

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  150091	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  02/08/2012
NAME OF PROVIDER OR SUPPLIER  PARKVIEW HUNTINGTON HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 2001 STULTS RD HUNTINGTON, IN 46750		
(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: 2/6/2012 through 2/8/2012</p> <p>Facility Number: 005081</p> <p>Surveyors: Albert Daeger, CFM, SFPIO Medical Surveyor</p> <p>Saundra Nolfi, RN PH Nurse Surveyor</p> <p>QA: claughlin 02/21/12</p>	S0000			

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:  150091	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  02/08/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  PARKVIEW HUNTINGTON HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 2001 STULTS RD HUNTINGTON, IN 46750
--	---

(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
--------------------	--	---------------	---	----------------------

S0610	<p>410 IAC 15-1.5-2(f)(3)(D)(x)</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>(x) A program of food preparation and storage for all personnel involved in food handling which includes, but is not limited to, the following:</p> <p>(AA) Storage of employee food in patient refrigerators.</p> <p>(BB) Medications in nutrition refrigerators.</p> <p>(CC) Refrigerator and freezer temperature monitoring.</p> <p>Based on observation and documentation review, the facility failed to comply with hospital policies and 410 IAC 7-24, Retail Food Establishment Sanitation Requirements, for safe handling and preparation of food in the kitchen.</p> <p>Findings included:</p> <p>1. Sanitation and Safety Laws and Regulation for Nutritional Services states,</p>	S0610	<p><b>Tag S610 Infection Control By what date are you going to have the deficiency corrected? 2/15/12 How are you going to correct the deficiency?</b> Nutritional Services staff was in-serviced by Infection Control on 2-7-12 on Basic Hand-Washing and Glove Usage as required in the Indiana Food Code Section 128-131 and Section 246. (Attachment)Ecolab provided a service call and adjusted the parts per million</p>	02/15/2012
-------	--	-------	--	------------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  150091		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  02/08/2012	
NAME OF PROVIDER OR SUPPLIER  PARKVIEW HUNTINGTON HOSPITAL				STREET ADDRESS, CITY, STATE, ZIP CODE 2001 STULTS RD HUNTINGTON, IN 46750			
(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>"All employees of the Food Service Department are Responsible for knowing and following the laws and regulations for safe handling and preparation of foods as set forth by the Indiana State Board of Health."</p> <p>2. 1. Retail Food Establishment Sanitation Requirements, 410 IAC 7-24-129, When to Wash Hands states, "Food employees shall clean their hands and exposed portions of their arms as specified under section 106 immediately before engaging in food preparation, including working with exposed food, clean equipment and utensils, and unwrapped single-service and single-use articles and the following: After touching bare human body parts other than clean hands and clean, exposed portions of arms; After using the toilet room; After caring for or handling service animals or aquatic animals as specified in section 116(b) of this rule; After coughing, sneezing, or using a handkerchief or disposable tissue; After drinking, other than as specified in section 113(b) of this rule, using tobacco, or eating; After handling soiled surfaces, equipment, or utensils; During food preparation, as often as necessary to remove soil and contamination and to prevent cross contamination when changing tasks; When switching between working with</p>		<p>quantity dispensing. Staff was in-serviced by the Supervisor and Manager on 2-15-12 regarding general sanitation and cleaning according to the standards of the Indiana Food Code Section 295-296. <b>How are you going to prevent the deficiency from reoccurring?</b> A re-occurring in-service has been added to monthly department meetings, to include hand washing and glove use. This will be monitored during monthly food safety audit and the food safety walk through checklist. We also have added this as an indicator on our Measures of Success Departmental Dashboard to ensure ongoing monitoring. The sanitizing solution will be tested at the time of dispensing for proper strength and recorded on the Sanitizer Solution Log two times per day. This will also be monitored during the monthly food safety audit and food safety walk through checklist. This was added to the departmental Measures of Success Performance Improvement Dashboard to ensure ongoing monitoring. <b>Responsible Leader:</b> Nutritional Services Manager</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  150091	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  02/08/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  PARKVIEW HUNTINGTON HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 2001 STULTS RD HUNTINGTON, IN 46750
--	---

(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>raw food and working with ready-to-eat food; Before touching food or food-contact surfaces; Before placing gloves on hands; and after engaging in other activities that contaminate the hands."</p> <p>3. At 11:00 AM on 2/6/2012, the main kitchen and the cafeteria was toured. One staff member was observed removing their glove from their left hand and handle a non-food items and replaced the same glove back on their left hand. Three staff members were observed changing gloves without washing their hands between changing of the gloves.</p> <p>4. Chemical sanitizers and other chemical antimicrobials applied to food-contact surfaces shall meet the requirements specified in 21 CFR 178.1010..</p> <p>5. Staff member was observed dispensing Ecolab Multi Quat (150 to 400 PPM requirement) into a red bucket. The chemical was tested by staff and it exceeded 500 parts per million quaternary ammonia. A staff member was also observed wash/rinse/sanitize an utensil in the three compartment sink. The utensil was dipped in the rinse and sanitizer for less than a second. The manufacturer requires an item to be dipped in the</p>			
--	--	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  150091	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  02/08/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  PARKVIEW HUNTINGTON HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 2001 STULTS RD HUNTINGTON, IN 46750
--	---

(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
	sanitizer for a minimum of 2 minutes.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  150091		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  02/08/2012	
NAME OF PROVIDER OR SUPPLIER  PARKVIEW HUNTINGTON HOSPITAL				STREET ADDRESS, CITY, STATE, ZIP CODE 2001 STULTS RD HUNTINGTON, IN 46750			
(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
S0674	<p>410 IAC 15-1.5-3(f)</p> <p>(f) If sufficient or suitable outside facilities are not provided by undertakers or others, the hospital shall have a morgue or a low temperature body holding room. Policies covering appropriate refrigeration requirements and length of holding bodies shall be approved by the medical staff. If autopsies are performed in the hospital, there shall be a refrigerated storage unit designed for holding bodies, along with hand washing facilities and other necessary personal hygiene facilities available.</p> <p>Based on observation, documentation review, and staff interview, the facility failed to ensure the body holding room meets the American Association of Tissue Banks for bodies held non-refrigerated.</p> <p>Findings included</p> <p>1. Staff member #2 provided the hospital written response from an Indiana State Health Department deficiency for holding bodies in a non-temperature regulated room for more than 4 hours dated June 1-3, 2010. The plan of correction states, "Officers have been instructed to strictly adhere to our policy guidelines of holding a body "no longer than 3 hours" (educated June 18, 2010)."</p> <p>2. The Body Holding Area policy article</p>			S0674	<p><b>Tag S674 Laboratory By what date are you going to have the deficiency corrected? 3/5/12</b></p> <p><b>How are you going to correct the deficiency?</b> The Body Holding Policy was updated on 3/2/12 to reflect current body holding times in accordance with the Indiana Organ Procurement Organization guidelines. (Attachment) <b>How are you going to prevent the deficiency from reoccurring?</b> Shift supervisors were educated on 3/5/12 regarding the updated policy and this process will be discussed at their monthly supervisor meeting scheduled on 3/9/12. The Security Manager educated our security officers regarding the updated body holding policy and process including the importance of documentation of body pickup time on 3/5/12. The Security Manager will be responsible for</p>		03/05/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  150091		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  02/08/2012	
NAME OF PROVIDER OR SUPPLIER  PARKVIEW HUNTINGTON HOSPITAL				STREET ADDRESS, CITY, STATE, ZIP CODE 2001 STULTS RD HUNTINGTON, IN 46750			
(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>III section D states, "The shift supervisor or designee will instruct the receiving facility that Parkview Huntington Hospital cannot hold a body for an extended period of time - (in excess of 16 hours). The receiving facility must sign the Body Receipt before removing the body from the hospital"</p> <p>3. Staff member #2 provided the American Association of Tissue Banks document which states, "Warm Ischemic Time - The time limit shall not exceed 15 hours if the body was not cooled or refrigerated."</p> <p>4. At 12:40 PM on 2/8/2012, the outside ambulance bay area was inspected. A secured set of double doors in the outside bay were open and it contained a gurney, hand sink, and a storage rack of assorted office supplies and coveralls. Staff member #10 indicated the room was a holding area for bodies. The body holding room was not a cold temperature control nor the facility did not have any temperature control sheets of the holding room. The Body Holding room had a cooling blanket stored in it with instructions on the packaged blanket. The instruction sheet stated, "Place ice, double bagged, alongside the patient. Put bagged ice in the groin area as well. The more ice, the better just make sure it doesn't get</p>		<p>conducting a weekly check to ensure the proper documentation is occurring on the body holding log. In addition the updated policy will be presented at the next scheduled Safety Committee, Patient Care Committee and Clinical Committee meetings to ensure understanding regarding this important process. <b>Responsible Leader:</b> Director of Patient Care Services</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  150091	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  02/08/2012
NAME OF PROVIDER OR SUPPLIER  PARKVIEW HUNTINGTON HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 2001 STULTS RD HUNTINGTON, IN 46750		
(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>too heavy. Soak evaporative blanket in water. Wring out excess water so that the blanket is damp. Lay blanket on the patient, over the bags of ice."</p> <p>5. The Death Log revealed 32 deaths from January 14, 2011 thru January 7, 2012. The facility receipt logs of the bodies held in the holding room were reviewed. Four of the bodies that were picked up had no time documented. A Body receipt dated 12/28/2011 recorded the time of death at 10:31 AM and the body was picked up on 12/29/2011 at 7:32 AM. The Body Receipt was marked as a "IOPO Donor Case". The body was held in the non-refrigerated holding room over 20 hours exceeding American Association of Tissue Banks warm holding requirements of 15 hours.</p> <p>6. At 12:45 PM on 2/8/2012, staff member #10 indicated the facility utilizes a cooling blanket to keep the body cooled while being stored in the non-refrigerated body holding room. The staff member confirmed the use of the cooling blanket is not made part of their Body Holding Policy.</p> <p>7. At 1:45 P:M on 2/8/2012, staff member #2 indicated the plan of correction provided to the Indiana State Department of Health was different then</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  150091	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/08/2012
---	--	--	--

NAME OF PROVIDER OR SUPPLIER  PARKVIEW HUNTINGTON HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 2001 STULTS RD HUNTINGTON, IN 46750
--	---

(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
--------------------------	--	---------------------	--	----------------------------

	the hospital's policy and procedure and the policy should be 15 hours not 16 hours as stated on the policy to be in compliant with American Association of Tissue Banks.			
--	--	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  150091		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  02/08/2012	
NAME OF PROVIDER OR SUPPLIER  PARKVIEW HUNTINGTON HOSPITAL				STREET ADDRESS, CITY, STATE, ZIP CODE 2001 STULTS RD HUNTINGTON, IN 46750			
(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			
S0748	<p>410 IAC 15-1.5-4 (e)(3)</p> <p>(e) All entries in the medical record shall be:</p> <p>(3) authenticated and dated promptly in accordance with subsection (c)(3).</p> <p>Based on medical record review, policy and procedure review, and interview, the facility failed to ensure the physician orders were authenticated as written or reviewed per policy for 6 of 18 closed in-patient records reviewed (#N8, N9, N11, N14, N17, and N19).</p> <p>Findings included:</p> <ol style="list-style-type: none"> <li>The medical record for patient #N8 indicated physician discharge orders from 12/18/11 that were initialed, but not signed by the nurse reviewing and completing them. The record also indicated a clarification of a Home Med medication written by a nurse, but failed to document how this clarification was obtained.</li> <li>The medical record for patient #N9 indicated two orders from 11/23/11 that were initialed, but not signed by the nurse reviewing and completing them.</li> <li>The medical record for patient #N11 indicated physician discharge orders from 06/26/11 that were checked, but not</li> </ol>	S0748	<p><b>Tag S748 Medical Records By what date are you going to have the deficiency corrected? 2/24/12 How are you going to correct the deficiency?</b></p> <p>Education Packets were provided to staff on 2/20/12, including instructions on order authentication. Staff was required to submit an authenticated form noting validation of their understanding related to the importance of this process. (Attachment)<b>How are you going to prevent the deficiency from reoccurring?</b> The nursing departments have initiated monthly documentation audits to ensure sustained compliance and they will also report their progress quarterly to the Patient Care Committee via their departmental Measures of Success Performance Improvement Dashboards. <b>Responsible Leader:</b> Inpatient/Constant Care Unit/Family Birthing Center Manager</p>	02/24/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  150091		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  02/08/2012	
NAME OF PROVIDER OR SUPPLIER  PARKVIEW HUNTINGTON HOSPITAL				STREET ADDRESS, CITY, STATE, ZIP CODE 2001 STULTS RD HUNTINGTON, IN 46750			
(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 nurse reviewing and completing them.</p> <p>4. The medical record for patient #N14 indicated a written physician order from 04/21/11 that was not initialed, checked, or signed by the nurse to indicate it was reviewed and completed.</p> <p>5. The medical record for patient #N17 indicated a printed Postoperative Pain Order set that was completed and signed by the physician on 05/20/11. One of the thirteen checked items was initialed, but the form was not signed by the nurse to indicate the orders were reviewed and completed. A second printed sheet, SCIP Abbreviated Order Set, was signed by the physician on 05/20/11 and had only one item checked, but it was not initialed, checked, or signed to indicate whether or not it was implemented.</p> <p>6. The medical record for patient #N19 indicated a telephone order from 10/14/11 that was initialed, but not signed by the nurse reviewing and completing it.</p> <p>7. The facility policy "Medical Records Administration", last reviewed 12/10, indicated on page 7, "D. Documentation Standards: 1. All entries in the medical record will be dated, timed, and authenticated by written signature,</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  150091	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  02/08/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  PARKVIEW HUNTINGTON HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 2001 STULTS RD HUNTINGTON, IN 46750
--	---

(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>initials, electronic signature, or other unique author identification. a. Initials must be identifiable to the full signature when used. b. The author's role/discipline will be identified by written credentials on paper entries and by role code in electronic documentation."</p> <p>8. The facility policy "Orders: Nursing Verification Of", last reviewed 06/09, indicated on page 1, "1. Overview: To verify that orders written on the Physician Order form are currently applicable and accurately transcribed. A. A registered nurse must review the physician orders written on his/her working shift (except in the Continuing Care Center where an RN or LPN is acceptable) and verify the review by: 1. Completing the nurse review process in the electronic medical record. 2. Signing his/her name followed by date, and time to each set of written orders reviewed."</p> <p>9. At 11:00 AM on 02/08/12, staff member #P3 confirmed the medical record findings.</p>			
--	---	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  150091	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  02/08/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  PARKVIEW HUNTINGTON HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 2001 STULTS RD HUNTINGTON, IN 46750
--	---

(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
--------------------	--	---------------	---	----------------------

S0871	<p>410 IAC 15-1.5-5(b)(3)(O)</p> <p>(b) The medical staff shall adopt and enforce bylaws and rules to carry out its responsibilities. These bylaws and rules shall:</p> <p>(3) include, but not be limited to, the following:</p> <p>(O) A requirement that all verbal orders must be authenticated by the responsible individual in accordance with hospital and medical staff policies. The individual receiving a verbal order shall date, time, and sign the verbal order in accordance with hospital policy. Authentication of a verbal order must occur within forty-eight (48) hours unless a read back and verify process described under items (i) and (ii) is utilized. If a patient is discharged within forty-eight (48) hours of the time that the verbal order was given, authentication shall occur within thirty (30) days after the patient's discharge.</p> <p>(i) As an alternative, hospital policy may provide for a read back and verify process for verbal orders. Any read back and verify process must require that the individual receiving the order shall immediately read back the order to the ordering physician or other responsible individual who shall immediately verify that the read back order is correct.</p> <p>(ii) The individual receiving the verbal order shall document in the patient's medical record that the order was read back and verified. Where the read back and verify process is followed, the hospital shall require authentication of the verbal order not later than thirty (30) days after the patient's discharge.</p> <p>Based on medical record review, medical staff rules and regulations review,</p>	S0871	Tag S871 Medical Staff By what date are you going to have the	02/27/2012
-------	---	-------	---	------------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  150091		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  02/08/2012	
NAME OF PROVIDER OR SUPPLIER  PARKVIEW HUNTINGTON HOSPITAL				STREET ADDRESS, CITY, STATE, ZIP CODE 2001 STULTS RD HUNTINGTON, IN 46750			
(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>physician assistant clinical privileges review, and interview, the facility failed to ensure the staff documented "read back and verified (r/v)" for physician orders that were obtained verbally or by telephone for 7 of 18 closed in-patient records reviewed (#N5, N7, N9, N11, N12, N17, and N18).</p> <p>Findings included:</p> <ol style="list-style-type: none"> <li>1. The medical record for patient #N5 indicated physician orders received per telephone by the nurse on 12/20/11, but lacked the notation of "read back and verified" or "r/v".</li> <li>2. The medical record for patient #N7 indicated physician orders received verbally by the respiratory therapist on 12/12/11 and again on 12/13/11, but lacked the notation of "read back and verified" or "r/v".</li> <li>3. The medical record for patient #N9 indicated physician orders received per telephone by the nurse on 11/23/11, but lacked the notation of "read back and verified" or "r/v".</li> <li>4. The medical record for patient #N11 indicated physician orders received verbally by the nurse on 06/24/11, but lacked the notation of "read back and</li> </ol>		<p><b>deficiency corrected? 2/27/12</b> <b>How are you going to correct the deficiency?</b> -Education Packets were provided to nursing staff on 2/20/12, including read back and verify instructions and example (attached). Staff were required to submit an authenticated from noting validation of their understanding related to the importance of this process. -Educational information was provided to the cardiopulmonary team on 2/27/2012 and will also be reinforced at the next scheduled department's unit meeting on 3/21/12. (Attachment)<b>How are you going to prevent the deficiency from reoccurring?</b> Both nursing and cardiopulmonary departments have initiated monthly documentation audits to ensure sustained compliance and both departments will also report their progress quarterly to the Patient Care Committee via their departmental Measures of Success Performance Improvement Dashboards. <b>Responsible Leader:</b> Inpatient/Constant Care Unit/Family Birthing Center Manager and the Diagnostics Manager</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  150091	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  02/08/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  PARKVIEW HUNTINGTON HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 2001 STULTS RD HUNTINGTON, IN 46750
--	---

(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
--------------------	--	---------------	---	----------------------

	<p>verified" or "r/v".</p> <p>5. The medical record for patient #N12 indicated physician orders received per telephone by the nurse on 10/08/11, but lacked the notation of "read back and verified" or "r/v".</p> <p>6. The medical record for patient #N17 indicated physician orders received verbally by the nurse on 05/21/11, but lacked the notation of "read back and verified" or "r/v".</p> <p>7. The medical record for patient #N18 indicated physician orders received verbally by the physician assistant (#P20) on 09/26/11, 09/28/11, and 09/29/11, but lacked the notation of "read back and verified" or "r/v".</p> <p>8. The facility's Medical Staff Rules and Regulations, last revised June 2011, indicated on page 13, :...E. When transcribed, verbal, written and telephone orders must include the following: ...3. the first initial, last name, and credential of the individual receiving the order. 4. annotation that the order was a verbal order (v.o.), telephone order (t.o.), or written order (w.o.). 5. a notation that the order was read back and verified (r/v) (if a verbal or telephone order)."</p>			
--	---	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  150091	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  02/08/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  PARKVIEW HUNTINGTON HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 2001 STULTS RD HUNTINGTON, IN 46750
--	---

(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>9. The facility's Clinical Privileges for the physician assistant, staff member #P20, indicated under the clinical privileges list, "...Write physician orders designated as V.O. (for verbal orders) or T.O. (for telephone orders) and note that those orders have been read back and verified (R.V)."</p> <p>10. At 11:00 AM on 02/08/12, staff member #P3 confirmed the medical records findings and indicated R/V should be written after any verbal or telephone orders.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  150091	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  02/08/2012
NAME OF PROVIDER OR SUPPLIER  PARKVIEW HUNTINGTON HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 2001 STULTS RD HUNTINGTON, IN 46750		
(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	
S1118	<p>410 IAC 15-1.5-8 (b)(2)</p> <p>(b) The condition of the physical plant and the overall hospital environment shall be developed and maintained in such a manner that the safety and well-being of patients are assured as follows:</p> <p>(2) No condition shall be created or maintained which may result in a hazard to patients, public, or employees.</p> <p>Based on observation, documentation review, and staff interview, the facility failed to ensure the Generator room and the Production kitchen was maintained in a safe and effective manner for patients, staff, and visitors.</p> <p>Findings included:</p> <p>1. Parkview Huntington Hospital. Fire and Evacuation Plan section D, Evacuation Plan, states, "In the event you get separated from any dietary group, go to nearest double exit and report to the designated dietary meeting area. 1. Cafeteria and Dining guests - exit through the door that is down the vending hallway and continue straight out the double doors at the end of the hallway; 2. Critical areas - Evacuate to the nearest exit."</p> <p>2. At 12:30 PM on 2/6/2012, the production kitchen was toured. The room</p>	S1118	<p><b>Tag S1118 Physical Plant</b></p> <p><b>By what date are you going to have the deficiency corrected?</b> 3/6/12</p> <p><b>How are you going to correct the deficiency?</b> Exits signs will be added to dietary doors by 3/6/2012. An eye wash unit will be installed adjacent to generator room by 3/6/2012.</p> <p><b>How are you going to prevent the deficiency from reoccurring?</b> Not applicable. <b>Responsible Leader:</b> Hospitality Director</p>	03/06/2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  150091	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  02/08/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  PARKVIEW HUNTINGTON HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 2001 STULTS RD HUNTINGTON, IN 46750
--	---

(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>had two exit doors propped open. Neither exit door was marked with a "Fire Exit" signage for access to the proper fire exit route in case of an evacuation of the Production Kitchen.</p> <p>3. At 12:35 PM on 2/6/2012, staff member #10 states the 2 propped open doors in the kitchen were fire exit routes and the staff member agreed the routes should be clearly marked as a fire exit route for evacuation.</p> <p>4. The Parkview Huntington Hospital policies and procedures require the hospital to comply with all OSHA regulations. This was confirmed by staff member #10 at 3:30 PM on 2/7/2012.</p> <p>5. Because 1910.178 does not have a specific requirement for eyewash facilities, the general standard at 1910.151 applies. When necessary, facilities for drenching or flushing the eyes 'shall be provided within the work area for immediate emergency use. In applying these general terms, OSHA would consider the guidelines set by such sources as American National Standards Institute (ANSI) Z358.1 -1998, Emergency Eyewash and Shower Equipment, which states, at section 7.4.4, that eyewash facilities are to be located to require no more than 10 seconds to reach</p>			
--	---	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  150091	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  02/08/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  PARKVIEW HUNTINGTON HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 2001 STULTS RD HUNTINGTON, IN 46750
--	---

(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>but that where a strong acid or caustic is used, the unit should be immediately adjacent to the hazard."</p> <p>6. The generator room was toured at 11:00 AM on 2/8/2012. The generator had 2 large 12-volt sulfuric acid batteries uncovered and exposed. The room did not have easy access to an eye washing facility in case of acid splash into a person's eyes.</p>			
--	---	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  150091		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  02/08/2012	
NAME OF PROVIDER OR SUPPLIER  PARKVIEW HUNTINGTON HOSPITAL				STREET ADDRESS, CITY, STATE, ZIP CODE 2001 STULTS RD HUNTINGTON, IN 46750			
(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			
S1168	<p>410 IAC 150-1.5-8 (d)(3)</p> <p>(d) The equipment requirements are as follows:</p> <p>(3) Defibrillators shall be discharged at least in accordance with manufacturers recommendations and a discharge log with initialed entries shall be maintained.</p> <p>Based on document review, interview, manufacturer's directions, and policy and procedure review, the facility failed to ensure the defibrillator checks on the Med/Surg Unit were performed according to policy and manufacturer's instructions.</p> <p>Findings included:</p> <p>1. During the tour of the Med/Surg Unit at 10:35 AM on 02/07/12, accompanied by staff members #P2 and P21, the Defibrillator Checklist for February 2012 was reviewed. The form indicated documentation for the night shift checks being done for the first 6 days of the month, but lacked documentation for 3 of the 6 day shift checks. The January 2012 checklist lacked documentation of checks being done twice daily for 7 of the 31 days and the December 2011 checklist lacked twice daily checks for 6 of the 31 days.</p> <p>Staff member #P2 indicated the checks were only required once daily, but he/she</p>	S1168	<p><b>Tag S1168 Defibrillator Checks</b> <b>By what date are you going to have the deficiency corrected?</b> <b>2/24/12</b> <b>How are you going to correct the deficiency?</b> -Inpatient nursing staff was educated regarding the need to conduct per shift defibrillator checks. -Charge nurses will conduct daily audits to ensure per shift defibrillator check compliance. -The policy has been updated to reflect the manufacturer recommendations for system checks. <b>How are you going to prevent the deficiency from reoccurring?</b> The Inpatient nursing department has initiated monthly documentation audits to ensure per shift sustained defibrillator check compliance and will also report progress quarterly to the Patient Care Committee via their departmental Measures of Success Performance Improvement Dashboard. <b>Responsible Leader:</b> Inpatient Manager</p>	02/24/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  150091	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  02/08/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  PARKVIEW HUNTINGTON HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 2001 STULTS RD HUNTINGTON, IN 46750
--	---

(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>aimed for twice daily to be sure they were done at least daily. He/she indicated the unit was staffed by 2 different shifts.</p> <p>2. The manufacturer's manual for the HeartStart XL Defibrillator/Monitor indicated, "Every Shift- Perform a 'Shift/System Check' every shift to verify that the HeartStart XL is functioning properly and to ensure that necessary supplies and accessories are present and ready for use. You should test every shock delivery method that is used with this unit."</p> <p>3. The facility policy "Crash Cart/Defibrillator/AED Checks", last reviewed 12/10, indicated, "Definitions: A. Shift: Shift is defined to include the following: 1. In areas that provide 24-hour patient care, the check must be performed each shift."</p>			
--	---	--	--	--