Official Accreditation Report

The University of Texas MD Anderson Cancer Center
1515 Holcombe Boulevard
Houston, TX 77030-4095

Organization Identification Number: 9087

Executive Summary

Requirements for Improvement

Observations noted within the Requirements for Improvement (RFI) section require follow up through the Evidence of Standards Compliance (ESC) process. The timeframe assigned for completion is due in either 45 or 60 days, depending upon whether the observation was noted within a direct or indirect impact standard. (Please Note: if your survey event resulted in a Preliminary Denial of Accreditation status, your timeframe for ESC completion will be 45 days.) The identified timeframes of submission for each observation are found within the Requirements for Improvement Summary portion of the final onsite survey report. If a follow-up survey is required, the unannounced visit will focus on the requirements for improvement although other areas, if observed, could still become findings. The time frame for performing the unannounced follow-up visit is dependent on the scope and severity of the issues identified within the Requirements for Improvement.

Opportunities for Improvement

Observations noted within the Opportunities for Improvement (OFI) section of the report represent single instances of non-compliance noted under a C category Element of Performance. Although these observations do not require official follow up through the Evidence of Standards Compliance (ESC) process, they are included to provide your organization with a robust analysis of all instances of non-compliance noted during survey.
Executive Summary

<table>
<thead>
<tr>
<th>Program(s)</th>
<th>Survey Date(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Accreditation</td>
<td>09/19/2016-09/23/2016</td>
</tr>
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</table>

Hospital Accreditation: As a result of the accreditation activity conducted on the above date(s), Requirements for Improvement have been identified in your report. You will have follow-up in the area(s) indicated below:

- Evidence of Standards Compliance (ESC)

If you have any questions, please do not hesitate to contact your Account Executive.

Thank you for collaborating with The Joint Commission to improve the safety and quality of care provided to patients.
Requirements for Improvement – Summary

Observations noted within the Requirements for Improvement (RFI) section require follow up through the Evidence of Standards Compliance (ESC) process. The timeframe assigned for completion is due in either 45 or 60 days, depending upon whether the observation was noted within a direct or indirect impact standard. (*Please Note: if your survey event resulted in a Preliminary Denial of Accreditation status, your timeframe for ESC completion will be 45 days.*) The identified timeframes of submission for each observation are found within the Requirements for Improvement Summary portion of the final onsite survey report. If a follow-up survey is required, the unannounced visit will focus on the requirements for improvement although other areas, if observed, could still become findings. The timeframe for performing the unannounced follow-up visit is dependent on the scope and severity of the issues identified within the Requirements for Improvement.

Evidence of DIRECT Impact Standards Compliance is due within 45 days from the day the survey report was originally posted to your organization’s extranet site (For those with a Preliminary Denial of Accreditation decision: DIRECT and INDIRECT Impact Standards Compliance are due within 45 days):

<table>
<thead>
<tr>
<th>Program:</th>
<th>Hospital Accreditation Program</th>
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<tbody>
<tr>
<td>Standards:</td>
<td></td>
</tr>
<tr>
<td>EC.02.05.01</td>
<td>EP8,EP15</td>
</tr>
<tr>
<td>IC.02.02.01</td>
<td>EP1</td>
</tr>
<tr>
<td>MM.03.01.03</td>
<td>EP2</td>
</tr>
<tr>
<td>MM.05.01.07</td>
<td>EP2</td>
</tr>
<tr>
<td>PC.01.02.07</td>
<td>EP3</td>
</tr>
<tr>
<td>PC.02.01.01</td>
<td>EP15</td>
</tr>
<tr>
<td>PC.02.01.03</td>
<td>EP1,EP7</td>
</tr>
<tr>
<td>PC.02.01.11</td>
<td>EP2</td>
</tr>
<tr>
<td>PC.02.02.03</td>
<td>EP11</td>
</tr>
<tr>
<td>PC.03.01.03</td>
<td>EP1</td>
</tr>
<tr>
<td>RI.01.01.03</td>
<td>EP2</td>
</tr>
</tbody>
</table>

Evidence of INDIRECT Impact Standards Compliance is due within 60 days from the day the survey report was originally posted to your organization’s extranet site:

<table>
<thead>
<tr>
<th>Program:</th>
<th>Hospital Accreditation Program</th>
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</thead>
<tbody>
<tr>
<td>Standards:</td>
<td></td>
</tr>
<tr>
<td>EC.02.02.01</td>
<td>EP5,EP11</td>
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<tr>
<td>EC.02.03.05</td>
<td>EP16</td>
</tr>
<tr>
<td>EC.02.05.09</td>
<td>EP3</td>
</tr>
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</table>
Evidence of INDIRECT Impact Standards Compliance is due within 60 days from the day the survey report was originally posted to your organization's extranet site:

<table>
<thead>
<tr>
<th>Rule</th>
<th>Requirements</th>
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<tbody>
<tr>
<td>EC.02.06.01</td>
<td>EP1</td>
</tr>
<tr>
<td>LS.02.01.10</td>
<td>EP5,EP9</td>
</tr>
<tr>
<td>LS.02.01.20</td>
<td>EP13,EP31</td>
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<td>LS.02.01.30</td>
<td>EP2,EP23</td>
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<tr>
<td>LS.02.01.34</td>
<td>EP4</td>
</tr>
<tr>
<td>LS.02.01.35</td>
<td>EP6,EP14</td>
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<tr>
<td>LS.02.01.70</td>
<td>EP1,EP2</td>
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<tr>
<td>MM.01.01.03</td>
<td>EP2</td>
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<tr>
<td>PC.01.02.01</td>
<td>EP1</td>
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<tr>
<td>PC.03.05.03</td>
<td>EP2</td>
</tr>
<tr>
<td>PC.03.05.05</td>
<td>EP1</td>
</tr>
</tbody>
</table>
CoP: §482.13  Tag: A-0115  Deficiency: Standard

Corresponds to: HAP

Text: §482.13 Condition of Participation: Patient's Rights

A hospital must protect and promote each patient’s rights.

<table>
<thead>
<tr>
<th>CoP Standard</th>
<th>Tag</th>
<th>Corresponds to</th>
<th>Deficiency</th>
</tr>
</thead>
<tbody>
<tr>
<td>§482.13(e)(5)</td>
<td>A-0168</td>
<td>HAP - PC.03.05.05/EP1</td>
<td>Standard</td>
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<tr>
<td>§482.13(e)(4)(i)</td>
<td>A-0166</td>
<td>HAP - PC.03.05.03/EP2</td>
<td>Standard</td>
</tr>
</tbody>
</table>

CoP: §482.23  Tag: A-0385  Deficiency: Standard

Corresponds to: HAP

Text: §482.23 Condition of Participation: Nursing Services

The hospital must have an organized nursing service that provides 24-hour nursing services. The nursing services must be furnished or supervised by a registered nurse.

<table>
<thead>
<tr>
<th>CoP Standard</th>
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<th>Deficiency</th>
</tr>
</thead>
<tbody>
<tr>
<td>§482.23(c)</td>
<td>A-0405</td>
<td>HAP - MM.05.01.07/EP2</td>
<td>Standard</td>
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<tr>
<td>§482.23(c)(4)</td>
<td>A-0409</td>
<td>HAP - PC.02.01.01/EP15</td>
<td>Standard</td>
</tr>
<tr>
<td>§482.23(c)(3)</td>
<td>A-0406</td>
<td>HAP - PC.02.01.03/EP1</td>
<td>Standard</td>
</tr>
</tbody>
</table>

CoP: §482.41  Tag: A-0700  Deficiency: Standard

Corresponds to: HAP

Text: §482.41 Condition of Participation: Physical Environment

The hospital must be constructed, arranged, and maintained to ensure the safety of the patient, and to provide facilities for diagnosis and treatment and for special hospital services appropriate to the needs of the community.

<table>
<thead>
<tr>
<th>CoP Standard</th>
<th>Tag</th>
<th>Corresponds to</th>
<th>Deficiency</th>
</tr>
</thead>
<tbody>
<tr>
<td>§482.41(a)</td>
<td>A-0701</td>
<td>HAP - EC.02.02.01/EP5, EP11, EC.02.05.01/EP8, EC.02.06.01/EP1</td>
<td>Standard</td>
</tr>
<tr>
<td>§482.41(c)(2)</td>
<td>A-0724</td>
<td>HAP - EC.02.03.05/EP16, EC.02.05.09/EP3</td>
<td>Standard</td>
</tr>
</tbody>
</table>

CoP: §482.42  Tag: A-0747  Deficiency: Standard

Corresponds to: HAP - EC.02.05.01/EP15
§482.42 Condition of Participation: Infection Control

The hospital must provide a sanitary environment to avoid sources and transmission of infections and communicable diseases. There must be an active program for the prevention, control, and investigation of infections and communicable diseases.

<table>
<thead>
<tr>
<th>CoP Standard</th>
<th>Tag</th>
<th>Corresponds to</th>
<th>Deficiency</th>
</tr>
</thead>
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<tr>
<td>§482.42(a)</td>
<td>A-0748</td>
<td>HAP - IC.02.02.01/EP1</td>
<td>Standard</td>
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</table>

§482.57 Condition of Participation: Respiratory Care Services

The hospital must meet the needs of the patients in accordance with acceptable standards of practice. The following requirements apply if the hospital provides respiratory care services.

<table>
<thead>
<tr>
<th>CoP Standard</th>
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<th>Corresponds to</th>
<th>Deficiency</th>
</tr>
</thead>
<tbody>
<tr>
<td>§482.57(b)(3)</td>
<td>A-1163</td>
<td>HAP - PC.02.01.03/EP1</td>
<td>Standard</td>
</tr>
</tbody>
</table>
Requirements for Improvement – Detail

Chapter: Environment of Care
Program: Hospital Accreditation
Standard: EC.02.02.01

Standard Text: The hospital manages risks related to hazardous materials and waste.

Element(s) of Performance:

5. The hospital minimizes risks associated with selecting, handling, storing, transporting, using, and disposing of hazardous chemicals.

Scoring Category: C
Score: Insufficient Compliance

11. For managing hazardous materials and waste, the hospital has the permits, licenses, manifests, and safety data sheets required by law and regulation.

Scoring Category: A
Score: Insufficient Compliance

Observation(s):
The condition of the physical plant and the overall hospital environment must be developed and maintained in such a manner that the safety and well-being of patients are assured.

This Standard is NOT MET as evidenced by:

**Observed in Individual Tracer at University of Texas MD Anderson Cancer Center (1515 Holcombe Boulevard, Houston, TX) site for the Hospital deemed service.**

In 2 of 2 eyewash logs reviewed, it was noted that eyewash stations were not being flushed weekly. This was noted while conducting tracer activity in the main pharmacy and in G-14 pharmacy. It was noted that caustic and corrosive items were used in these areas which make an eyewash station necessary. The organization had completed a risk assessment on 8/11/16 entitled eyewash and Safety Shower Risk Assessment. Under section VI. Eyewash Testing Schedule it is stated, “Areas with emergency safety equipment installed that are required to meet alternative guidelines of an accrediting body or regulatory agency will manage testing and documentation for plumbed emergency equipment in accordance with the ANSI Z358.1-2014 recommendation of weekly.” These 2 pharmacy areas mentioned above meet the criteria outlined in the risk assessment for weekly checks based on information provided by the organizations risk assessment.

**Observed in Individual Tracer at University of Texas MD Anderson Cancer Center (1515 Holcombe Boulevard, Houston, TX) site for the Hospital deemed service.**

It was observed on the G10W Medical Oncology unit that the standard was not met. An environmental services cart with multiple cleaning chemicals accessible on top of the cart was observed unattended in the hallway near the elevator.

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**Chapter:** Environment of Care  
**Program:** Hospital Accreditation  
**Standard:** EC.02.03.05
Standard Text: The hospital maintains fire safety equipment and fire safety building features. Note: This standard does not require hospitals to have the types of fire safety equipment and building features described below. However, if these types of equipment or features exist within the building, then the following maintenance, testing, and inspection requirements apply.

Element(s) of Performance:

16. Every 12 months, the hospital performs maintenance on portable fire extinguishers. The completion date of the maintenance is documented.

Note 1: There are many ways to document the maintenance, such as using bar-coding equipment, using check marks on a tag, or using an inventory. Note 2: For additional guidance on maintaining fire extinguishers, see NFPA 10, 1998 edition (Sections 1-6, 4-3, and 4-4).

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 16
§482.41(c)(2) - (A-0724) - (2) Facilities, supplies, and equipment must be maintained to ensure an acceptable level of safety and quality. This Standard is NOT MET as evidenced by:

Observed in Building Tour at University of Texas MD Anderson Cancer Center (1515 Holcombe Boulevard, Houston, TX) site for the Hospital deemed service. There was a fire extinguisher in the construction area on G7 that the last annual inspection was in July 2015. (removed during the survey)
15. In areas designed to control airborne contaminants (such as biological agents, gases, fumes, dust), the ventilation system provides appropriate pressure relationships, air-exchange rates, filtration efficiencies, relative humidity, and temperature. (See also EC.02.06.01, EP 13 and EC.02.06.05, EP 1)

Note: Areas designed for control of airborne contaminants include spaces such as all classes of operating rooms, special procedure rooms that require a sterile field, caesarean delivery rooms, rooms for patients diagnosed with or suspected of having airborne communicable diseases (for example, airborne infection isolation rooms, rooms for patients with pulmonary or laryngeal tuberculosis, bronchoscopy treatment rooms), patients in 'protective environment' rooms (for example, rooms for patients receiving bone marrow transplants), laboratories, pharmacies, sterile supply/processing rooms, and other sterile spaces. For further information, refer to Guidelines for Design and Construction of Health Care Facilities, 2010 edition, administered by the Facility Guidelines Institute and published by the American Society for Healthcare Engineering (ASHE).

Scoring Category : A
Score : Insufficient Compliance
Observation(s):

EP 8 §482.41(a) - (A-0701) - §482.41(a) Standard: Buildings

The condition of the physical plant and the overall hospital environment must be developed and maintained in such a manner that the safety and well-being of patients are assured.

This Standard is NOT MET as evidenced by:

Observed in Building Tour at University of Texas MD Anderson Cancer Center | 1515 Holcomb (1515 Holcombe Boulevard, Houston, TX) site for the Hospital deemed service.
In 4 of 6 Circuit breaker panel checks, BP2CPLA did not have a schedule, LP12NPLA1 missing the numbers on numerous breakers, LP12NPLA2 did not have numbers on the breakers and the panel for the Hybrid OR in the Interventional Radiology Department did not have a schedule.
§482.42 - (A-0747) - §482.42 Condition of Participation: Condition of Participation: Infection Control
This Standard is NOT MET as evidenced by:

**Observed in Building Tour at University of Texas MD Anderson Cancer Center (1515 Holcombe Boulevard, Houston, TX) site for the Hospital deemed service.**

In 4 of 10 Mays Clinic ambulatory surgery center pressure relationship checks, the sterile receiving core cart storage area, room ACB4.2508, was negative to the sterile corridor; the soiled utility room, ACB4, 2504 was positive to the staff corridor; the clean utility cysto supply room, ACB4 was negative to the staff corridor; the anesthesia storage room, ACB4, 2517 was negative to the sterile corridor. (all the pressure relationships in these rooms were corrected on site)

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**Chapter:** Environment of Care  
**Program:** Hospital Accreditation  
**Standard:** EC.02.05.09  
**Standard Text:** The hospital inspects, tests, and maintains medical gas and vacuum systems.  
Note: This standard does not require hospitals to have the medical gas and vacuum systems discussed below. However, if a hospital has these types of systems, then the following inspection, testing, and maintenance requirements apply.

**Element(s) of Performance:**

3. The hospital makes main supply valves and area shutoff valves for piped medical gas and vacuum systems accessible and clearly identifies what the valves control.

**Scoring Category:** A  
**Score:** Insufficient Compliance  

**Observation(s):**
EP 3
§482.41(c)(2) - (A-0724) - (2) Facilities, supplies, and equipment must be maintained to ensure an acceptable level of safety and quality.
This Standard is NOT MET as evidenced by:

Observed in Building Tour at University of Texas MD Anderson Cancer Center | 1515 Holcomb (1515 Holcombe Boulevard, Houston, TX) site for the Hospital deemed service.
In 8 of 12 Medical Gas cutoff valve checks, the medical gas zone cutoff valves in the OR were not labeled consistently. Some had the architectural room number, some had the room name, and some had both. (the OR zone cutoff valves were standardized with room numbers and architectural room number during the survey. Medical gas zone cutoff valve 6, on G7 near G7.3511 had architectural room numbers on the sign above the valve and actual room numbers on the valves. (these were standardized during the survey) The medical zone valve, on P3 near 331, was labeled P332/P3.3032. There was no room P332. (changed to room 331 during the survey).

Chapter: Environment of Care
Program: Hospital Accreditation
Standard: EC.02.06.01
Standard Text: The hospital establishes and maintains a safe, functional environment.
Note: The environment is constructed, arranged, and maintained to foster patient safety, provide facilities for diagnosis and treatment, and provide for special services appropriate to the needs of the community.

Element(s) of Performance:
1. Interior spaces meet the needs of the patient population and are safe and suitable to the care, treatment, and services provided.

Scoring Category : C
Score : Insufficient Compliance

Observation(s):
§482.41(a) - (A-0701) - §482.41(a) Standard: Buildings

The condition of the physical plant and the overall hospital environment must be developed and maintained in such a manner that the safety and well-being of patients are assured.

This Standard is NOT MET as evidenced by:

**Observed in Building Tour at University of Texas MD Anderson Cancer Center (1515 Holcombe Boulevard, Houston, TX) site for the Hospital deemed service.**
There was a open junction box above the ceiling near G18.3555. (repaired during the survey)

**Observed in Building Tour at University of Texas MD Anderson Cancer Center (1515 Holcombe Boulevard, Houston, TX) site for the Hospital deemed service.**
The key was left in a portable X-Ray machine on G7 across from G73471. (removed at the time of the survey)

**Observed in Building Tour at University of Texas MD Anderson Cancer Center (1515 Holcombe Boulevard, Houston, TX) site for the Hospital deemed service.**
In 3 of 3 crash cart checks, the three crash carts, in the Interventional Radiology Department, were equipped with non 1363A relocatable power taps.

**Observed in Building Tour at University of Texas MD Anderson Cancer Center (1515 Holcombe Boulevard, Houston, TX) site for the Hospital deemed service.**
There were two relocatable power taps daisy chained in the PACU area in the Mays ambulatory surgery center. (removed during the survey)

**Observed in Individual Tracer at University of Texas MD Anderson Cancer Center (1515 Holcombe Boulevard, Houston, TX) site for the Hospital deemed service.**
During tracer activity it was observed that the standard was not met. A facilities maintenance cart was observed unlocked and unattended in a hallway with patient and visitor access.

**Observed in Individual Tracer at University of Texas MD Anderson Cancer Center (1515 Holcombe Boulevard, Houston, TX) site for the Hospital deemed service.**
It was noted in the hallway leading into the Pediatric Infusion Center on G-9, that there were two unattended wheeled carts filled with paint and painting supplies that posed a risk for children and people in that hallway, if anyone would push or roll the cart, lift the paint cans, or use the supplies for other purposes.

**Observed in Individual Tracer at University of Texas MD Anderson Cancer Center (1515 Holcombe Boulevard, Houston, TX) site for the Hospital deemed service.**
It was noted in the Child Life room in the waiting area of the Child and Adolescent Clinic in the Main Building on the Seventh Floor, that there were two young children in that area without any supervision and alone, playing with toys. Also in this area was an accessible full-service dish washer, that children may have used, or entered, or turned on causing a safety risk.

**Observed in Tracer Activities at The Proton Therapy Center (1840 Old Spanish Trail, Houston, TX) site for the Hospital deemed service.**
While performing tracer activities it was noted that an oxygen tank that was labeled as "Full" was only half full.
Program: Hospital Accreditation
Standard: IC.02.02.01
Standard Text: The hospital reduces the risk of infections associated with medical equipment, devices, and supplies.

Element(s) of Performance:

1. The hospital implements infection prevention and control activities when doing the following: Cleaning and performing low-level disinfection of medical equipment, devices, and supplies. *
   Note: Low-level disinfection is used for items such as stethoscopes and blood glucose meters.
   Additional cleaning and disinfecting is required for medical equipment, devices, and supplies used by patients who are isolated as part of implementing transmission-based precautions.
   Footnote *: For further information regarding cleaning and performing low-level disinfection of medical equipment, devices, and supplies, refer to the website of the Centers for Disease Control and Prevention (CDC) at http://www.cdc.gov/hicpac/Disinfection_Sterilization/acknowledg.html.

Scoring Category: C
Score: Partial Compliance

Observation(s):

EP 1
§482.42(a) - (A-0748) - §482.42(a) Standard: Organization and Policies

(a) Standard: Organization and policies. A person or persons must be designated as infection control officer or officers to develop and implement policies governing control of infections and communicable diseases. The infection control officer or officers must develop a system for identifying, reporting, investigating, and controlling infections and communicable diseases of patients and personnel.
This Standard is NOT MET as evidenced by:

Observed in Individual Tracer at University of Texas MD Anderson Cancer Center (1515 Holcombe Boulevard, Houston, TX) site for the Hospital deemed service.
It was noted that heavy tape residue was on the face of the crash cart stored in the main pharmacy. This prevented the ability to complete low level disinfection.

Observed in Individual Tracer at University of Texas MD Anderson Cancer Center (1515 Holcombe Boulevard, Houston, TX) site for the Hospital deemed service.
It was noted that heavy tape residue was on the face of IV Smart Pumps which prevented the ability to complete low-level disinfection.
Building and fire protection features are designed and maintained to minimize the effects of fire, smoke, and heat.

5. Doors required to be fire rated have functioning hardware, including positive latching devices and self-closing or automatic-closing devices. Gaps between meeting edges of door pairs are no more than 1/8 inch wide, and undercuts are no larger than 3/4 inch. (See also LS.02.01.30, EP 2; LS.02.01.34, EP 2) (For full text and any exceptions, refer to NFPA 101-2000: 8.2.3.2.3.1, 8.2.3.2.1 and NFPA 80-1999: 2-4.4.3, 2-3.1.7, and 1-11.4)

Score: Partial Compliance

9. The space around pipes, conduits, bus ducts, cables, wires, air ducts, or pneumatic tubes that penetrate fire-rated walls and floors are protected with an approved fire-rated material. Note: Polyurethane expanding foam is not an accepted fire-rated material for this purpose. (For full text and any exceptions, refer to NFPA 101-2000: 8.2.3.2.4.2)

Score: Insufficient Compliance

Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the Federal Register to announce the changes.

This Standard is NOT MET as evidenced by:

**Observed in Building Tour at University of Texas MD Anderson Cancer Center (1515 Holcombe Boulevard, Houston, TX) site for the Hospital deemed service.**

In 2 of 10 fire barrier door checks, fire rated doors G19.3324 did not close and latch when tested. The fire rated door on the two hour fire-rated wall between the Lutheran and Anderson building had a gap greater than 3/4 inches on the undercut.

In 5 of 12 fire barrier wall checks, there was mixed fire caulk sealing openings on the two hour fire walls near G193555, G193757, G183555 on the G6 interstitial space and on the two hour fire-rated wall between the Lutheran and Anderson building.

There was an open one inch conduit in the 8th floor mechanical room that was connected to a junction box and had conduit running through a fire-rated wall. (repaired during the survey)

In 1 of 1 IT room checks, there was an open 8 X 8 junction box that had conduit going through the 2 hour ceiling deck in the IT closet on G6. (repaired during the survey)
Chapter: Life Safety  
Program: Hospital Accreditation  
Standard: LS.02.01.20  
Standard Text: The hospital maintains the integrity of the means of egress.

Element(s) of Performance:

13. Exits, exit accesses, and exit discharges are clear of obstructions or impediments to the public way, such as clutter (for example, equipment, carts, furniture), construction material, and snow and ice. (For full text and any exceptions, refer to NFPA 101-2000: 7.1.10.1)

Scoring Category: C  
Score: Insufficient Compliance

31. Exit signs are visible when the path to the exit is not readily apparent. Signs are adequately lit and have letters that are 4 or more inches high (or 6 inches high if externally lit). (For full text and any exceptions, refer to NFPA 101-2000: 7.10.1.2, 7.10.5, 7.10.6.1, and 7.10.7.1)

Scoring Category: C  
Score: Partial Compliance

Observation(s):

Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the Federal Register to announce the changes.

This Standard is NOT MET as evidenced by:

Observed in Building Tour at University of Texas MD Anderson Cancer Center (1515 Holcombe Boulevard, Houston, TX) site for the Hospital deemed service.
In 3 of 3 Corridor clutter checks, there were two locations in the OR area where TV monitors extended greater than 4 inches into the exit corridor and there was a UV light in the OR exit corridor that extended greater than 4 inches into the corridor.

Observed in Building Tour at University of Texas MD Anderson Cancer Center (1515 Holcombe Boulevard, Houston, TX) site for the Hospital deemed service.
In 3 of 4 Corridor clutter checks, there were storage racks in the OR exit corridor by OR 20, equipment by OR 17 and a storage rack, equipment and C arms by OR five.

Observed in Building Tour at University of Texas MD Anderson Cancer Center (1515 Holcombe Boulevard, Houston, TX) site for the Hospital deemed service.
There were two freezers, a Harris and a Fisher Scientific Freezer, that extended greater than four inches into the exit corridor across from G3.3621.

Observed in Building Tour at University of Texas MD Anderson Cancer Center (1515 Holcombe Boulevard, Houston, TX) site for the Hospital deemed service.
There was a chair and cabinet placed in the entry corridor into the Interventional Radiology Department. This area was not part of the life safety suite. (moved into the suite area)

Observed in Building Tour at University of Texas MD Anderson Cancer Center (1515 Holcombe Boulevard, Houston, TX) site for the Hospital deemed service.
There was a chair being stored underneath the stairwell on the basement landing of stairwell CC. (removed at the time of the survey)

Observed in Building Tour at University of Texas MD Anderson Cancer Center (1515 Holcombe Boulevard, Houston, TX) site for the Hospital deemed service.
In 9 of 10 Corridor clutter checks, On P3A there was a TV monitor that extended greater than four inches into the exit corridor.
EP 31

Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the Federal Register to announce the changes.

This Standard is NOT MET as evidenced by:

**Observed in Building Tour at University of Texas MD Anderson Cancer Center (1515 Holcombe Boulevard, Houston, TX) site for the Hospital deemed service.**

**In 2 of 10 Exit light checks, The exit sign by OR five only had one chevron illuminated and should have had chevrons illuminated in both directions. There was an exit sign installed in the eighth floor mechanical that did not lead to an exit. (this sign was corrected during the survey)**

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**Chapter:** Life Safety

**Program:** Hospital Accreditation

**Standard:** LS.02.01.30

**Standard Text:** The hospital provides and maintains building features to protect individuals from the hazards of fire and smoke.

**Element(s) of Performance:**

2. All hazardous areas are protected by walls and doors in accordance with NFPA 101-2000:
   18/19.3.2.1. (See also LS.02.01.10, EP 5;
   LS.02.01.20, EP 18) Hazardous areas include, but are not limited, to the following:
   Boiler/fuel-fired heater rooms
   - Existing boiler/fuel-fired heater rooms have sprinkler systems, resist the passage of smoke, and have doors with self-closing or automatic-closing devices; or the rooms have 1-hour fire-rated walls and 3/4-hour fire-rated doors.
   - New boiler/fuel-fired heater rooms have sprinkler systems and have 1-hour fire-rated walls and 3/4-hour fire-rated doors.
   Central/bulk laundries larger than 100 square feet
   - Existing central/bulk laundries larger than 100 square feet have sprinkler systems, resist the passage of smoke, and have doors with self-closing or automatic-closing devices; or the laundries have 1-hour fire-rated walls and 3/4-hour fire-rated doors.
   - New central/bulk laundries larger than 100 square
feet have sprinkler systems and have 1-hour fire-rated walls and 3/4-hour fire-rated doors.
Flammable liquid storage rooms (See NFPA 30-1996:4-4.2.1 and 4-4.4.2)
- Existing flammable liquid storage rooms have 2-hour fire-rated walls with 1 1/2-hour fire-rated doors.
- New flammable liquid storage rooms have sprinkler systems and have 2-hour fire-rated walls with 1 1/2-hour fire-rated doors.
Laboratories (See NFPA 45-1996 to determine if a laboratory is a 'severe hazard' area)
- Existing laboratories that are not severe hazard areas have sprinkler systems, resist the passage of smoke, and have doors with self-closing or automatic-closing devices; or the laboratories have walls fire rated for 1 hour with 3/4-hour fire-rated doors.
- New laboratories that are not severe hazard areas have sprinkler systems, resist the passage of smoke, and have doors with self-closing or automatic-closing devices.
- Existing laboratories that are severe hazard areas (See NFPA 99-1999: 10-3.1.1) have 2-hour fire-rated walls with 1 1/2-hour fire-rated doors. When there is a sprinkler system, the walls are fire rated for 1 hour with 3/4-hour fire-rated doors.
- New laboratories that are severe hazard areas (See NFPA 99-1999: 10-3.1.1) have sprinkler systems and have 1-hour fire-rated walls with 3/4-hour fire-rated doors.
- Existing flammable gas storage rooms in laboratories have 2-hour fire-rated walls with 1 1/2-hour fire-rated doors. (See NFPA 99-1999: 10-10.2.2)
- New flammable gas storage rooms in laboratories have sprinkler systems and have 2-hour fire-rated walls with 1 1/2-hour fire-rated doors. (See NFPA 99-1999: 10-10.2.2)
Maintenance repair shops
- Existing maintenance repair shops have sprinkler systems, resist the passage of smoke, and have doors with self-closing or automatic-closing devices; or the shops have 1-hour fire-rated walls with at least 3/4-hour fire-rated doors.
- New maintenance repair shops have sprinkler systems and have 1-hour fire-rated walls with 3/4-hour fire-rated doors.
Piped oxygen tank supply rooms (See NFPA 99-1999: 4-3.1.1.2)
- Existing piped oxygen tank supply rooms have 1-hour fire-rated walls with 3/4-hour fire-rated doors.
- New piped oxygen tank supply rooms have sprinkler systems and have 1-hour fire-rated walls with 3/4-hour fire-rated doors.
Paint shops that are not severe hazard areas
- Existing paint shops that are not severe hazard areas have sprinkler systems, resist the passage of smoke, and have doors with self-closing or
automatic-closing devices; or the shops have 1-hour fire-rated walls with 3/4-hour fire-rated doors.
- New paint shops that are not severe hazard areas have sprinkler systems and have 1-hour fire-rated walls with 3/4-hour fire-rated doors.
Soiled linen rooms
- Existing soiled linen rooms have sprinkler systems, resist the passage of smoke, and have doors with self-closing or automatic-closing devices; or the rooms have 1-hour fire-rated walls with 3/4-hour fire-rated doors.
- New soiled linen rooms have sprinkler systems and have 1-hour fire-rated walls with 3/4-hour fire-rated doors.
Storage rooms
- Existing storage rooms for combustible materials larger than 50 square feet have sprinkler systems, resist the passage of smoke, and have doors with self-closing or automatic-closing devices; or the rooms have 1-hour fire-rated walls with 3/4-hour fire-rated doors.
- New storage rooms for combustible materials 50 to 100 square feet are sprinklered, resist the passage of smoke, and have doors with self-closing or automatic-closing devices.
- New storage rooms for combustible materials larger than 100 square feet are sprinklered and have 1-hour fire-rated walls with 3/4-hour fire-rated doors.
Trash collection rooms
- Existing trash collection rooms have sprinkler systems, resist the passage of smoke, and have doors with self-closing or automatic-closing devices; or the rooms have 1-hour fire-rated walls with 3/4-hour fire-rated doors.
- New trash collection rooms are sprinklered and have 1-hour fire-rated walls with 3/4-hour fire-rated doors.

Scoring Category: C
Score: Insufficient Compliance

23. Doors in smoke barriers are self-closing or automatic-closing, constructed of 1 3/4-inch or thicker solid bonded wood core or constructed to resist fire for not less than 20 minutes, and fitted to resist the passage of smoke. The gap between meeting edges of door pairs is no wider than 1/8 inch, and undercuts are no larger than 3/4 inch. Doors do not have nonrated protective plates more than 48 inches above the bottom of the door. (For full text and any exceptions, refer to NFPA 101-2000: 18/19.3.7.5, 18/19.3.7.6, and 8.3.4.1)

Scoring Category: C
Score: Insufficient Compliance
Observation(s):

EP 2

Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the Federal Register to announce the changes.

This Standard is NOT MET as evidenced by:

Observed in Building Tour at University of Texas MD Anderson Cancer Center (1515 Holcombe Boulevard, Houston, TX) site for the Hospital deemed service.
In 2 of 10 storage and hazardous room checks, storage room G143441 was larger than 50 square feet and was not equipped with a self-closing or automatic-closing device and the door did not close and latch in the !R 19 equipment room when tested. (both of these were corrected on site)

Observed in Building Tour at University of Texas MD Anderson Cancer Center (1515 Holcombe Boulevard, Houston, TX) site for the Hospital deemed service.
There was a ceiling tile out in Housekeeping closet G19.3729 and in wheelchair storage G1.3782. (corrected on site during the survey)

Observed in Building Tour at University of Texas MD Anderson Cancer Center (1515 Holcombe Boulevard, Houston, TX) site for the Hospital deemed service.
There was greater than a 1/4 inch gap between the meeting edges of the door pairs on the sterilizer equipment service room in the Mays ambulatory surgery center. (repaired on site during the survey)

Observed in Tracer Activities at University of Texas MD Anderson Cancer Center (1515 Holcombe Boulevard, Houston, TX) site for the Hospital deemed service.
It was noted that an escutcheon plate was absent from a sprinkler head in the dietary department where the meals were being placed on trays and near the stove area.

Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the Federal Register to announce the changes.

This Standard is NOT MET as evidenced by:

**Observed in Building Tour at University of Texas MD Anderson Cancer Center (1515 Holcombe Boulevard, Houston, TX) site for the Hospital deemed service.**
In 9 of 15 smoke barrier door checks, the smoke barrier doors by OR 15, by G3.3621, on P12, P11, P9 and P7 had been modified. The down rod had been removed. The smoke doors by G3.3621, near G1.3712 and on P11 did not close and latch when tested.

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**Chapter:** Life Safety  
**Program:** Hospital Accreditation  
**Standard:** LS.02.01.34  
**Standard Text:** The hospital provides and maintains fire alarm systems.

**Element(s) of Performance:**


**Score:** Partial Compliance

**Observation(s):**

Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the Federal Register to announce the changes.

This Standard is NOT MET as evidenced by:

Observed in Building Tour at University of Texas MD Anderson Cancer Center (1515 Holcombe Boulevard, Houston, TX) site for the Hospital deemed service.

In 2 of 2 Fire alarm panel and circuit identification checks, the location of the dedicated branch circuit for the fire alarm panel was not identified on the main fire alarm panel. The fire alarm circuit at the circuit breaker panel did not have a red marking. NFPA 72, 2010, 10.5.5.2 Circuit Identification and Accessibility.

10.5.5.2.1 The location of the dedicated branch circuit disconnecting means shall be permanently identified at the control unit. 10.5.5.2.2 For fire alarm systems the circuit disconnecting means shall be identified as “FIRE ALARM CIRCUIT.” 10.5.5.2.3 For fire alarm systems the circuit disconnecting means shall have a red marking. (corrected during the survey)

Chapter: Life Safety
Program: Hospital Accreditation
Standard: LS.02.01.35

Element(s) of Performance:

6. There are 18 inches or more of open space maintained below the sprinkler deflector to the top of storage.  
Note: Perimeter wall and stack shelving may extend up to the ceiling when not located directly below a sprinkler head. (For full text and any exceptions, refer to NFPA 13-1999: 5-8.5.2.1)

Scoring Category : C
Score : Partial Compliance

Scoring Category : C
Score : Insufficient Compliance

Observation(s):

EP 6

Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the Federal Register to announce the changes.

This Standard is NOT MET as evidenced by:

**Observed in Building Tour at University of Texas MD Anderson Cancer Center (1515 Holcombe Boulevard, Houston, TX) site for the Hospital deemed service.**

In 2 of 20 18 inch rule checks, items were stored within 18 inches of the sprinkler deflectors in the Gift Shop storage room and in the storage room P4, 3116. (removed at the time of the survey)

EP 14

Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the Federal Register to announce the changes.

This Standard is NOT MET as evidenced by:

**Observed in Building Tour at University of Texas MD Anderson Cancer Center (1515 Holcombe Boulevard, Houston, TX) site for the Hospital deemed service.**

There was a fire extinguisher blocked by a patient bed near G14.3247. (moved at the time of the survey)

**Observed in Building Tour at University of Texas MD Anderson Cancer Center (1515 Holcombe Boulevard, Houston, TX) site for the Hospital deemed service.**

In 2 of 100 Fire extinguisher checks, there was a fire extinguisher in the construction area on G7, near the doors into Critical Care B & C, and there was a fire extinguisher in the Immunocyto-Chemistry Pathology, both blocked by a carts. (corrected during the survey)
Chapter: Life Safety
Program: Hospital Accreditation
Standard: LS.02.01.70

Standard Text: The hospital provides and maintains operating features that conform to fire and smoke prevention requirements.

Element(s) of Performance:

1. The hospital prohibits all combustible decorations that are not flame retardant. (For full text and any exceptions, refer to NFPA 101-2000: 18/19.7.5.4)

Scoring Category: C
Score: Partial Compliance

2. Soiled linen and trash receptacles larger than 32 gallons (including recycling containers) are located in a room protected as a hazardous area. (For full text and any exceptions, refer to NFPA 101-2000: 18/19.7.5.5)

Scoring Category: C
Score: Partial Compliance

Observation(s):


Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the Federal Register to announce the changes.

This Standard is NOT MET as evidenced by:

Observed in Building Tour at University of Texas MD Anderson Cancer Center (1515 Holcombe Boulevard, Houston, TX) site for the Hospital deemed service.
In 2 of 10 wall covering checks, there were walls, on the 12th and 16th floor that had over 30% of the wall covered with paper on bulletin boards.
EP 2

Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the Federal Register to announce the changes.

This Standard is NOT MET as evidenced by:

**Observed in Building Tour at University of Texas MD Anderson Cancer Center (1515 Holcombe Boulevard, Houston, TX) site for the Hospital deemed service.**

In 2 of 5 container checks, there was a greater than 32 gallon container in the housekeeping closet G17.3529 and a greater than 32 gallon container in the entry corridor into Interventional Radiology. (moved to hazardous areas at the time of the survey)

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### Chapter: Medication Management
### Program: Hospital Accreditation
### Standard: MM.01.01.03
### Standard Text:
The hospital safely manages high-alert and hazardous medications.

### Element(s) of Performance:

2. The hospital has a process for managing high-alert and hazardous medications. (See also EC.02.02.01, EP 8; MM.03.01.01, EP 9)

Note: This element of performance is also applicable to sample medications.

### Scoring Category : A
### Score : Insufficient Compliance

Observation(s):
Observed in Individual Tracer at University of Texas MD Anderson Cancer Center (1515 Holcombe Boulevard, Houston, TX) site.
While conducting a medication management tracer, the process for managing high-alert medications was reviewed. The organization has a policy titled High Alert Medication Policy #CLN1042. The policy’s stated purpose was to complement the standards for managing high alert medications to include safe storage, prescribing, dispensing, administering and monitoring of all medications. Based on the review of the policy, the organization had not developed a written process for guidance on storage of high alert medications either inside or outside of the pharmacy.

Chapter: Medication Management
Program: Hospital Accreditation
Standard: MM.03.01.03
Standard Text: The hospital safely manages emergency medications.

Element(s) of Performance:

2. Emergency medications and their associated supplies are readily accessible in patient care areas. (See also PC.03.01.01, EP 8)

Scoring Category: A
Score: Insufficient Compliance

Observation(s):

EP 2

Observed in Individual Tracer at University of Texas MD Anderson Cancer Center (1515 Holcombe Boulevard, Houston, TX) site.
Pediatric emergency carts throughout the organization did not have appropriate supplies or equipment to manage low volume infusions or minimal doses of medications for infants. Also noted in the two floor Emergency Department, where the first floor is used for triage for 16 of 24 hours/day, there was no pediatric oxygen masks and cannulas on the first floor. Consequently, there were oxygen cylinders in stock on the first floor without a means to deliver oxygen to the pediatric population.
Program: Hospital Accreditation
Standard: MM.05.01.07
Standard Text: The hospital safely prepares medications.

Element(s) of Performance:

2. Staff use clean or sterile techniques and maintain clean, uncluttered, and functionally separate areas for product preparation to avoid contamination of medications.

Scoring Category : C
Score : Insufficient Compliance

Observation(s):

EP 2
§482.23(c) - (A-0405) - (c) Standard: Preparation and administration of drugs.
This Standard is NOT MET as evidenced by:

Observed in Individual Tracer at MD Anderson Katy | 19770 Kingsland Blvd., Houston, TX (19770 Kingsland Blvd., Houston, TX) site for the Hospital deemed service.

In 3 of 5 steps reviewed for sterile compounding and associated processes, the following items were observed out of compliance with the requirements of this standard.

1. Improper cleaning of the back of the laminar airflow hood in the non-hazardous sterile compounding area. It was observed that cleaning was being completed in a vertical manner instead of a horizontal manner.
2. The inappropriate placement of hands which then blocked airflow between the HEPA filter and the work items in respect to critical sites in the hazardous sterile compounding area.
3. Blocking of critical sites after cleaning with alcohol swabs while attaching PhaSeal closed transfer devices to vials with machinery in the hazardous sterile compounding area.

Chapter: Provision of Care, Treatment, and Services
Program: Hospital Accreditation
Standard: PC.01.02.01
Standard Text: The hospital assesses and reassesses its patients.
Element(s) of Performance:
1. The hospital defines, in writing, the scope and content of screening, assessment, and reassessment information it collects. (See also RC.02.01.01, EP 2)

Note 1: In defining the scope and content of the information it collects, the organization may want to consider information that it can obtain, with the patient’s consent, from the patient’s family and the patient’s other care providers, as well as information conveyed on any medical jewelry.

Note 2: Assessment and reassessment information includes the patient’s perception of the effectiveness of, and any side effects related to, his or her medication(s).

Scoring Category: A
Score: Insufficient Compliance

Observation(s):

EP 1

Observed in Tracer Activities at MD Anderson Memorial City | 925 Gessner Road, Medical Plaza (925 Gessner Road, Medical Plaza 4, Houston, TX) site.
In 2 of 2 patient records reviewed, it was noted that the 30 day needs assessment was not fully completed. Hospital policy stated that the patient needs assessment would be fully completed every 30 days on all patients.

Chapter: Provision of Care, Treatment, and Services
Program: Hospital Accreditation
Standard: PC.01.02.07
Standard Text: The hospital assesses and manages the patient's pain.

Element(s) of Performance:

3. The hospital reassesses and responds to the patient’s pain, based on its reassessment criteria.

Scoring Category: C
Score: Partial Compliance

Observation(s):
Observed in Individual Tracer at University of Texas MD Anderson Cancer Center (1515 Holcombe Boulevard, Houston, TX) site.
In 2 of 8 tracers conducted, on G19 Medical Oncology Unit and G10E it was observed that the standard was not met. In one example, the patient’s pain score was not documented as reassessed within 30 minutes after administration of IV pain medication as required by the pain management policy. In the second case, the patient’s pain score was not documented as reassessed within one hour after administration of oral pain medication as required by policy.

Chapter: Provision of Care, Treatment, and Services
Program: Hospital Accreditation
Standard: PC.02.01.01
Standard Text: The hospital provides care, treatment, and services for each patient.

15. For hospitals that use Joint Commission accreditation for deemed status purposes: Blood transfusions and intravenous medications are administered in accordance with state law and approved medical staff policies and procedures.

Scoring Category: A
Score: Insufficient Compliance

Observation(s):
EP 15
§482.23(c)(4) - (A-0409) - (4) Blood transfusions and intravenous medications must be administered in accordance with State law and approved medical staff policies and procedures.
This Standard is NOT MET as evidenced by:

Observed in Individual Tracer at University of Texas MD Anderson Cancer Center (1515 Holcombe Boulevard, Houston, TX) site for the Hospital deemed service.
On P9 it was observed that the standard was not met. The assessment of vital signs required by policy #CLN 1115 during a blood transfusion was not completed 15 minutes after starting the blood transfusion. The assessment was documented as completed at 31 minutes.

Observed in Tracer Activities at MD Anderson Katy (19770 Kingsland Blvd., Houston, TX) site for the Hospital deemed service.
In 2 of 2 patient records reviewed, it was noted that vital signs performed during blood transfusions were not taken in accordance with the hospital policy #CLN1115 which states "Fifteen (15) minutes after the patient has received the initial transfusion of blood component reassess the patient, including vital signs... Obtain vital signs and observe the patient for signs and symptoms of a Transfusion Reactions 30 minutes after the completion of the transfusion."

Observed in Tracer Activities at MD Anderson Bay Area (18100 St. John Dr., Houston, TX) site for the Hospital deemed service.
In 2 of 2 patient records reviewed, it was noted that vital signs performed during blood transfusions were not taken in accordance with the hospital policy #CLN1115 which states "Fifteen (15) minutes after the patient has received the initial transfusion of blood component reassess the patient, including vital signs... Obtain vital signs and observe the patient for signs and symptoms of a Transfusion Reactions 30 minutes after the completion of the transfusion.".

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Chapter: Provision of Care, Treatment, and Services
Program: Hospital Accreditation
Standard: PC.02.01.03
Standard Text: The hospital provides care, treatment, and services as ordered or prescribed, and in accordance with law and regulation.
Element(s) of Performance:
1. For hospitals that use Joint Commission accreditation for deemed status purposes: Prior to providing care, treatment, and services, the hospital obtains or renews orders (verbal or written) from a licensed independent practitioner or other practitioner in accordance with professional standards of practice; law and regulation; hospital policies; and medical staff bylaws, rules, and regulations. *

Note: Outpatient services may be ordered by a practitioner not appointed to the medical staff as long as he or she meets the following:
- Responsible for the care of the patient
- Licensed to practice in the state where he or she provides care to the patient or in accordance with Veterans Administration and Department of Defense licensure requirements
- Acting within his or her scope of practice under state law
- Authorized in accordance with state law and policies adopted by the medical staff and approved by the governing body to order the applicable outpatient services

Footnote *: For law and regulation guidance pertaining to those responsible for the care of the patient, refer to 42 CFR 482.12(c).

Scoring Category : A
Score : Insufficient Compliance

7. For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital provides care, treatment, and services using the most recent patient order(s).

Scoring Category : A
Score : Insufficient Compliance

Observation(s):
§482.57(b)(3) - (A-1163) - (3) Services must only be provided under the orders of a qualified and licensed practitioner who is responsible for the care of the patient, acting within his or her scope of practice under State law, and who is authorized by the hospital’s medical staff to order the services in accordance with hospital policies and procedures and State laws. This Standard is NOT MET as evidenced by:

§482.23(c)(3) - (A-0406) - (3) With the exception of influenza and pneumococcal polysaccharide vaccines, which may be administered per physician-approved hospital policy after an assessment of contraindications, orders for drugs and biologicals must be documented and signed by a practitioner who is authorized to write orders in accordance with State law and hospital policy, and who is responsible for the care of the patient as specified under §482.12(c). This Standard is NOT MET as evidenced by:

**Observed in Individual Tracer at University of Texas MD Anderson Cancer Center (1515 Holcombe Boulevard, Houston, TX) site for the Hospital deemed service.**

During record review of a patient in the surgical intensive care unit it was observed that an order was written for weaning from mechanical ventilation per protocol and a copy of the protocol was not included in the medical record. While the organization had a policy and accompanying algorithm, those documents or content of the ordered protocol were not included in the record.

**Observed in Individual Tracer at University of Texas MD Anderson Cancer Center (1515 Holcombe Boulevard, Houston, TX) site for the Hospital deemed service.**

In 2 of 2 patients who had orders for ventilator weaning according to protocol, it was determined that the ordered protocol, itself, was not part of the medical record. While the organization had a policy and accompanying algorithm, those documents or content of the ordered protocol were not included in the record.

**Observed in Individual Tracer at University of Texas MD Anderson Cancer Center (1515 Holcombe Boulevard, Houston, TX) site for the Hospital deemed service.**

A patient in the medical critical care unit had an order for an infusion to be titrated according to the comfort care order set. When the comfort care order set was reviewed to determine titration parameters, it referenced the titration order set. While the titration order set included some parameters for titration, there was no targeted pain or sedation level. Organization policy on patient care orders (March, 2016) required the treatment goal be part of titration orders.

EP 7
Observed in Individual Tracer at University of Texas MD Anderson Cancer Center (1515 Holcombe Boulevard, Houston, TX) site.
A patient in the medical critical care unit had an order to increase an infusion so as to maintain an acceptable level of pain. However, on one day of care the infusion was increased without the associated pain score to justify the infusion increase according to the provider order.

Observed in Individual Tracer at University of Texas MD Anderson Cancer Center (1515 Holcombe Boulevard, Houston, TX) site.
A patient in the medical critical care unit had an order for an infusion to be titrated so as to maintain a desired pain level. However, there was a one hour period (1530-1630) when the infusion was increased from the starting dose to the maximum dose without a documented pain score. Further, the ordered titration instructions included to decrease the dose if the pain was stable for eight hours. However, there were no adjustments in the infusion for at least a four day period. On one of those four days, the patient’s pain level did not change for 13 hours with no decrease in the infusion as required by the physician’s order.

Observed in Tracer Activities at University of Texas MD Anderson Cancer Center (1515 Holcombe Boulevard, Houston, TX) site.
While performing tracer activities, it was noted that a patient received peritoneal dialysis which followed the patient’s home order for dialysis, however, it did not follow the most recent physician inpatient order.

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**Chapter:** Provision of Care, Treatment, and Services

**Program:** Hospital Accreditation

**Standard:** PC.02.01.11

**Standard Text:** Resuscitation services are available throughout the hospital.

**Element(s) of Performance:**

2. Resuscitation equipment is available for use based on the needs of the population served.

*Note:* For example, if the hospital has a pediatric population, pediatric resuscitation equipment should be available. (See also EC.02.04.03, EP 2)

**Scoring Category:** A

**Score:** Insufficient Compliance

**Observation(s):**

**EP 2**

*Observed in Individual Tracer at University of Texas MD Anderson Cancer Center (1515 Holcombe Boulevard, Houston, TX) site.*
While conducting tracer activity, a crash cart located in the G-14 pharmacy did not have daily defibrillator checks completed on 9/15/16, 9/17/16, 9/18/16 as evidenced by the rhythm strip attached to the machine.
Chapter: Provision of Care, Treatment, and Services
Program: Hospital Accreditation
Standard: PC.02.02.03

Standard Text: The hospital makes food and nutrition products available to its patients.

Element(s) of Performance:

11. The hospital stores food and nutrition products, including those brought in by patients or their families, using proper sanitation, temperature, light, moisture, ventilation, and security.

Scoring Category: C
Score: Insufficient Compliance

Observation(s):

EP 11

Observed in Tracer Activities at University of Texas MD Anderson Cancer Center (1515 Holcombe Boulevard, Houston, TX) site.
Review of the food cart temperatures on the P8 unit revealed that the temperatures documented for 9/1/16 were out of the expected range. The hot side was documented as 107 degrees, and the range was supposed to be within 140 to 180 degrees. The cold side was documented as 52 degrees, and the range was supposed to be 34 to 41 degrees. There was no documentation of communication with maintenance or management, which was what staff indicated should be documented.

Observed in Tracer Activities at University of Texas MD Anderson Cancer Center (1515 Holcombe Boulevard, Houston, TX) site.
Review of the food cart temperature log on the P8 unit revealed that no temperatures were logged for 1030 on 9/18 and 19/16, and no temperatures were logged for 9/18/16 for 1700. The temperatures were supposed to be documented three times every day.

Observed in Tracer Activities at University of Texas MD Anderson Cancer Center (1515 Holcombe Boulevard, Houston, TX) site.
Observation of the overnight refrigerator on the P8 unit revealed that it needed to be cleaned. Staff present, including nursing and dietary, were unaware of whose responsibility it was to keep the refrigerator clean and sanitary.
Program: Hospital Accreditation
Standard: PC.03.01.03

Standard Text: The hospital provides the patient with care before initiating operative or other high-risk procedures, including those that require the administration of moderate or deep sedation or anesthesia.

Element(s) of Performance:

1. Before operative or other high-risk procedures are initiated, or before moderate or deep sedation or anesthesia is administered: The hospital conducts a presedation or preanesthesia patient assessment. (See also RC.02.01.01, EP 2)

Scoring Category: A
Score: Insufficient Compliance

Observation(s):

EP 1

Observed in Individual Tracer at University of Texas MD Anderson Cancer Center (1515 Holcombe Boulevard, Houston, TX) site.
A patient who required sedation for a procedure did not have a presedation assessment as the organization required. Organization policy on sedation for procedures (July, 2015) required a focused physical examination to include auscultation of heart and lungs as well as an airway assessment. Further, the organization had created an electronic documentation template that included spaces for documenting airway, heart and lung assessments, and dentition. However, in the patient traced, there was no evidence the heart, lung, and dental assessments were completed prior to the procedure; these portions of the form were blank.

Observed in Individual Tracer at University of Texas MD Anderson Cancer Center (1515 Holcombe Boulevard, Houston, TX) site.
Organization policy requires presedation assessments to be inclusive of dental and cardiac descriptions, however on four presedation assessments documented for procedures completed in April, May, July and September, the documented cardiac and dental assessments were blank.
2. For hospitals that use Joint Commission accreditation for deemed status purposes: The use of restraint and seclusion is in accordance with a written modification to the patient's plan of care.

Scoring Category: C
Score: Insufficient Compliance

Observation(s):

EP 2 §482.13(e)(4)(i) - (A-0166) - (i) in accordance with a written modification to the patient's plan of care. This Standard is NOT MET as evidenced by:

Observed in Individual Tracer at University of Texas MD Anderson Cancer Center | 1515 Holcomb (1515 Holcombe Boulevard, Houston, TX) site for the Hospital deemed service.
In 3 of 3 care plans reviewed for patients in the MICU who required restraint use, it was determined that there was not a modification to the electronic plan of care to reflect the need for this intervention. While two of the three patients had a "confusion" care plan activated in the electronic medical record, the associated interventions did not include restraint care. The organization policy on restraints (August, 2015) also required a modification to the care plan when restraints were used.

Chapter: Provision of Care, Treatment, and Services
Program: Hospital Accreditation
Standard: PC.03.05.05
Standard Text: For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital initiates restraint or seclusion based on an individual order.

Element(s) of Performance:

1. For hospitals that use Joint Commission accreditation for deemed status purposes: A physician, clinical psychologist, or other authorized licensed independent practitioner primarily responsible for the patient’s ongoing care orders the use of restraint or seclusion in accordance with hospital policy and law and regulation.
Note: The definition of ‘physician’ is the same as that used by the Centers for Medicare & Medicaid Services (CMS) (refer to the Glossary).

Scoring Category: A
Score: Insufficient Compliance

Observation(s):
§482.13(e)(5) - (A-0168) - (5) The use of restraint or seclusion must be in accordance with the order of a physician or other licensed independent practitioner who is responsible for the care of the patient as specified under §481.12(c) and authorized to order restraint or seclusion by hospital policy in accordance with State law. This Standard is NOT MET as evidenced by:

**Observed in Individual Tracer at University of Texas MD Anderson Cancer Center | 1515 Holcomb (1515 Holcombe Boulevard, Houston, TX) site for the Hospital deemed service.**

A patient in the MICU required restraints as part of their treatment. However, there was not an order for restraint initiation. For example, a patient was placed in restraints following intubation in the afternoon of one day of care. However, an order was not added to the electronic medical record until the following day.
Observations noted within the Opportunities for Improvement (OFI) section of the report represent single instances of non-compliance noted under a C category Element of Performance. Although these observations do not require official follow up through the Evidence of Standards Compliance (ESC) process, they are included to provide your organization with a robust analysis of all instances of non-compliance noted during survey.

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Opportunities for Improvement – Detail

Chapter: Environment of Care
Program: Hospital Accreditation
Standard: EC.02.01.03
Standard Text: The hospital prohibits smoking except in specific circumstances.

Element(s) of Performance:
6. The hospital takes action to maintain compliance with its smoking policy.  

Scoring Category : C
Score : Satisfactory Compliance

Observation(s):
EP6
Observed in Building Tour at University of Texas MD Anderson Cancer Center (1515 Holcombe Boulevard, Houston, TX) site.
The hospital policy prohibits smoking anywhere on the campus. There was a cigarette that had been put out on the floor inside stairwell DD on the top landing.

Chapter: Human Resources
Program: Hospital Accreditation
Standard: HR.01.06.01
Standard Text: Staff are competent to perform their responsibilities.

Element(s) of Performance:
6. Staff competence is assessed and documented once every three years, or more frequently as required by hospital policy or in accordance with law and regulation.  

Scoring Category : C
Score : Satisfactory Compliance

Observation(s):
EP6
Observed in Tracer Activities at University of Texas MD Anderson Cancer Center (1515 Holcombe Boulevard, Houston, TX) site.
It was noted that competencies were not completed to represent the tasks being performed by staff members as evidenced by the following observations:
1. A competency for staff using the Bio Room was not documented. This area was mainly used for the compounding of BCG.
2. No process for competency validation for environmental services staff for cleaning of the sterile compounding area for both hazardous and non-hazardous items was defined.
3. No competency for hazardous sterile compounding for pharmacists or technicians was documented.
4. A crash cart was noted to be stored in the G14 pharmacy for use during a code blue emergency in observation unit area. The pharmacist responsible for completing the crash cart check was not aware that the defibrillator was to be discharged during the crash cart check. The competency checklist used for crash cart competency for pharmacists was reviewed, and the steps for defibrillator testing were not outlined in the checklist.

Chapter: Infection Prevention and Control
Program: Hospital Accreditation
Standard: IC.02.01.01
Standard Text: The hospital implements its infection prevention and control plan.

Element(s) of Performance:
2. The hospital uses standard precautions, * including the use of personal protective equipment, to reduce the risk of infection. (See also EC.02.02.01, EP 4)
Note: Standard precautions are infection prevention and control measures to protect against possible exposure to infectious agents. These precautions are general and applicable to all patients.
Footnote *: For further information regarding standard precautions, refer to the website of the Centers for Disease Control and Prevention (CDC) at http://www.cdc.gov/hai/ (Infection Control in Healthcare Settings).

Scoring Category: C
Score: Satisfactory Compliance

Observation(s):
EP2
Observed in Individual Tracer at University of Texas MD Anderson Cancer Center (1515 Holcombe Boulevard, Houston, TX) site.
It was noted during the sedation procedure for a pediatric patient receiving a lumbar puncture, the RN did not have her nose covered with her mask while the procedure was occurring.
Standard: IM.02.02.01
Standard Text: The hospital effectively manages the collection of health information.

Element(s) of Performance:

3. The hospital follows its list of prohibited abbreviations, acronyms, symbols, and dose designations, which includes the following:
   - U, μ
   - IU
   - Q.D., QD, q.d., qd
   - Q.O.D., QOD, q.o.d, qod
   - Trailing zero (X.0 mg)
   - Lack of leading zero (.X mg)
   - MS
   - MSO4
   - MgSO4
   Note 1: A trailing zero may be used only when required to demonstrate the level of precision of the value being reported, such as for laboratory results, imaging studies that report the size of lesions, or catheter/tube sizes. It may not be used in medication orders or other medication-related documentation.
   Note 2: The prohibited list applies to all orders, preprinted forms, and medication-related documentation. Medication-related documentation can be either handwritten or electronic.

Scoring Category: C
Score: Satisfactory Compliance

Observation(s):

EP3
Observed in Individual Tracer at University of Texas MD Anderson Cancer Center (1515 Holcombe Boulevard, Houston, TX) site.
During the review of the medical record, it was noted that the unapproved abbreviation VP 16 was used several times in the history and progress notes.
Element(s) of Performance:

5. Sprinkler heads are not damaged and are free from corrosion, foreign materials, and paint. (For full text and any exceptions, refer to NFPA 25-1998: 2-2.1.1)

Scoring Category: C
Score: Satisfactory Compliance

Observation(s):

EP5
Observed in Building Tour at University of Texas MD Anderson Cancer Center (1515 Holcombe Boulevard, Houston, TX) site.
There was a sprinkler head, in the corridor near P2 3104, that was extremely dirty. (Verified cleaned during the survey)

Chapter: Medication Management
Program: Hospital Accreditation
Standard: MM.03.01.01
Standard Text: The hospital safely stores medications.

Element(s) of Performance:

7. All stored medications and the components used in their preparation are labeled with the contents, expiration date, and any applicable warnings.
Note: This element of performance is also applicable to sample medications.

Scoring Category: C
Score: Satisfactory Compliance

Observation(s):

EP7
Observed in Individual Tracer at University of Texas MD Anderson Cancer Center (1515 Holcombe Boulevard, Houston, TX) site.
While conducting tracer activity on G-12, it was noted that a multiple dose vial of insulin was dated with an expiration date of 10/11/2018. This was not in accordance with the 28 day expiration date policy for multiple dose vials.

Chapter: Medication Management
Program: Hospital Accreditation
Standard: MM.04.01.01
Standard Text: Medication orders are clear and accurate.
13. The hospital implements its policies for medication orders.

Scoring Category: C
Score: Satisfactory Compliance

Observation(s):

EP13
Observed in Tracer Activities at University of Texas MD Anderson Cancer Center (1515 Holcombe Boulevard, Houston, TX) site.
During the review of the medical record, it was noted that three medications were ordered for nausea. The Phenergan was ordered as both the 1st and 4th choices, while the Compazine was the 2nd choice and the Zofran was also the 4th choice. There was no indicated 3rd choice. This set of orders was not clarified with the physician to identify which medication was clearly 1st, 2nd and 3rd choice. Which did not follow hospital policy.

Chapter: National Patient Safety Goals
Program: Hospital Accreditation
Standard: NPSG.07.04.01
Note: This requirement covers short- and long-term central venous catheters and peripherally inserted central catheter (PICC) lines.

Element(s) of Performance:

3. Implement policies and practices aimed at reducing the risk of central line–associated bloodstream infections. These policies and practices meet regulatory requirements and are aligned with evidence-based standards (for example, the Centers for Disease Control and Prevention (CDC) and/or professional organization guidelines).

Scoring Category: C
Score: Satisfactory Compliance

Observation(s):

EP3
Observed in Individual Tracer at University of Texas MD Anderson Cancer Center (1515 Holcombe Boulevard, Houston, TX) site.
It was noted that in some areas of the hospital, that the RNs who were changing central line dressings or accessing implanted central line vascular access devices did not don masks during these procedures as per national guidelines, nor were observers or family members offered masks to wear during the accessing procedure.

Chapter: Provision of Care, Treatment, and Services
Program: Hospital Accreditation
Standard: PC.01.02.03
Standard Text: The hospital assesses and reassesses the patient and his or her condition according to defined time frames.

Element(s) of Performance:

5. For a medical history and physical examination that was completed within 30 days prior to registration or inpatient admission, an update documenting any changes in the patient's condition is completed within 24 hours after registration or inpatient admission, but prior to surgery or a procedure requiring anesthesia services. (See also MS.03.01.01, EP 8; RC.02.01.03, EP 3)

Scoring Category: C
Score: Satisfactory Compliance

Observation(s):

EP5
Observed in Individual Tracer at University of Texas MD Anderson Cancer Center (1515 Holcombe Boulevard, Houston, TX) site.
There was no update to a prior completed history and physical examination on the day of an outpatient invasive procedure requiring sedation.

Chapter: Provision of Care, Treatment, and Services
Program: Hospital Accreditation
Standard: PC.03.05.15
Standard Text: For hospitals that use Joint Commission accreditation for deemed status purposes:
The hospital documents the use of restraint or seclusion.
Element(s) of Performance:

1. For hospitals that use Joint Commission accreditation for deemed status purposes:
   Documentation of restraint and seclusion in the medical record includes the following:
   - Any in-person medical and behavioral evaluation for restraint or seclusion used to manage violent or self-destructive behavior
   - A description of the patient’s behavior and the intervention used
   - Any alternatives or other less restrictive interventions attempted
   - The patient’s condition or symptom(s) that warranted the use of the restraint or seclusion
   - The patient’s response to the intervention(s) used, including the rationale for continued use of the intervention
   - Individual patient assessments and reassessments
   - The intervals for monitoring
   - Revisions to the plan of care
   - The patient’s behavior and staff concerns regarding safety risks to the patient, staff, and others that necessitated the use of restraint or seclusion
   - Injuries to the patient
   - Death associated with the use of restraint or seclusion
   - The identity of the physician, clinical psychologist, or other licensed independent practitioner who ordered the restraint or seclusion
   - Orders for restraint or seclusion
   - Notification of the use of restraint or seclusion to the attending physician
   - Consultations

Note: The definition of ‘physician’ is the same as that used by the Centers for Medicare & Medicaid Services (CMS) (refer to the Glossary).

Scoring Category: C
Score: Satisfactory Compliance

Observation(s):

EP1
Observed in Individual Tracer at University of Texas MD Anderson Cancer Center (1515 Holcombe Boulevard, Houston, TX) site.
A patient did not have restraint monitoring documented in the electronic medical record as the organization required; as evidenced by, the organization policy on restraints (August, 2015) required at least every two hour monitoring, however, with this patient, there was no documented restraint monitoring during a night shift.