the medical staff.</p> <p>The Governing Body also failed to:</p> <p>B. ensure blood transfusions were administered in accordance with their facility's policy/procedures and acceptable nursing standards in 1 (Pt. #34) of 1 patient chart reviewed.</p> <p>C. ensure nurses continually assessed patients during transfusions of blood and platelets. Vital signs were not monitored or obtained during transfusion; vital signs were not taken in the first 15-30 minutes after the transfusion was initiated or after completion of the transfusion in accordance with facility policy. Vital signs flagged as abnormal were not assessed or reassessed in 1 (34) of 1 patient chart reviewed.</p> <p>D. ensure nurses notified the physician of changes in vital signs and changes in condition on patients receiving transfusions of blood and platelets in 1 (34) of 1 patients chart reviewed.</p> <p>These findings were not in accordance with hospital policy and presents the risk that serious blood transfusion reactions may not be detected or assessed in an expeditious manner, which</p> | A 043 | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 450076 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED C 05/17/2019 |
|--|--|---|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER UNIVERSITY OF TEXAS M D ANDERSON CANCER CENTER, THE | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1515 HOLCOMBE BLVD HOUSTON, TX 77030 | | |
| (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) COMPLETION DATE | |
| A 043 | <p>Continued From page 4</p> <p>could result in severe complications or death to a patient receiving blood or blood products.</p> <p>E. the hospital failed to ensure that Hand-Off Communication was performed in transferring a patient with an infectious disease (Patient #30) from a patient unit to the operating room. Contact isolation precautions for safe care were subsequently not implemented.</p> <p>Refer to tag A0144 for additional information.</p> <p>F. ensure 20 (Patient #'s 2, 4, 5, 6, 7, 8, 9, 10, 12, 16, 17, 18, 23, 24, 26, 28, 29, 31, 32, and 34) of 34 sampled patients were allowed to make informed decisions regarding their care.</p> <p>Patients received transfusions of blood and blood products and did not have current signed informed consents.</p> <p>The facility failed to ensure there was documentation that patients who received blood transfusions received information and disclosures needed to make informed decisions during their current hospitalization. There was no current documentation that patients were provided the right to refuse treatments, being informed of other alternatives, or repeated consents after reassessment.</p> <p>Facility staff used consents from previous admissions which ranged from 1 month to 5 years old. There was one chart without a blood transfusion consent prior to transfusions.</p> <p>Refer to tag A0131 for additional information.</p> | A 043 | | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/30/2019
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 450076 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED C 05/17/2019 |
|--|---|---|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER UNIVERSITY OF TEXAS M D ANDERSON CANCER CENTER, THE | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1515 HOLCOMBE BLVD HOUSTON, TX 77030 | | |
| (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) COMPLETION DATE | |
| A 043 | Continued From page 5 G. Protect the patients privacy and dignity by having a X-ray door/room accessible to the public. The patients could be exposed to anyone in the hallway that was passing by the room. Refer to tag A0143 for additional information. | A 043 | | | |
| A 115 | PATIENT RIGHTS CFR(s): 482.13 A hospital must protect and promote each patient's rights. This CONDITION is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure patient's rights were protected. The facility failed to: A. ensure blood transfusions were administered in accordance with their facility's policy/procedures and acceptable nursing standards in 1 (34) of 1 patient chart reviewed. | A 115 | | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/30/2019
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 450076 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED C 05/17/2019 |
|--|---|---|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER UNIVERSITY OF TEXAS M D ANDERSON CANCER CENTER, THE | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1515 HOLCOMBE BLVD HOUSTON, TX 77030 | | |
| (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) COMPLETION DATE | |
| A 115 | <p>Continued From page 6</p> <p>B. ensure nurses continually assessed patients during transfusions of blood and platelets. Vital signs were not monitored or obtained during transfusion; vital signs were not taken in the first 15-30 minutes after the transfusion was initiated or after completion of the transfusion in accordance with facility policy. Vital signs flagged as abnormal were not assessed or reassessed in 1 (34) of 1 patient chart reviewed.</p> <p>C. ensure nurses notified the physician of changes in vital signs and condition of patients receiving transfusions of blood and platelets in 1 (34) of 1 patients chart reviewed.</p> <p>These findings were not in accordance with hospital policy and presents the risk that serious blood transfusion reactions may not be detected or assessed in an expeditious manner, which could result in severe complications or death to a patient receiving blood or blood products.</p> <p>D. the hospital failed to ensure that Hand-Off Communication was performed in transferring a patient with an infectious disease (Patient #30) from a patient unit to the operating room. Contact isolation precautions for safe care were subsequently not implemented.</p> <p>Refer to tag A0144 for additional information.</p> <p>E. ensure 20 (Patient #'s 2, 4, 5, 6, 7, 8, 9, 10, 12, 16, 17, 18, 23, 24, 26, 28, 29, 31, 32, and 34) of 34 sampled patients were allowed to make informed decisions regarding their care.</p> | A 115 | | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/30/2019
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 450076 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED C 05/17/2019 |
|--|--|---|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER UNIVERSITY OF TEXAS M D ANDERSON CANCER CENTER, THE | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1515 HOLCOMBE BLVD HOUSTON, TX 77030 | | |
| (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) COMPLETION DATE | |
| A 115 | Continued From page 7 Patients received transfusions of blood and blood products and did not have current signed informed consents. The facility failed to ensure there was documentation that patients who received blood transfusions received information and disclosures needed to make informed decisions during their current hospitalization. There was no current documentation that patients were provided the right to refuse treatments, being informed of other alternatives, or repeated consents after reassessment. Facility staff used consents from previous admissions which ranged from 1 month to 5 years old. There was one chart without a blood transfusion consent prior to transfusions. Refer to tag A0131 for additional information. | A 115 | | | |
| A 131 | Refer to tag A0143 for additional information. PATIENT RIGHTS: INFORMED CONSENT CFR(s): 482.13(b)(2) The patient or his or her representative (as allowed under State law) has the right to make informed decisions regarding his or her care. | A 131 | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 450076 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED C 05/17/2019 |
|--|--|---|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER UNIVERSITY OF TEXAS M D ANDERSON CANCER CENTER, THE | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1515 HOLCOMBE BLVD HOUSTON, TX 77030 | | |
| (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) COMPLETION DATE | |
| A 131 | <p>Continued From page 8</p> <p>The patient's rights include being informed of his or her health status, being involved in care planning and treatment, and being able to request or refuse treatment. This right must not be construed as a mechanism to demand the provision of treatment or services deemed medically unnecessary or inappropriate.</p> <p>This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure 20 (Patient #'s 2, 4, 5, 6, 7, 8, 9, 10, 12, 16, 17, 18, 23, 24, 26, 28, 29, 31, 32, and 34) of 34 sampled patients were allowed to make informed decisions regarding their care.</p> <p>Patients received transfusions of blood and blood products and did not have current signed informed consents.</p> <p>The facility failed to ensure there was documentation that patients who received blood transfusions received information and disclosures needed to make informed decisions during their current hospitalization. There was no current documentation that patients were provided the right to refuse treatments, being informed of other alternatives, or repeated consents after reassessment.</p> <p>Facility staff used consents from previous admissions which ranged from 1 month to 5 years old. There was one chart without a blood transfusion consent prior to transfusions.</p> <p>This deficient practice had the likelihood to cause harm in all patients who received blood and blood products.</p> <p>Findings:</p> | A 131 | | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/30/2019
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 450076 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED C 05/17/2019 |
|--|--|---|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER UNIVERSITY OF TEXAS M D ANDERSON CANCER CENTER, THE | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1515 HOLCOMBE BLVD HOUSTON, TX 77030 | | |
| (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) COMPLETION DATE | |
| A 131 | Continued From page 9 Patient #10 Review of the clinical record on Patient #10 revealed, he was a 62-year-old male who was admitted to the hospital on 03/15/2019. Review of transfusion records revealed, Patient #10 received a blood transfusion on 05/03/2019. Review of the "Disclosure and Consent To Receive or Refuse Blood Transfusion" revealed, it was signed off by Patient #10 on 2/11/2019 (over 3 months ago). There was no current blood transfusion consent on the chart for this admission. Patient #23 Review of the clinical record on Patient #23 revealed, he was a 68-year-old male who was admitted to the hospital on 03/19/2019 to receive chemotherapy. Review of transfusion records revealed, Patient #23 received a blood transfusion on 04/01/2019 and experienced a transfusion reaction. Review of the "Disclosure and Consent To Receive or Refuse Blood Transfusion" revealed, it was signed off by Patient #23 on 11/25/2018 (over 4 months ago). There was no current blood transfusion consent on the chart for this admission | A 131 | | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/30/2019
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 450076 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED C 05/17/2019 |
|--|--|---|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER UNIVERSITY OF TEXAS M D ANDERSON CANCER CENTER, THE | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1515 HOLCOMBE BLVD HOUSTON, TX 77030 | | |
| (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) COMPLETION DATE | |
| A 131 | Continued From page 10 Patient #26 Review of the clinical record on Patient #26 revealed, she was a 59-year-old female who was admitted to the hospital on 03/25/2019 for thoracic surgery (chest cavity). Review of transfusion records revealed, Patient #26 received a blood transfusion on 03/30/2019. Review of the "Disclosure and Consent To Receive or Refuse Blood Transfusion" revealed, it was signed off by Patient #26 on 12/04/2018 (over 3 months prior). There was no current blood transfusion consent on the chart for this admission Patient #18 Review of the clinical record on Patient #18 revealed, she was a 56-year-old female who was admitted to the hospital on 03/25/2019 for chemotherapy. Review of transfusion records revealed, Patient #18 received a blood transfusion on 03/30/2019. Review of the "Disclosure and Consent To Receive or Refuse Blood Transfusion" revealed it was signed off by Patient #18 on 12/04/2018 (over 3 months prior). There was no current blood transfusion consent on the chart for this admission | A 131 | | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/30/2019
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 450076 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED C 05/17/2019 |
|--|--|---|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER UNIVERSITY OF TEXAS M D ANDERSON CANCER CENTER, THE | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1515 HOLCOMBE BLVD HOUSTON, TX 77030 | | |
| (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) COMPLETION DATE | |
| A 131 | <p>Continued From page 11</p> <p>Patient #17</p> <p>Review of the clinical record on Patient #17 revealed, he was a 17-year-old male admitted to the hospital on 03/27/2019 with complaints of nosebleed and medication reaction.</p> <p>Review of transfusion records revealed, Patient #17 received a blood transfusion on 04/01/2019 and experienced a transfusion reaction.</p> <p>Review of the "Disclosure and Consent To Receive or Refuse Blood Transfusion" revealed, it was signed off by Patient #17 on 06/25/2018 (over 9 months prior).</p> <p>There was no current blood transfusion consent on the chart for this admission.</p> <p>Patient #7</p> <p>Review of the clinical record revealed, Patient #7 was an 85-year-old male who was admitted on 04/11/2019 and had diagnoses which included lymphoma (cancer of lymph nodes).</p> <p>Review of transfusion documentation revealed, Patient #7 was given platelets and experienced a transfusion reaction on 04/24/2019.</p> <p>Review of the "Disclosure and Consent To Receive or Refuse Blood Transfusion" revealed, it was signed off by Patient #7 on 03/21/2018 (over 1 year ago).</p> <p>There was no current blood transfusion consent on the chart for this admission.</p> | A 131 | | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/30/2019
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 450076 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED C 05/17/2019 |
|--|--|---|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER UNIVERSITY OF TEXAS M D ANDERSON CANCER CENTER, THE | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1515 HOLCOMBE BLVD HOUSTON, TX 77030 | | |
| (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) COMPLETION DATE | |
| A 131 | Continued From page 12 During an interview on 05/14/2019 after 9:30 a.m. and 05/15/2019 after 8:50 a.m., Registered nurse (RN#18) confirmed the dates on the consents. RN#18 said the facility did not obtain new blood consents when the patients come in each time. Patient #28 Patient #28 was admitted to MD Anderson on 3/14/19. Patient #28 received 1 unit of RBCs the afternoon of 3/14/19. Review of the "MD Anderson Cancer Center Disclosure and Consent To Receive or Refuse Blood Transfusion" revealed that Patient #28 signed the consent form on 1/10/2017 at 14:04, over 2 years prior to the admission on 3/14/2019. Patient #24 Patient #24 was admitted to MD Anderson on 5/12/19. On 5/13/19 Patient #24 received Platelets at 0710 and 1752, and Red Blood Cells at 1040 and 1410. On 5/14/19, Patient #24 received Red Blood Cells at 1330 and 1735. Review of the "MD Anderson Cancer Center Disclosure and Consent To Receive or Refuse Blood Transfusion" revealed that Patient #24 signed the consent form on 5/5/2018 at 22:47, over 1 year prior to the admission on 5/12/19. Patient #32 Patient #32 was admitted to MD Anderson on 5/1/2019. On 5/14/19, Patient #32 received Red | A 131 | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 450076 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED C 05/17/2019 |
|--|---|---|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER UNIVERSITY OF TEXAS M D ANDERSON CANCER CENTER, THE | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1515 HOLCOMBE BLVD HOUSTON, TX 77030 | | |
| (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) COMPLETION DATE | |
| A 131 | <p>Continued From page 13 Blood Cells at 1215.</p> <p>Review of the "MD Anderson Cancer Center Disclosure and Consent To Receive or Refuse Blood Transfusion" revealed that Patient #32 signed the consent form on 3/20/2019 at 10:53, prior to the admission on 5/1/2019.</p> <p>Patient #8</p> <p>Patient #8 was admitted to MD Anderson on 5/8/2019. On 5/13/19, Patient #8 received Red Blood Cells at 0627.</p> <p>Review of the "MD Anderson Cancer Center Disclosure and Consent To Receive or Refuse Blood Transfusion" revealed that Patient #8 signed the consent form on 4/26/2019 at 12:10 prior to the admission on 5/13/2019.</p> <p>Patient #29</p> <p>Patient #29 was admitted to MD Anderson on 3/21/2019. On 3/21/19, Patient #29 received Red Blood Cells at 1815.</p> <p>Review of the "MD Anderson Cancer Center Disclosure and Consent To Receive or Refuse Blood Transfusion" revealed that Patient #29 signed the consent form on 9/4/2018 at 9:29, prior to the admission on 3/21/2019.</p> <p>Patient #16</p> <p>Patient #16 was admitted to MD Anderson on</p> | A 131 | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 450076 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED C 05/17/2019 |
|--|--|---|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER UNIVERSITY OF TEXAS M D ANDERSON CANCER CENTER, THE | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1515 HOLCOMBE BLVD HOUSTON, TX 77030 | | |
| (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) COMPLETION DATE | |
| A 131 | <p>Continued From page 14</p> <p>3/17/2019. On 3/24/19, Patient #16 received Red Blood Cells at 1210.</p> <p>Review of the "MD Anderson Cancer Center Disclosure and Consent To Receive or Refuse Blood Transfusion" revealed that Patient #16 signed the consent form on 2/4/2019 at 11:15, prior to the admission on 3/17/2019.</p> <p>There was no documented evidence in the current admission for the above medical records to indicate that:</p> <ul style="list-style-type: none"> - Patients were provided with the right to ask questions and receive answers prior to deciding whether to proceed with the blood transfusion; - Staff discussed with the patient any reasonable alternatives to the proposed care, including the risks, side effects, and benefits associated with these reasonable alternatives, including the possible results of not receiving any care or treatment, and any probable consequences; - Whether or not the patient's condition had changed since the original Informed Consent was signed, which could have resulted in a significant change in the risks, hazards, limitations, side effects, or benefits of a blood product transfusion; and - The patient was informed of the right to withdraw or revoke their consent at any time. <p>The above findings were confirmed during the record review in the 8th floor conference room the afternoon of 5/16/19 with RN #12. Patient #34</p> | A 131 | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 450076 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED C 05/17/2019 |
|--|--|---|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER UNIVERSITY OF TEXAS M D ANDERSON CANCER CENTER, THE | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1515 HOLCOMBE BLVD HOUSTON, TX 77030 | | |
| (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) COMPLETION DATE | |
| A 131 | <p>Continued From page 15</p> <p>Review of Patient #34's medical record revealed a transfusion of pooled platelets was initiated on 12/06/2018 at 10:12 PM and completed at 11:15 PM. There was no blood consent in the medical chart provided to administer the platelets.</p> <p>Review of Medical Records on 5-15-2019 after 8:45 AM in an Administrative conference room revealed the following:</p> <p>Patient #2</p> <p>Patient #2 was a 26-year-old male admitted on 3/30/2019 for evaluation of CAR T cell therapy. Patient #2 received Platelets on 3/31/2019 at 11:03 PM. Review of the facility document, "MD Anderson Cancer Disclosure and Consent, To Receive or Refuse Blood Transfusion" revealed, the patient signed the consent on 2-12-2019 at 10:07 AM, 1 ½ months prior to the current admission. There was an illegible physician signature dated 3-1-2019 at 9:38 AM.</p> <p>Patient #4</p> <p>Patient #4 was an 81-year-old male admitted on 5-11-2019. Patient #4 received Red Blood Cells on 5/12/2019 at 2:19 PM and 7:51 PM. Review of the facility document, "MD Anderson Cancer Disclosure and Consent, To Receive or Refuse Blood Transfusion" revealed the patient signed the consent on 11-6-2018 at 2:57 PM, almost 6 months prior to the current admission.</p> <p>Patient #5</p> <p>Patient #5 was a 22-year-old female admitted on</p> | A 131 | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 450076 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED C 05/17/2019 |
|--|---|---|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER UNIVERSITY OF TEXAS M D ANDERSON CANCER CENTER, THE | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1515 HOLCOMBE BLVD HOUSTON, TX 77030 | | |
| (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) COMPLETION DATE | |
| A 131 | <p>Continued From page 16</p> <p>1-15-2019. Review of a sample of transfusion infusion records in the record showed Patient #5 received Platelets on 4-8-2019 at 6:38 AM and 5-2-2019 at 11:01 AM. Patient #5 received Red Blood cells on 5-2-2019 at 2:02 AM. Review of the facility document, "MD Anderson Cancer Disclosure and Consent, To Receive or Refuse Blood Transfusion" revealed the patient signed the consent on 12-10-2018 at 11:32 AM, almost 1 month prior to current admission date.</p> <p>Patient #6</p> <p>Patient #6 was a 61-year-old year old female admitted on 3-1-2019. Patient #5 received platelets on 3-9-2019 at 3:21 PM. Review of the facility document, "MD Anderson Cancer Disclosure and Consent, To Receive or Refuse Blood Transfusion" revealed the patient signed the consent on 11-8-2018 at 5:47 PM, over 4 months prior to current admission.</p> <p>Patient #9</p> <p>Patient #9 was a 58-year-old female admitted on 2-25-2019 with relapsed AML (Acute Myelocytic Leukemia). Patient #9 received Platelets on 3-11-2019. Review of the facility document, "MD Anderson Cancer Disclosure and Consent, To Receive or Refuse Blood Transfusion" revealed the patient signed the consent on 11-29-2017 at 8:39 AM, 3 months prior to the current admission.</p> <p>Patient #12</p> <p>Patient #12 was an 81-year-old male with a</p> | A 131 | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 450076 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED C 05/17/2019 |
|--|---|---|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER UNIVERSITY OF TEXAS M D ANDERSON CANCER CENTER, THE | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1515 HOLCOMBE BLVD HOUSTON, TX 77030 | | |
| (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) COMPLETION DATE | |
| A 131 | <p>Continued From page 17</p> <p>history of squamous cell carcinoma of lung who was admitted for anemia on 3-6-2019. Patient #12 received Red Blood Cells on 3-10-2019 at 3:49 AM. Review of the facility document, "MD Anderson Cancer Disclosure and Consent, To Receive or Refuse Blood Transfusion" revealed the patient signed the consent on 2-14-2014, Five (5) years prior to the current admission date.</p> <p>Patient #31</p> <p>Patient #31 was a 70-year-old female admitted on 5/9/2019. Patient #31 received Red Blood cells on 5-13-2019 at 11:51 AM and 10:24 PM. Review of the facility document, "MD Anderson Cancer Disclosure and Consent, To Receive or Refuse Blood Transfusion" revealed the patient signed the consent on 5-9-2016 at 10:24 PM, three (3) years prior to current admission date.</p> <p>There was no documentation in the above medical records to indicate that:</p> <ol style="list-style-type: none"> 1. The patient's current condition had been reassessed with the current admission for changes since the Informed Consent was received. 2. The Physician or other staff member talked with the patient or Patient Representative to answer any additional questions. 3. The Patient was provided education on any outstanding indications that the patient or Patient Representative did not understand. 4. Discussed with the patient information | A 131 | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 450076 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED C 05/17/2019 |
|--|---|---|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER UNIVERSITY OF TEXAS M D ANDERSON CANCER CENTER, THE | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1515 HOLCOMBE BLVD HOUSTON, TX 77030 | | |
| (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) COMPLETION DATE | |
| A 131 | <p>Continued From page 18 regarding new significant risks, hazards, limitations, side effects, or benefits after the Informed Consent was received.</p> <p>5. Discussed with the patient any information regarding new alternatives after Informed Consent was received.</p> <p>6. Informed the patient of the right to withdraw or revoke their consent at any time.</p> <p>Staff #21 confirmed the above findings.</p> <p>Review of MD Anderson Institutional Policy #CLN0547 with a published date of 1/18/2019, Version #40 revealed the following:</p> <p>"8.3 Duration: Informed Consent lasts or extends for a reasonable period after it has been given by the patient or Patient Representative, or for a specific period if specified on the Informed Consent form ...</p> <p>10.0 Re-Consenting</p> <p>10.1 Following a patient reassessment, the Informed Consent process should be repeated, and a new Informed Consent form signed if any of the following circumstances occurs:</p> <p>A. The patient's condition has changed since the Informed Consent was received such that the likely risks, hazards, limitations, side effects, or benefits may have changed significantly ...</p> <p>B. The patient or Patient Representative has</p> | A 131 | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 450076 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED C 05/17/2019 |
|--|--|---|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER UNIVERSITY OF TEXAS M D ANDERSON CANCER CENTER, THE | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1515 HOLCOMBE BLVD HOUSTON, TX 77030 | | |
| (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) COMPLETION DATE | |
| A 131 | Continued From page 19 additional questions that may substantially affect decisions about the proposed treatment, care, services, intervention, or procedure ... C. Any outstanding indications that the patient or Patient Representative does not understand the care, treatment, services, medications, interventions, or procedure for which Informed Consent was previously provided. D. Information regarding new significant risks, hazards, limitations, side effects, or benefits relating to all the applicable treatment, care, services, intervention, or procedure becomes available after the Informed Consent was received. E. Information regarding new alternatives to the applicable care, treatment, services, intervention, or procedure becomes available after Informed Consent was received, which may substantially affect decisions about the proposed treatment, care, services, intervention, or procedure. | A 131 | | | |
| A 143 | 11.0 Revocation / Right to Revoke Patients have the right to withdraw or revoke their consent at any time." PATIENT RIGHTS: PERSONAL PRIVACY CFR(s): 482.13(c)(1) The patient has the right to personal privacy. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to protect the patients privacy and dignity by having a X-ray door/room accessible to the public. | A 143 | | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/30/2019
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 450076 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED C 05/17/2019 |
|--|--|---|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER UNIVERSITY OF TEXAS M D ANDERSON CANCER CENTER, THE | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1515 HOLCOMBE BLVD HOUSTON, TX 77030 | | |
| (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) COMPLETION DATE | |
| A 143 | Continued From page 20 A tour of the facility was conducted on the morning of 5/13/19 with Staff #5. On unit P3 and P4 was an X-ray door in the patient /visitor hallway. An X-ray sign "in use" was above the door. To the side of the doors was a metal push button that opened the doors. When the button was pushed the doors opened up and the X-ray equipment and room was exposed to the hallway. Staff # 24 was asked if the doors locked and could not be accessed from the hall when a patient was receiving an x-ray. Staff #24 reported the doors could still be opened from the outside even if a patient was in the room receiving an x-ray. Staff #24 was asked if he was ever worried about someone pushing the button during a patients treatment. Staff #24 stated, " That's not our concern. The radiation was minimal." Staff #24 was questioned about the patients privacy and risk of being exposed to the public when the chest area may not be covered. Staff #24 had no comment and Staff # 5 confirmed that was not considered and possibly needed to be looked at. | A 143 | | | |
| A 144 | PATIENT RIGHTS: CARE IN SAFE SETTING CFR(s): 482.13(c)(2) The patient has the right to receive care in a safe setting. This STANDARD is not met as evidenced by: Based on record review, the facility failed to: 1. ensure blood transfusions were administered in accordance with their facility's policy/procedures and acceptable nursing standards in 1 (Pt. #34) of 1 patients chart reviewed. A. ensure nurses continually assessed patients during transfusions of blood and platelets. Vital | A 144 | | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/30/2019
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 450076 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED C 05/17/2019 |
|--|---|--|---|---|
| NAME OF PROVIDER OR SUPPLIER UNIVERSITY OF TEXAS M D ANDERSON CANCER CENTER, THE | | STREET ADDRESS, CITY, STATE, ZIP CODE 1515 HOLCOMBE BLVD HOUSTON, TX 77030 | | |
| (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) COMPLETION DATE |
| A 144 | <p>Continued From page 21</p> <p>signs were not monitored or obtained during transfusion; vital signs were not taken in the first 15-30 minutes after the transfusion was initiated or after completion of the transfusion in accordance with facility policy. Vital signs flagged as abnormal were not assessed or reassessed in 1 (Pt. #34) of 1 patients chart reviewed.</p> <p>B. ensure nurses notified the physician of changes in vital signs and in condition of patients receiving transfusions of blood and platelets in 1 (Pt. #34) of 1 patients chart reviewed.</p> <p>These findings were not in accordance with hospital policy and presents the risk that serious blood transfusion reactions may not be detected or assessed in an expeditious manner, which could result in severe complications or death to a patient receiving blood or blood products.</p> <p>2. the hospital failed to ensure that Hand-Off Communication was performed in transferring a patient with an infectious disease (Patient #30) from a patient unit to the operating room. Contact isolation precautions for safe care were subsequently not implemented.</p> <p>Patient #34</p> <p>Review of Patient #34's medical record revealed, she was a 23 y/o with pre-B cell acute lymphoblastic leukemia (ALL). Review of the physician progress notes dated 12/7/18 revealed:</p> <p>"HISTORY OF PRESENT ILLNESS: _____ (patient #34) is a 23 y.o. year old female with a</p> | A 144 | | |

| | | | | |
|--|--|--|---|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 450076 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED C 05/17/2019 |
| NAME OF PROVIDER OR SUPPLIER UNIVERSITY OF TEXAS M D ANDERSON CANCER CENTER, THE | | STREET ADDRESS, CITY, STATE, ZIP CODE 1515 HOLCOMBE BLVD HOUSTON, TX 77030 | | |
| (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) COMPLETION DATE |
| A 144 | <p>Continued From page 22</p> <p>history of ALL and 2 previous transplants who was admitted to the hospital on 9/25/18 and underwent haploidentical stem cell transplant on 10/2/18, Her most recent transplant course has been complicated by severe BK cystitis necessitating daily transfusions and bilateral nephrostomy tube placement. Her left nephrostomy tube was dislodged in the evening of 12/5. On 12/6 she underwent IR replacement of the tube. When she returned to the floor she was noted to be less responsive and hypotensive. She was transferred to the ICU early in the morning of 12/7 for further management. She underwent transfusion of blood products for lib of 4.0 with response, however, later in the morning she became hypotension refractory to resuscitation, requiring escalating vasopressor support.</p> <p>Significant ICU Events: 12/7/18 - admitted to ICU with hypotension and anemia in early morning, transfused; pressors started in morning; intubated in late morning</p> <p>SIGNIFICANT EVENTS IN LAST 24 hours: per above - transferred to ICU; new fever this morning</p> <p>ALLERGIES: Allergies Allergen Amphotericin B "I just started feeling bad" Clindamycin."</p> <p>During an interview with Staff #25 on 5-14-19, Staff #25 provided a positive culture results from the platelets administered to Patient #34. The report revealed the culture from the pooled platelet showed growth of gram negative coccobacilli. On 12/8/18, the organism from the culture was identified as Serratia marcescens. Patient #34's condition worsened and she expired</p> | A 144 | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/30/2019
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 450076 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED C 05/17/2019 |
|--|--|---|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER UNIVERSITY OF TEXAS M D ANDERSON CANCER CENTER, THE | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1515 HOLCOMBE BLVD HOUSTON, TX 77030 | | |
| (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) COMPLETION DATE | |
| A 144 | <p>Continued From page 23 on 12/8/18.</p> <p>Review of Patient #34's medical record revealed a transfusion of pooled platelets was initiated on 12/06/2018 at 10:12 PM and completed at 11:15 PM. There was no blood consent in the medical chart provided to administer the platelets. Patient #34's transfusion records revealed the following vital signs documented during the transfusion:</p> <p>12/06/2018 10:12 PM (Initiation of transfusion) No vitals signs documented or pre-vitals documented.</p> <p>12/06/2018 10:26 PM Blood Pressure 101/57 Temperature 36.7 C (98.1F) O2 sat 100% No pulse documented.</p> <p>12/06/2018 11:15 PM (End of transfusion) No vitals documented.</p> <p>12/06/2018 11:19 PM O2 sat 79% No pulse or temperature documented.</p> <p>12/06/2018 11:22 PM Blood Pressure 76/39, O2 sat 73% no pulse or temperature. The patient had a significant drop in blood pressure with no nursing documentation of assessment or physician notification found.</p> <p>Review of the "BLOOD COMPONENT TRANSFUSION ADMINISTRATION PROCEDURE" revealed:</p> <p>"7.21 When prompted by the electronic health record, document the blood administration rate and vital signs. Note: If greater than 30 minutes of time passed since the initial vital signs were</p> | A 144 | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 450076 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED C 05/17/2019 |
|--|---|---|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER UNIVERSITY OF TEXAS M D ANDERSON CANCER CENTER, THE | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1515 HOLCOMBE BLVD HOUSTON, TX 77030 | | |
| (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) COMPLETION DATE | |
| A 144 | <p>Continued From page 24</p> <p>obtained, repeat the vital signs and re-assess patient condition prior to spiking the blood component with the administration tubing/set or starting the transfusion...</p> <p>8.8. First 15 minutes of transfusion: A. Monitor patient for signs and symptoms of Transfusion Reaction... B. Reassess vital signs after fifteen (15) minutes (not to exceed 30 minutes) from initiation of blood."</p> <p>Nursing documentation and transfusion record dated 12/6/18 revealed there was no consistent or complete vital signs, nursing assessments, or reassessments documented during the transfusions. Nursing would not be able to alert the physician or lab for a potential transfusion reaction if the patient was not properly assessed.</p> <p>An interview was conducted on 5/16/19 in the afternoon. Staff # 31 confirmed, there were no nursing competencies for blood administration.</p> <p>Review of the MD Anderson Institutional Policy attachment for Blood Component Transfusion Administration Procedure with a revised date of 3-12-2019 revealed the following:</p> <p>"1.0 General Information: Administration of Blood Components 1.1 ...Omitting safety steps that are intended to prevent transfusion errors may result in a fatal life event for the patient ...</p> <p>1.3 Maximum transfusion time per unit of Packed Red Blood Cells (PRBCs) is four (4) hours, unless Ordered otherwise by an Authorized</p> | A 144 | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 450076 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED C 05/17/2019 |
|--|--|---|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER UNIVERSITY OF TEXAS M D ANDERSON CANCER CENTER, THE | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1515 HOLCOMBE BLVD HOUSTON, TX 77030 | | |
| (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) COMPLETION DATE | |
| A 144 | <p>Continued From page 25</p> <p>Provider or approved by a Transfusion Medicine Physician (TMP) ...</p> <p>8.0 Administration Initiate administration after the above instructions have been performed, then: ...</p> <p>8.8 First 15 minutes of transfusion:</p> <p>A. Monitor patient for signs and symptoms of Transfusion Reaction ...</p> <p>B. Reassess vital signs after fifteen (15) minutes (not to exceed 30 minutes) from initiation of blood transfusion.</p> <p>C. Note: If the patient is stable, increase the transfusion rate appropriate to blood component and patient status ...</p> <p>8.9 Continue to evaluate the patient for signs and symptoms of Transfusion Reaction and tolerance throughout the transfusion. Vital signs may be obtained more frequently, if clinically indicated ...</p> <p>8.10 At completion of blood component transfusion: ...</p> <p>C. Within thirty (30) minutes from completion of the transfusion, reassess patient, including:</p> <ul style="list-style-type: none"> - Vital signs. - Signs and symptoms of Transfusion Reaction ..." <p>10.0 Documentation 10.1 The following should be documented in the medical record...</p> | A 144 | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 450076 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED C 05/17/2019 |
|--|---|---|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER UNIVERSITY OF TEXAS M D ANDERSON CANCER CENTER, THE | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1515 HOLCOMBE BLVD HOUSTON, TX 77030 | | |
| (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) COMPLETION DATE | |
| A 144 | Continued From page 26 C. Vital signs.... E. Assessment, interventions, and evaluation. - Patient's tolerance during the initial 15 minutes, and throughout the transfusion - Symptoms of Transfusion Reaction, if indicated. - of the transfusion and completion of the transfusion record. Review of MD Anderson Institutional Policy # CLN0647, Nursing Documentation of Patient Care Policy with a Published date of 1-8-2016, Version #58 revealed the following: "It is the policy of The University of Texas MD Anderson Cancer Center (MD Anderson) that: Documentation is recorded in the medical record by the RN providing the care. All nursing team members who document in the medical record are accountable for the accuracy, legibility, readability, timeliness, accessibility and completeness of that documentation ... Procedure 1.0 General Information and Collection of Information 1.1 Subjective and objective data identifying patient problems/alterations, interventions/nursing actions, and responses/outcomes relative to patient problems should be documented ... 3.0 Reassessment | A 144 | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 450076 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED C 05/17/2019 |
|--|--|---|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER UNIVERSITY OF TEXAS M D ANDERSON CANCER CENTER, THE | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1515 HOLCOMBE BLVD HOUSTON, TX 77030 | | |
| (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) COMPLETION DATE | |
| A 144 | <p>Continued From page 27</p> <p>Reassessment of a patient should be documented:</p> <p>3.1 Prior to, during, and after a procedure or treatment, as indicated.</p> <p>3.2 Within an appropriate timeframe, such as within an hour, after an intervention for the evaluation of the effectiveness of the intervention ..."</p> <p>Findings included:</p> <p>A facility event report provided to the survey team stated that on 3/1/19 at approximately 1445 at shift report, there was an ongoing case in the OR with a patient that was VRE positive (vancomycin-resistant enterococci infection). The case was proceeding without indication of contact isolation status, including a lack of signage on the doors, and protective gowns and PPE were not being used.</p> <p>Review of the electronic medical record for Patient #30 the afternoon of 5/16/19 with RN #12 revealed a yellow flagged area (which appeared at the top of every screen for patient #30) which indicated Patient #30 was on Contact Isolation on 3/1/19 and had been since 2/22/19. The yellow area provided the following information:</p> <p>"Isolation Status: Contact Added: 2/22/19 by [name], RN Contact with Mask Added: 2/22/19 by [name], RN Contact, Contact with Mask, MDR-Enterobacter cloacae complex-non respiratory source, Vancomycin Resistant Enterococcus</p> | A 144 | | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/30/2019
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 450076 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED C 05/17/2019 |
|--|--|---|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER UNIVERSITY OF TEXAS M D ANDERSON CANCER CENTER, THE | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1515 HOLCOMBE BLVD HOUSTON, TX 77030 | | |
| (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) COMPLETION DATE | |
| A 144 | <p>Continued From page 28</p> <p>(VRE)-respiratory source, Vancomycin Resistant Enterococcus (VRE)-non respiratory source"</p> <p>Review of the Hand-Off Communication for Patient #30 on 3/1/19 revealed that there was no Hand-Off Communication documented in the medical record when patient #30 was transferred from a patient room on G-19 to the OR at 1317.</p> <p>An interview was conducted with RN #12 during the record review, who stated that during the Hand-Off Communication, the sending and the receiving nurse are both looking at a patient's medical record at the same time. RN #12 stated that the Hand-Off Communication would then be documented in the flow chart in a designated space of the medical record. RN #12 stated that the yellow flagged Contact Isolation status for Patient #30 would have been visible to both parties during the Hand-Off Communication on 3/1/19. However, there was no Hand-Off Communication documented in the medical record for Patient #30 for the transfer from G-19 to the OR.</p> <p>MD Anderson Institutional Policy, # CLN0513, Hand-Off Communication Policy, provided to the survey team, stated, in part, "It is the policy of The University of Texas MD Anderson Cancer Center (MD Anderson) to support effective and efficient communication between Health Care Providers by establishing a standardized approach to Hand-Off Communications that is real-time, interactive, includes an opportunity to ask and respond to questions, and provides up-to-date information about the patient's treatment, condition, and any recent or anticipated changes ...</p> | A 144 | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 450076 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED C 05/17/2019 |
|--|--|---|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER UNIVERSITY OF TEXAS M D ANDERSON CANCER CENTER, THE | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1515 HOLCOMBE BLVD HOUSTON, TX 77030 | | |
| (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) COMPLETION DATE | |
| A 144 | Continued From page 29 Definitions Hand-Off Communication: A standardized, real-time, interactive process of passing patient-specific information from one healthcare provider to another or from one team to another for the purpose of ensuring continuity and safety of patient care. This process should include the opportunity to clarify, ask, and respond to questions about the patient's care and needs ..." MD Anderson Institutional Policy Attachment Nurse to Health Care Provider Hand-Off Communication, provided to the survey team, stated, in part, "1.2 Nurse to Health Care Provider Hand-Off Communications should be documented in the medical record as applicable ... 1.3 Verbal communication must occur between the sending and receiving Health Care Providers, for the opportunity to clarify any needed information, prior to patient Hand-Off and transport." MD Anderson Institutional Policy #CLN0432, Isolation Policy, provided to the survey team, stated, in part, "Procedure. I. General Information ... 1.2 All patients, including readmitted patients who have been previously Colonized or infected with a multi-drug resistant organism or suspected of having diseases or conditions requiring isolation, will be noted in the Isolation/Organism section of the patients electronic medical record. Their status must be resolved upon readmission or | A 144 | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 450076 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED C 05/17/2019 |
|--|---|---|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER UNIVERSITY OF TEXAS M D ANDERSON CANCER CENTER, THE | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1515 HOLCOMBE BLVD HOUSTON, TX 77030 | | |
| (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) COMPLETION DATE | |
| A 144 | Continued From page 30 outpatient encounter. See Disease Specific Recommendations List ... for criteria to discontinue isolation. ... 1.3 Isolation status can be found in the Isolation/Organism section of the patient medical record. 1.4 Precautions should be instituted as soon as a communicable disease is suspected, without waiting for confirmation of diagnosis ... 5.0 Contact Isolation 5.1 Purpose: In addition to Standard Precautions, use Contact Isolation to prevent the transmission of highly transmissible organisms such as: ... B. Vancomycin resistant Enterococcus (VRE) from non-pulmonary source." The above findings for Patient #24 were confirmed the afternoon of 5/16/19 with RN #12 in the administrative conference room. | A 144 | | | |
| A 263 | QAPI CFR(s): 482.21 The hospital must develop, implement and maintain an effective, ongoing, hospital-wide, data-driven quality assessment and performance improvement program. The hospital's governing body must ensure that the program reflects the complexity of the hospital's organization and services; involves all hospital departments and services (including those services furnished under contract or | A 263 | | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/30/2019
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 450076 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED C 05/17/2019 |
|--|---|---|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER UNIVERSITY OF TEXAS M D ANDERSON CANCER CENTER, THE | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1515 HOLCOMBE BLVD HOUSTON, TX 77030 | | |
| (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) COMPLETION DATE | |
| A 263 | <p>Continued From page 31 arrangement); and focuses on indicators related to improved health outcomes and the prevention and reduction of medical errors.</p> <p>The hospital must maintain and demonstrate evidence of its QAPI program for review by CMS.</p> <p>This CONDITION is not met as evidenced by: Based on interview and record review, the hospital failed to develop, implement, and maintain an effective, ongoing, hospital wide, and data driven quality assessment and performance improvement programs (QAPI).</p> <p>The Governing Body failed to ensure there was a quality program that reflected the complexity of the hospital's organization and services, including services furnished under contract or arrangement, and focus on indicators related to improved health outcomes and the prevention and reduction of medical errors.</p> <p>An interview was conducted on 5/13/19 at approximately 2:50 pm with Staff #7. Staff #7 reported there was no formal hospital wide QAPI plan in place, no quality council, or quality meeting minutes.</p> <p>The facility was requested to provide their hospital-wide quality assessment and performance improvement program for review. On 5/14/19, Staff #7 provided a document titled "Quality and Safety Plan for Clinical Operations", effective fiscal year 9/1/16 - 8/31/17.</p> <p>During an interview on 5/14/19 at approximately 3:45 pm, Staff #7 confirmed from August 31, 2017 to present, the facility did not have and</p> | A 263 | | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/30/2019
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 450076 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED C 05/17/2019 |
|--|---|---|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER UNIVERSITY OF TEXAS M D ANDERSON CANCER CENTER, THE | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1515 HOLCOMBE BLVD HOUSTON, TX 77030 | | |
| (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) COMPLETION DATE | |
| A 263 | Continued From page 32 | A 263 | | | |
| A 385 | <p>currently does not have an approved and functioning QAPI program in place.</p> <p>NURSING SERVICES CFR(s): 482.23</p> <p>The hospital must have an organized nursing service that provides 24-hour nursing services. The nursing services must be furnished or supervised by a registered nurse.</p> <p>This CONDITION is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure that nursing services provided care and services that meets the needs of patient in accordance with accepted standrads of practice. The facility failed to:</p> <p>A. ensure blood transfusions were administered in accordance with their facility's policy/procedures and acceptable nursing standards in 19 (Patient #'s 2, 3,4, 5, 6, 7, 8, 12, 14, 17, 18, 23, 24, 26, 28, 29, 32, 33, and 34) of 34.</p> <p>The facility failed to ensure nurses continually assessed patients during transfusions of blood and platelets. Vital signs were not monitored or obtained during transfusion; vital signs were not taken in the first 15-30 minutes after the transfusion was initiated or after completion of the transfusion in accordance with facility policy. Vital signs flagged as abnormal were not assessed or reassessed.</p> <p>The facility failed to ensure nurses provided and documented timely, complete and accurate assessments on patients who experienced</p> | A 385 | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 450076 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED C 05/17/2019 |
|--|---|---|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER UNIVERSITY OF TEXAS M D ANDERSON CANCER CENTER, THE | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1515 HOLCOMBE BLVD HOUSTON, TX 77030 | | |
| (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) COMPLETION DATE | |
| A 385 | <p>Continued From page 33</p> <p>transfusion reactions. There was no means to determine when symptoms consistent with a potential acute transfusion reaction developed, as there was no consistent documented patient assessment during a transfusion and vital signs were not assessed until after the transfusion was completed. Nurses performing blood transfusions relied on patient report to detect symptoms of a potential transfusion reaction.</p> <p>The facility failed to ensure nurses notified the physician of changes in vital signs and in condition of patients receiving transfusions of blood and platelets.</p> <p>The facility failed to ensure nurses had complete and accurate physician orders prior to initiating transfusions. Blood products were not infused at the duration specified in the physician order for transfusion; orders were not clarified and the physician was not notified that the order had not been followed.</p> <p>The facility failed to ensure nurses followed physician's order for the transfusion rates on patients.</p> <p>Refer to A tag 0409 for additional information.</p> <p>B. ensure sufficient numbers of staff to provide patient care on 2 (G9 Pedi SW&NE and G9 PICS NW) of 2 areas observed.</p> <p>The facility failed to ensure they staffed RN's</p> | A 385 | | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/30/2019
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 450076 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED C 05/17/2019 |
|--|---|---|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER UNIVERSITY OF TEXAS M D ANDERSON CANCER CENTER, THE | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1515 HOLCOMBE BLVD HOUSTON, TX 77030 | | |
| (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) COMPLETION DATE | |
| A 385 | Continued From page 34 (Registered Nurses) in 2 areas per the facility staffing Grid. The facility was short staffed on RN's 18 of 21 days reviewed. The facility failed to ensure they staffed PCT (Patient Care Tech) in 2 areas per the facility staffing Grid. The facility was short on PCT's 17 of 21 days reviewed. The facility failed to ensure they staffed PSC (Unit Secretary) in 2 areas per the facility staffing Grid. The facility was short 19 of 21 days reviewed. Refer to A tag 0392 for additional information. C. ensure nurses working on the Pediatrics intensive care unit had annual competencies (PCT #1, RN #42 and RN #43). | A 385 | | | |
| A 392 | Refer to A tag 0397 for additional information. STAFFING AND DELIVERY OF CARE CFR(s): 482.23(b) The nursing service must have adequate numbers of licensed registered nurses, licensed practical (vocational) nurses, and other personnel to provide nursing care to all patients as needed. There must be supervisory and staff personnel for each department or nursing unit to ensure, when needed, the immediate availability of a registered nurse for bedside care of any patient. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure sufficient numbers of staff to | A 392 | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 450076 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED C 05/17/2019 |
|--|---|---|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER UNIVERSITY OF TEXAS M D ANDERSON CANCER CENTER, THE | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1515 HOLCOMBE BLVD HOUSTON, TX 77030 | | |
| (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) COMPLETION DATE | |
| A 392 | <p>Continued From page 35</p> <p>provide patient care on 2 (G9 Pedi SW&NE and G9 PICS NW) of 2 areas observed.</p> <p>The facility failed to:</p> <p>A. ensure they staffed RN's (Registered Nurses) in 2 areas per the facility staffing Grid. The facility was short staffed on RN's 18 of 21 days reviewed.</p> <p>B. ensure they staffed PCT (Patient Care Tech) in 2 areas per the facility staffing Grid. The facility was short on PCT's 17 of 21 days reviewed.</p> <p>C. ensure they staffed PSC (Unit Secretary) in 2 areas per the facility staffing Grid. The facility was short 19 of 21 days reviewed.</p> <p>This deficient practice had the likelihood to cause harm to all patients admitted to both units.</p> <p>Review of the staffing for 12-1-2018 to 12-6-2018 on 2 units (G9 Pedi SW&NE and PICS NW) revealed the following:</p> <p>G09 SW/NE</p> <p>12-1-2018</p> <p>The unit was short 1 RN on the 7am - 7 pm shift. The unit was short 1 RN on the 7pm - 7 am shift. The unit was short 1 PCT on the 7am - 7 pm shift. The unit was short 1 PCT on the 7pm - 7 am shift. The unit was short 1 PSE on the 7 pm - 7 am</p> | A 392 | | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/30/2019
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 450076 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED C 05/17/2019 |
|--|--|---|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER UNIVERSITY OF TEXAS M D ANDERSON CANCER CENTER, THE | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1515 HOLCOMBE BLVD HOUSTON, TX 77030 | | |
| (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) COMPLETION DATE | |
| A 392 | Continued From page 36 shift. 12-2-2018 The unit was short 1 RN on the 7am - 7 pm shift. The unit was short 1 RN on the 7pm - 7 am shift. The unit was short 1 PCT on the 7am - 7 pm shift. The unit was short 1 PSE on the 7 am - 7 pm shift. 12-3-2018 The unit was short 1 RN on the 7am - 7 pm shift. The unit was short 1 RN on the 7pm - 7 am shift. The unit was short 1 PCT on the 7am - 7 pm shift. The unit was short 1 PCT on the 7pm - 7 am shift. The unit was short 1 PSE on the 7 am - 7 pm shift. The unit was short 1 PSE on the 7 pm - 7 am shift. 12-4-2018 The unit was short 1 RN on the 7am - 7 pm shift. The unit was short 1 PCT on the 7am - 7 pm shift. 12-5-2018 The unit was short 1 PCT on the 7am - 7 pm shift. 12-6-2018 The unit was short 1 PCT on the 7pm - 7 am shift. | A 392 | | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/30/2019
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 450076 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED C 05/17/2019 |
|--|--|---|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER UNIVERSITY OF TEXAS M D ANDERSON CANCER CENTER, THE | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1515 HOLCOMBE BLVD HOUSTON, TX 77030 | | |
| (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) COMPLETION DATE | |
| A 392 | Continued From page 37 G9 PICS NW 12-1-2018 to 12-6-2018 The unit was short one PCT on the 7 am- 7 pm shift and one PCT on the 7am - 7 pm shift each day. 12-2-2018 The unit was short 1 PSC on the 7am - 7 pm shift. The unit was short 1 PSC on the 7pm - 7 am shift. Review of the staffing for 5-1-2019 to 5-15-2019 on 2 units (G9 Pedi SW&NE and PICS NW) revealed the following: G09 SW/NE 5-1-2019 The unit was short 2 RN's on the 7pm - 7 am shift. The unit was short 1 PCT on the 7pm - 7 am shift. The unit was short 1 PSE on the 7am - 7 pm shift. The unit was short 1 PSE on the 7pm - 7 am shift. 5-2-2019 The unit was short 2 RN's on the 7am - 7 pm shift. The unit was short 2 RN's on the 7pm - 7 am shift. The unit was short 1 PCT on the 7am - 7 pm shift. The unit was short 1 PSC on the 7am - 7 pm shift. | A 392 | | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/30/2019
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 450076 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED C 05/17/2019 |
|--|--|---|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER UNIVERSITY OF TEXAS M D ANDERSON CANCER CENTER, THE | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1515 HOLCOMBE BLVD HOUSTON, TX 77030 | | |
| (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) COMPLETION DATE | |
| A 392 | Continued From page 38 The unit was short 1 PSC on the 7pm - 7am shift. 5-3-2019 The unit was short 2 RN's on the 7am - 7 pm shift. The unit was short 1 RN's on the 7pm - 7 am shift. The unit was short 1 PSC on the 7am - 7 pm shift. 5-4-2019 The unit was short 2 RN's on the 7am - 7 pm shift. The unit was short 1 RN on the 7pm - 7 am shift. The unit was short 2 PSC's on the 7am - 7 pm shift. The unit was short 1 PSC on the 7pm - 7 am shift. 5-5-2019 The unit was short 1 RN on the 7am - 7 pm shift. The unit was short 1 PSC on the 7pm - 7 am shift. 5-6-2019 The unit was short 1 PSC on the 7am - 7pm shift. 5-7-2019 The unit was short 1 RN on the 7am - 7pm shift. 5-8-2019 The unit was short 1 RN on the 7am - 7 pm shift. The unit was short 4 RN's on the 7pm - 7 am shift. The unit was short 1 PCT on the 7pm - 7 am shift. The unit was short 1 PSC on the 7 am - 7 pm shift. | A 392 | | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/30/2019
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 450076 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED C 05/17/2019 |
|--|---|---|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER UNIVERSITY OF TEXAS M D ANDERSON CANCER CENTER, THE | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1515 HOLCOMBE BLVD HOUSTON, TX 77030 | | |
| (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) COMPLETION DATE | |
| A 392 | Continued From page 39 5-9-2019 The unit was short 4 RN's on the 7am - 7 pm shift. The unit was short 4 RN's on the 7pm - 7 am shift. The unit was short 1 PCT on the 7pm - 7 am shift. The unit was short 1 PSC on the 7 am - 7 pm shift. 5-10-2019 The unit was short 3 RN's on the 7am - 7 pm shift. The unit was short 2 RN's on the 7pm - 7 am shift. The unit was short 2 PSC's on the 7 am - 7 pm shift. The unit was short 2 PSC's on the 7 pm - 7 am shift. 5-11-2019 The unit was short 1 RN on the 7am - 7 pm shift. The unit was short 1 RN on the 7pm - 7 am shift. The unit was short 2 PSC's on the 7am - 7 pm shift. 5-12-2019 The unit was short 2 RN's on the 7am - 7 pm shift. The unit was short 2 PSC's on the 7am - 7 pm shift. 5-13-2019 The unit was short 1 RN on the 7am - 7 pm shift. The unit was short 1 PSC on the 7am - 7 pm shift. The unit was short 1 PSC on the 7pm - 7 am shift. | A 392 | | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/30/2019
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 450076 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED C 05/17/2019 |
|--|---|---|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER UNIVERSITY OF TEXAS M D ANDERSON CANCER CENTER, THE | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1515 HOLCOMBE BLVD HOUSTON, TX 77030 | | |
| (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) COMPLETION DATE | |
| A 392 | Continued From page 40 5-14-2019 The unit was short 1 RN on the 7am - 7 pm shift. The unit was short 4 RN's on the 7pm - 7 am shift. The unit was short 1 PSC on the 7am - 7 pm shift. 5-15-2019 The unit was short 1 RN on the 7pm - 7 am shift. The unit was short 1 PSC on the 7pm - 7am shift. G9 PICS NW 5-1-2019 The unit was short 1 PCT on the 7am - 7pm shift. The unit was short 1 PCT on the 7pm - 7am shift. The unit was short 1 PSC on the 7am - 7pm shift. 5-2-2019 The unit was short 1 PSC on the 7am- 7pm shift. The unit was short 1 PSC on the 7pm - 7am shift. 5-3-2019 The unit was short 1 RN on the 7am - 7pm shift. The unit was short 1 PSC on the 7pm - 7am shift. 5-4-2019 The unit was short 1 RN on the 7am - 7pm shift. The unit was short 1 RN on the 7pm - 7am shift. The unit was short 1 PCT on the 7am - 7pm shift. The unit was short 1 PCT on the 7pm - 7am shift. 5-5-2019 The unit was short 1 RN on the 7am - 7pm shift. The unit was short 1 RN on the 7pm - 7am shift. The unit was short 1 PCT on the 7am - 7pm shift. The unit was short 1 PCT on the 7pm - 7am shift. 5-6-2019 | A 392 | | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/30/2019
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 450076 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED C 05/17/2019 |
|--|--|---|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER UNIVERSITY OF TEXAS M D ANDERSON CANCER CENTER, THE | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1515 HOLCOMBE BLVD HOUSTON, TX 77030 | | |
| (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) COMPLETION DATE | |
| A 392 | Continued From page 41 The unit was short 1 RN on the 7am - 7pm shift. The unit was short 1 PCT on the 7am - 7pm shift. The unit was short 1 PCT on the 7pm - 7am shift. The unit was short 1 PSC on the 7pm - 7am shift. 5-7-2019 The unit was short 1 RN on the 7am - 7pm shift. The unit was short 1 PCT on the 7pm - 7am shift. The unit was short 1 PSC on the 7am - 7pm shift. 5-8-2019 The unit was short 1 RN on the 7pm - 7am shift. The unit was short 1 PSC on the 7pm - 7am shift. 5-9-2019 The unit was short 1 RN on the 7am - 7pm shift. The unit was short 1 RN on the 7am - 7pm shift. The unit was short 1 PCT on the 7pm - 7am shift. The unit was short 1 PSC on the 7am - 7pm shift. The unit was short 1 PSC on the 7pm - 7am shift. 5-10-2019 The unit was short 1 RN on the 7am-7pm shift. The unit was short 1 PCT on the 7am - 7pm shift. 5-11-2019 The unit was short 1 RN on the 7am - 7pm shift. The unit was short 1 PCT on the 7am - 7pm shift. The unit was short 1 PSC on the 7pm - 7am shift. 5-12-2019 The unit was short 1 PCT on the 7am - 7pm shift. The unit was short 1 PSC on the 7pm - 7am shift. 5-14-2019 The unit was short 1 PSC on the 7pm - 7am shift. Interview with Staff #'s 8 & 12 on May 16th after | A 392 | | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/30/2019
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 450076 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED C 05/17/2019 |
|--|--|---|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER UNIVERSITY OF TEXAS M D ANDERSON CANCER CENTER, THE | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1515 HOLCOMBE BLVD HOUSTON, TX 77030 | | |
| (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) COMPLETION DATE | |
| A 392 | Continued From page 42 1:00 PM revealed the following: Staff #8 said the Staffing Matrix was based on "ideal staffing" for budget purposes. Staff #8 said the Staffing Matrix was not the minimum safe staffing for the facility. Staff #12 said the unit did not use the Staffing Matrix as a minimum safe staffing level. Staff #12 said the Staffing Matrix was based on budget. Staff #8 was asked to provide any additional information to show the minimum safe staffing levels she was referring to. Staff #12 said there was no other Staffing Matrix used at the facility. | A 392 | | | |
| A 397 | Staff #8 & #12 confirmed the above findings. PATIENT CARE ASSIGNMENTS CFR(s): 482.23(b)(5) A registered nurse must assign the nursing care of each patient to other nursing personnel in accordance with the patient's needs and the specialized qualifications and competence of the nursing staff available. This STANDARD is not met as evidenced by: Based on record review and interview, the hospital failed to ensure that nursing personnel had annual competencies before assigning care for each patient in accordance with the individual needs of each patient, citing 3 of 4 staff (#1, #42, and #43) The findings include: Review of personnel records indicated the | A 397 | | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/30/2019
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 450076 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED C 05/17/2019 |
|--|--|---|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER UNIVERSITY OF TEXAS M D ANDERSON CANCER CENTER, THE | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1515 HOLCOMBE BLVD HOUSTON, TX 77030 | | |
| (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) COMPLETION DATE | |
| A 397 | <p>Continued From page 43 following 3 personnel did not have annual competencies.</p> <p>Staff #1 (PCT), hired 2/23/15, had no evidence of having had annual training nor comprehensive skills checklist in the personnel records.</p> <p>Staff #42 (RN), hired 2/22/16, last had annual competencies on 7/21/16, no evidence of current annual competencies nor comprehensive skills checklist in the personnel records.</p> <p>Staff #43 (RN), hired 2/22/16, last had annual competencies on 7/29/16, no evidence of current annual competencies nor comprehensive skills checklist in the personnel records.</p> <p>In an interview on 4/1/15, at 1:00 PM, with Personnel #17 revealed that the facility does conduct a self-administered training course, but not an annual comprehensive competency course for the nursing and non-nursing staff to demonstrate their skills. Personnel #17 confirmed that the above employees did not have evidence of having had annual competencies to demonstrate competencies in their respective personnel records.</p> <p>Record review of the facility policy, titled Division of Nursing Competency Policy, published 4/11/19, states in part: It is the policy to assess and validate the competence of nursing staff during initial orientation and periodically throughout employment, to include: Registered Nurses, Licensed Vocational Nurses, Non-Licensed Nursing Personnel, and Certified Monitoring</p> | A 397 | | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/30/2019
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 450076 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED C 05/17/2019 |
|--|---|---|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER UNIVERSITY OF TEXAS M D ANDERSON CANCER CENTER, THE | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1515 HOLCOMBE BLVD HOUSTON, TX 77030 | | |
| (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) COMPLETION DATE | |
| A 397 | Continued From page 44 Technicians in the division of nursing. On an annual basis, a standardized learning needs assessment will be distributed to nursing staff. | A 397 | | | |
| A 409 | BLOOD TRANSFUSIONS AND IV MEDICATIONS CFR(s): 482.23(c)(4) Blood transfusions and intravenous medications must be administered in accordance with State law and approved medical staff policies and procedures. If blood transfusions and intravenous medications are administered by personnel other than doctors of medicine or osteopathy, the personnel must have special training for this duty. This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure blood transfusions were administered in accordance with the facility's policy/procedures and acceptable nursing standards in 19 (Patient #'s 2, 3,4, 5, 6, 7, 8, 12, 14, 17, 18, 23, 24, 26, 28, 29, 32, 33, and 34) of 34 patients reviewed. The facility failed to: A. ensure nurses continually assessed patients during transfusions of blood and platelets. Vital signs were not monitored or obtained during transfusion; vital signs were not taken in the first 15-30 minutes after the transfusion was initiated or after completion of the transfusion in accordance with facility policy. Vital signs flagged as abnormal were not assessed or reassessed. B. ensure nurses provided and documented | A 409 | | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/30/2019
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 450076 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED C 05/17/2019 |
|--|--|---|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER UNIVERSITY OF TEXAS M D ANDERSON CANCER CENTER, THE | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1515 HOLCOMBE BLVD HOUSTON, TX 77030 | | |
| (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) COMPLETION DATE | |
| A 409 | <p>Continued From page 45</p> <p>timely, complete and accurate assessments on patients who experienced transfusion reactions. There was no means to determine when symptoms consistent with a potential acute transfusion reaction developed, as there was no consistent documented patient assessment during a transfusion and vital signs were not assessed until after the transfusion was completed. Nurses performing blood transfusions relied on patient report to detect symptoms of a potential transfusion reaction.</p> <p>C. ensure nurses notified the physician of changes in vital signs and changes in condition on patients receiving transfusions of blood and platelets.</p> <p>D. ensure nurses had complete and accurate physician orders prior to initiating transfusions. Blood products were not infused at the duration specified in the physician order for transfusion; orders were not clarified and the physician was not notified that the order had not been followed.</p> <p>E. ensure nurses followed physician's order for the transfusion rates on patients.</p> <p>These findings were not in accordance with hospital policy and presents the risk that serious blood transfusion reactions may not be detected or assessed in an expeditious manner, which could result in severe complications or death to a patient receiving blood or blood products.</p> | A 409 | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 450076 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED C 05/17/2019 |
|--|---|---|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER UNIVERSITY OF TEXAS M D ANDERSON CANCER CENTER, THE | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1515 HOLCOMBE BLVD HOUSTON, TX 77030 | | |
| (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) COMPLETION DATE | |
| A 409 | <p>Continued From page 46</p> <p>These deficient practices had the potential to affect all patients receiving blood or blood components at the hospital.</p> <p>Findings:</p> <p>Patient #34</p> <p>Review of Patient #34's medical record revealed she was a 23 y/o with pre-B cell acute lymphoblastic leukemia (ALL). Review of the physician progress notes dated 12/7/18 revealed:</p> <p>"HISTORY OF PRESENT ILLNESS: _____ (patient #34) is a 23 y.o. year old female with a history of ALL and 2 previous transplants who was admitted to the hospital on 9/25/18 and underwent haploidentical stem cell transplant on 10/2/18, Her most recent transplant course has been complicated by severe BK cystitis necessitating daily transfusions and bilateral nephrostomy tube placement. Her left nephrostomy tube was dislodged in the evening of 12/5. On 12/6 she underwent IR replacement of the tube. When she returned to the floor she was noted to be less responsive and hypotensive. She was transferred to the ICU early in the morning of 12/7 for further management. She underwent transfusion of blood products for lib of 4.0 with response, however, later in the morning she became hypotension refractory to resuscitation, requiring escalating vasopressor support.</p> <p>Significant ICU Events: 12/7/18 - admitted to ICU with hypotension and anemia in early morning, transfused; pressors started in morning; intubated</p> | A 409 | | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/30/2019
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 450076 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED C 05/17/2019 |
|--|--|---|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER UNIVERSITY OF TEXAS M D ANDERSON CANCER CENTER, THE | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1515 HOLCOMBE BLVD HOUSTON, TX 77030 | | |
| (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) COMPLETION DATE | |
| A 409 | <p>Continued From page 47 in late morning</p> <p>SIGNIFICANT EVENTS IN LAST 24 hours: per above - transferred to ICU; new fever this morning ALLERGIES: Allergies Allergen Amphotericin B "I just started feeling bad" Clindamycin."</p> <p>During an interview with Staff #25 on 5-14-19, Staff #25 provided a positive culture results from the platelets administered to Patient #34. The report revealed the culture from the pooled platelet showed growth of gram negative coccobacilli. On 12/8/18 the organism from the culture was identified as Serratia marcescens. Patient #34's condition worsened and she expired on 12/8/18.</p> <p>Review of Patient #34's medical record revealed a transfusion of pooled platelets was initiated on 12/06/2018 at 10:12 PM and completed at 11:15 PM. There was no blood consent in the medical chart provided to administer the platelets. Patient #34's transfusion records revealed the following vital signs documented during the transfusion:</p> <p>12/06/2018 10:12 PM (Initiation of transfusion) No vitals signs documented or pre-vitals documented.</p> <p>12/06/2018 10:26 PM Blood Pressure 101/57 Temperature 36.7 C (98.1F) O2 sat 100% No pulse documented.</p> <p>12/06/2018 11:15 PM (End of transfusion) No vitals documented.</p> <p>12/06/2018 11:19 PM O2 sat 79% No pulse or</p> | A 409 | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 450076 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED C 05/17/2019 |
|--|--|---|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER UNIVERSITY OF TEXAS M D ANDERSON CANCER CENTER, THE | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1515 HOLCOMBE BLVD HOUSTON, TX 77030 | | |
| (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) COMPLETION DATE | |
| A 409 | <p>Continued From page 48 temperature documented.</p> <p>12/06/2018 11:22 PM Blood Pressure 76/39, O2 sat 73% no pulse or temperature. The patient had a significant drop in blood pressure with no nursing documentation of assessment or physician notification found.</p> <p>Review of the "BLOOD COMPONENT TRANSFUSION ADMINISTRATION PROCEDURE" revealed:</p> <p>"7.21 When prompted by the electronic health record, document the blood administration rate and vital signs. Note: If greater than 30 minutes of time passed since the initial vital signs were obtained, repeat the vital signs and re-assess patient condition prior to spiking the blood component with the administration tubing/set or starting the transfusion...</p> <p>8.8. First 15 minutes of transfusion:</p> <p>A. Monitor patient for signs and symptoms of Transfusion Reaction...</p> <p>B. Reassess vital signs after fifteen (15) minutes (not to exceed 30 minutes) from initiation of blood."</p> <p>Nursing documentation and transfusion record dated 12/6/18 revealed, there was no consistent or complete vital signs, nursing assessments, or reassessments documented during the transfusions. Nursing would not be able to alert the physician or lab for a potential transfusion reaction if the patient was not properly assessed.</p> | A 409 | | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/30/2019
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 450076 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED C 05/17/2019 |
|--|--|---|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER UNIVERSITY OF TEXAS M D ANDERSON CANCER CENTER, THE | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1515 HOLCOMBE BLVD HOUSTON, TX 77030 | | |
| (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) COMPLETION DATE | |
| A 409 | <p>Continued From page 49</p> <p>An interview was conducted on 5/16/19 in the afternoon. Staff # 31 confirmed there were no nursing competencies for blood administration.</p> <p>During interviews on 05/13/2019 after 10:45 a.m., the following was reported from nursing staff about blood administration:</p> <p>EPIC (facility's software system) does not give any kind of alerts for blood pressure, pulse and respirations. There are no parameters in the computer. They would consider it a transfusion reaction if the temperature went up or down by 1 degree.</p> <p>They relied on the patients to tell them when they were having a reaction.</p> <p>The transfusion reaction policy was initiated when the patients were tachypnea (elevated heart rate) or hypotensive (low blood pressure). The scale the nurses used was a 10 % increase of 10 % decrease in the vital signs</p> <p>There were no blood pressure parameters. They were individualized to the patient. The nurse said she assumed the reaction policy was initiated when the blood pressure went up by 20 mm of Mercury.</p> <p>The nurses were taught to check the vital signs 30 minutes' pre-transfusion, 15-30 minutes after starting and 30 minutes after the transfusion had stopped. If there were signs and symptoms, they should take the vital signs more often.</p> | A 409 | | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/30/2019
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 450076 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED C 05/17/2019 |
|--|--|---|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER UNIVERSITY OF TEXAS M D ANDERSON CANCER CENTER, THE | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1515 HOLCOMBE BLVD HOUSTON, TX 77030 | | |
| (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) COMPLETION DATE | |
| A 409 | <p>Continued From page 50</p> <p>Review of clinical records on 05/14/2019 through 05/16/2019 in the Administrative conference room revealed the following:</p> <p>Patient #17</p> <p>Review of an Emergency department (ED) note on Patient #17 revealed he was a 17- year -old male admitted to the hospital on 03/27/2019 with complaints of nosebleed and medication reaction. Patient #17 had a diagnosis of lymphoblastic leukemia (cancer of the blood and bone marrow). According to the allergy section in the ED notes Patient #17 had blood product sensitivity reactions.</p> <p>Review of physician orders dated 03/28/2019 revealed the following: "Vital signs- Transfusion related, within 30 minutes prior to initiating blood component transfusion, after 15 minutes but not to exceed 30 minutes after initiation, and within 30 minutes after infusion completion"</p> <p>Review of physician orders dated 04/01/2019 revealed Patient #17 had an order to transfuse one unit of packed red blood cells over 4 hours.</p> <p>Review of the blood transfusion record revealed that a set of vitals were taken at 4:45 a.m., on 04/01/2019.</p> <p>At 4:49 a.m., the blood transfusion was started.</p> <p>At 5:12 a.m., the only vital sign taken was a blood pressure. There was no documentation of a temperature, respiration, and pulse within 30</p> | A 409 | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 450076 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED C 05/17/2019 |
|--|--|---|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER UNIVERSITY OF TEXAS M D ANDERSON CANCER CENTER, THE | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1515 HOLCOMBE BLVD HOUSTON, TX 77030 | | |
| (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) COMPLETION DATE | |
| A 409 | <p>Continued From page 51 mins. after initiation of the blood.</p> <p>The infusion was stopped at 9:00 a.m. and a set of vital signs were taken at 9:22 a.m.</p> <p>Patient #17 had no continuous monitoring of vital signs for a timeframe of over 4 hours. The staff failed to follow the physician's order to obtain vital signs within 30 minutes after initiating the blood transfusion.</p> <p>Review of physician orders dated 04/02/2019 revealed Patient #17 had an order to transfuse one unit of platelets over 1 hour.</p> <p>Review of the blood transfusion record revealed the following:</p> <p>At 12:00 p.m., 133/59 blood pressure, 101 pulse (highlighted in red), 18 respirations, and 36.6 degrees Celsius (temperature).</p> <p>At 12:22 p.m., the platelets were started.</p> <p>At 12:40 p.m., 122/55 blood pressure, 95 pulse, 19 respirations, and 36.8 degrees Celsius (temperature).</p> <p>At 1:17 p.m., the platelets were stopped.</p> <p>At 1:40 p.m., 125/62 blood pressure, 98 pulse, 19 respirations, and 36.8 degrees Celsius (temperature).</p> <p>At 3:35 p.m. (almost 2 hours later) the vital signs were 136/73 blood pressure, 114 pulse (highlighted in red), 18 respirations, and 37.0 degrees Celsius (temperature).</p> | A 409 | | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/30/2019
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 450076 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED C 05/17/2019 |
|--|---|---|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER UNIVERSITY OF TEXAS M D ANDERSON CANCER CENTER, THE | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1515 HOLCOMBE BLVD HOUSTON, TX 77030 | | |
| (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) COMPLETION DATE | |
| A 409 | <p>Continued From page 52</p> <p>Review of a transfusion reaction investigation report dated 04/02/2019 at 5:21 p.m., revealed the suspected reaction occurred at 1:44 p.m.</p> <p>There was no documentation of an assessment of a reaction in the nurses notes around 1:44 p.m. Nurses staff failed to document anything under the category for "Suspected Transfusion Reaction". There was a place underneath the category for provider notified, reactions symptoms, and reaction interventions.</p> <p>The first documentation of a nursing assessment about the reaction was at 7:05 p.m. on 04/02/2019 (over 5.5 hours after it occurred). The following was documented:</p> <p>"(Patient #17) received platelets. After completion, he complained of itching on head, hives, and swelling of lips. Vitals stable, no meds given. About 20 min later, he complained of throat "feeling weird." MD aware and at bedside. Rapidly resolved. No additional meds ordered ..."</p> <p>During an interview on 05/14/2019 after 9:30 a.m., and 05/15/2019 after 8:50 a.m., RN#18 confirmed the missing vital signs and assessments. RN #18 said the elevated pulse that was in red prior to the initiation of the infusion meant it was outside the parameters set in the computer.</p> <p>RN#18 showed the vital sign parameters in the computer and they were as follows:</p> | A 409 | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 450076 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED C 05/17/2019 |
|--|---|---|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER UNIVERSITY OF TEXAS M D ANDERSON CANCER CENTER, THE | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1515 HOLCOMBE BLVD HOUSTON, TX 77030 | | |
| (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) COMPLETION DATE | |
| A 409 | <p>Continued From page 53</p> <p>Heart rate (60-100) Respiratory rate (12-20) Oxygen saturation (93-100) Blood pressure systolic 60-190, diastolic 40-90.</p> <p>RN#18 said the parameters have always been in the computer and are for every patient. RN#18 said that nursing should have called the physician and showed why they continued with the transfusion with the vital signs being out of range.</p> <p>Patient #23</p> <p>Review of the clinical record on Patient #23 revealed he was a 68-year-old male who was admitted to the hospital on 03/19/2019 to receive chemotherapy.</p> <p>Review of physician orders dated 04/02/2019 revealed an order to Transfuse one unit of platelets for a duration of 2 hours.</p> <p>Review of transfusion records dated 04/02/2019 revealed vital signs were taken at 10:27 a.m. and the blood pressure was 141/79 and the pulse was 74.</p> <p>At 10:32 a.m., the platelets were started.</p> <p>At 10:47 a.m., the blood pressure had increased to 158/82 and pulse of 83.</p> <p>At 1:14 p.m., the blood pressure was 142/87 and pulse was 81.</p> <p>At 1:25 p.m., the platelets were stopped (almost 3 hours later).</p> | A 409 | | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/30/2019
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 450076 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED C 05/17/2019 |
|--|---|---|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER UNIVERSITY OF TEXAS M D ANDERSON CANCER CENTER, THE | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1515 HOLCOMBE BLVD HOUSTON, TX 77030 | | |
| (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) COMPLETION DATE | |
| A 409 | <p>Continued From page 54</p> <p>At 1:25 p.m., the blood pressure had increased to 149/97 (red alert was on). There was documentation that Patient #23 reported that it "feels like throat is closed up."</p> <p>At 1:33 p.m., the anti-inflammatory hydrocortisone injection was given.</p> <p>Review of the nurse's notes revealed nursing failed to document anything under the category for "Suspected Transfusion Reaction". There was a place underneath the category for provider notified, reactions symptoms, and reaction interventions that was not completed.</p> <p>The first detailed documentation by nursing about the reaction and what was done was at 6:35 p.m. 04/02/2019 (over 5.0 hours after it occurred).</p> <p>During an interview on 05/15/2019 after 1:30 p.m., RN#18 confirmed the missing assessments and that the platelets ran over the timeframe the physician ordered without documentation of justification.</p> <p>Patient #26</p> <p>Review of the clinical record on Patient #26 revealed she was a 59-year-old female who was admitted to the hospital on 03/25/2019 for thoracic surgery (chest cavity).</p> <p>Review of physician orders revealed Patient #26 was to receive 2 units of packed red blood cells and the duration was over 2 hours for each unit.</p> | A 409 | | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/30/2019
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 450076 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED C 05/17/2019 |
|--|---|--|---|---|
| NAME OF PROVIDER OR SUPPLIER UNIVERSITY OF TEXAS M D ANDERSON CANCER CENTER, THE | | STREET ADDRESS, CITY, STATE, ZIP CODE 1515 HOLCOMBE BLVD HOUSTON, TX 77030 | | |
| (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) COMPLETION DATE |
| A 409 | Continued From page 55 Review of the transfusion records dated 03/30/3019 revealed the following: Unit #1 At 1:40 p.m., 111/76 blood pressure, 36.6 temperature and at 1:56 p.m. pulse of 94 and respirations of 18. At 1:56 p.m., the blood was started. At 2:11 p.m., 127/70 blood pressure, 95 pulse, 18 respirations, 37.0 temperature, and oxygen saturation of 99 percent. At 3:00 p.m., pulse of 96 and respirations of 16. At 3:07 p.m., pulse of 98 and respirations of 16. At 3:35 p.m., 113/74 blood pressure, 101 pulse (highlighted in red), 17 respirations and oxygen saturation of 97 percent. There was no documentation of physician notification or the blood being stopped with the pulse being out of range. At 4:51 p.m., over an hour later the vital signs were 147/88 blood pressure, 105 pulse (highlighted in red), 18 respirations, and 36.7 temperature. The blood was completed at 4:51 p.m., which was almost an hour over the physician ordered timeframe. | A 409 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 450076 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED C 05/17/2019 |
|--|--|---|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER UNIVERSITY OF TEXAS M D ANDERSON CANCER CENTER, THE | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1515 HOLCOMBE BLVD HOUSTON, TX 77030 | | |
| (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) COMPLETION DATE | |
| A 409 | <p>Continued From page 56</p> <p>Unit #2</p> <p>At 5:22 p.m., the next unit of blood was started. The vital signs were 145/87 blood pressure, 104 pulse (highlighted in red), 32 respirations (highlighted in red), oxygen saturation of 95 percent.</p> <p>The pulse rate remained in the red while the blood was transfusing.</p> <p>At 9:00 p.m., the blood was completed, which was almost an hour and a half over the physician ordered timeframe.</p> <p>The vital signs at this time were 150/67 blood pressure, 109 pulse (highlighted in red), 30 respirations (highlighted in red) and oxygen saturation of 92 percent (highlighted in red).</p> <p>.</p> <p>There was no documentation of physician notification for the second unit of blood to run with the vital signs being elevated nor for the blood to run at a slower rate.</p> <p>During an interview on 05/15/2019 after 1:30 p.m., RN#18 confirmed the missing assessments, rates of the infusions, and there being no documentation of justification for running the blood with the vital signs out of range.</p> <p>Patient #18</p> <p>Review of the clinical record on Patient #18 revealed, she was a 56-year-old female who was</p> | A 409 | | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/30/2019
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 450076 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED C 05/17/2019 |
|--|--|---|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER UNIVERSITY OF TEXAS M D ANDERSON CANCER CENTER, THE | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1515 HOLCOMBE BLVD HOUSTON, TX 77030 | | |
| (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) COMPLETION DATE | |
| A 409 | <p>Continued From page 57</p> <p>admitted to the hospital on 03/25/2019 for chemotherapy.</p> <p>Review of transfusion records revealed, Patient #18 received a blood transfusion on 03/30/2019.</p> <p>Review of lab results dated 04/01/2019 collected at 4:59 a.m. revealed, Patient #18 had a low white blood cell count of 0.4 (reference ranges 4.0-11.0) and a low platelet count of 10 (reference ranges 140-440).</p> <p>Review of a physician's order dated 04/01/2019 at 7:01 a.m., revealed, an order to transfuse platelets at gravity. There was no duration written on the order.</p> <p>Over 12 hrs. later at 9:00 p.m., the unit of platelets were started. The vital signs were 153/74 blood pressure, 73 pulse, 18 respirations, 36.8 temperature and oxygen saturation of 100 percent.</p> <p>At 10:30 p.m., the vital signs were 137/75 blood pressure, 77 pulse, 18 respirations, 36.6 temperature and oxygen saturation of 100 percent. The blood was stopped due to Patient #18 complaints of itching.</p> <p>Over 6 hours later was the next documentation of vital signs at 4:50 a.m. They were 152/71 blood pressure, 79 pulse, 16 respirations, 36.9 temperature and 96 percent oxygen saturation.</p> <p>During an interview on 05/15/2019 after 1:30 p.m., RN#18 confirmed the missing post vital signs, the time the blood was administered, and missing rate on the transfusion order.</p> | A 409 | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 450076 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED C 05/17/2019 |
|--|--|---|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER UNIVERSITY OF TEXAS M D ANDERSON CANCER CENTER, THE | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1515 HOLCOMBE BLVD HOUSTON, TX 77030 | | |
| (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) COMPLETION DATE | |
| A 409 | <p>Continued From page 58</p> <p>Patient #3</p> <p>Review of ED record on Patient #3 revealed, he was a 62-year-old male who presented on 3/23/2019 with complaints of general body aches and mouth lesions. Patient #3 was admitted into the hospital and some of the diagnoses listed were moderate dehydration, neutropenia, acute-on-chronic renal failure, pleural effusion, and cancer associated pain.</p> <p>Review of physician orders dated 03/24/2019 revealed, an order to Transfuse packed red blood cells over a duration of 3 hours.</p> <p>Review of physician orders dated 03/24/2019 revealed, an order to Transfuse one unit of platelets over a duration of 4 hours.</p> <p>Review of the blood transfusion record dated 03/24/2019 revealed the following:</p> <p>At 1:20 a.m., the vital signs were 90/55 blood pressure, 100 pulse, 17 respirations, 36.9 temperature and oxygen saturation of 99 percent.</p> <p>At 0121 a.m., the red blood cells were started.</p> <p>At 0140 a.m. the vital signs were 98/56 blood pressure, 104 pulse (highlighted in red), 17 respirations, 36.9 temperature and oxygen saturation of 99 percent.</p> <p>At 4:03 a.m., the blood was completed.</p> <p>At 4:34 a.m., a set of vital signs were taken. This was almost 3 hours after the vital signs were taken at 0140 a.m. when the pulse was out of</p> | A 409 | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 450076 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED C 05/17/2019 |
|--|--|---|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER UNIVERSITY OF TEXAS M D ANDERSON CANCER CENTER, THE | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1515 HOLCOMBE BLVD HOUSTON, TX 77030 | | |
| (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) COMPLETION DATE | |
| A 409 | <p>Continued From page 59 range.</p> <p>Review of the blood transfusion record revealed Patient #3 received another unit of packed red blood cells on 03/24/2019 which started at 6:54 p.m.</p> <p>At 7:10 p.m. the temperature was 99.0 degrees Fahrenheit. The same as the pre-transfusion temperature.</p> <p>At 9:55 p.m., the transfusion was complete.</p> <p>At 10:25 p.m., a set of post vital signs were taken and the temperature was elevated at 100.6 degrees Fahrenheit (1.6 degrees higher).</p> <p>At 12:42 midnight (over 2 hour later) on 03/25/2019, was when another temperature was taken and it was 99.5 degrees Fahrenheit.</p> <p>Review of the transfusion record dated 03/25/2019 at 12:42 midnight, revealed the platelets were started.</p> <p>At 2:00 a.m., the platelets were stopped. There was documentation of Patient #3 complaining of itching all over because of a transfusion reaction.</p> <p>There was no documentation of continuous monitoring while the blood was being administered and after Patient #3 had an elevated pulse. There was no documentation of continuous monitoring of the elevated temperature or documentation to continue with the transfusion when the vital signs were out of range.</p> | A 409 | | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/30/2019
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 450076 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED C 05/17/2019 |
|--|---|---|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER UNIVERSITY OF TEXAS M D ANDERSON CANCER CENTER, THE | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1515 HOLCOMBE BLVD HOUSTON, TX 77030 | | |
| (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) COMPLETION DATE | |
| A 409 | <p>Continued From page 60</p> <p>During an interview on 05/15/2019 after 1:30 p.m., RN#18 confirmed the lack of vital signs, the time the blood was administered, and lack of documentation to continue with the transfusion with the vital signs out of range.</p> <p>Patient #7</p> <p>Review of the clinical record revealed, Patient #7 was an 85-year-old male who was admitted on 04/11/2019 and had diagnoses which included lymphoma (cancer of lymph nodes).</p> <p>Review of a physician orders dated 04/24/2019 revealed, Patient #7 had an order to Transfuse 1 unit of platelets by "Gravity drip." There was no documentation of the timeframe for the transfusion.</p> <p>Review of transfusion documentation dated 04/24/2019 revealed the following:</p> <p>At 10:22 p.m., the pre-vital signs were 123/57 blood pressure, 61 pulse, 36.8 temperature and 98 percent oxygen saturation on room air.</p> <p>At 10:33 p.m., the platelets were started.</p> <p>At 11:00 p.m., the vitals were 104/53 blood pressure, 62 pulse, 18 respirations, 36.7 temperature and oxygen saturation at 100 percent on room air.</p> <p>At 12:05 a.m. (midnight) the vital signs were 114/59 blood pressure, 71 pulse, 20 respirations, 39.4 temperature (highlighted in red) and oxygen saturation at 99 percent on oxygen at</p> | A 409 | | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/30/2019
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 450076 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED C 05/17/2019 |
|--|--|---|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER UNIVERSITY OF TEXAS M D ANDERSON CANCER CENTER, THE | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1515 HOLCOMBE BLVD HOUSTON, TX 77030 | | |
| (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) COMPLETION DATE | |
| A 409 | <p>Continued From page 61 3 liters per nasal cannula.</p> <p>At 12:52 a.m., the vital signs were 118/59 blood pressure, 74 pulse, 20 respirations, 39.0 temperature (highlighted in red) and oxygen saturation at 99 percent on 3 liter of oxygen per nasal cannula.</p> <p>Review of the nurse's notes revealed, they failed to document anything under the category for "Suspected Transfusion Reaction". There was a place underneath the category for provider notified, reactions symptoms, and reaction interventions which were not completed.</p> <p>The next set of vital signs were taken over 3 hour later at 4:08 a.m.</p> <p>The first detailed nursing assessment on the transfusion reaction was over 8 hours after the reaction at 8:37 a.m. Some of the following was documented on the assessment:</p> <p>"..Pt received Platelets for Plt count 10k. Pt spike T39.4 at infusion stop time. Post blood vitals T39.0. Pt breathing became labored and oxygen decreased to 70-90's and had chills. Placed pt on nasal cannula 3l. Oxygen saturation then >95 %. Pt work of breathing decreased. Administered Tylenol 650mg PO X1 for temperature. Notified Dr....received orders for transfusion reaction investigational request.."</p> <p>During an interview on 05/16/2019 after 2:00 p.m., RN#18 confirmed the incomplete physician order, lack of vital signs and nursing assessment</p> | A 409 | | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/30/2019
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 450076 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED C 05/17/2019 |
|--|---|---|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER UNIVERSITY OF TEXAS M D ANDERSON CANCER CENTER, THE | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1515 HOLCOMBE BLVD HOUSTON, TX 77030 | | |
| (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) COMPLETION DATE | |
| A 409 | <p>Continued From page 62</p> <p>not being timely in relation to the transfusion reaction.</p> <p>Review of Medical Records on 5-15-2019 after 8:45 AM in an Administrative conference room revealed the following:</p> <p>Patient #2</p> <p>Patient #2 was a 26-year-old male admitted on 3/30/2019 for evaluation of CAR T cell therapy. Patient #2 received Platelets on 3/31/2019 at 11:03 PM. The vital signs noted pre-transfusion were Blood Pressure 105/51, Pulse 89, RR 20, Oxygen Saturation 97%, Temperature 37.3 C. The transfusion was stopped on 4-1-2019 at 1250 am. The record notes the transfusion was stopped due to reaction. The change in condition was noted as temperature change from 37.3 to 38.2. Vital signs taken on 4-1-2019 at 1245 am were, Blood Pressure 100/56, Pulse 87, Respirations 20, Oxygen Saturation 98% on room air, Temperature 38.2 C.</p> <p>A transfusion reaction form was initiated. There was no date or time on the form. The form noted that the physician was notified on 4-1-2019 at 1250 am. The blood bank was notified on 4-1-2019 at 1:05 am.</p> <p>There was no progress note in the medical record from the provider that addressed the reported reaction.</p> <p>Vitals signs recorded on 4-1-2019 at 1:15 am were Blood Pressure 127/61, Heart Rate 79, RR 20, Oxygen Saturation 95% on room air. There was a temperature recorded on 4-1-2019 at 2:20 am of 36.9 C. There were no vital signs or assessments noted in the record again until 4:21</p> | A 409 | | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/30/2019
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 450076 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED C 05/17/2019 |
|--|---|---|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER UNIVERSITY OF TEXAS M D ANDERSON CANCER CENTER, THE | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1515 HOLCOMBE BLVD HOUSTON, TX 77030 | | |
| (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) COMPLETION DATE | |
| A 409 | <p>Continued From page 63</p> <p>am; over three hours from the last recorded vitals. There was no documentation in the nursing flowsheets or nurse notes that documented the patient was assessed after a transfusion reaction was called.</p> <p>Patient #4</p> <p>Patient #4 was an 81-year-old male admitted on 5-11-2019. Patient #4 received Red Blood Cells (RBC) on 5/12/2019 at 2:19 PM and 7:51 PM.</p> <p>Review of the Blood Administration Record for the unit of RBC that was started on 5-12-2019 at 2:19 PM revealed the following:</p> <p>At 2:13 pm on 5/12/2019 there was a temperature recorded at of 36.8 C. No other vitals were recorded. There was documentation that the patient refused vital signs.</p> <p>At 2:55 pm on 5/12/2019 vital signs were Oxygen 95% on room air, pulse 72, respiration 20. There was no blood pressure recorded.</p> <p>At 6:00 pm on 5/12/2019 the patient refused all vital signs.</p> <p>Review of the Blood Administration Record for the unit of RBC that was started on 5-12-2019 at 7:51 pm revealed the following:</p> <p>There was documentation that the patient refused vital signs at 7:51 pm and 8:00 pm.</p> <p>At 8:00 pm on 5-12-2019 there was documentation in the blood administration record</p> | A 409 | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 450076 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED C 05/17/2019 |
|--|--|---|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER UNIVERSITY OF TEXAS M D ANDERSON CANCER CENTER, THE | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1515 HOLCOMBE BLVD HOUSTON, TX 77030 | | |
| (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) COMPLETION DATE | |
| A 409 | <p>Continued From page 64</p> <p>that Patient #4 had diminished bilateral breath sounds. There was no note to indicate if the diminished breath sounds were a change in condition after starting the blood transfusion.</p> <p>There was no documentation in the medical record notifying the provider of the patient's refusal of vital signs. The nurse administered the blood products without clarifying the physician wanted to proceed with the treatments.</p> <p>Patient #5</p> <p>Patient #5 was a 22-year-old female admitted on 1-15-2019. Review of a sample of transfusion infusion records in the record showed Patient #5 received Platelets on 4-8-2019 at 6:38 AM and 5-2-2019 at 11:01 AM.</p> <p>4-8-2019 Transfusion</p> <p>The physician order for 4/8/2019 read, "Transfuse platelets". The transfusion duration was listed as "Gravity drip". There was no documentation in the record to indicate that the nurse called the ordering provider to clarify the duration of the transfusion. The platelet transfusion was started on 4/8/2019 at 6:39 am. Vital signs at 6:38 am were Blood pressure 121/61, Pulse 104, RR 18, Oxygen saturation 98%, Temperature 37.1 C. There were no vital signs or assessments documented as required by facility policy for 15-30-minute check. The transfusion was stopped at 7:25 pm for transfusion reaction. Vital signs documented at 7:25 were Blood pressure 135/76, Pulse 113, RR 22, Oxygen Saturation 99% on room air, Temperature 37.8. The patient</p> | A 409 | | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/30/2019
FORM APPROVED
OMB NO. 0938-0391

| | | | | |
|--|--|--|---|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 450076 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED C 05/17/2019 |
| NAME OF PROVIDER OR SUPPLIER UNIVERSITY OF TEXAS M D ANDERSON CANCER CENTER, THE | | STREET ADDRESS, CITY, STATE, ZIP CODE 1515 HOLCOMBE BLVD HOUSTON, TX 77030 | | |
| (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) COMPLETION DATE |
| A 409 | <p>Continued From page 65</p> <p>was noted to have inspiratory wheezes. An evaluation note in the medical record dated 4/8/2019 at 4:13 pm documented the patient complaining of shortness of breath and feeling like throat is closing. An APN (Advanced Practice Nurse) was notified and at the bedside immediately.</p> <p>A transfusion reaction form was initiated. There was no date or time on the record. The form noted the provider was notified at 7:25 pm. The blood bank was notified at 7:59 am.</p> <p>There was a note in the record from the provider noting the possible platelet transfusion reaction with symptoms of feeling like throat was closing. The provider noted the symptoms resolved with Benadryl and steroids.</p> <p>At 8:05 am on 4-8-2019 vital signs were Blood Pressure 128/68, Pulse 94, Oxygen saturation 100%.</p> <p>At 9:00 am on 4-8-2019 vital signs were pulse 92, Oxygen saturation 99%, Temperature 37.4. There was no respiration rate or blood pressure documented.</p> <p>At 11:00 am there was an oxygen saturation documented of 100%. There was not blood pressure, respiration rate, pulse, or temperature documented.</p> <p>The next vitals were documented at 12:00 pm, 4 hours from the last complete set of vitals. There was no documentation in the nursing flowsheets or nurse notes that documented the patient was assessed during these 4 hours after a transfusion reaction was called. The vital signs at 12:00 pm</p> | A 409 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 450076 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED C 05/17/2019 |
|--|--|---|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER UNIVERSITY OF TEXAS M D ANDERSON CANCER CENTER, THE | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1515 HOLCOMBE BLVD HOUSTON, TX 77030 | | |
| (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) COMPLETION DATE | |
| A 409 | <p>Continued From page 66</p> <p>were Blood pressure 117/56, Pulse 90, Respiration 19, Oxygen Saturation 95% (5% lower than the 11:00 am vitals), Temperature 37.4 C.</p> <p>5-2-2019 RBC Transfusion</p> <p>The physician order dated 5-2-2019 was to transfuse RBC over 3 hours. The RBC transfusion was initiated 5-2-2019 at 2:02 am. The transfusion was completed 5-2-2019 at 4:10 am. The transfusion was completed over 1 hour faster than ordered by the physician. The vital signs noted in the record at 2:02 am (start of the transfusion) were Blood Pressure 111/67, Pulse 84, Respiration 18, Temperature 36.8 C. No Oxygen saturation was documented. An Oxygen saturation was documented at 2:18 am that was 97% on room air</p> <p>The next set of vital signs were documented at 4:25 a, over 2 hours later... The vital signs were Blood Pressure 119/75, Pulse 59, Respiration 16, Pulse 59 (almost 30 beats per minute lower than 2:02 am reading), Oxygen Saturation 97% room air. There was no documentation in the chart that the physician was notified of the lower pulse rate/change in patient's condition.</p> <p>5-2-2019 Platelet Transfusion</p> <p>The physician order dated 5-2-2019 was to "Transfuse Platelets". The order duration was "Gravity Drip". There was no documentation in the record to indicate that the nurse called the ordering provider to clarify the duration of the transfusion. The platelet transfusion was started on 5-2-2019 at 11:01 am and was completed on 5-2-2019 at 11:50 am. The platelets were given at 75 ml hour. The duration rate was set by the</p> | A 409 | | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/30/2019
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 450076 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED C 05/17/2019 |
|--|--|---|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER UNIVERSITY OF TEXAS M D ANDERSON CANCER CENTER, THE | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1515 HOLCOMBE BLVD HOUSTON, TX 77030 | | |
| (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) COMPLETION DATE | |
| A 409 | <p>Continued From page 67</p> <p>nurse and the blood administration was started without clarifying the duration rate with the ordering provider.</p> <p>Patient #6</p> <p>Patient #6 was a 61-year-old year old female admitted on 3-1-2019. Patient #6 received platelets on 3-9-2019 at 3:21 PM. The physician order dated 3-9-2019 at 11:43 am was to "Transfuse Platelets". The order duration was "Gravity Drip". There was no documentation in the record to indicate that the nurse called the ordering provider to clarify the duration of the transfusion. The platelet transfusion was started on 3-9-2019 at 3:21 pm and was completed on 3-9-2019 at 5:00 pm. The platelets were given at 75 ml hour. The duration rate was set by the nurse and the blood administration was started without clarifying the duration rate with the ordering provider.</p> <p>There were no initial vital signs documented in the record prior to the blood transfusion was started. On 3-9-2019 at 3:36 pm vital signs were Blood pressure 128/77, Pulse 72, Respiration 18, Oxygen Saturation 97%, Temperature 36.9 C.</p> <p>The next set of vital signs were documented at 5:30 pm, over 2 hours later. The vital signs at 5:30 pm were Blood Pressure 141/80, Pulse 71, Respirations 18, Oxygen Saturation 99%, Temperature 36.9 C. There was no documentation in the chart of any assessment done on the patient while the blood transfusion was infusing.</p> | A 409 | | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/30/2019
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 450076 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED C 05/17/2019 |
|--|---|---|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER UNIVERSITY OF TEXAS M D ANDERSON CANCER CENTER, THE | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1515 HOLCOMBE BLVD HOUSTON, TX 77030 | | |
| (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) COMPLETION DATE | |
| A 409 | Continued From page 68 Patient #12 Patient #12 was an 81-year-old male with a history of squamous cell carcinoma of lung who was admitted for anemia on 3-6-2019. Patient #12 received Red Blood Cells on 3-10-2019 at 3:49 AM. The physician order read "Transfuse RBC". The duration time for the transfusion was listed as 4 hours. The transfusion was started on 3-10-2019 at 3:49 pm. The transfusion was completed on 3-10-2019 at 8:05 pm. At 3:49 pm on 3-10-2019 vital signs were Blood Pressure 118/59, Pulse 78, Respirations 14, Temperature 36.7 C, No Oxygen Saturation was noted. At 4:05 pm on 3-10-2019 vital signs were Blood Pressure 124/61, Pulse 76, Respirations 16, Temperature 36.9 C. No Oxygen Saturation was noted. At 7:35 pm on 3-10-2019, over 3 ½ hours later vital signs were Blood Pressure 133/68, Pulse 76, Respirations 18, Oxygen Saturation was 92% on Nasal Cannula, 2 LPM (Liters per minute). Breath Sounds were noted as bilateral diminished. There was no documentation in the medical record that addressed the change in patient condition. There was no documentation that the provider was notified of the patient change in condition. Transfusion was continued. At 8:00 pm on 3-10-2019 vital signs were Pulse 79, Respirations 18, Oxygen 92% Nasal Cannula 2 LPM, Bilateral diminished breath sounds. There was no additional documentation on change in patient condition. Transfusion was continued. | A 409 | | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/30/2019
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 450076 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED C 05/17/2019 |
|--|--|---|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER UNIVERSITY OF TEXAS M D ANDERSON CANCER CENTER, THE | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1515 HOLCOMBE BLVD HOUSTON, TX 77030 | | |
| (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) COMPLETION DATE | |
| A 409 | Continued From page 69 At 8:14 pm on 3-10-2019 vital signs were Pulse 78, Respirations 18, Breath sounds were noted as bilateral diminished. Transfusion was continued. At 8:05 on 3-10-2019 pm transfusion was completed. At 8:20 pm on 3-10-2019 vital signs were Blood Pressure 142/72, Pulse 81, Respirations 18. Temperature 36.9 C, Oxygen Saturation was 93% on Nasal Canula 2 LPM. At 9:40 pm Patient #2 complained of chills. Assessment flow sheet indicates the Mid-Level provider was notified and waiting for response. Blood transfusion reaction form was initiated, 2 hours after change in status was noted in Epic vital sign flowsheet. Patient was given Tylenol 650 mg by mouth. At 11:01 pm on 3-10-2019 vital signs were Blood Pressure 126/60, Pulse 97, Respirations 26, Oxygen 83% Nasal Cannula, Temperature 38.2 C. At 11:15 pm on 3-10-2019 at 11:15 pm vital signs were pulse 95, Oxygen Saturation 93%. Patient was placed on Non-Breather Mask. There was a progress noted from FNP (Family Nurse Practitioner) noting chills and desaturation after transfusion. At 11:35 pm on 3-10-2019 vital signs were Pulse 101, Respirations 22, No Blood Pressure or Pulse rate were noted. At 12:10 on 3-11-2019 vital signs were Blood | A 409 | | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/30/2019
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 450076 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED C 05/17/2019 |
|--|--|---|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER UNIVERSITY OF TEXAS M D ANDERSON CANCER CENTER, THE | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1515 HOLCOMBE BLVD HOUSTON, TX 77030 | | |
| (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) COMPLETION DATE | |
| A 409 | <p>Continued From page 70</p> <p>Pressure 104/55, Pulse 94, Respirations 20, Oxygen Saturation 97% Non-Rebreather Mask, Temperature 37.1 C.</p> <p>At 3:59 am on 3-11-2019, almost 4 hours later the next set of full vital signs were documented. Vital Signs were Blood Pressure 99/50, Pulse 81, Oxygen Saturation 91% on Nasal Cannula, Temperature 37.7 C. There was no additional documentation in the chart to show that Patient # 12 was assessed during this 4 hours period after a change in status and Transfusion reaction was noted and reported.</p> <p>Patient #33</p> <p>Patient #33 was a 75-year-old male admitted on 4/28/2019 for hypotension and hypokalemia with a history of leukocytosis and thrombocytosis since March 2017.</p> <p>The physician order on 4-30-2019 read, "Transfuse platelets". The transfusion duration time was noted as "Gravity Drip". There was no documentation in the record to indicate that the nurse called the ordering provider to clarify the duration of the transfusion. The platelet transfusion was started on 4-30-2019 at 11:47 am and was completed on 4-30-2019 at 1:06 pm. The platelets were given at 200 ml hour. The duration rate was set by the nurse and the blood administration was started without clarifying the duration rate with the ordering provider.</p> <p>At 11:45 am on 4-30-2019 vital signs were Blood Pressure 138/76, Pulse 53, Respirations 19, Oxygen Saturation 97% room air, Temperature 36.9 C.</p> | A 409 | | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/30/2019
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 450076 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED C 05/17/2019 |
|--|---|---|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER UNIVERSITY OF TEXAS M D ANDERSON CANCER CENTER, THE | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1515 HOLCOMBE BLVD HOUSTON, TX 77030 | | |
| (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) COMPLETION DATE | |
| A 409 | <p>Continued From page 71</p> <p>At 12:15 pm on 4-30-2019 vital signs were Blood Pressure 140/79, Pulse 54, Respiration 20, Oxygen Saturation 98% on room air.</p> <p>At 1:06 pm on 4-30-2019 vital signs were Blood Pressure 170/87, Pulse 55, Respiration 18, Oxygen Saturation 96% on room air. Transfusion was stopped at 1:06 pm, patient was noted to have hives. The transfusion reaction form was initiated. The transfusion reaction form noted the physician was notified at 1:10 pm. The blood bank was notified at 1:15 pm.</p> <p>At 4:59 pm on 4-30-2019, almost 4 hours later the next set of vital signs were documented. The vitals at 4:59 were Blood Pressure 156/77, Pulse 62, Respirations 20, Oxygen Saturation 96%, Temperature 36.7 C.</p> <p>There was no additional documentation in the chart to show that Patient # 12 was assessed during this 4-hour period after a change in status and Transfusion reaction was noted and reported.</p> <p>Staff # 21 confirmed the above findings.</p> <p>During interviews on 5-13-2019 after 10:00 AM the following was revealed:</p> <p>Staff #17 said, vital sign for blood transfusions are required to be done Pre-Transfusion (No more than 30 minutes), 15 minutes after blood transfusion is started, and at completion of blood transfusion. (No more than 30 minutes).</p> <p>Staff #38 said, prior to starting the transfusion</p> | A 409 | | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/30/2019
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 450076 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED C 05/17/2019 |
|--|--|---|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER UNIVERSITY OF TEXAS M D ANDERSON CANCER CENTER, THE | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1515 HOLCOMBE BLVD HOUSTON, TX 77030 | | |
| (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) COMPLETION DATE | |
| A 409 | <p>Continued From page 72</p> <p>vital signs should be taken and documented, check blood product with two RN's, stay in the room 15 minutes after initiating the transfusion to assess the patient for reactions, check the vital signs after completion and document on the Blood Transfusion Report and vital sign flow sheet.</p> <p>Staff # 2 said, if a patient has a blood transfusion reaction the nurse is required to document the vital signs, stop the transfusion, stay with the patient to document reaction, send blood and urine to lab, initiate the Blood Transfusion reaction form. Staff #2 said the Epic system will alert you to abnormal vital signs by highlighting them in red and putting an exclamation point next to the abnormal. Staff #2 said the nurse is required to respond to the alert and document the abnormal vital sign and any response or reaction to the abnormal value.</p> <p>Staff #15 said, Vitals are required to be taken every hour. During a Blood transfusion vitals are required within 30 minutes prior to start, 15-30 minutes after initiation of the transfusion, and every 4 hours after that. Staff #15 said there are no requirements for documentation of assessment/vital signs during the blood transfusion.</p> <p>Staff #41 said, vital signs are required to be taken 30 minutes prior to initiating of blood transfusion, 15 minutes after start of transfusion, and post transfusion.</p> <p>An interview was conducted with RN #14 and Staff #27, RN, on 5/13/19 at approximately 11:15 am on Unit P-12. When asked how a nurse would detect a potential transfusion reaction in a patient, Staff #27 stated, "We educate the patients about</p> | A 409 | | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/30/2019
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 450076 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED C 05/17/2019 |
|--|---|---|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER UNIVERSITY OF TEXAS M D ANDERSON CANCER CENTER, THE | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1515 HOLCOMBE BLVD HOUSTON, TX 77030 | | |
| (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) COMPLETION DATE | |
| A 409 | <p>Continued From page 73</p> <p>the transfusion. Patients know to call." RN #14 stated, "Vital signs are 30 minutes before, 15 to 30 minutes after the start of the transfusion, and 30 minutes after the transfusion is finished and nurses do rounds." Staff #27 confirmed that vital signs are only taken as above unless the patient notifies the nurse of symptoms such as "fever, back pain, or chest pain or something like that."</p> <p>An interview was conducted with RN #23 on 5/13/19 at approximately 1:33 pm on Unit G-15. When asked how a nurse would detect a potential transfusion reaction in a patient, RN #23 stated, "If the patient complains of chills, itching, hives, fever, post transfusion or during. We give them education, talking to the patient. Most of the patients have had transfusions before. We educate them and their family members to notify us if they have any symptoms." RN #23 confirmed that vital signs are only taken within 30 minutes before starting a transfusion, within 30 minutes after starting a transfusion, and within 30 minutes after the transfusion has ended unless a patient or family member notifies the nurse they are having symptoms. When asked if patient assessments are documented in the medical record, RN #23 stated, "Yes."</p> <p>An interview was conducted with RN #24 on 5/13/19 at approximately 2:14 pm on Unit G-15. When asked how a nurse would detect a potential transfusion reaction in a patient, RN #24 stated, "We ask if a patient had a previous reaction...we check the vital signs before we start the transfusion, we stay with the patient for 15 minutes and recheck the vital signs. We educate the patient for anything unusual, if there are chills, fever, anaphylaxis, itching, to let the nurse know. Then we would check the vital signs. If there is</p> | A 409 | | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/30/2019
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 450076 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED C 05/17/2019 |
|--|--|---|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER UNIVERSITY OF TEXAS M D ANDERSON CANCER CENTER, THE | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1515 HOLCOMBE BLVD HOUSTON, TX 77030 | | |
| (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) COMPLETION DATE | |
| A 409 | <p>Continued From page 74</p> <p>any temperature, rashes, chills, if they are asking for a warm blanket, I would check the temperature ...vital signs are checked 3 times for a blood transfusion if there is no reaction." When asked how a nurse would monitor a patient that could not communicate or did not appear to understand, RN #24 stated they would monitor the patient more closely. When asked if the nurse would document any assessment of a patient during a blood transfusion, RN #24 stated that it would be documented in the medical record.</p> <p>An interview was conducted with RN #25 on 5/13/19 at approximately 2:40 pm on Unit G-15. When asked how a nurse would detect a potential transfusion reaction in a patient, RN #25 stated that vital signs are taken 30 minutes before, 15 minutes after, and 30 minutes after the end of the transfusion. RN #25 stated, " If there is a change in status, if there is a fever, shortness of breath, itching, skin rash, we do quick vital signs and notify the doctor and the blood bank."</p> <p>An interview was conducted with RN #33 on 5/13/19 at approximately 2:14 pm on Unit G-15. When asked how a nurse would detect a potential transfusion reaction in a patient, RN #33 stated, "Watch for reaction, especially if they have had numerous transfusions in the past. Short of breath, chills, rashes, flank pain." When asked about vital signs, RN #33 stated, "Vital signs 30 minutes before, 15 minutes after starting, and after completing within 30 minutes." When asked if additional vital signs would be taken, as the transfusion could last up to 4 hours, RN #33 stated, "We don't take vital signs unless the patient is manifesting symptoms." RN #33 stated that patients are monitored during the transfusion. When asked if the monitoring</p> | A 409 | | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/30/2019
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 450076 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED C 05/17/2019 |
|--|---|---|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER UNIVERSITY OF TEXAS M D ANDERSON CANCER CENTER, THE | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1515 HOLCOMBE BLVD HOUSTON, TX 77030 | | |
| (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) COMPLETION DATE | |
| A 409 | <p>Continued From page 75</p> <p>was documented in the patient record, RN #33 confirmed that assessments are documented in the medical record.</p> <p>Patient #14</p> <p>The medical record for Patient #14, who received blood and blood product transfusions, was reviewed the afternoon of 5/16/19 with RN #12 in the administrative conference room.</p> <p>Blood Product Administration Module: Transfuse platelets, 95 mL transfused Transfusion duration per unit (hrs): 2 Start 5/2/19 at 1640 End 5/2/19 at 1902</p> <p>5/2/19 1633 BP 149/67 Temp 36.6 C/97.9F Pulse 107! Resp 16 SpO2 95%</p> <p>Platelets started at 1640.</p> <p>5/2/19 1700 BP 139/67 Temp 36.2 C/97.5F Pulse 102! Resp 16 SpO2 97%</p> <p>Platelets stopped at 1902.</p> <p>5/2/19 1902 BP 137/67 Temp 36.4 C/97.5 F</p> | A 409 | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 450076 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED C 05/17/2019 |
|--|---|---|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER UNIVERSITY OF TEXAS M D ANDERSON CANCER CENTER, THE | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1515 HOLCOMBE BLVD HOUSTON, TX 77030 | | |
| (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) COMPLETION DATE | |
| A 409 | <p>Continued From page 76</p> <p>Pulse 97 Resp 16 SpO2 Not documented</p> <p>5/2/19 1925 BP 134/68 Temp 36.4 C/97.6 F Pulse 92 Resp 18 SpO2 96%</p> <p>There were no documented vital signs for Patient #14 during the transfusion for over 2 hours, between 1700 and 1902, despite a flagged, elevated pulse. There was a nursing note on 5/2/19 at 1759 which stated "Pt [patient] alert and oriented x3 ...1 unit of platelet receiving ..."</p> <p>There was a nursing note on 5/2/19 at 2038 regarding PICC insertion [Peripherally Inserted Central venous Catheter] to right arm, however there was no mention of the platelet transfusion or vital sign assessment.</p> <p>Patient #14 had an order to transfuse platelets with a 2 hour transfusion duration per unit. Review of the Single Transfusion Record revealed that the unit was started on 5/2/19 at 1640 and ended on 5/2/19 at 1902. There was no documentation in the record stating why the blood products were not infused at the duration specified in the physician order and the transfusion duration was over 2 hours and 20 minutes. The order was not clarified and the physician was not notified.</p> <p>Review of facility event reporting revealed a reported filed on 5/2/19 at 2100 which stated, "Patient had new right arm PIV this afternoon for</p> | A 409 | | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/30/2019
FORM APPROVED
OMB NO. 0938-0391

| | | | | |
|--|---|--|---|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 450076 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED C 05/17/2019 |
| NAME OF PROVIDER OR SUPPLIER UNIVERSITY OF TEXAS M D ANDERSON CANCER CENTER, THE | | STREET ADDRESS, CITY, STATE, ZIP CODE 1515 HOLCOMBE BLVD HOUSTON, TX 77030 | | |
| (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) COMPLETION DATE |
| A 409 | <p>Continued From page 77</p> <p>blood transfusion. 1 unit of platelet infusion started at 1640 per MD order, assessed site and reaction at 1700 and 1745. Patient started having pain on site and son called me for assessment. Found out infiltration at 1902, vital sign stable, bruising on infiltrated site. Stopped infusion immediately, discontinue IV, and warm compress on site. Reported to night shift nurse, [name] RN. [Name] notified to nocturnal doctor."</p> <p>Review of the medical record on 5/16/19 with RN #12 revealed no documentation of the infiltration of the peripheral IV and the immediate discontinuation of the platelet infusion on 5/2/19. There was no documentation in the medical record that the physician was notified of the infiltration or the incomplete platelet transfusion. There was no documentation of a physician note in the medical record.</p> <p>A second blood administration record was reviewed for Patient #14: Blood Product Administration Module: Transfuse RBC 346.67 mL Transfusion duration per unit (hrs): 1 Start 5/4/19 1655 End 5/4/19 2023</p> <p>5/4/19 1640 BP 125/66 Temp 36.4 C/97.6 F Pulse 95 Resp 20 SpO2 95%</p> <p>RBC started 1655</p> <p>5/4/19 1716 BP 134/72 Temp 36.2 C/97.1 F</p> | A 409 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 450076 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED C 05/17/2019 |
|--|--|---|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER UNIVERSITY OF TEXAS M D ANDERSON CANCER CENTER, THE | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1515 HOLCOMBE BLVD HOUSTON, TX 77030 | | |
| (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) COMPLETION DATE | |
| A 409 | <p>Continued From page 78</p> <p>Pulse 105! Flagged Resp 18 SpO2 96%</p> <p>5/4/19 1835 Nursing Note "Patient alert and oreanted (sic), receiving one unit of blood now ..."</p> <p>5/4/19 2010 Respiratory Assessment documented.</p> <p>RBC stopped 2023</p> <p>5/4/19 2053 BP 130/63 Temp 36.4 C/97.6 F Pulse 99 Resp 17 SpO2 94%</p> <p>There were no documented vital signs for Patient #14 during the transfusion after a flagged, elevated pulse was documented at 1716. The pulse was not rechecked until 2035, over 3 hours later and after the transfusion had ended.</p> <p>There was no documented assessment for Patient #14 during the transfusion for 1 hour and 35 minutes, between 1835 and 2010, which was confirmed by RN #12 during the record review.</p> <p>Patient #14 had an order to transfuse RBCs with a 1 hour transfusion duration per unit on 5/2/19. Review of the Single Transfusion Record revealed that the unit was started on 5/2/19 at 1655 and ended on 5/2/19 at 2023. There was no documentation in the record to clarify the order or stating why the transfusion duration was approximately 3 hours and 20 minutes, or notification of the physician. The above findings</p> | A 409 | | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/30/2019
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 450076 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED C 05/17/2019 |
|--|---|---|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER UNIVERSITY OF TEXAS M D ANDERSON CANCER CENTER, THE | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1515 HOLCOMBE BLVD HOUSTON, TX 77030 | | |
| (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) COMPLETION DATE | |
| A 409 | <p>Continued From page 79 for Patient #14 was confirmed by RN #12 the afternoon of 5/15/19 in the administrative conference room during the medical record review.</p> <p>Patient #29</p> <p>The medical record for Patient #29, who received a blood transfusion on 3/21/19, was reviewed the afternoon of 5/15/19 with RN #12 in the administrative conference room.</p> <p>Blood Product Administration Module: Transfuse RBC, (mL transfused amount was not documented) Transfusion duration per unit (hrs): 2 Start 3/21/19 at 1815 End 3/21/19 at 2030</p> <p>Blood Administration monitoring: 3/21/19 at 1812 BP 130/69 Temp 36.6 C/97.9 F Pulse 80 Resp 18 SpO2 Not documented</p> <p>The RBC transfusion started at 1815 and was completed at 2030.</p> <p>There were no vital signs taken after the blood transfusion was initiated or during the blood transfusion for Patient #29. There was no documented evidence of patient monitoring for signs and symptoms of a transfusion reaction during the first 15-30 minutes from initiation of the transfusion.</p> <p>The patient developed a fever during the</p> | A 409 | | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/30/2019
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 450076 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED C 05/17/2019 |
|--|--|---|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER UNIVERSITY OF TEXAS M D ANDERSON CANCER CENTER, THE | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1515 HOLCOMBE BLVD HOUSTON, TX 77030 | | |
| (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) COMPLETION DATE | |
| A 409 | <p>Continued From page 80</p> <p>transfusion, which was not detected, assessed and was without intervention until the temperature had increased 1.9° C from the pre-transfusion temperature. Per policy, signs of a suspected acute transfusion reaction onset include "Fever (increase 1°C or more from baseline temperature) ..."</p> <p>There were no vital signs taken until after the RBC transfusion was stopped at 2030, 2 hours and 18 minutes later. At the end of the transfusion at 2030 when vital signs were taken, the patient's temperature was 38.5 C/101.3 F (1.9° C increase).</p> <p>Nursing note at 2314 stated, "Patient was admitted for 2unit of blood transfusion. The first unit was completed at 2030 hours.temperature 38.5.Called (sic) ATC on call NP [name]. Who kindly seen the patient in ATC. She suggested patient need to go to ED. So the patient was set to ED ...ED MD suggested all possible c/s work to initiate in Emergency department.Patient (sic) was transferred to ED." A Transfusion Medicine Consultation was subsequently initiated and completed.</p> <p>There was no means to determine when symptoms consistent with a potential acute transfusion reaction developed, as there was no documented patient assessment for over 2 hours during the transfusion and vital signs were not assessed until after the transfusion was completed.</p> <p>The above findings for Patient #29 were confirmed during the record review with RN #12 at approximately 2:30 pm on 5/15/19, who stated, "There were no other vital signs documented. You can't see them in the medical record because it</p> | A 409 | | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/30/2019
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 450076 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED C 05/17/2019 |
|--|---|---|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER UNIVERSITY OF TEXAS M D ANDERSON CANCER CENTER, THE | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1515 HOLCOMBE BLVD HOUSTON, TX 77030 | | |
| (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) COMPLETION DATE | |
| A 409 | Continued From page 81 wasn't documented." Patient #28 The medical record for Patient #28, who received blood and blood product transfusions, was reviewed the afternoon of 5/15/19 with RN #12 in the administrative conference room. Blood Product Administration Module: Transfuse RBC, 353 mL transfused Transfusion duration per unit (hrs): 2 Start 3/14/19 1555 End 3/14/19 1815 Blood Administration monitoring: 3/14/19 at 1548 BP 106/63 Temp 36.8 C/98.2 F Pulse 97 Resp 20 SpO2 Not documented RBC transfusion started at 1555 3/14/19 at 1605 BP 103/65 Temp 36.8 C/98.2 F Pulse 93 Resp 20 SpO2 Not documented RBC stopped at 1815 3/14/19 at 1815 BP 112/71 Temp 36.8 C/98.2 F Pulse 90 | A 409 | | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/30/2019
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 450076 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED C 05/17/2019 |
|--|---|---|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER UNIVERSITY OF TEXAS M D ANDERSON CANCER CENTER, THE | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1515 HOLCOMBE BLVD HOUSTON, TX 77030 | | |
| (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) COMPLETION DATE | |
| A 409 | <p>Continued From page 82</p> <p>Resp 18 SpO2 Not documented</p> <p>There was no documented assessment and no vital signs taken for 2 hours and 10 minutes during the transfusion between 1605 and 1815. The above findings were confirmed afternoon of 5/15/19 with RN #12 in the administrative conference room.</p> <p>A second blood administration record was reviewed for Patient #28: Blood Product Administration Module: Transfuse RBC, mL transfused amount was not documented Transfusion duration per unit (hrs): 2 Start 3/14/19 1835 End 3/14/19 2025</p> <p>Blood Administration monitoring: 3/14/19 at 1825 BP 119/71 Temp 36.7 C/98.1 F Pulse 94 Resp 20 SpO2 Not documented</p> <p>RBC transfusion started at 1835</p> <p>3/14/19 at 1850 BP 120/80 Temp 36.7 C/98.1 F Pulse 94 Resp 20 SpO2 Not documented</p> <p>The RBC transfusion was stopped at 2025. Nursing note stated, "2025: Blood stopped. Patient having c/o shaking and chills. Notified on</p> | A 409 | | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/30/2019
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 450076 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED C 05/17/2019 |
|--|--|---|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER UNIVERSITY OF TEXAS M D ANDERSON CANCER CENTER, THE | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1515 HOLCOMBE BLVD HOUSTON, TX 77030 | | |
| (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) COMPLETION DATE | |
| A 409 | <p>Continued From page 83</p> <p>call waiting for response." A Transfusion Medicine Consultation was subsequently initiated and completed.</p> <p>There were no vital signs or documented nursing assessment for 1 hour and 50 minutes, between 1835 and 2025. Patient #28 complained of shaking and chills at 2025.</p> <p>There was no means to determine when Patient #28 began having these symptoms of a potential transfusion reaction as there was no documented nursing assessment during the transfusion. Per hospital policy, signs of a suspected acute transfusion reaction onset include "Persistent chills that do not respond to supportive measures, often but not always associated with fever ..."</p> <p>The total volume of blood component transfused was not documented in the "Single Blood Transfusion" record for Patient #28.</p> <p>The above findings for Patient #28 were confirmed the afternoon of 5/15/19 with RN #12 in the administrative conference room.</p> <p>Patient #32</p> <p>The medical record for Patient #32, who received blood and blood product transfusions, was reviewed the morning of 5/15/19 with RN #12 in the administrative conference room.</p> <p>Blood Product Administration Module: Transfuse RBC, 215 mL transfused Transfusion duration per unit (hrs): 2 Start 5/14/19 at 1215 End 5/14/19 at 1500</p> | A 409 | | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/30/2019
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 450076 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED C 05/17/2019 |
|--|---|---|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER UNIVERSITY OF TEXAS M D ANDERSON CANCER CENTER, THE | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1515 HOLCOMBE BLVD HOUSTON, TX 77030 | | |
| (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) COMPLETION DATE | |
| A 409 | Continued From page 84 5/14/19 12:08 BP 119/58 Temp 36.4 C/97.5 F Pulse 88 Resp 16 SpO2 100% The RBC transfusion started at 12:15 5/14/19 12:40 BP 123/62 Temp 36.8 C/98.2 F Pulse 90 Resp 16 SpO2 98% The RBC transfusion stopped at 1500 5/14/19 15:10 BP 161/78! Temp 37 C/98.6 F Pulse 82 Resp 18 SpO2 100% Review of blood pressures for Patient #32 on 5/14/19 revealed the following: 1208 - 119/58 1240 - 123/62 1510 - 161/78 Flagged! 1724 - 147/82 Comment: BP: bp re-check at 05/14/19 1724 1901 - 166/85 Flagged! 5/15/19 0018 - 141/70 There was no documented evidence that Patient #32 was assessed during the blood transfusion | A 409 | | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/30/2019
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 450076 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED C 05/17/2019 |
|--|--|---|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER UNIVERSITY OF TEXAS M D ANDERSON CANCER CENTER, THE | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1515 HOLCOMBE BLVD HOUSTON, TX 77030 | | |
| (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) COMPLETION DATE | |
| A 409 | <p>Continued From page 85</p> <p>between 1240 and 1510, over 2 1/2 hours. The blood pressure for Patient #32 was flagged as abnormal at 1510. There was no blood pressure recheck until 1724, which was 2 hours and 14 minutes after the abnormal blood pressure was flagged.</p> <p>Nursing note on 5/14/19 at 1850 for Patient #32 stated, in part, "Pt AOx4. VSS on RA. Afebrile. SBP >16- x1; Resolved w/o intervention. Hgb=7.7; 1 unit RBCs given."</p> <p>At 1901, Patient #32 had another abnormal blood pressure flagged. There was no documentation that Patient #32 was assessed or that blood pressure was rechecked until 0018, over 4 hours after the flagged, elevated blood pressure. An interview was conducted with RN #12 during the record review, who confirmed there was no entry in the medical record for over 4 hours after a flagged, abnormal blood pressure.</p> <p>The blood transfusion duration was ordered for 2 hours per unit. The blood was transfused between 1215 and 1500, which was 2.75 hours. There was no documented evidence in the medical record stating why the RBCs were transfused at a different duration than had been ordered or that the ordering physician was notified.</p> <p>An interview was conducted with RN #12 during the record review morning of 5/15/19 in the administrative conference room, who confirmed the above findings and stated, "There should have been a note, she should have rechecked the vitals." RN #12 confirmed there was no documented provider notification of the abnormal vital signs or the transfusion duration change.</p> | A 409 | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 450076 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED C 05/17/2019 |
|--|---|---|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER UNIVERSITY OF TEXAS M D ANDERSON CANCER CENTER, THE | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1515 HOLCOMBE BLVD HOUSTON, TX 77030 | | |
| (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) COMPLETION DATE | |
| A 409 | <p>Continued From page 86</p> <p>On 4/6/19, Patient #32 had an order to transfuse RBC with a 2 hour transfusion duration per unit. Review of the Single Transfusion Record revealed that the unit was started on 4/6/19 at 0456 and ended on 4/6/19 at 0800, a duration of greater than 3 hours.</p> <p>Nursing note at 0601 on 4/6/19 stated "1 unit of PRBCs ordered and transfusing now" however there was no further documentation stating why the RBCs were transfused at a different duration than was ordered.</p> <p>There was no documentation that the ordering physician was notified or the order clarified.</p> <p>During the record review, RN #12 confirmed there was no documented provider notification of the transfusion duration change.</p> <p>Patient #24</p> <p>The medical record for Patient #24, who received blood and blood product transfusions, was reviewed the morning of 5/15/19 with RN #12 in the administrative conference room.</p> <p>Review of the medical record for Patient #24 revealed an order to "Transfuse platelets" on 5/13/2019. The "Transfusion duration per unit (hrs)" was documented as "Gravity Drip"; there was no duration of infusion in the order. Documentation reflected that the unit was transfused over one hour, between 0710 and 0810.</p> <p>Subsequent transfusion records for Patient #24 were reviewed with RN #12.</p> | A 409 | | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/30/2019
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 450076 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED C 05/17/2019 |
|--|---|---|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER UNIVERSITY OF TEXAS M D ANDERSON CANCER CENTER, THE | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1515 HOLCOMBE BLVD HOUSTON, TX 77030 | | |
| (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) COMPLETION DATE | |
| A 409 | Continued From page 87 Blood Product Administration Module: Transfuse RBC, 306 mL transfused Transfusion duration per unit (hrs): 3 Start 5/13/19 1040 End 5/13/19 1300 Blood Administration monitoring: 5/13/19 at 1023 BP 121/60 Temp 36.4 C/97.5 F Pulse 76 Resp 18 SpO2 99% RBC transfusion started at 1040. 5/13/19 at 1100 BP 125/60 Temp 36.7 C/98.1 F Pulse 78 Resp 19 SpO2 100% RBC transfusion stopped at 1300. 5/13/19 at 1325 BP 128/60 Temp 36.7 C/98.1 F Pulse 80 Resp 19 SpO2 99% There was no documented assessment between 1100 and the time the RBC transfusion was ended at 1300, there were no vital signs taken for 2 hours and 25 minutes during the transfusion, between 1100 and 1325. There was no means to determine that Patient | A 409 | | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/30/2019
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 450076 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED C 05/17/2019 |
|--|---|---|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER UNIVERSITY OF TEXAS M D ANDERSON CANCER CENTER, THE | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1515 HOLCOMBE BLVD HOUSTON, TX 77030 | | |
| (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) COMPLETION DATE | |
| A 409 | <p>Continued From page 88 #24 was monitored during the transfusion.</p> <p>Blood Product Administration Module: Transfuse RBC, 375 mL transfused Transfusion duration per unit (hrs): 3 Start 5/14/19 1330 End 5/14/19 1610</p> <p>5/14/19 at 1320 BP 109/53 Temp 36.4 C/97.5 F Pulse 70 Resp 16 SpO2 94%</p> <p>RBC transfusion started at 1330.</p> <p>5/14/19 at 1345 BP 127/60 Temp 36.3 C/97.3 F Pulse 71 Resp 18 SpO2 97%</p> <p>RBC stopped at 1610.</p> <p>5/14/19 at 1632 BP 126/65 Temp 36.3 C/97.3 F Pulse 75 Resp 15 SpO2 96%</p> <p>There was no assessment or vital signs documented during the transfusion for 2 hours and 47 minutes, between 1345 and 1632. There was no means to determine that Patient #24 was monitored during the transfusion.</p> | A 409 | | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/30/2019
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 450076 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED C 05/17/2019 |
|--|---|---|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER UNIVERSITY OF TEXAS M D ANDERSON CANCER CENTER, THE | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1515 HOLCOMBE BLVD HOUSTON, TX 77030 | | |
| (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) COMPLETION DATE | |
| A 409 | <p>Continued From page 89</p> <p>Blood Product Administration Module: Transfuse RBC, 357.5 mL transfused Transfusion duration per unit (hrs): 3 Start 5/14/19 1735 End 5/14/19 2020</p> <p>5/14/19 at 1731 BP 128/62 Temp 36.3 C/97.3 F Pulse 70 Resp 18 SpO2 Not documented</p> <p>RBC transfusion started at 1735.</p> <p>5/14/19 at 1750 BP 123/61 Temp 36.3 C/97.3 F Pulse 70 Resp 17 SpO2 97%</p> <p>RBC transfusion stopped at 2020.</p> <p>5/14/19 at 2030 BP 124/66 Temp 35.7 C/96.3 F Pulse 70 Resp 15 SpO2 94%</p> <p>There was no assessment or vital signs documented during the transfusion for 2 hours and 30 minutes, between 1750 and 2020. There was no means to determine that Patient #24 was monitored during the transfusion.</p> <p>The above findings for Patient #24 were confirmed the morning of 5/15/19 with RN #12 in</p> | A 409 | | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/30/2019
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 450076 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED C 05/17/2019 |
|--|--|---|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER UNIVERSITY OF TEXAS M D ANDERSON CANCER CENTER, THE | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1515 HOLCOMBE BLVD HOUSTON, TX 77030 | | |
| (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) COMPLETION DATE | |
| A 409 | <p>Continued From page 90 the administrative conference room.</p> <p>Patient #8</p> <p>The medical record for Patient #8, who received a blood transfusion, was reviewed the morning of 5/15/19 with RN #12 in the administrative conference room.</p> <p>Blood Product Administration Module: Transfuse RBC 683.5 mL Transfusion duration per unit (hrs): 2 Start 5/13/19 at 0627 End 5/13/19 at 0900</p> <p>5/13/19 0609 BP 110/70 Temp 36.7 C/98.1 F Pulse 64 Resp 17 SpO2 98%</p> <p>Vital signs were documented again at 0620 and 0627.</p> <p>The RBC transfusion started at 0627</p> <p>5/13/19 0642 BP 118/70 Temp 36.8 C/98.2 F Pulse 61 Resp 17 SpO2 100%</p> <p>The RBC transfusion stopped at 0900</p> <p>5/13/19 0909 BP 123/74</p> | A 409 | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 450076 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED C 05/17/2019 |
|--|---|---|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER UNIVERSITY OF TEXAS M D ANDERSON CANCER CENTER, THE | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1515 HOLCOMBE BLVD HOUSTON, TX 77030 | | |
| (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) COMPLETION DATE | |
| A 409 | <p>Continued From page 91</p> <p>Temp 36.9 C/98.4 F Pulse 75 Resp 19 SpO2 100%</p> <p>The shift report hand-off communication occurred at 0700, however there was no documented assessment or vital signs for Patient #8 during the transfusion for 2 hours, between 0700 and 0900. There was no means to determine that Patient #8 was monitored during the transfusion.</p> <p>The above findings for Patient #24 were confirmed the morning of 5/15/19 with RN #12 in the administrative conference room.</p> <p>Review of MD Anderson Institutional Policy #CLN1140, Patient Care Orders Policy with a publish date of 11-6-2017 Version #34 revealed the following:</p> <p>"7.0. Clarification and Modification of Orders.</p> <p>7.1 There are situations that require an HCP to communicate promptly with the Authorized Prescriber. The following include but are not limited to ...</p> <p>B. Orders that are incomplete, unclear, or illegible for handwritten orders ...</p> <p>7.2 Clarification of Orders is the responsibility of all Health Care Practitioners who provide patient care."</p> <p>Review of the MD Anderson Institutional Policy attachment for Blood Component Transfusion</p> | A 409 | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 450076 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED C 05/17/2019 |
|--|---|---|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER UNIVERSITY OF TEXAS M D ANDERSON CANCER CENTER, THE | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1515 HOLCOMBE BLVD HOUSTON, TX 77030 | | |
| (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) COMPLETION DATE | |
| A 409 | <p>Continued From page 92</p> <p>Administration Procedure with a revised date of 3-12-2019 revealed the following:</p> <p>"1.0 General Information: Administration of Blood Components 1.1 ...Omitting safety steps that are intended to prevent transfusion errors may result in a fatal life event for the patient ...</p> <p>1.3 Maximum transfusion time per unit of Packed Red Blood Cells (PRBCs) is four (4) hours, unless Ordered otherwise by an Authorized Provider or approved by a Transfusion Medicine Physician (TMP) ...</p> <p>8.0 Administration Initiate administration after the above instructions have been performed, then: ...</p> <p>8.8 First 15 minutes of transfusion:</p> <p>A. Monitor patient for signs and symptoms of Transfusion Reaction ...</p> <p>B. Reassess vital signs after fifteen (15) minutes (not to exceed 30 minutes) from initiation of blood transfusion.</p> <p>C. Note: If the patient is stable, increase the transfusion rate appropriate to blood component and patient status ...</p> <p>8.9 Continue to evaluate the patient for signs and symptoms of Transfusion Reaction and tolerance throughout the transfusion. Vital signs may be obtained more frequently, if clinically indicated ...</p> <p>8.10 At completion of blood component transfusion: ...</p> <p>C. Within thirty (30) minutes from completion of</p> | A 409 | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 450076 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED C 05/17/2019 |
|--|--|---|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER UNIVERSITY OF TEXAS M D ANDERSON CANCER CENTER, THE | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1515 HOLCOMBE BLVD HOUSTON, TX 77030 | | |
| (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) COMPLETION DATE | |
| A 409 | <p>Continued From page 93</p> <p>the transfusion, reassess patient, including:</p> <ul style="list-style-type: none"> - Vital signs. - Signs and symptoms of Transfusion Reaction ..." <p>10.0 Documentation</p> <p>10.1 The following should be documented in the medical record...</p> <p>C. Vital signs....</p> <p>E. Assessment, interventions, and evaluation.</p> <ul style="list-style-type: none"> - Patient's tolerance during the initial 15 minutes, and throughout the transfusion - Symptoms of Transfusion Reaction, if indicated. - of the transfusion and completion of the transfusion record. <p>Review of MD Anderson Institutional Policy # CLN0647, Nursing Documentation of Patient Care Policy with a Published date of 1-8-2016, Version #58 revealed the following:</p> <p>"It is the policy of The University of Texas MD Anderson Cancer Center (MD Anderson) that: Documentation is recorded in the medical record by the RN providing the care. All nursing team members who document in the medical record are accountable for the accuracy, legibility, readability, timeliness, accessibility and completeness of that documentation ...</p> <p>Procedure</p> <p>1.0 General Information and Collection of Information</p> <p>1.1 Subjective and objective data identifying patient problems/alterations, interventions/nursing actions, and responses/outcomes relative to</p> | A 409 | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 450076 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED C 05/17/2019 |
|--|---|--|---|---|
| NAME OF PROVIDER OR SUPPLIER UNIVERSITY OF TEXAS M D ANDERSON CANCER CENTER, THE | | STREET ADDRESS, CITY, STATE, ZIP CODE 1515 HOLCOMBE BLVD HOUSTON, TX 77030 | | |
| (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) COMPLETION DATE |
| A 409 | <p>Continued From page 94 patient problems should be documented ...</p> <p>3.0 Reassessment</p> <p>Reassessment of a patient should be documented:</p> <p>3.1 Prior to, during, and after a procedure or treatment, as indicated.</p> <p>3.2 Within an appropriate timeframe, such as within an hour, after an intervention for the evaluation of the effectiveness of the intervention ..."</p> <p>Review of the Standards of Nursing Practice, Texas Nurse Practice Act 217.11, states, in part,</p> <p>"(1) Standards Applicable to All Nurses. All vocational nurses, registered nurses and registered nurses with advanced practice authorization shall:</p> <p>(A) Know and conform to the Texas Nursing Practice Act and the board's rules and regulations as well as all federal, state, or local laws, rules or regulations affecting the nurse's current area of nursing practice;</p> <p>(B) Implement measures to promote a safe environment for clients and others;</p> <p>(C) Know the rationale for and the effects of medications and treatments and shall correctly administer the same;</p> <p>(D) Accurately and completely report and document:</p> | A 409 | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/30/2019
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 450076 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED C 05/17/2019 |
|--|---|---|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER UNIVERSITY OF TEXAS M D ANDERSON CANCER CENTER, THE | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1515 HOLCOMBE BLVD HOUSTON, TX 77030 | | |
| (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) COMPLETION DATE | |
| A 409 | Continued From page 95 (i) the client's status including signs and symptoms; (ii) nursing care rendered; (iii) physician, dentist or podiatrist orders; (iv) administration of medications and treatments; (v) client response(s); and (vi) contacts with other health care team members concerning significant events regarding client's status;" | A 409 | | | |
| A 576 | LABORATORY SERVICES CFR(s): 482.27 The hospital must maintain, or have available, adequate laboratory services to meet the needs of its patients. The hospital must ensure that all laboratory services provided to its patients are performed in a facility certified in accordance with Part 493 of this chapter. This CONDITION is not met as evidenced by: A. Based on record review and interviews, the hospital failed to ensure that the laboratory quality assurance activities were integrated into the hospital-wide QAPI program. Finding: A review of the laboratory policy "Division Quality Management Plan" (DIV QIP 0206, 08/01/2003) revealed: "This quality management plan provides for the | A 576 | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 450076 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED C 05/17/2019 |
|--|--|---|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER UNIVERSITY OF TEXAS M D ANDERSON CANCER CENTER, THE | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1515 HOLCOMBE BLVD HOUSTON, TX 77030 | | |
| (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) COMPLETION DATE | |
| A 576 | <p>Continued From page 96</p> <p>continuous monitoring and evaluation of every aspect of the services provided by the Departments of Hematopathology, Pathology, and Laboratory medicine. The purpose of the Quality Management Plan is to identify, evaluate and resolve problem in the pre-analytic, analytic, and post-analytic processes and in information management in all sections of all departments.</p> <p>The Division of Pathology and Laboratory Medicine's management plan is overseen by the Quality Council. The Council consists of the Section Chief of Quality, the Division Administrator, the Director of Clinical Operations, the Department Administrators for each department, the Laboratory Managers for each section, the Clinical Administrative Director, the Quality Director, the Coordinator of Transfusion Medicine and the Coordinator of Quality and Regulatory Management.</p> <p>The Quality Council meets quarterly to discuss quality indicators and any other quality improvement actions that need to be addressed. The quality program is shared with the managers to incorporate all aspects into the daily operation."</p> <p>In an interview of staff 17 on 05/15/2019, at 0914 hours, in the pathology laboratory medicine quality assurance office, she stated that each of 24 laboratory sections or areas collect quality data monthly and then forwards to the quality assurance office. She then prepares a report quarterly for the Division Quality Meeting. In addition, she provides the data to staff #40 who bundles it up and sends out to the institution.</p> <p>In an interview of staff #40 on 05/15/2019, at</p> | A 576 | | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/30/2019
FORM APPROVED
OMB NO. 0938-0391

| | | | | |
|--|---|--|---|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 450076 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED C 05/17/2019 |
| NAME OF PROVIDER OR SUPPLIER UNIVERSITY OF TEXAS M D ANDERSON CANCER CENTER, THE | | STREET ADDRESS, CITY, STATE, ZIP CODE 1515 HOLCOMBE BLVD HOUSTON, TX 77030 | | |
| (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) COMPLETION DATE |
| A 576 | <p>Continued From page 97</p> <p>0920 hours, in the pathology laboratory medicine quality assurance office, he stated the only quality assurance data he sends is Critical Value calls to Clinical Informatics who puts the data into the institutional metrics. In addition, he stated that the only feedback he gets is "if don't send it".</p> <p>In an interview of staff #52 on 05/16/2019, at 0827 hours, in the conference room, she stated that Clinical Informatics was responsible for uploading the Critical Calls data to a server. The information displays as a metric in the Midas Statit program for National Patient Safety reporting.</p> <p>In an interview of staff #7 on 05/16/2019 at, 1346 hours, in the conference room, he stated that the laboratory quality assurance reports don't go to ECMS (Executive Committee Medical Staff), they don't go further that the laboratory division head.</p> <p>In an interview of staff #58 on 05/16/2019, at 1422 hours, in her office, she stated that the laboratory quality assurance doesn't go to a hospital quality committee. I did try to find who to send it to.</p> <p>B. Based on record review and interviews, the hospital failed to ensure that the 1 of 21 CLIA (Clinical Laboratory Improvement Amendments) laboratory locations was included in the laboratory quality assurance activities and hospital-wide QAPI program.</p> <p>Finding:</p> <p>A review of the hospital database worksheet revealed 21 CLIA laboratory locations.</p> | A 576 | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/30/2019
FORM APPROVED
OMB NO. 0938-0391

| | | | | |
|--|---|--|---|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 450076 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED C 05/17/2019 |
| NAME OF PROVIDER OR SUPPLIER UNIVERSITY OF TEXAS M D ANDERSON CANCER CENTER, THE | | STREET ADDRESS, CITY, STATE, ZIP CODE 1515 HOLCOMBE BLVD HOUSTON, TX 77030 | | |
| (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) COMPLETION DATE |
| A 576 | Continued From page 98 A review of the laboratory quality indicators monthly report form revealed 1 of 21 CLIA laboratory locations with no quality assurance data. (laboratory location 21 / off-site location #12) In an interview with staff 17 on 05/14/2019 at 1610 hours in the pathology laboratory medicine quality assurance office, she stated, I didn't know they were under the hospital. | A 576 | | |