

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151302	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/05/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER INDIANA UNIVERSITY HEALTH BLACKFORD HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 410 PILGRIM BLVD HARTFORD CITY, IN47348
--	---

(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
S0000	<p>This visit was for a State hospital licensure survey.</p> <p>Dates: 10/3/2011 through 10/5/2011</p> <p>Facility Number: 005101</p> <p>Surveyors: Albert Daeger, CFM, SFPIO Medical Surveyor</p> <p>Saundra Nolfi, RN PH Nurse Surveyor</p> <p>QA: cloughlin 10/24/11</p>	S0000		
S0286	<p>410 IAC 15-1.4-1 (b)(4)</p> <p>(b) The governing board is responsible for the conduct of the medical staff. The governing board shall do the following:</p> <p>(4) Ensure that the medical staff is accountable and responsible to the governing board for the quality of care provided to patients.</p> <p>Based on document review and interview, the facility failed to ensure all credential medical staff were evaluated for 1 of 5 medical staff members.(#28)</p>	S0286	<p>Tag S 286 Plan of Correction The Medical Staff Peer Review Committee will continue to meet quarterly, reviewing a representative sample of each practitioner's cases. Effective with the October</p>	10/25/2011

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

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151302	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/05/2011
NAME OF PROVIDER OR SUPPLIER INDIANA UNIVERSITY HEALTH BLACKFORD HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 410 PILGRIM BLVD HARTFORD CITY, IN47348		
(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	
	<p>Findings included:</p> <ol style="list-style-type: none"> 1. Review of five credential files indicated Physician #28 was not evaluated by the Peer Review Committee. 2. Medical Staff By-laws, approved by the Governing Board, section 12.1-8 noted under Peer Review Committee stated, "A committee Comprised of the members of the Active Staff shall meet, at least quarterly, to review a representative sample of each practitioner's cases." 3. Review of the Peer Review Case Summary indicated Physician #28 was not listed for review. 4. At 10:00 AM on 10/4/2011, staff member #3 confirmed that the Medical Staff By-laws requires all physicians to be evaluated. 		<p>25, 2011 Peer Review Committee meeting, an expanded schedule of cases was reviewed by the Committee. That review included cases of Physician #28, as identified in the ISDH Summary of deficiencies. This approach to Peer Review shall continue and a summary of the Peer Review Committee's activities shall be presented to the Board of Directors on a quarterly basis. The first such report will be presented at the November 23, 2011 or December 22, 2011 meeting of the Board of Directors. The responsibility for implementation of the POC described is shared by the QI Coordinator, the CEO, and the Medical Staff President. The Peer Review Committee findings are considered by the Credentials Committee and Medical Staff when making recommendations concerning Medical Staff reappointments and privilege changes. The policy entitled "Peer Review Guidelines" is attached. (Attachment #S 286) <u>Addendum</u> The Chief Executive Officer (CEO) is responsible for the implementation of and ongoing monitoring of the POC.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151302	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/05/2011
NAME OF PROVIDER OR SUPPLIER INDIANA UNIVERSITY HEALTH BLACKFORD HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 410 PILGRIM BLVD HARTFORD CITY, IN47348		
(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	
S0394	<p>410 IAC 15-1.4-1(f)(3)</p> <p>(f) The governing board is responsible for services delivered in the hospital whether or not they are delivered under contracts. The governing board shall insure the following:</p> <p>(3) That the hospital maintains a list of all contracted services, including the scope and nature of the services provided.</p> <p>Based on document review and interview, the facility failed to provide an exclusive list of all contracted services delivered in the hospital.</p> <p>Findings included:</p> <p>1. Review of IU Blackford Hospital policy Contract Services effective date January 1, 2011 policy indicated, "As of January 1, 2011, the following services provided at Indiana University Health Blackford Hospital are provided as contracted services. The approved policy listed 13 contracted services. The following contractual services were not listed in the approved policy of contractual services: #JC1, #KFS1, #E1, #UHL1, #RC1 and #IBC1.</p> <p>2. At 11:30 AM on 10/5/2011, staff member #3 indicated the list was created based on his/her concept of the State standard and he/she felt it did not mean all</p>	S0394	<p>Tag S 394 Plan of Correction A master listing of contracts has been developed as of November 4, 2011 by the Director of Support Services (Attachment #S 394). <u>Prevention</u>: The contract master listing will be maintained by the Director of Support Services on an ongoing basis. <u>Responsibility</u>: Director of Support Services <u>Date Completed</u>: November 4, 2011 <u>Addendum</u> The Director of Support Services, in addition to maintaining the list of contracts, is responsible for ensuring that an evaluation of each contract service is conducted annually. The annual evaluations will use a form similar to the form included in Attachment #S 394 B. The results of each evaluation will be reported to the QI coordinator for inclusion in the QI program. In addition, as indicated in the POC for Tag #S 406, the contracted services of Linen, Security, Bio-hazardous Waste, Mobile Services (MRI), Transcription, Medical Records, and Sleep Lab</p>	11/04/2011	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151302	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/05/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER INDIANA UNIVERSITY HEALTH BLACKFORD HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 410 PILGRIM BLVD HARTFORD CITY, IN47348
--	---

(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
S0406	<p>contractual services provided to the the hospital.</p> <p>410 IAC 15-1.4-2(a)(1)</p> <p>(a) The hospital shall have an effective, organized, hospital-wide, comprehensive quality assessment and improvement program in which all areas of the hospital participate. The program shall be ongoing and have a written plan of implementation that evaluates, but is not limited to, the following:</p> <p>(1) All services, including services furnished by a contractor.</p> <p>Based on document review and interview, the facility failed to evaluate 9 of 29 hospital service indicators through the IU Blackford Hospital Quality Assessment Program. (Central Sterile, Housekeeping, Laundry/Linen, Medical Records, Security, Transcription, Biohazardous Waste, Mobile Services and the Sleep Lab)</p> <p>Findings included:</p> <p>1. The Quality Assessment Program was reviewed with staff member #22 at 10:00 AM on 10/5/2011. The 2011 program stated, "Blackford Hospital's Performance Improvement Program is centered around</p>	S0406	<p>all have quality indicators being added to the 2012 Quality Improvement Plan.</p> <p>Tag S 406 Plan of Correction <u>Quality Assessment Indicators</u> Quality Assurance indicators for Central Sterile, Housekeeping, Laundry/Linen, Medical Records, Transcription, Security, Bio-hazardous Waste, Mobile Services, and the Sleep Lab have been added to the 2012 Quality Improvement Plan and will begin collecting data on November 15, 2011 and reporting data on or before January 12, 2012. (Attachment #S 406). The Quality Improvement Committee meets quarterly. The first meeting that will include these data elements will be in February, 2012. The Hospital's Department Managers are responsible for ensuring that all</p>	10/13/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151302	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/05/2011
NAME OF PROVIDER OR SUPPLIER INDIANA UNIVERSITY HEALTH BLACKFORD HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 410 PILGRIM BLVD HARTFORD CITY, IN47348		
(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	
	<p>improving patient clinical outcomes and overall Hospital performance in measurable ways and promoting patient safety and risk reduction activities." The performance improvement program noted it will evaluate all services that would have an impact on patient clinical outcomes, risk and safety.</p> <p>2. The required hospital performance improvement indicators were reviewed and indicated 9 required services lacked being a part of the Quality Assurance Process. Quality Assurance staff member #22 could not provide any documentation that Central Sterile, Housekeeping, Laundry/Linen, Medical Records, Security, Transcription, Biohazardous Waste, Mobile Services and Sleep Lab were being monitored and evaluated by the QA process.</p> <p>3. The previous 12 months of PI Committee Meeting Minutes and Quality Council Meeting Minutes lacked indication that Central Sterile, Housekeeping, Laundry/Linen, Medical Records, Security, Transcription, Biohazardous Waste, Mobil Services and Sleep Lab had been evaluated.</p> <p>4. At 2:45 PM on 10/3/2011, staff member #1 indicated the indicator Biohazardous Waste has not been part of</p>		<p>data needed (or observations to occur), for their departments, that relate to these QA elements are collected. The Hospital's QI Coordinator is responsible for preparing the quarterly QI report that will include the QA indicators. <u>Addendum</u> The Hospital's Quality Improvement Coordinator is responsible for the implementation of and ongoing monitoring of the POC.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151302	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/05/2011
NAME OF PROVIDER OR SUPPLIER INDIANA UNIVERSITY HEALTH BLACKFORD HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 410 PILGRIM BLVD HARTFORD CITY, IN47348		
(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	
S0554	<p>the performance improvement program for at least 2 years.</p> <p>5. At 10:30 AM on 10/5/2011, staff member #22 indicated Central Sterile, Housekeeping, Laundry/Linen, Medical Records, Security, Transcription, Biohazardous Waste, Mobil Services and Sleep Lab indicator's documentation and assessments were not provided to the Performance Improvement Committee.</p> <p>410 IAC 15-1.5-2(a)</p> <p>(a) The hospital shall provide a safe and healthful environment that minimizes infection exposure and risk to patients, health care workers, and visitors.</p> <p>Based on observation and interview, the facility failed to ensure 2 of 3 hand washing sinks from the possibility of contamination of blood exposure.</p> <p>Findings included:</p> <p>1. At 12:45 PM on 10/3/2011, staff member 29 indicated the Laboratory Department had three hand washing sinks.</p>	S0554	<p>Tag S 554 Plan of Correction A work order (#204-11) was issued by the Lab Manager on October 28, 2011 (Attachment #S 554, page 1) for the placement of a Plexiglas barrier at the hand wash sink in urinalysis to prevent splashing. The Lab Manager has designated by policy and signage (Attachment #S 554, page 2) that the sink in Blood Bank (Processing) is not a hand washing sink (Attachment #S</p>	10/28/2011	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151302	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/05/2011
NAME OF PROVIDER OR SUPPLIER INDIANA UNIVERSITY HEALTH BLACKFORD HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 410 PILGRIM BLVD HARTFORD CITY, IN47348		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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	
S0596	<p>2. At 12:50 PM, the Laboratory Department was toured. Two of three hand washing sinks that were located in the Urinalysis room and the Blood Bank were observed with microscopes located within 12 to 15 inches of each hand sink basin. The hand sink located near the blood bank was observed with blood specimen slides next to the sink basin and the hand sink in the Urinalysis room had a centrifuge touching the rim of the hand sink basin.</p> <p>410 IAC 15-1.5-2(f)(3)(D)(iii)</p> <p>(f) The hospital shall establish an infection control committee to monitor and guide the infection control program in the facility as follows: (3) The infection control committee responsibilities shall include, but not be limited to, the following: (D) Reviewing and recommending changes in procedures, policies, and programs which are pertinent to infection control. These include, but are not limited to, the following:</p> <p>(iii) Cleaning, disinfection, and sterilization.</p> <p>Based on document review, the facility failed to utilize a high-level disinfectant for their Phillips Ultrasound TEE transducer used in the Radiology</p>	S0596	<p>554, page 3). <u>Prevention</u> The Lab Manager will be responsible to be sure the splashguard and signage is in place. <u>Responsibility</u> Maintenance will be responsible to place the splashguard. The Lab Manager shall be responsible to place the signage and to be certain the splashguard is in place. <u>Completion Date</u> Splashguard will be in place by November 18, 2011. <u>Addendum</u> The Hospital's Lab Manager is responsible for ensuring that the POC actions are implemented and remain "in place" after implementation. The Lab Manager will document ongoing compliance with the POC.</p> <p>Tag S 596 Plan of Correction A new policy and procedure, Ultrasound Wand – "High Level Disinfection Process" (Attachment #S 596) was created</p>	10/31/2011	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151302	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/05/2011
NAME OF PROVIDER OR SUPPLIER INDIANA UNIVERSITY HEALTH BLACKFORD HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 410 PILGRIM BLVD HARTFORD CITY, IN47348		
(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	
	<p>Department.</p> <p>Findings included:</p> <ol style="list-style-type: none"> At 3:20 PM on 10/3/2011, the Radiology Department was toured. The portable ultrasound equipment was inspected. The disinfectant used for the equipment was Ecolab TOR HB cleaner/disinfectant. The chemical TOR HB is a general use disinfectant and the manufacturer's label identifies the item as an all-purpose general disinfectant and not a high-level disinfectant. Staff member #7 provided the manufacturer's instructions on how to disinfect the Phillip's TEE Transducer. The manufacturer requires a High-level disinfectant to be used on the Ultrasound piece of equipment for proper cleaning after used. 		<p>to utilize high level disinfectant for the cleaning of the Phillips Ultrasound TEE transducer used in the Radiology Department. The Radiology staff was educated on the policy and procedure on October 31, 2011. Annual training will take place on the policy and procedure and the Radiology Department will track this as a Quality Indicator. The Radiology Department Lead Tech and Department Manager will be responsible for the annual training and the collection of data for the Quality Indicator. <u>Addendum</u> The Hospital's Radiology Manager is responsible for implementation of the POC and for ensuring that the POC actions remain "in place." Compliance with the attached policy and procedure will become one of the Radiology Department's quality indicators for 2012 and will be reported to the QI Coordinator.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151302	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/05/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER INDIANA UNIVERSITY HEALTH BLACKFORD HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 410 PILGRIM BLVD HARTFORD CITY, IN47348
--	---

(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
S0718	<p>410 IAC 15-1.5-4 (c)(3)</p> <p>(c) An adequate medical record shall be maintained with documentation of service rendered for each individual who is evaluated or treated as follows:</p> <p>(3) The hospital shall use a system of author identification and record maintenance that ensures the integrity of the authentication and protects the security of all record entries. Each entry shall be authenticated promptly in accordance with the hospital and medical staff policies.</p> <p>Based on medical record review, document review, and interview, the facility failed to ensure the discharge summaries were signed within 30 days of discharge/death in 6 of 24 patients (#N8, N9, N16, N20, N21, and N24).</p> <p>Findings included:</p> <p>1. Review of closed medical records indicated the following:</p> <p>A. Patient #N8 was admitted 02/25/11 and discharged 03/02/11. The discharge summary was dictated 03/02/11, transcribed 03/02/11, but not electronically signed by the physician until 06/03/11.</p> <p>B. Patient #N9 was admitted 03/17/11 and discharged 03/23/11. The discharge summary was dictated 07/19/11, transcribed 07/20/11, and electronically</p>	S0718	<p>Tag S 718 Plan of Correction As explained in the deficiency relating to this TAG, the Hospital temporarily stopped enforcing the Medical Staff Rules and Regulations relating to automatic suspensions due to delinquent medical records. The Medical Staff held a special meeting on November 4, 2011 and agreed to begin medical record related automatic suspensions immediately. An updated delinquent record report will be published on November 9, 2011. That list will be distributed to the affected Medical Staff members on November 10. Any practitioners who do not clear their delinquent records on or before 7:00am on November 14, 2011, will automatically be temporarily suspended on November 14, 2011. The automatic suspension will remain in effect until all delinquent</p>	11/04/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151302	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/05/2011
NAME OF PROVIDER OR SUPPLIER INDIANA UNIVERSITY HEALTH BLACKFORD HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 410 PILGRIM BLVD HARTFORD CITY, IN47348		
(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	
	<p>signed by the physician on 07/25/11.</p> <p>C. Patient #N16 was admitted 04/08/11 and discharged 04/13/11. The discharge summary was dictated 04/13/11, transcribed 04/13/11, but not electronically signed by the physician until 06/13/11.</p> <p>D. Patient #N20 was admitted 06/23/11 and discharged 06/26/11. The discharge summary was dictated 06/26/11, transcribed 06/27/11, but not electronically signed by the physician until 10/03/11.</p> <p>E. Patient #N21 was admitted 06/04/11 and discharged 06/08/11. The discharge summary was dictated 06/08/11, transcribed 06/08/11, but not electronically signed by the physician until 07/10/11.</p> <p>F. Patient #N24 was admitted 03/23/11 and died 03/24/11. The death/discharge summary was dictated 07/19/11, transcribed 07/20/11, and electronically signed by the physician on 07/25/11.</p> <p>2. Review of the facility's Medical Staff Bylaws Rules and Regulations indicated the actions that would be taken for incomplete medical records, "All medical records should be complete following discharge of the patient from the hospital including progress notes, final diagnosis, and clinical resume. When this is not possible due to delay in reports, the</p>		<p>records are complete. As the attached policy indicates, enforcement of the medical record completion requirements will be continued in this fashion on an ongoing basis. (Attachment #S 718) The Hospital CEO and the Health Information Management staff are responsible for implementation of this POC and are responsible for the ongoing monitoring of the records completion process. <u>Addendum</u> As specified in the Medical Staff Rules and Regulations, the CEO is the party responsible for implementation of and ongoing compliance with the POC.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151302	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/05/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER INDIANA UNIVERSITY HEALTH BLACKFORD HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 410 PILGRIM BLVD HARTFORD CITY, IN47348
--	---

(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
S0952	<p>incomplete record(s) shall be available in the doctor's dictation lounge." The document outlined the procedures to follow if records remained incomplete 22 and 29 days after discharge, up to and including, suspension of the practitioner.</p> <p>3. At 11:00 AM on 10/05/11, staff member A3 indicated all charts were to be completed and signed within 30 days of discharge. He/she indicated some of the delays were related to changing over to the electronic charting system. He/she confirmed the Rules and Regulations weren't followed because so many of the practitioners would have been suspended.</p> <p>410 IAC 15-1.5-6(d)</p> <p>(d) Blood transfusions and intravenous medications shall be administered in accordance with state law and approved medical staff policies and procedures. If the blood transfusions and intravenous medications are administered by personnel other than physicians, the personnel shall have special training for these procedures in accordance with subsection (b)(6). Based on medical record review, policy review, personnel file review, and interview, the facility failed to ensure vital signs were taken according to policy for 3 of 5 patients who received blood transfusions (#N6, N9, and N10) and failed to ensure 3 of 7 registered nurse</p>	S0952	<p>Tag S 952 Plan of Correction "Blood transfusions shall be administered in accordance with State law and approved policies and procedures." Actions to resolve the deficiencies noted were implemented immediately after the conclusion of the October 3-5,</p>	11/04/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151302	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/05/2011
NAME OF PROVIDER OR SUPPLIER INDIANA UNIVERSITY HEALTH BLACKFORD HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 410 PILGRIM BLVD HARTFORD CITY, IN47348		
(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	
	<p>staff who administered blood received annual training (#P2, P3, and P5).</p> <p>Findings included:</p> <p>1. Review of closed medical records indicated the following:</p> <p>A. Patient #N6 received 2 units of blood on 03/08/11. The first unit was completed at 1220, but the ending vital signs were documented as 1245. The second unit was completed at 1632, but the ending vital signs were documented as 1702.</p> <p>B. Patient #N9 received 2 units of blood on 03/18/11. The second unit was started at 1250 and completed at 1510. The pretransfusion vital signs were documented as 1235, the 15 minutes vital signs as 1205, and the completion vital signs as 1530.</p> <p>C. Patient #N10 received a unit of blood on 01/13/11 and the documentation indicated it was completed at 0625, but the completion vital signs were documented as 0700.</p> <p>2. The facility policy, "Blood and Blood Component Administration: Adult", last amended October 2008, indicated on page 6, "...14. After 15 minutes, the temperature, heart rate, respiration and blood pressure will be taken and recorded on the transfusion document." The policy continued on page 7, "...26. Assess the</p>		<p>2011 ISDH survey, as described below. The "Blood Administration" policy and the "Blood and Blood Component Administration Adult" policy (Attachment # S 952) provides standards for the administration of blood and blood components. Those policies and procedures are now being followed. The Laboratory monitors the completion of documentation of blood and blood component administration as a Quality Indicator. The Laboratory Manager is responsible for this monitoring function. The information collected is given to the QI Coordinator for inclusion in the QI quarterly report. Nurses shall have mandatory annual training on the administration of blood and blood components. The policy "Competency, Nursing" is attached (Attachment # S 952). Nurses not completing the required annual competency training will not be scheduled to work. The Education Manager will monitor the annual monitor training for all nurses on administration of blood and blood components. The three nurses who failed to complete annual training on administration of blood and blood components completed this training on November 4, 2011. <u>Addendum</u> The Hospital's Chief Nursing Officer is responsible for ensuring continued compliance with the POC. The initial actions of the POC have already been</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151302	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/05/2011
NAME OF PROVIDER OR SUPPLIER INDIANA UNIVERSITY HEALTH BLACKFORD HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 410 PILGRIM BLVD HARTFORD CITY, IN47348		
(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	
	<p>patient's vital signs when the transfusion is finished and record on the transfusion document."</p> <p>3. Review of the facility's "Organization Wide Plan", which was provided as the plan followed for the educational requirements of registered nurses who administered blood, indicated on page 15, that a goal of the department was to coordinate yearly mandatory in-servicing and competencies for staff.</p> <p>4. Review of the personnel files for the registered nurses indicated the following: A. The last blood transfusion competency for staff member P2 was 02/2010. B. The last blood transfusion competency for staff member P3 was 02/2010. C. The last blood transfusion competency for staff member P5 was 02/2010.</p> <p>5. At 9:00 AM on 10/05/11, staff member A14 indicated all registered nurses should receive annual blood transfusion competency and he/she provided it in February of 2010 and in March-April of 2011. He/she confirmed the 3 nurses did not have documentation of training for this year.</p>		implemented.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151302		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/05/2011	
NAME OF PROVIDER OR SUPPLIER INDIANA UNIVERSITY HEALTH BLACKFORD HOSPITAL				STREET ADDRESS, CITY, STATE, ZIP CODE 410 PILGRIM BLVD HARTFORD CITY, IN47348			
(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			
S1022	<p>410 IAC 15-1.5-7 (d)(2)(B)</p> <p>(d) Written policies and procedures shall be developed and implemented that include the following:</p> <p>(2) Ensure the monthly inspection of all areas where drugs and biologicals are stored and which address, but are not limited to, the following:</p> <p>(B) Appropriate storage conditions. Based on observation and interview, the facility failed to properly store and monitor a prescription medication in the radiology department.</p> <p>Findings included:</p> <p>1. During the tour of the radiology department at 12:30 PM on 10/03/11, and accompanied by staff member A7, a plastic container of medication was observed in a metal cabinet in the fluoroscopy room. The cabinet handle was in the locked position, but the cabinet opened when the handle was turned. The medication container had a plain white label with the typed information, "Anaspaz 0.125 mg. 10/13 K877811". The label was taped over a similar plain white label and 6/10 and initials could be seen on the under label. There were 10 white tablets in the container.</p> <p>2. At 10:40 AM on 10/04/11, staff</p>	S1022	<p>Tag S 1022 Plan of Correction The medication in question was removed on October 3, 2011. At that time, the medication in question began to be handled like all other medications ordered within the Hospital. A replacement cabinet was ordered on November 3, 2011 (Attachment #S 1022) by the Director of Support Services. The cabinet arrived and was put in service November 4, 2011. The deficiency will be prevented in the future by educating the Radiology staff on the "Use of Medications in Radiology" policy. (Attachment # S 1022) The Radiology Lead Tech, the Radiology Manager, and the Pharmacy Manager are responsible for the development of the policy and the education of the Radiology staff. Education on the "Use of Medications in Radiology" policy was completed on November 4, 2011. <u>Addendum</u> The Pharmacy Manager is responsible for ensuring continued compliance with the policy and procedure(s)</p>	11/04/2011			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151302	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/05/2011
NAME OF PROVIDER OR SUPPLIER INDIANA UNIVERSITY HEALTH BLACKFORD HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 410 PILGRIM BLVD HARTFORD CITY, IN47348		
(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	
	<p>member A7 indicated the medication was used in the event a patient's colon went into spasms during a barium enema test. The medication would be requested by the radiologist who would then administer it to the patient. Staff member A7 indicated this process had been going on for years and the medication was supplied by the pharmacy. He/she indicated the container only needed to be refilled occasionally, but the medication was not signed out as it was administered. He/she indicated the medication was kept in a locked cabinet.</p> <p>3. At 10:50 AM on 10/04/11, the director of pharmacy, staff member A5, indicated Anaspaz was a prescription medication, although not a controlled substance, and should be labeled accordingly and dispensed as needed. He/she indicated he/she was not aware of the process of using this medication in the radiology department and was not even aware of the medication being there. He/she indicated this process might have been a carry-over from the old hospital. There was no documentation of refills or of the 10 tablets of Anaspaz being stored in the radiology department.</p>		included within the POC.		