

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150164	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/12/2015
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NAME OF PROVIDER OR SUPPLIER MONROE HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 4011 S MONROE MEDICAL PARK BLVD BLOOMINGTON, IN 47403
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S 0000 Bldg. 00	This visit was for a State hospital licensure survey. Dates: 8/10/2015 through 8/12/2015 Facility Number: 004287 QA: cjl 09/10/15	S 0000		
S 0554 Bldg. 00	410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(a) (a) The hospital shall provide a safe and healthful environment that minimizes infection exposure and risk to patients, health care workers, and visitors. Based on observation and interview, the facility failed to ensure clean supplies and equipment were protected from contamination in the Materials Handling Department. Findings included: 1. During the tour of the Materials Handling Department at 3:15 PM on 8/11/2015, accompanied by staff members #5 (Support Services) and #20	S 0554	S-554 All shipping boxes have been removed from the Material Management Supply room. An area within Material Management has been designated as a "break out area" away from the clean supplies to check-in shipments and break down cardboard boxes. All cardboard is removed from Material Management daily. Supplies are removed from their shipping boxes and placed in covered totes. All staff have been educated on the process	09/10/2015

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.

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S 0762 Bldg. 00	<p>(Shipping Supervisor), several cardboard shipping boxes of supplies were observed stored alongside unprotected clean equipment and supplies on chrome wire storage shelves. The shipping boxes evidenced shipping labels. Shipping boxes were observed stored on shelves directly above clean unprotected assorted supplies that were displayed on shelves outside their shipping boxes.</p> <p>2. At 3:25 PM on 8/11/2015, staff member #20 (Shipping Supervisor) confirmed the shipping boxes could be stored in warehouses with no idea of possible contamination that could occur to the shipping boxes. The staff member confirmed the storage of shipping boxes stored directly over unprotected health care supplies was an infection control concern.</p> <p>410 IAC 15-1.5-4 MEDICAL RECORD SERVICES 410 IAC 15-1.5-4(f)(13)</p> <p>(f) All inpatient records, except those in subsections (g), shall document and contain, but not be limited to, the following:</p> <p>(13) A discharge summary authenticated by the physician. A final progress note may be substituted</p>		9/9/2015. Material Management department is checked ongoing to ensure no shipping boxes are in the designated clean supply area. A daily log has been implemented to verify the department has been checked for shipping cardboard in the clean supply area. The Supervisor, Material Management is responsible for ensuring the process is maintained. All shipping boxes were removed on September 10, 2015.		

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	<p>for the discharge summary in the case of a normal newborn infant and uncomplicated obstetric delivery. The final progress note should include any instruction given to the patient and family.</p> <p>Based on document review and interview, the facility failed to ensure all medical records for patients contained a timely and authenticated discharge summary for 6 of 29 (#5, 19, 21, 24, 25, and 29) records reviewed of patients who were discharged over 30 days ago.</p> <p>Findings included:</p> <ol style="list-style-type: none"> The facility policy "Health Record Documentation- General Requirements", last revised August 2013, indicated, "9. Discharge Summary: A discharge summary must be dictated or legibly written and signed within thirty (30) days of patient discharge. For patients whose stay is under 48 hours and/or for surgical one day patients a discharge summary is not required. However, a Short Stay Summary is required for observation of stays under 48 hours in length." The medical record for patient #5, who was admitted on 05/16/15 and discharged on 05/20/15, lacked a written or dictated physician discharge summary. The medical record for patient #19, 	S 0762	<p>S-0762 The HIM Manager was directed and supported by hospital Administration; CEO, CNO, and CMO to enforce physician suspension for delinquent Discharge Summary per Medical Staff Suspension Policy on 9/16/2015. Per Medical Staff Suspension Policy, the physician will be suspended if a discharge summary in not completed within 30 days post patient discharge. After day 15 post patient discharge, HIM sends a reminder notice to the physician via fax and phone call to the physician's office to complete the Discharge Summary. If no Discharge Summary is completed by day 31 post patient discharge, the physician's hospital privilege is suspended. HIM department serves the suspension notice by phone call and fax to the physician's office and mailing a certified letter to the physician. The physician receives instructions to turn over all care of all current inpatients and planned procedures to a current privileged physician. The physician's privileges are reinstated and suspension overturned when the delinquent Discharge Summary is completed. HIM department also</p>	09/28/2015

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	<p>who was admitted on 05/11/15 and expired on 05/12/15, lacked a written or dictated physician discharge summary, Short Stay Summary, or physician progress note.</p> <p>4. The medical record for patient #21, who was admitted on 01/05/15 and discharged on 01/08/15, indicated a physician discharge summary dictated on 02/15/15, greater than 30 days after discharge.</p> <p>5. The medical record for patient #24, who was admitted on 01/21/15 and expired on 01/22/15, lacked a written or dictated physician discharge summary, Short Stay Summary, or physician progress note.</p> <p>6. The medical record for patient #25, who was admitted on 01/26/15 and discharged on 01/30/15, lacked a written or dictated physician discharge summary.</p> <p>7. The medical record for patient #29, who was admitted on 04/13/15 and discharged on 04/21/15, lacked a written or dictated physician discharge summary.</p> <p>8. At 11:30 AM on 08/12/15, staff member #18, technology coordinator, confirmed the medical record findings regarding the missing or late discharge</p>		<p>sends copy of the physician's suspension notification to hospital Administration. HIM sends a copy of the physician's reinstatement of privileges to hospital Administration when the delinquent Discharge Summary is completed. Medical Staff Suspension Policy was reviewed and accepted at MEC meeting 9/15/2015. Medical Staff Suspension Policy was reviewed and accepted at Governing Board meeting 9/22/2015. Physicians will be educated regarding Administration's instruction for HIM to enforce physician suspension per Medical Staff Suspension Policy for delinquent Discharge Summary on 9/28/2015. Physician education of Medical Staff Suspension Policy will be provided by HIM. HIM will place a notice of Administration's support in enforcing physician suspension for delinquent Discharge Summary in the hospital's physician lounge on 9/28/15. HIM will fax or call the physician's office of Administration's support in enforcing physician suspension for delinquent Discharge Summary on 9/28/15. HIM will send a letter to the physician's office giving notice of Administration's support in enforcing physician suspension for delinquent Discharge Summary on 9/28/15 HIM department audits 100% of inpatient accounts to ensure a</p>	

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	documentation.		Discharge Summary is completed within 30 days post patient discharge. Monthly, the HIM Manager will submit a delinquent record report that includes Discharge Summary report to Administration and Medical Executive Committee. The HIM Manager is responsible for ensuring the accounts are audited for completed inpatient Discharge Summary within 30 days of inpatient discharge. The HIM Manager is responsible to ensure Administration receives the monthly delinquent record report. The HIM Manager is responsible to remind physicians to complete inpatient discharge summary at 15 days post inpatient discharge for records not having completed Discharge Summary. The HIM Manager is responsible to contact physicians who are suspended for delinquent Discharge Summary. The HIM Manager is responsible to enforce Medical Staff Suspension Policy physician suspension for inpatient Discharge Summary not completed within 30 days post inpatient discharge. The HIM Manager is responsible for physician notification of privilege suspension for delinquent Discharge Summary not completed within 30 days post inpatient discharge. The Discharge Summary deficiency will be corrected 9/28/2015	

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S 1118 Bldg. 00	<p>410 IAC 15-1.5-8 PHYSICAL PLANT 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 document review, observation and interview, the hospital failed to ensure eye wash station/shower combo was flushed at least weekly for the Laboratory Department and the safety of the staff when handling chemicals in 2 areas (Endoscopy Room and Surgical Decontamination Room).</p> <p>Findings included:</p> <p>1. Monroe Hospital Safety Program Management Plan policy #S 11.1 (last reviewed October 13, 2013) indicated the responsibility of the safety program was to ensure compliance with applicable local, state, and federal regulations.</p> <p>2. OSHA considers the guidelines set by such sources as American National Standards Institute proper maintenance and weekly testing was necessary to</p>			S 1118	<p>S-1118 The Laboratory Department Emergency Shower testing schedule was changed to weekly testing on 8/27/2015. Staff members have been educated on requirements of frequency of (weekly) shower and eyewash station testing in the Lab 8/27/2015. Housekeeping personnel conducts the weekly shower and eyewash station testing. Weekly testing record is maintained in a log in Lab. The Director of Support Services is responsible to ensure testing of the Lab shower and eyewash station are conducted weekly. Lab personnel are responsible for monitoring and maintaining the weekly shower/eyewash station testing log. The Laboratory shower and eyewash station testing was corrected on 8/27/2015 The Facilities Department installed an eyewash station in the Endoscopy area on 8/30/2015 that meets the</p>		09/18/2015

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	<p>ensure that Emergency Drench Showers and Eyewash Stations are functioning safely and properly. Weekly testing helps clear the supply lines of sediment and bacteria build-up that is caused from stagnant water. The ANSI standard states that plumbed flushing equipment, "shall be activated weekly for a period long enough to verify operation and ensure that flushing fluid is available." The eyewash station/shower combo has to be flushed weekly and documented of each flush conducted.</p> <p>3. At 2:10 PM on 8/11/2015, the Laboratory Department was toured and accompanied with staff member #26 (Lab Technician). The staff member located the eyewash station logs. The Laboratory Eye Wash Station/Shower combo station records were reviewed. The records evidenced the eye wash station flushed on a daily basis. However, the shower station of the eye wash station combo was flushed less frequently. The shower flushes were done the following days within the previous 3 years: 4/26/12; 10/25/12; 4/25/13; 10/24/13; 4/28/14; and 4/28/15. Therefore, the shower stations were not flushed weekly as required by OSHA to ensure loose sediment has been flushed from the lines.</p> <p>4. During the tour of the Endoscopy</p>		<p>standard to be able to flush the eyes for at least 15 minutes. Installation of the Endoscopy eyewash station is a permanent solution. Staff were educated to perform weekly eyewash station testing and maintaining eyewash station testing log on 8/30/2015. Peri-operative staff conduct weekly testing of the eyewash station. Eyewash station testing log is maintained in the Peri-operative area. The Director of Support Services is responsible for the installation of an eyewash station meeting the standard to be able to flush the eyes for at least 15 minutes for Endoscopy. The Director of Peri-Operative Services is responsible to ensure peri-operative staff conduct weekly eyewash station testing in Endoscopy area and eyewash testing log is maintained. The deficiency was corrected 8/30/2015 The hospital purchased an eyewash station meeting the standard of being able to flush the eyes for at least 15 minutes for Surgery Decontamination area. The eyewash station was installed 9/18/2015. The purchase and installation of the eyewash station for Surgery Decontamination area is a permanent solution. Staff were educated to perform weekly eyewash station testing and maintaining eyewash station testing log on 9/18/2015. Peri-operative staff conduct</p>		

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	<p>Room at 1:35 PM on 08/10/15, accompanied by staff members #3, the Chief Nursing Officer, and staff member #12, the Perioperative Director, the high-level disinfectant, Cidex OPA, was observed for use with the scopes after the procedures. No eye wash station was observed, but only a 16-ounce bottle of flush solution in a wall-mounted unit.</p> <p>5. Manufacturer's directions were to wear personal protective equipment, goggles, gloves, and apron, when handling the chemical and to flush the eyes for at least 15 minutes if a splash occurred.</p> <p>6. At 1:40 PM on 08/10/15, staff member #13, the Certified Surgical Tech in the Endo Room, confirmed the use of the chemical to disinfect the scope and indicated the flush solution was the only first aide available. He/she indicated he/she was not aware of any actual eye wash station near this area.</p> <p>7. During the tour of the surgical area at 2:00 PM on 08/10/15, accompanied by staff member #12, the high-level disinfectant, Cidex, was observed in the decontamination room for use with some equipment that required manual disinfection. The manufacturer's directions were the same as the Cidex</p>		<p>weekly testing of the eyewash station. Eyewash station testing log is maintained in the Peri-operative area. The Director of Support Services is responsible for the newly purchased eyewash station installation has been completed. The Director of Peri-Operative Services is responsible to ensure peri-operative staff conduct weekly eyewash station testing in the Surgery Decontamination area and eyewash testing log is maintained. The eyewash station was installed in Surgery Decontamination area on 9/18/2015.</p>				

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S 1216 Bldg. 00	<p>OPA. No eye wash station was observed, but only a 16-ounce bottle of flush solution in a wall-mounted unit.</p> <p>8. At 2:10 PM on 08/10/15, staff member #15, the Certified Surgical Tech in the decontamination room, indicated the chemical was used for manual disinfection of some equipment, then three rinses were performed. He/she indicated the wall-mounted bottle of flush was the only eye wash station he/she was aware of.</p> <p>410 IAC 15-1.5-9 RADIOLOGIC SERVICES 410 IAC 15-1.5-9(b)(1)(A)(B)(i)(ii)(iii)(iv)(v)(C) (b) The services that use ionizing radiation shall not compromise the health, safety, and welfare of patients or personnel in accordance with federal and state rules, as follows: (1) Proper safety precautions shall be maintained against radiation hazards in accordance with the hospital's radiation and safety program as developed by the radiation safety officer. This includes, but is not limited to, the following: (A) Adequate shielding for patients, personnel, and facilities. (B) Procedures for monitoring: (i) skin dosage; (ii) radionuclide contamination; (iii) quality control;</p>						

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	<p>(iv) technique charts, where applicable; and</p> <p>(v) handling of hazardous materials.</p> <p>(C) Appropriate storage, use, and disposal of radioactive materials.</p> <p>Based on document review, observation and interview, the hospital failed to ensure the MRI (magnetic resonance imaging) portable extinguisher was magnetic free.</p> <p>Findings included:</p> <ol style="list-style-type: none"> Monroe Hospital Safety Program Management Plan policy #S 11.1 (last reviewed October 13, 2013) indicated the responsibility of the safety program was to ensure compliance with applicable local, state, and federal regulations. Food and Drug Administration indicated there are no known harmful side-effects associated with temporary exposure to the strong magnetic field used by MRI scanners. However, there are important safety concerns to consider before performing or undergoing an MRI scan: Any loose metal object may cause damage or injury if it gets pulled toward the magnet. This is the main reason that all MRI suites are to have available a MRI ABC Fire Extinguisher that has no part of it that is magnetic. 	S 1216	<p>S-1216 MRI portable extinguisher pull pin was magnetic and needed to be replaced with an aluminum pull pin. The Facilities Department changed the magnetic safety pin in the fire extinguisher to a nonmagnetic aluminum pull pin. The Security Staff conducts a fire extinguisher pull pin check monthly during the monthly fire extinguisher inspections. Security maintains a log of the monthly fire extinguisher inspections and pull pin checks. The monthly fire extinguisher inspections and pull pin checks are reported to the Safety Committee. The Safety Committee report is submitted to Performance Improvement and included in the quality data dashboard. Quality data dashboard is submitted quarterly to MEC and Governing Board for review and acceptance. The Director of Support Services is responsible to ensure monthly fire extinguisher pull pin checks are conducted and the monthly log is maintained. The correction of replacement of magnetic pull pin to an aluminum pull pin was 8/13/2015. Fire safety inspection conducted 9/8/2015.</p>	08/13/2015

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S 1230 Bldg. 00	<p>3. At 2:25 PM on 8/11/2015, staff member #21 (Radiology Tech) and #5 (Support Services) tested the MRI white extinguisher safety pin for it being magnetized and the magnet identified the safety pin was made of material that was magnetic. The staff used a red magnet that would be used to test material and people for the possibility of anything that can cause a safety hazard.</p> <p>4. At .2:32 on 8/11/2015, staff member #5 (Support Services) indicated the safety pin on the MRI extinguisher was obviously made of material that is magnetic and could cause injury if it was used on the MRI.</p> <p>410 IAC 15-1.5-9 RADIOLOGIC SERVICES 410 IAC 15-1.5-9 (b)(4)</p> <p>(b) The services that use ionizing radiation shall not compromise the health, safety, and welfare of patients or personnel in accordance with federal and state rules, as follows:</p> <p>(4) Written preventive maintenance policies and procedures, in accordance</p>				

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	<p>with manufacturer's recommendations and hospital policy, shall be maintained and compliance shall be documented.</p> <p>Based on document review and interview, the hospital failed to ensure 3 pieces of radiology equipment had a preventive maintenance inspection as required by the manufacturer's recommendations.</p> <p>Findings included:</p> <ol style="list-style-type: none"> Gamma Camera preventive maintenance work order specified the piece of equipment should have its preventive maintenance inspection every 6-month period. The work order noted to most recent preventive maintenance inspection was 6/21/2013. The 64 slice Cat Scan preventive maintenance work order specified the piece of equipment should have its preventive maintenance inspection every 6-month period. The work order noted to most recent preventive maintenance inspection was 4/20/2014. Mammography room was observed with a preventive maintenance tag on the portable Densitometer which noted it was last inspected 11/21/12. At 2:00 PM on 8/11/2015, staff 	S 1230	<p>S-1230 The Gamma Camera preventative maintenance was conducted on 8/14/2015. The Gamma Camera preventative maintenance schedule has been put into the Biomed Tech's preventive maintenance computer program. The Biomed Tech will be alerted when preventive maintenance inspections are due. Biomed is responsible for conducting preventative maintenance work and maintaining records when preventative maintenance was completed. The preventive maintenance on the Gamma Camera was completed on 8/14/2015. The 64 Slice CT Scanner preventative maintenance was conducted on 8/12/2015. The 64 Slice CT Scanner preventative maintenance schedule has been put into the Biomed Tech's preventive maintenance computer program. The Biomed Tech will be alerted when preventive maintenance inspections are due. Biomed is responsible for conducting preventative maintenance work and maintaining records when preventative maintenance was completed. The 64 Slice CT Scanner preventative maintenance was completed on 8/12/2015. The Densitometer</p>	08/18/2015

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	<p>member #8 (Director of Radiology) provided the documents of the last preventive maintenance inspections performed on the gamma camera and the cat scan. The staff member understood that those items passed their semiannual inspection dates but new equipment has been ordered to be delivered within the next 6 to 8 weeks. The preventive maintenance was not performed on the older equipment because the service contract expired due to bankruptcy.</p> <p>5. At 2:21 PM on 8/11/2015, staff member #7 (Biomed Account Coordinator) confirmed the Densitometer had never been scheduled to be inspected and was forgotten to have its preventive maintenance.</p>		<p>preventative maintenance was conducted on 8/18/2015. The Densitometer preventative maintenance schedule has been put into the Biomed Tech's preventative maintenance computer program. The Biomed Tech will be alerted when preventative maintenance inspections are due. Biomed is responsible for conducting preventative maintenance work and maintaining records when preventative maintenance was completed. The Densitometer preventative maintenance was completed on 8/18/2015. The preventative maintenance reports are submitted quarterly to Safety Committee. Safety Committee submits their quality data quarterly to Performance Improvement. Quarterly Performance Improvement submits the quality data to MEC and the Governing Board for review and acceptance.</p>		