STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	150021	A. BUILDING 00 B. WING	04/13/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKVIEW REGIONAL MEDICAL CENTER	11109 PARKVIEW PLAZA DRIVE FORT WAYNE, IN 46845

(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 0000 Bldg. 00	This visit was for investigation of two Federal hospital complaints. Date: 4/11/16 - 4/13/16 Facility Number: 005020 Complaint Numbers: IN00193613: Substantiated; deficiencies related to the allegations are cited IN00197016: Unsubstantiated; lack of sufficient evidence. Deficiency unrelated to the allegations is cited QA: cjl 04/22/16	A 0000		
A 0395 Bldg. 00	482.23(b)(3) RN SUPERVISION OF NURSING CARE A registered nurse must supervise and evaluate the nursing care for each patient. Based on document review and interview, the nursing supervisor failed to ensure that nursing staff documented repositioning every 2 hours, for those patients scoring as a moderate or high risk for skin issues, for 3 of 10 patients, patients #5, #6 and #10 and nursing supervisor failed to ensure nursing staff	A 0395	1. Describe what the facility did to correct the deficient practice for each client cited in the deficiency. Response: The staff on the units where the deficiency occurred will receive education regarding the policy expectations (documenting	09/01/2016

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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	followed policy & procedure for vital signs for 2 of 10 patients (patient #3 and #8). Findings Include: 1. Review of the policy Skin Assessment and Prevention of Pressure Ulcers, no policy number, last approved on 4/13, indicated the Braden scoring tool is utilized to assess possible skin issues for patients. A. On page 5, it reads that a score of 15 to 18 is Mild Risk and the patient is to have a "Care plan: Mild Risk for Pressure Ulcer 15 - 18" with the nursing staff to "Reposition minimally every 2 hours if unable to turn self." B. On page 6, it reads that for scores of 13 - 14, a Moderate Risk, the patient is to be "...Repositioned minimally every 2 hours if unable to turn self...". C. On page 7, it reads that for scores of 10 - 12, High Risk, the patient is to be "...Repositioned minimally every 2 hours if unable to turn self...". 2. Review of patient medical records indicated: A. Pt. #5 scored 14 (Moderate Risk) on the Braden tool on admission 3/15/16. It was also noted on: a. 3/15/16 at 2200 hours that the patient "turns self". b. 3/16/16 at 0018 hours that the		turns every 2 hours for patients who have a moderate to high risk score on the Braden Scale). Nursing Services will provide documentation education with a PowerPoint presentation that includes screen shots from the electronic medical record. Continual education during daily huddles, monthly unit meetings, and one-to-one coaching. 2. Describe how the facility reviewed all clients in the facility that could be affected by the same deficient practice, and state, what actions the facility took to correct the deficient practice for any client the facility identified as being affected. Response: A skin assessment will be completed for all patients at risk for pressure sores or who have pressure sores. 3. Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur , including any in-services, but this also should include any system changes you made. Response: a. Nurse leads will conduct 2 audits per shift (4 total for each calendar day). Audits will continue until 90% compliance is attained for 3 consecutive months.	

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	patient was "bedrest" and needed "mod assist". c. 3/16/16 lacked documentation for repositioning from 0800 hours to 1252 hours and from 1400 hours to 2051 hours. d. 3/17/16 from 0200 hours to 0710 hours lacked documentation of repositioning. B. Pt. #6 scored 12 (High Risk) on admission (3/15/16) according to the Braden scoring tool and later scored 12, 11, 10 and 8. Other documentation included: a. On the med/surg nursing unit on 3/15/16 from 1819 hours to 0047 on 3/16/16 lacked repositioning documentation or on 3/16/16 from 0047 to 0421 and 0421 hours to 0854 hours. b. On 3/16/16, in the ICU (intensive care unit), there was no every two hours repositioning noted between 0854 hours and 1200 hours and from 1200 hours to 1500 hours. c. On 3/17/16, lacked documentation of repositioning every two hours between 0600 hours and 0900 hours. C. Pt. #10 was a 68 year old admitted on 4/11/16 with a Braden score initially of 15 (Mild Risk) with other assessments being 14 and 15. a. On 4/12/16, lacked repositioning		b. System-wide review to identify and close any gaps. 4. Describe how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. Response: ·Parkview Health Chief Nursing Executive will be responsible for implementing the education and audits.The system by which the responsible person(s) will monitor · Nurse leads will conduct 2 audits per shift (4 total for each calendar day). Audits will continue until 90% compliance is attained for 3 consecutive months. · Unit education will begin May 10, 2016 and will be completed by June 01, 2016. Unit audits will begin June 01, 2016 until 3 consecutive months of 90% compliance is attained.	

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	documentation between 0100 hours and 0600 hours; from 0900 hours to 1600 hours; and from 1600 hours to 2300 hours b. Lacked repositioning documentation from 2300 on 4/12/16 to 0612 on 4/13/16, and lacked documentation made after 0612 hours to the time of record review at 1206 hours. 3. At 3:10 PM on 4/12/16 and 11:15 AM on 4/13/16, interview with staff members #50 and #55, quality and accreditation specialists, confirmed that documentation for patients #5, #6 and #10 lacked documentation every two hours, per policy and care plans, regarding repositioning, or that the patient was turning themselves. 4. Review of the policy Clinical Standards of Care Perioperative, no policy number, last approved on 6/2015, indicated on page 6: "Vital Signs" were to be taken at "Admit/every 5 min x5 (sic), then every 15 min...". 5. Review of the medical record for patient #3 indicated the patient arrived in the PACU (post anesthesia care unit) at 1149 hours on 1/22/16 and had VS taken at 1150 hours, 1155 hours and 1200 hours with no further VS noted until a code blue was initiated at 1214 hours.			

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	6. Review of the document Critical Care Standards --Advanced Post- Operative ICU (intensive care unit) Patient Care Standards, no number or date of approval, indicated patients who recover in the critical or intensive care units are to have documentation for: "...Document warming device and temperature on Admission; Vitals on Admit then every 5 minutes x 5, then every 15 minutes x7 (sic), then hourly...". 7. Review of the medical record for patient #8 indicated they went to the critical/intensive care unit after surgery on 4/12/16 at 1815 hours and had VS taken every 15 minutes at 1815 hours, 1830 hours, 1845 hours, 1900 hours, 1915 hours, 1930 hours and 1945 hours. 8. At 11:30 AM on 4/13/16, interview with staff member #55, a quality and accreditation specialist, confirmed that the post op VS for patients #3 and #8 were not every 5 minutes x 5 as per facility policies and protocols.			

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A 0450 Bldg. 00	482.24(c)(1) MEDICAL RECORD SERVICES All patient medical record entries must be legible, complete, dated, timed, and authenticated in written or electronic form by the person responsible for providing or evaluating the service provided, consistent with hospital policies and procedures. Based on document review and interview, the facility failed to ensure the completeness of PACU (post anesthesia care unit) documentation in the medical record for 1 of 3 surgical patient records reviewed, Patient #3. Findings Include: 1. Review of the document Critical Care Standards --Advanced Post- Operative ICU (intensive care unit) Patient Care Standards, no number or date of approval, indicated patients who recover in the critical or intensive care units are to have documentation for: "...Vitals on Admit then every 5 minutes x 5, then every 15 minutes x7 (sic), then hourly...". 2. Review of medical records indicated: A. Patient #3 had surgery on 1/22/16, was taken to PACU at 1149 hours with the first VS (vital signs) taken at 1150	A 0450	Describe what the facility did to correct the deficient practicefor each client cited in the deficiency. ·Provide education to nursing staff on the policy for documentingvital signs ·Provide education for ICU and PACU nursing staff regardingverifying and validating vital signs ·Provide competency training and education for PACU nursesregarding extubation documentation requirements. ·Update Clinical Standards of Care Perioperative policy toinclude extubation criteria for PACU nurses ·Mandate staff review of the updated policy related to extubation Describe how the facility reviewed all clients in the facilitythat could be affected by the same deficient practice, and state, what actionsthe facility took to correct the deficient practice for any client the facilityidentified as being	06/30/2016

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	hours. At 1151 hours, the patient was documented as being on the ventilator. VS were taken at 1155 hours and 1200 hours. At 1205 hours no VS were charted and the oxygen level was at 91%; at 1210 hours, respirations were 13 and the oxygen saturation was 92%, but no VS were taken. The medical record noted that a Code Blue was called at 1214 hours with compressions initiated. B. Patient #3 had a hospitalist note written at 1255 hours on 1/22/16, and "filed" at 1328 hours, that indicated: "Called for code blue. Patient sp (status post) lap cholecystectomy. Developed respiratory failure post extubation and then went into PEA (pulseless electrical activity). CPR (cardio pulmonary resuscitation) initiated. Patient was reintubated...". 3. Review of the document related to the code blue committee evaluation on 2/11/16 of patient #3's code indicated: "...Code Blue was initiated. More than thirty (30) people responded. The first endotracheal tube was placed and resuscitation efforts began. The Code went well ...The first tube was pulled and the second one placed and the ETCO2 (End-Tidal Carbon Dioxide) (winky) was used and confirmed the endotracheal tube was correctly positioned to ventilate the lungs. After the second intubation, the		affected. ·Nurse Leader will audit 2 charts per day to verify documentationof vital signs. Audits will continue until 90% compliance is attained for 3consecutive months. ·Nurse Leader will audit 100% cases with extubation in PACU andreport audit findings and completion of education biweekly to qualitymanagement and the leadership team. Any compliance issues will be addressedwith the responsible co-worker. Describe the steps or systemic changes the facility has made orwill make to ensure that the deficient practice does not recur , including anyin-services, but this also should include any system changes you made. ·Clinical Standards of Care Perioperative policy will be updatedto include extubation criteria for PACU nurses ·Competency training and well as written education for PACUnurses regarding extubation documentation requirements will be provided. ·Staff will sign off that they reviewed and attest to educationof the updated policy. ·Education for nursing staff regarding verifying andvalidating vital signs per the policy will be provided ·In-service education of nursing staff on the policy. Describe how the corrective action(s) will be monitored	

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	team got [the patient] back right away..." 4. At 11:50 AM on 4/12/16 interview with staff member P1, the pre op nurse for patient #3 on 1/22/16, confirmed that they remembered the patient was "fully awake when extubated" in the PACU, prior to the arrest. 5. At 10:05 AM on 4/13/16, interview with PACU nurse #59 confirmed that there was no other nursing notes or documentation in patient #3's medical record related to the patient's PACU time between 1210 hours (respirations and oxygen saturation level) and 1214 hours, that there was no documentation related to patient #3 being extubated in PACU, and that criteria had been met to complete the extubation process. 6. At 11:15 AM on 4/13/16 , interview with staff member #55, a quality and accreditation specialist, confirmed that: A. There is no facility policy related to the completeness of medical records. B. The medical record for patient #3 was incomplete for documentation related to extubation time prior to a re intubation during the code blue, as noted by the hospitalist who attended the code. It was also confirmed that there was no PACU documentation between 1210 hours and the code which began 1214		toensure the deficient practice will not recur, i.e., what quality assuranceprogram will be put into place. ·Nursing review of policy completed by May 31, 2016. ·Nursing education regarding validating and verifying vital signscompleted by May 31, 2016. ·Competency training and education for PACU nurses regardingextubation documentation requirements completed by May 31, 2016. ·Clinical Standards of Care Perioperative policy updated toinclude extubation criteria by PACU nurses by June 30, 2016. ·Mandatory staff review of the updated policy completed by May31, 2016. Who is responsible ·The Vice President of Nursing at the Randallia location will beresponsible for implementing education and ongoing compliance with this actionplan.	

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	hours. C. It was unclear what occurred in the PACU prior to the code of 1214 hours on 1/22/16.			
S 0000 Bldg. 00	This visit was for investigation of two hospital licensure complaints. Date: 4/11/16 - 4/13/16 Facility Number: 005020 Complaint Numbers: IN00193613: Substantiated, Deficiencies cited related to the allegations. IN00197016: Unsubstantiated, Lack of sufficient evidence, deficiency cited	S 0000		

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	unrelated to the allegations. QA: cjl 04/22/16			
S 0744 Bldg. 00	410 IAC 15-1.5-4 MEDICAL RECORD SERVICES 410 IAC 15-1.5-4 (e)(1) (e) All entries in the medical record shall be: (1) legible and complete; Based on document review and interview, the facility failed to ensure the completeness of PACU (post anesthesia care unit) documentation in the medical record for 1 of 3 surgical patient records reviewed, Patient #3. Findings Include: 1. Review of the document Critical Care Standards --Advanced Post- Operative ICU (intensive care unit) Patient Care Standards, no number or date of approval, indicated patients who recover in the critical or intensive care units are to have documentation for: "...Vitals on Admit then every 5 minutes x 5, then every 15 minutes x7 (sic), then hourly...". 2. Review of medical records indicated: A. Patient #3 had surgery on 1/22/16, was taken to PACU at 1149 hours with the first VS (vital signs) taken at 1150	S 0744	·Describe what the facility did to correct the deficient practicefor each client cited in the deficiency. ·Provide education to nursing staff on the policy for documentingvital signs ·Provide education for ICU and PACU nursing staff regardingverifying and validating vital signs ·Provide competency training and education for PACU nursesregarding extubation documentation requirements. ·Update Clinical Standards of Care Perioperative policy toinclude extubation criteria for PACU nurses ·Mandate staff review of the updated policy related to extubation ·Describe how the facility reviewed all clients in the facilitythat could be affected by the same deficient practice, and state, what actionsthe facility took to correct the deficient practice	06/30/2016

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	hours. At 1151 hours, the patient was documented as being on the ventilator. VS were taken at 1155 hours and 1200 hours. At 1205 hours no VS were charted and the oxygen level was at 91%; at 1210 hours, respirations were 13 and the oxygen saturation was 92%, but no VS were taken. The medical record noted that a Code Blue was called at 1214 hours with compressions initiated. B. Patient #3 had a hospitalist note written at 1255 hours on 1/22/16, and "filed" at 1328 hours, that indicated: "Called for code blue. Patient sp (status post) lap cholecystectomy. Developed respiratory failure post extubation and then went into PEA (pulseless electrical activity). CPR (cardio pulmonary resuscitation) initiated. Patient was reintubated...". 3. Review of the document related to the code blue committee evaluation on 2/11/16 of patient #3's code indicated: "...Code Blue was initiated. More than thirty (30) people responded. The first endotracheal tube was placed and resuscitation efforts began. The Code went well ...The first tube was pulled and the second one placed and the ETCO2 (End-Tidal Carbon Dioxide) (winky) was used and confirmed the endotracheal tube was correctly positioned to ventilate the lungs. After the second intubation, the		for any client the facilityidentified as being affected. ·Nurse Leader will audit 2 charts per day to verify documentationof vital signs. Audits will continue until 90% compliance is attained for 3consecutive months. ·Nurse Leader will audit 100% cases with extubation in PACU andreport audit findings and completion of education biweekly to qualitymanagement and the leadership team. Any compliance issues will be addressedwith the responsible co-worker. ·Describe the steps or systemic changes the facility has made orwill make to ensure that the deficient practice does not recur , including anyin-services, but this also should include any system changes you made. ·Clinical Standards of Care Perioperative policy will be updatedto include extubation criteria for PACU nurses ·Competency training and well as written education for PACUnurses regarding extubation documentation requirements will be provided. ·Staff will sign off that they reviewed and attest to educationof the updated policy. ·Education for nursing staff regarding verifying andvalidating vital signs per the policy will be provided ·In-service education of nursing staff on the policy.	

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	team got [the patient] back right away..." 4. At 11:50 AM on 4/12/16 interview with staff member P1, the pre op nurse for patient #3 on 1/22/16, confirmed that they remembered the patient was "fully awake when extubated" in the PACU, prior to the arrest. 5. At 10:05 AM on 4/13/16, interview with PACU nurse #59 confirmed that there was no other nursing notes or documentation in patient #3's medical record related to the patient's PACU time between 1210 hours (respirations and oxygen saturation level) and 1214 hours, that there was no documentation related to patient #3 being extubated in PACU, and that criteria had been met to complete the extubation process. 6. At 11:15 AM on 4/13/16 , interview with staff member #55, a quality and accreditation specialist, confirmed that: A. There is no facility policy related to the completeness of medical records. B. The medical record for patient #3 was incomplete for documentation related to extubation time prior to a re intubation during the code blue, as noted by the hospitalist who attended the code. It was also confirmed that there was no PACU documentation between 1210 hours and the code which began 1214		·Describe how the corrective action(s) will be monitored toensure the deficient practice will not recur, i.e., what quality assuranceprogram will be put into place. ·Nursing review of policy completed by May 31, 2016. ·Nursing education regarding validating and verifying vital signscompleted by May 31, 2016. ·Competency training and education for PACU nurses regardingextubation documentation requirements completed by May 31, 2016. ·Clinical Standards of Care Perioperative policy updated toinclude extubation criteria by PACU nurses by June 30, 2016. ·Mandatory staff review of the updated policy completed by May31, 2016. ·Who is responsible ·The Vice President of Nursing at the Randallia location will beresponsible for implementing education and ongoing compliance with this actionplan.	

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	hours. C. It was unclear what occurred in the PACU prior to the code of 1214 hours on 1/22/16.			
S 0912 Bldg. 00	410 IAC 15-1.5-6 NURSING SERVICE 410 IAC 15-15-6 (a)(2)(B)(i)(ii) (iii)(iv)(v) (a) The hospital shall have an organized nursing service that provides twenty-four (24) hour nursing service furnished or supervised by a registered nurse. The service shall have the following: (2) A nurse executive who is: (B) responsible for the following: (i) The operation of the services, including, but not limited to, determining the types and numbers of nursing personnel and staff necessary to provide care for all patient care areas of the hospital. (ii) Maintaining a current nursing service organization chart. (iii) Maintaining current job descriptions with reporting responsibilities for all nursing staff positions.			

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(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
	(iv) Ensuring that all nursing personnel meet annual in-service requirements as established by hospital and medical staff policy and procedure, and federal and state requirements. (v) Establishing the standards of nursing care and practice in all settings in which nursing care is provided in the hospital. Based on document review and interview, the nursing supervisor failed to ensure that nursing staff documented repositioning every 2 hours, for those patients scoring as a moderate or high risk for skin issues, for 3 of 10 patients, patients #5, #6, and #10; and failed to ensure that nursing staff followed the facility policies related to post op VS (vital signs) documentation for 2 of 3 surgical patients, patients #3 and 8. Findings Include: 1. Review of the policy Skin Assessment and Prevention of Pressure Ulcers, no policy number, last approved on 4/13, indicated the Braden scoring tool is utilized to assess possible skin issues for patients. A. On page 5, it reads that a score of 15 to 18 is Mild Risk and the patient is to have a "Care plan: Mild Risk for Pressure Ulcer 15 - 18" with the nursing staff to "Reposition minimally every 2 hours if unable to turn self." B. On page 6, it reads that for scores of	S 0912	1. Describe what the facility did to correct the deficient practice for each client cited in the deficiency. Response: The staff on the units where the deficiency occurred will receive education regarding the policy expectations (documenting turns every 2 hours for patients who have a moderate to high risk score on the Braden Scale). Nursing Services will provide documentation education with a PowerPoint presentation that includes screen shots from the electronic medical record. Continual education during daily huddles, monthly unit meetings, and one-to-one coaching. 2. Describe how the facility reviewed all clients in the facility that could be affected by the same deficient practice, and state, what actions the facility took to correct the deficient practice for any client the facility identified as being affected. Response: A skin assessment will be completed for all patients at risk for pressure sores or who have pressure sores. 3. Describe the steps or systemic changes the facility has	09/01/2016

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	150021	A. BUILDING 00 B. WING	04/13/2016

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	13 - 14, a Moderate Risk, the patient is to be "...Repositioned minimally every 2 hours if unable to turn self...". C. On page 7, it reads that for scores of 10 - 12, High Risk, the patient is to be "...Repositioned minimally every 2 hours if unable to turn self...". 2. Review of patient medical records indicated: A. Pt. #5 scored 14 (Moderate Risk) on the Braden tool on admission 3/15/16. It was also noted on: a. 3/15/16 at 2200 hours that the patient "turns self". b. 3/16/16 at 0018 hours that the patient was "bedrest" and needed "mod assist". c. 3/16/16 lacked documentation for repositioning from 0800 hours to 1252 hours and from 1400 hours to 2051 hours. d. 3/17/16 from 0200 hours to 0710 hours lacked documentation of repositioning. B. Pt. #6 scored 12 (High Risk) on admission (3/15/16) according to the Braden scoring tool and later scored 12, 11, 10 and 8. Other documentation included: a. On the med/surg nursing unit on 3/15/16 from 1819 hours to 0047 on 3/16/16 lacked repositioning		made or will make to ensure that the deficient practice does not recur , including any in-services, but this also should include any system changes you made. Response: a. Nurse leads will conduct 2 audits per shift (4 total for each calendar day). Audits will continue until 90% compliance is attained for 3 consecutive months. b. System-wide review to identify and close any gaps. 4. Describe how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. Response: ·Parkview Health Chief Nursing Executive will be responsible for implementing the education and audits.The system by which the responsible person(s) will monitor · Nurse leads will conduct 2 audits per shift (4 total for each calendar day). Audits will continue until 90% compliance is attained for 3 consecutive months. · Unit education will begin May 10, 2016 and will be completed by June 01, 2016. Unit audits will begin June 01, 2016 until 3 consecutive months of 90% compliance is attained.	

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	documentation or on 3/16/16 from 0047 to 0421 and 0421 hours to 0854 hours. b. On 3/16/16, in the ICU (intensive care unit), there was no every two hours repositioning noted between 0854 hours and 1200 hours and from 1200 hours to 1500 hours. c. On 3/17/16, lacked documentation of repositioning every two hours between 0600 hours and 0900 hours. C. Pt. #10 was a 68 year old admitted on 4/11/16 with a Braden score initially of 15 (Mild Risk) with other assessments being 14 and 15. a. On 4/12/16, lacked repositioning documentation between 0100 hours and 0600 hours; from 0900 hours to 1600 hours; and from 1600 hours to 2300 hours b. Lacked repositioning documentation from 2300 on 4/12/16 to 0612 on 4/13/16, and lacked documentation made after 0612 hours to the time of record review at 1206 hours. 3. At 3:10 PM on 4/12/16 and 11:15 AM on 4/13/16, interview with staff members #50 and #55, quality and accreditation specialists, confirmed that documentation for patients #5, #6 and #10 lacked documentation every two hours, per policy and care plans, regarding repositioning, or that the patient was			

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	turning themselves. 4. Review of the policy Clinical Standards of Care Perioperative, no policy number, last approved on 6/2015, indicated on page 6: "Vital Signs" were to be taken at "Admit/every 5 min x5 (sic), then every 15 min...". 5. Review of the medical record for patient #3 indicated the patient arrived in the PACU (post anesthesia care unit) at 1149 hours on 1/22/16 and had VS taken at 1150 hours, 1155 hours and 1200 hours with no further VS noted until a code blue was initiated at 1214 hours. 6. Review of the document Critical Care Standards --Advanced Post- Operative ICU (intensive care unit) Patient Care Standards, no number or date of approval, indicated patients who recover in the critical or intensive care units are to have documentation for: "...Document warming device and temperature on Admission; Vitals on Admit then every 5 minutes x 5, then every 15 minutes x7 (sic), then hourly...". 7. Review of the medical record for patient #8 indicated they went to the critical/intensive care unit after surgery on 4/12/16 at 1815 hours and had VS taken every 15 minutes at 1815 hours,			

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	1830 hours, 1845 hours, 1900 hours, 1915 hours, 1930 hours and 1945 hours. 8. At 11:30 AM on 4/13/16, interview with staff member #55, a quality and accreditation specialist, confirmed that the post op VS for patients #3 and #8 were not every 5 minutes x 5 as per facility policies and protocols.			