STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	450788	A. BUILDING _____ B. WING _____	C 06/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORPUS CHRISTI MEDICAL CENTER,THE	6629 WOODRIDGE ROAD CORPUS CHRISTI, TX 78414

(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	INITIAL COMMENTS An unannounced complaint survey was conducted from 6/25/19 to conduct a survey for complaint investigation TX00317717 An entrance conference was conducted on 6/25/19 in the conference room of the facility with the Director of Quality Management compliance, Chief Medical Officer,and Chief Nursing Officer in attendance. The purpose and process of the complaint survey were discussed, and an opportunity for questions was provided. Complaints TX00317717 was substantiated in the areas of Infection Control and Physical Environment. An exit conference was conducted on 6/25/19 in the conference room. The Director of Quality Management, Chief Nursing Officer, and Chief Medical Officer was in attendance. Preliminary findings of the survey were discussed and an opportunity for questions was provided.	A 000		
A 701	MAINTENANCE OF PHYSICAL PLANT CFR(s): 482.41(a) 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: Based on observation of the decontamination room, and interview the facility failed to ensure a sanitary environment in the decontamination	A 701		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Raeann J. Wulgot
TITLE: FVPQM
(X6) DATE: 8/2/19

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	450788	A. BUILDING _____ B. WING _____	C 06/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORPUS CHRISTI MEDICAL CENTER,THE	6629 WOODRIDGE ROAD CORPUS CHRISTI, TX 78414

(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 701	Continued From page 1 room this deficient practice had the likelihood to cause harm to facility patients. Findings: A tour of the decontam room was conducted on 06/25/19 beginning at 2:40 p.m. a. Staff #10 was asked to show the area for the drain for sterilizer #3. A metal panel was leaned up against a wall at the back of the left side of the room. A rolling cart was positioned in front of the panel. The manager moved the panel which was not secured to the wall. Observation revealed deteriorating wood, deteriorating sheetrock, rusty pipes, pieces of insulation and debris on the floor. b. Staff # 10 was asked to show the area for the drain for sterilizer #2. A metal panel held in place by a fastener on each side and a lip at the top of the panel. A rolling cart was positioned in front of the panel. The manager opened the panel. Observation revealed deteriorating sheetrock, rusty pipes, pieces of insulation, and debris on the floor including green fabric. c. A hopper sink to the front right of the room could not be flushed, the left faucet handle had green corrosion around it and water dripping in a steady stream, the faucet was dripping constantly, and the ceramic bowl had greenish brown debris in the bowl and around the edges. d. The metal door below the scope cleaner next to the hopper sink was covered with dried drippings. e. A rolling cart on the front left side of the room was covered with dusty debris, dried drippings	A 701		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	450788	A. BUILDING _____ B. WING _____	C 06/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORPUS CHRISTI MEDICAL CENTER,THE	6629 WOODRIDGE ROAD CORPUS CHRISTI, TX 78414

(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 701	Continued From page 2 and there was rust on the bottom shelf. Observations revealed 2 metal case carts outside of OR#2 and OR#3 with rust on all 4 wheels of both carts. Staff #10 was interviewed on 6/25/19 and according to him:All metal pans are wiped out when they are returned after a case. Any metal pans that go into the room with a patient in the room are sent thru the washer sterilizer.	A 701		
A 749	INFECTION CONTROL PROGRAM CFR(s): 482.42(a)(1) The infection control officer or officers must develop a system for identifying, reporting, investigating, and controlling infections and communicable diseases of patients and personnel. This STANDARD is not met as evidenced by: Based on observation of the decontamination room, and interview the facility failed to ensure a sanitary environment in the decontamination room this deficient practice had the likelihood to cause harm to facility patients. Observation of the washer sterilizer in use on 6/25/19 at that time revealed the presence of a metal tray in the washer sterilizer. 1:05 p.m. - Observation in the presence of staff member #10 revealed: A metal tray used for holding a Shake N Bake	A 749		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	450788	A. BUILDING _____ B. WING _____	C 06/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORPUS CHRISTI MEDICAL CENTER,THE	8629 WOODRIDGE ROAD CORPUS CHRISTI, TX 78414

(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 749	Continued From page 3 instrument set with dusty and sticky tannish debris in the bottom. Staff member #10 confirmed the observations. A metal tray used for holding a Red & Grey lami set with tannish debris and black flecks in the bottom that could be wiped out with a Sani cloth. staff member #10 confirmed the observations. Observation in the presence staff member #10 revealed: A metal tray that held a minor set was opened after having been sterilized by staff member #10. The minor set was lifted out of the tray. Tannish sticky debris with black and blue flecks was observed in the bottom of the tray that could be wiped up with a Sani cloth. Staff #10 was interviewed on 6/25/19 and according to him:All metal pans are wiped out when they are returned after a case. Any metal pans that go into the room with a patient in the room are sent thru the washer sterilizer.	A 749		

Tag	Plan of Corrections	Completion Date
A 749	The Steris contractor was contacted immediately because of the tannish debris and black flecks in the bottom of the metal tray and they were unable to identify the issue.	06/26/2019
	Because Steris was unable to identify the issue, South Texas Boiler company was requested to inspect of the boiler. It was determined that a thermostatic trap needed to be ordered.	06/26/2019
	The South Texas Boiler company completed a steam test which did not identify any issues.	07/17/2019
	The Director of Plant Operations ensured the pipe from the sterilizer was properly installed and insulated.	07/29/2019
	The South Texas Boiler company replaced the thermostatic trap.	07/29/2019
	The Chem-Aqua company completed a review of the steam which showed no contamination coming from high iron levels or boiler carryover. See attachment C.	07/29/2019
	The Steris company reviewed the sterilizer identified and corrected a blocked sprayer outlet in the washer.	07/29/2019
	The hospital tested the sterilizer with small amounts of flecks noted.	07/29/2019
	The filter was changed and further testing was done with no tannish debris or flecks noted.	07/30/2019
	1. The Director of Surgical Services/ICP/Designee will complete 20 Sterilization Audits for a month and then weekly for 4 months with a goal of 100%. If 100% compliance is not achieved within the timeframe, the audit will continue until 100% is sustained.Any noncompliance issues will be addressed with employees immediately with just-in-time training. 2. The Director of Surgical Services will report data from the monitoring to the QPSC monthly begin 8/2019. The Facility VP of QM will report to the MEC and BOT monthly beginning 8/2019.	08/05/2019
	The Director of Surgical Services/Manager educated the Sterile Processing staff on washing and sterilizing all metal pans when used. See attachment B-Education Sign In.	07/30/2019

	1. The Director of Surgical Services/ICP/Designee will complete 20 Sterilization Audits for a month and then weekly for 4 months with a goal of 100%. If 100% compliance is not achieved within the timeframe, the audit will continue until 100% is sustained. Any noncompliance issues will be addressed with employees immediately with just-in-time training. 2. The Director of Surgical Services will report data from the monitoring to the QPSC monthly begin 8/2019. The Facility VP of QM will report to the MEC and BOT monthly beginning 8/2019.	08/05/2019