

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150021	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/24/2012
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NAME OF PROVIDER OR SUPPLIER PARKVIEW REGIONAL MEDICAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 11109 PARKVIEW PLAZA DRIVE FORT WAYNE, IN 46805
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S0000	<p>The visit was for a licensure survey.</p> <p>Facility Number: 005020</p> <p>Survey Date: 5-21-12 to 05-24-12</p> <p>Surveyors: Brian Montgomery, RN Public Health Nurse Surveyor Linda Plummer, RN Public Health Nurse Surveyor Lynnette Smith, BS MLT (ASCP) Medical Surveyor 3</p> <p>QA: claughlin 06/22/12</p> <p>8/17/12 revised due to IDR</p>	S0000	<p>Parkview #5020Our apologies for action plans for tag #0606 and 1118 being entered twice. We tried several times to delete everything and re-enter the data, but it still appears twice. We sent an email to the SRS Help Desk on 7-2-2012. They responded, but did not tell us how to remove the duplicate text. We would like to dispute tag#1166 and have attached documentation. Thank you!</p>	

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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S0178	<p>410 IAC 15-1.3-2 POSTING OF LICENSE 410 IAC 15-1.3-2(a)</p> <p>(a)The license shall be conspicuously posted on the hospital premises in an area open to patients and public. A copy shall be conspicuously posted in an area open to patients and public on the premises of each separate hospital building of a multiple hospital building system.</p> <p>Based upon observation and interview, the facility failed to post a license copy in a common public area for each hospital services off-site location for 2 of 15 off-sites.</p> <p>Findings:</p> <ol style="list-style-type: none"> Lack of a posted license was observed in the common public areas of the following outpatient services: <ul style="list-style-type: none"> A. on 5-22-12 at 1415 hours, during a tour of the outpatient endoscopy suite. B. on 5-22-12 at 1515 hours, during a facility tour of the outpatient Magnetic Resonance Imaging (MRI). During an interview on 5-22-12 at 1415 hours, staff A3 confirmed the location lacked a posted license. During an interview on 5-22-12 at 1515 hours, staff A4 confirmed the location lacked a posted license. 	S0178	<p>How are you going to correct the deficiency? The Director of Quality and Accreditation assured the ISDH license was posted in the 2 off site HOPDs (Hospital Out Patient Department)during survey: Carew MRI (Completed 5/24/2012) and MOB 11 (Completed 5/23/2012). The Director of Quality and Accreditation also updated the HOPD listing and assigned a contact/owner for each site. Completed 6/14/12 How are you going to prevent the deficiency from recurring in the future?The Director of Quality and Accreditation is a member of the Parkview Health HOPD committee and will be informed of any changes to the HOPD listed sites so that a license can be posted. Who is going to be responsible for steps A and B above? The Director of Quality and Accreditation By what date are you going to have the deficiency corrected? 5/24/12</p>	05/25/2012			

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S0554	<p>410 IAC 15-1.5-2 INFECTION CONTROL 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 document review, observation and interview, the facility failed to follow its policy/procedure and failed to maintain a safe environment that minimized infection exposure and risk for employees in an equipment decontamination area of the hospital.</p> <p>Findings:</p> <p>1. The policy/procedure Food and Drink in the Workplace (reviewed 12-11) indicated the following: " Food and drink are restricted to departmentally specific, designated areas that are free from exposure to infectious materials and/or bloodborne pathogens ...eating and drinking are prohibited in ...areas involving sterile processing and decontamination. "</p> <p>2. During a tour on 5-22-12 at 1305 hours, the following condition was observed: a working drinking water fountain in an area restricted to the gross decontamination, cleaning, and high-level disinfecting of hospital equipment.</p>	S0554	<p>How are you going to correct the deficiency? The drinking fountain was removed from the area on 6/27/2012.How are you going to prevent the deficiency from recurring in the future?The drinking fountain was removed from the area on 6/27/2012.Who is going to be responsible for steps A and B above? The Director of FacilitiesBy what date are you going to have the deficiency corrected? 6/27/2012.</p>	06/27/2012			

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	3. During an interview on 5-22-12 at 1305 hours, staff A14 confirmed that the area was utilized for cleaning and high-level disinfecting of bedside commodes, IV pumps and durable medical equipment and confirmed that the drinking fountain presented a risk of infection exposure if used by staff.			

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S0560	<p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(d)</p> <p>(d) A person qualified by training or experience shall be designated as responsible for the ongoing infection control activities and the development and implementation of policies governing control of infections and communicable diseases. Based on job description review, employee file review, and staff interview, the facility failed to ensure that two of two infection control practitioners met the required qualifications for the position, according to the facility job description (infection control practitioners [ICP] P12 and P14).</p> <p>Findings: 1. at 1245 hours on 5/24/12, review of the job description titled: "Infection Control Practitioner", with a date of 8-30-2005, indicated: a. in the "Job Qualifications" section, it reads: "Education and Formal Training: Must be a graduate of a School of Nursing; BS (bachelor's in science) or BSN (bachelor's in science/nursing) required, MS (masters) preferred." 2. at 1245 hours on 5/24/12, review of the job description titled "Infection Preventionist", with a date of 01-12-2009, indicated:</p>	S0560	<p>How are you going to correct the deficiency? The Infection Preventionist job description/job profile has been updated to reflect the appropriate requirements. Completed 6/12/2012. How are you going to prevent the deficiency from recurring in the future? When an applicant is identified as a qualified candidate for the position, a review of the profile takes place to ensure qualifications and requirements are present. If the candidate does not currently possess the required qualifications, but still presents as the most qualified candidate, an exception to policy will be completed to document why the exception was made and an explanation of the candidates competencies and knowledge that will allow them to successfully perform the job. The explanation will include any additional education that the candidate will pursue and the plan to achieve the educational requirements. The exception to policy is loaded on an "Exception</p>	06/12/2012			

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	<p>a. in the "Job Qualifications" section, it reads: "Education and Formal Training: Must be a graduate of a School of Nursing; BS or BSN required, MS preferred...Experience: Minimum of two years hospital experience in Critical Care and Medical/Surgical Nursing Minimum of two years in infection control surveillance or monitoring experience Must have experience in statistical analysis and process control..."</p> <p>3. at 0930 hours on 5/24/12, review of employee files indicated:</p> <p>a. ICP P12 was hired to this infection control/preventionist position on 5/8/11 (original hire date was 11/8/99 as a staff nurse) and had the following education/experience listed in the employee file:</p> <p>A. BSN in 1990</p> <p>B. Charge Nurse (5/1990 - 7/1994), and QA Coordinator of Pediatric Intensive care unit 1993-1994</p> <p>C. Inservice Director 7/1994 to 10/1999 at a long term care facility with duties that included participating in the Quality Assurance program</p> <p>D. an application /internal transfer form dated 2/18/11 requesting to be considered for the ICP position (indicated the current shift was a 3 AM to 3 PM, 0.9 FTE as a "Staff/charge nurse, complete physical assessments, family based care unit and</p>		<p>to Policy Spreadsheet" and will be monitored by the Director of Human Resources. Who is going to be responsible for steps A and B above? The Director of Care Coordination ensures that if a candidate is chosen that does not meet the job profile, that the competencies and knowledge along with an education plan is well documented. The Director of Human Resources will be responsible to assure that any exceptions to policy are being monitored and addressed. By what date are you going to have the deficiency corrected? 6/12/2012</p>				

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	<p>that this staff member did "chart audits and hand washing audits"</p> <p>b. ICP P14 was hired into the ICP position on 6/8/08 (original hire date was 5/29/05 to the SAU [surgery admission unit])and had the following education/experience listed in the employee file:</p> <p>A. this RN had an AD (associate degree) from IPFW (Indiana Purdue Fort Wayne), but lacked any indication of having a BS or BSN</p> <p>B. the internal transfer from was dated 4/23/2008 and indicated this RN had worked at an orthopaedic hospital in the SAU/PAR (surgery admission unit/post anesthesia recovery unit) and as a RN on the med/surg nursing unit</p> <p>C. a projected date of graduation with a Bachelor of Science in Nursing was listed as 1/13/09</p> <p>4. interview with staff member #71 at 1245 hours on 5/24/12 indicated:</p> <p>a. the job description for the ICP requires a BS or BSN and previous experience (2 years) in infection control duties and statistical analysis background, making it unclear why staff member P14 was placed in the ICP position prior to receiving a BSN and why both P12 and P14 were placed without having the other listed expected experiences</p>						

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	<p>b. it is assumed that some of the requirements, per the job description, were "waived" to move current staff to the position of ICP without looking outside the agency</p> <p>c. there are no notes or documentation in the employee files that support the waiving of required elements of the job description</p> <p>5. interview with staff member #51 at 1330 hours on 5/24/12 indicated:</p> <p>a. in speaking with staff member P12, this ICP reported having done some infection control duties as part of the QA at the long term care facility</p> <p>b. P12 ended work at the long term care facility in 1999 to come to this facility and a lot has changed between 1999 and 5/8/11 when accepted to the ICP position</p> <p>c. it was also thought that doing chart audits and hand washing surveillance might give this staff member the background and experience needed to fill the ICP position</p> <p>6. interview with staff member #77 at 1340 hours on 5/24/12 indicated:</p> <p>a. this staff member became director/coordinator of the ICPs about June 2011 when the previous person vacated the position</p> <p>b. P12 and P14 were hired as ICPs prior to this staff member's taking the lead</p>			

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	<p>position</p> <p>c. there is no documentation or noting of any kind to indicate why staff members P12 and P14 were given ICP positions while lacking all of the requirements of the job descriptions</p>			

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S0606	<p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(f)(3)(D)(viii)</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>(viii) An employee health program to determine the communicable disease history of new personnel as required by state and federal agencies. Based on documentation review and interview, the employee health program failed to determine the communicable disease history of its health care workers for 13 (S5-6, S13-14, P1-5, P10-11, P15-16) of 30 personnel files reviewed.</p> <p>Findings:</p> <p>1. The Centers for Disease Control (CDC) Recommendations of the Advisory Committee on Immunization Practices (ACIP) report titled Immunization of Health-Care Personnel (HCP) dated 11-25-11 indicated the following: " History of disease is no longer considered adequate presumptive evidence of</p>	S0606	How are you going to correct the deficiency? Each deficient coworker received notice of non-compliance at the time of the survey, including instructions on how to correct the deficiency. If coworker has not yet met compliance by 6/29/12, their leader and HR will be notified with the expectation that the coworker will be placed off work per policy. Notice will be given to Senior Leaders to enforce the policy. Employee Health Services provided additional education to personnel regarding appropriate data entry into the Employee Health database. This education process established standard work that will produce consistent reporting results. This will	06/29/2012			

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	<p>measles or mumps immunity for HCP; laboratory confirmation of disease was added as acceptable presumptive evidence of immunity. History of disease has never been considered adequate evidence of immunity for rubella ...[and] ...Criteria for evidence of immunity to varicella were established. For HCP they include written documentation with 2 doses of vaccine, laboratory evidence of immunity or laboratory confirmation of disease, diagnosis of history of varicella disease by health-care provider, or diagnosis of history of herpes zoster by health-care provider. "</p> <p>2. Personnel health records for staff S5 and S14 lacked documentation of health care provider-diagnosed rubella, rubeola and varicella, vaccination records or laboratory evidence of immunity (or confirmation of varicella disease).</p> <p>3. Personnel health records for staff S6 and S13 lacked documentation of health care provider-diagnosed varicella, vaccination records or laboratory evidence of immunity or confirmation of disease.</p> <p>4. During an interview on 5-23-12 at 1000 hours, staff A23 confirmed that the personnel files lacked the indicated documentation.</p>		<p>improve the ability to monitor for deficiencies. Completed 6/8/2012 How are you going to prevent it from occurring again? There is an ongoing surveillance process through Employee Health Services that has already verified more than 2000 personal health records. From this point, the following process will continue:</p> <ul style="list-style-type: none"> Manually review approximately 3000 paper personal health records, enter data into the employee health database, and identify deficiencies. Communicate deficiency to coworkers with instructions on how to rectify and deadline. Any continued deficiency will be communicated to department leader and HR with the expectation that the coworker will be placed off work per policy. Notice will be given to Senior Leaders to enforce the policy. Anticipated progress is 25 chart reviews per day. <p>Additionally, review of required health elements with new coworkers by an Employee Health nurse occurs during the onboarding process. This education began on 6/18/12. This will reinforce the expectations of compliance prior to coworkers start date.</p> <p>Who is responsible for steps A and B above? The Executive Director of Employer Strategies, under the direction of the Chief Financial Officer is responsible that corrective actions are</p>		

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	<p>5. at 0930 hours on 5/24/12, review of the document provided by employee health staff as the guideline for new employee health/immunization requirements, was titled: "Healthcare Personnel Vaccination Recommendations" by the Immunization Action Coalition, dated 7/09, indicated:</p> <p>a. Hepatitis B "Give 3-dose series...Obtain anti-HBs serologic testing 1-2 months after dose #3"</p> <p>b. MMR "For healthcare personnel (HCP) born in 1957 or later without serologic evidence of immunity or prior vaccination, give 2 doses of MMR, 4 weeks apart..."</p> <p>c. Varicella "For HCP who have no serologic proof of immunity, prior vaccination, or history of varicella disease, give 2 doses of varicella vaccine, 4 weeks apart..."</p> <p>6. at 1320 hours on 5/24/12, review of the TST (Tuberculin Skin Testing) Program Updates 2011 indicated those at "Medium Risk Classification Facilities" would have "All healthcare workers are required to have a TST"</p> <p>7. at 1325 hours on 5/24/12, review of the 12/15/11 "Infection Prevention & Control Committee" meeting minutes indicated: "TST Program Report--PVH</p>		sustained.What date are you going to have the deficiency corrected? 6/29/2012				

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	<p>(Parkview Hospital),...are medium risk due to...licensure..."</p> <p>8. review of 16 employee and contracted nursing health files at 0935 hours on 5/24/12 indicated:</p> <p>a. staff member P1, an OB (obstetric) RN (registered nurse) hired 1/2/11 had:</p> <p>A. a 7/9/10 date in the area for a Varicella titer result, but no indication of level of titer, or positive notation--the information was sent from a previous employer and is unclear what the immunization status is for the employee</p> <p>B. had a last TB test on 1/3/11</p> <p>b. staff member P2, hired 1/3/11, had a hand written note on an "immunization record" copy that indicated:</p> <p>A. "March 7, 1975 to March 21, 1975 (2 weeks) she had chicken pox"--there was no physician authentication of this event (last physician entry was 1972)</p> <p>B. there was no Varicella titer in the health file</p> <p>c. staff member P3, an ER (emergency room) RN was hired 4/24/11 and had a last TB test on 4/11</p> <p>d. staff member P4, an OB RN was hired 3/14/10 and had a last TB test on 3/10</p>			

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	<p>e. staff member P5, hired 6/6/10, lacked any information in the health file related to Hepatitis B--there was documentation as follows:</p> <p>A. letter dated 7/29/10 stating: "I have received your pre hire chart and you stated you were interested in receiving the Hepatitis B series. You may have this done at no charge to you. You may go to Employee health at main or any Occupational health office to have these done..."</p> <p>B. a letter dated April 24, 2012 reading: "A recent audit of your employee health file revealed that we do not have all of the necessary information to be in compliance with the Indiana State Department of Health requirements...we need to have the following tests or vaccines completed. We are missing the following information. Hepatitis B series Dates; Hepatitis B Titer; Hepatitis B Declination...Please call any Parkview Occupational Health clinic to schedule an appointment to complete the requirements..."</p> <p>f. staff member P10, hired 4/17/11 did not receive their requested Hepatitis B series until 3/20/12--the form requesting the series was dated 4/6/11, and a letter of reminder to begin the series was dated 2/28/12</p>			

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	<p>g. staff member P11 was hired 3/12/12 and lacked documentation related to a Varicella titer score--had a "date done" of 10/19/1998, but it is unknown if this was the first or second Varicella immunization (original hire date was 12/5/10, changed positions 3/12/12)</p> <p>h. contracted dialysis RN P15 was hired 8/23/11 and had an equivocal Rubella titer result of "<5.0" with the equivocal range of 5.0 to 9.9</p> <p>i. contracted dialysis RN P16 was hired 8/23/11 and had an equivocal Rubeola with a result of "15.9" and a range of 15.0 to 19.9 as the range for equivocal</p> <p>9. interview with staff members #72 and #73 at 1115 hours on 5/24/12 indicated:</p> <p>a. the facility was broken down into high risk areas which are: ER, OB, FBC (family birthing center-OB), lab and radiology</p> <p>b. the TB risk assessment tool was done in June 2011 and did not include the current regional medical center that opened in March 2012--no risk assessment has been completed for the new facility, yet, but staff are assuming it is a low risk facility and that TB tests will not be completed annually</p> <p>c. some staff float between campuses, so with the "main" campus a medium</p>						

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	<p>risk, staff should have an annual TB (TST) test done to be in compliance with/at both facilities</p> <p>d. it is unknown why there is such a long wait time between a new staff member requesting to begin the Hepatitis B series and not getting notice reminders until a year or more later (P5 and P10--e. and g. above)</p> <p>10. interview with staff members #74 and #75 at 1115 hours on 5/24/12 indicated the contracted dialysis nurses do not have immunity to Rubella and Rubeola with equivocal titer scores--there should have been follow up done related to the lack of immunity for these communicable diseases</p> <p>11. interview with staff members #70 and #71 at 2:10 PM on 5/24/12 indicated:</p> <p>a. the contracted dialysis company did not require immunization history/documentation/immunity to communicable diseases, so no follow up was done related to this</p> <p>b. the facility employee health staff were not given the immunization information to clear the dialysis staff for work related to communicable disease history, titers, etc.</p> <p>c. there is no disciplinary action taken for staff who do not comply with notices by employee health to report to</p>						

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	occupational health for follow up on immunization, health information, etc. needed to complete employee health files				

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S0608	<p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(f)(3)(D)(ix)</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>(ix) Requirements for personal hygiene and attire appropriate for work settings.</p> <p>Based on policy and procedure review, observation, and interview, the surgery manager and infection preventionists failed to ensure appropriate attire was utilized within the restricted and semi restricted areas of two surgery departments and one family birthing center area.</p> <p>Findings: 1. at 1155 hours on 5/22/12, review of the policy and procedure "Dress Code Perioperative" with a last reviewed/revised date of 04/12, indicated: a. under "II Definitions", it reads: "...C. Restricted areas: All sterile areas (operating rooms with opened and unopened sterile instruments and</p>	S0608	<p>How are you going to correct the deficiency? A communication plan for Perioperative Staff and Medical Staff was provided regarding appropriate hair covering and use of masks. 6/30/2012 Information regarding appropriate hair covering and use of masks was discussed at departmental staff meeting and written communication was disseminated throughout the facility. 6/30/2012 The Anesthesia Specialty Representative sent doctors an email and reviewed it at the 6/24/2012 group meeting. He reminded doctors to cover their head with a bouffant if they wear skull caps. He also discussed the dangling mask issue. The Medical Director of Epidemiology</p>	06/30/2012			

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	<p>supplies)..."</p> <p>b. under "III. Procedure:...C. Restricted Areas...2. Head/Hair Coverings:...b. cloth head coverings may be worn under hospital bouffant/hood but must be completed covered by the bouffant/hood...4. Masks:...b. A new mask must be worn for each operative procedure ...d. Masks will not be hanging down from the neck..."</p> <p>c. "IV References: AORN..."</p> <p>2. at 0935 hours on 5/22/12, while on tour of the Randallia location OR (operating room) services area, in the company of staff members #51 and #57, it was observed that the anesthesiologist in OR suite #4 had a cloth skull cap on that lacked the covering of a bouffant hood and had hair uncovered below ear level and at the nape of the neck</p> <p>3. interview with staff member #57 at 0935 hours on 5/22/12 indicated the anesthesiologist was not following facility policy without a bouffant covering over the cloth skull cap and with hair at the nape not completely covered by a cap</p> <p>4. on 5/22/12 at 1310 hours, while on tour of the PRMC (Parkview Regional Medical Center) OR suite areas, in the company of staff members #51 and #57, it was observed that:</p>		<p>and Infection Prevention discussed proper attire and infection prevention practices with medical staff at the Medicine Division meeting on 6/27/2012 and the Surgery Division meeting on 6/28/2012. How are you going to prevent the deficiency from recurring in the future? Daily observations will be completed over the next 90 days.</p> <p>8/30/2012Who is responsible for steps A and B above?The Director of Perioperative Services and the Anesthesia Specialty Representative.By what date are you going to have the deficiency corrected? 6/30/2012.</p>				

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	<p>a. (at 1320 hours) 4 to 6 different surgical staff persons were wandering the semi restricted areas of the OR with surgical masks dangling about the neck</p> <p>b. (at 1322 hours) while observing the finishing of a surgical case and removing a patient from one OR suite, it was noted that 3 surgical staff had their surgical masks dangling about the neck while within the suite and also upon exiting the suite and traveling the semi restricted hallway</p> <p>5. on 5/23/12, while on tour of the FBC (Family Birthing Center) at the PRMC location, in the company of staff members #51 and #67, it was observed that:</p> <p>a. at 1120 hours 3 staff were noted to be walking in the semi restricted areas between the FBC and the OR North suites (a shared hallway) with surgical masks dangling about the neck</p> <p>6. interview with staff member #57 at 1320 on 5/22/12 indicated:</p> <p>a. when staff are walking in the semi restricted areas with masks about the neck, it is unknown if they reuse that mask or put on a new one, as required by policy, for each procedure</p> <p>b. it was unknown by this staff member that AORN (association of perioperative registered nurses) suggests no masks dangling about the neck in all areas of the</p>				

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	OR, not just the restricted areas			

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S0612	<p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(f)(3)(D)(xi)</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>(xi) A program of linen management for personnel involved in linen handling. Based on policy and procedure review, manufacturer's operational manual review, observation, and interview, the facility failed to ensure linen/blanket warmers were maintained at appropriate and consistent temperatures through out the facility and failed to implement cleaning schedules for the appliances to ensure proper infection control standards.</p> <p>Findings: 1. at 1155 hours on 5/22/12, review of the policy and procedure "Temperature Controlled Device Monitoring", with a last review/revision date of 4/12, indicated: a. under section "V. Temperature Ranges:" , it reads in section "D. Warmers" "1. Blanket 130 F/54 C</p>	S0612	<p>How are you going to correct the deficiency? Observed warmers were set to the correct temperature on 6/15/12. Staff were provided written education on 6/15/12 noting approved temperature ranges for these devices per policy. The cleaning policy and schedule cleaning log revisions will be completed on 7/15/12. How are you going to prevent the deficiency from recurring in the future? Temperature monitoring of these devices is electronic and will alert managers when the temperature is out of range. Routine cleaning of the device will occur per the scheduled cleaning. Who is responsible for steps A and B above? The Medical Director of Epidemiology and Infection Prevention is responsible for</p>	07/15/2012

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	<p>maximum..."</p> <p>b. references included: "ECRI (economic cycle research institute) Institute (July 13, 2009)...Recommendation for Temperature Limits on Blanket Warmers (update)."</p> <p>2. at 1550 hours on 5/22/12, review of the Blickman "Digital Warming Cabinet" user manual indicated:</p> <p>a. in section 3.2 "Recommended Settings:", it reads: "Blickman does not recommend any operating temperature set point. For appropriate heating temperatures, please contact the manufacturer of the goods being heated."</p> <p>b. in section 5.0 "Routine Preventative Maintenance", it reads in section 5.2 "Product Cleaning" "5.2.1 Regular cleaning is important to maintain the appearance of stainless steel equipment...5.2.2 Shelves, Sloping Top etc. can be cleaned with a solution of liquid dishwashing detergents..."</p> <p>3. at 1550 hours on 5/22/12, review of the "Bryton Corporation Digital Warming Cabinets" user manual indicated:</p> <p>a. on page one in "Location for use", it reads: This unit is intended for use in a stable ambient environment, with an ideal temperature of 72 degrees F or less. The unit should never be used directly next to any appliance that may produce heat, such</p>		<p>policy oversight. The Director of Facilities is responsible for maintaining the electronic monitoring system. By what date are you going to have the deficiency corrected? 7/15/12.</p>				

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	<p>as an autoclave..."</p> <p>b. on page one in "Recommended Settings", it reads: "Bryton does not recommend chamber set points. For appropriate heating temperatures, please contact the manufacturer of the goods being heated..."</p> <p>4. at 1455 hours on 5/21/12, while on tour of the ED (emergency department) in the company of staff members #51 and #59:</p> <p>a. in Trauma Room #20 it was observed that the Blickmam blanket warmer had a build up of dust under the lower shelf (Plenum)</p> <p>b. in the critical room hallway, the Blickaman 7924 TG blanket warmer had a build up of dust under the lower shelf (Plenum)</p> <p>c. a third blanket warmer on the unit (Model # 7924 TS) had a build up of dust under the lower shelf (Plenum)</p> <p>5. interview with staff members #51 and #59 at 1500 hours indicated the blanket warmers are not on a cleaning schedule--it was unknown that the blankets and linens stored in the warmers created such a dusty build up under the plenum shelf</p> <p>6. while on tour of the cath lab area at PRMC (Parkview Regional Medical Center) at 1620 hours on 5/21/12, in the</p>						

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	<p>company of staff members #51, #60 and #61, it was observed that the blanket warming cabinet had a set point of 140 degrees F and an actual temp of 140 degrees F</p> <p>7. at 0940 hours on 5/22/12, while on tour of the Randallia OR (operating room) services area, in the company of staff members # 51 and #57, it was observed that:</p> <ul style="list-style-type: none"> a. the Bryton warmer was located in a sub sterile room between two autoclaves b. a small note on the warmer indicated not to increase the warmer temperature above 110 degrees c. an 8 x 11 sheet of paper titled "guidelines" was posted on the front of the warmer that indicated 104 degrees was the desired warming temperature <p>8. interview with staff members #51 and #57 at 0940 hours on 5/22/12 indicated it was confusing what temperature was the appropriate temperature with the policy indicating 130 degrees (blankets) and the warmer had 110 and 104 degrees listed</p> <p>9. at 0950 on 5/22/12, while on tour of the ED (emergency department) at the Randallia location in the company of staff members #51 and #78, it was observed that the AMSCO blanket warmer was dusty under the lower shelf (Plenum)</p>				

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	<p>which created an infection control risk (temperature was 106 degrees F)</p> <p>10. interview with staff member #51 at 1340 hours on 5/23/12 indicated:</p> <p>a. the current policy related to temperature controlled devices does not have the current (2010) ECRI recommendations for maximum temperatures for warming blankets and fluids</p> <p>b. there are conflicting notes and guidelines on the various blanket warmers related to maximum temperatures that doesn't reflect the facility policy recommendations</p> <p>c. two manuals recommend contacting the "goods" provider to find the appropriate warming temperature, it is unknown if this was ever accomplished</p> <p>d. the policy related to temperature controlled devices does not address the dusty buildup of blanket warmers under the plenum shelf and the need for routine interior cleaning of the warmers for proper infection control processes and environmental cleanliness</p>			

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S0744	<p>410 IAC 15-1.5-4 MEDICAL RECORD SERVICES 410 IAC 15-1.5-4 (e)(1)</p> <p>(e) All entries in the medical record shall be:</p> <p>(1) legible and complete; Based on review of medical staff rules and regulations, patient medical record review, and staff interview, the facility failed to ensure the legibility of documentation and completion of forms for 2 of 2 surgical patient records reviewed. (pts. #12 and #13)</p> <p>Findings:</p> <p>1. at 1155 hours on 5/22/12, review of the medical staff rules and regulations, with a most recent approval date of 6/14/11, indicated:</p> <p>a. in section "II. Responsibilities": "...2...Documentation will be complete...3... must be legible...10. Entries in the medical record will be dated, timed, legible and authenticated...16. Entries in the medical record will be legible and on approved hospital forms..."</p> <p>2. review of the policy and procedure "Medical Records", with a last revised date of 12/09, indicated:</p> <p>a. under "III Procedure A. Documentation Standards", it reads: "1.</p>	S0744	<p>How are you going to correct the deficiency? The Director of Quality and Accreditation discussed the preliminary ISDH findings with the Medical Executive Committee on 6/12/2012. Policy requirements were shared regarding documentation on the anesthesia record. 6/12/2012The Anesthesia Specialty Representative provided education to the anesthesiologists concerning date/time documentation requirement on the anesthesia record. 6/24/2012The Quality Management Department completed a medical record for audit on the anesthesia record Jan-March 2012. Audit results were 97% compliant. 6/1/2012The Anesthesia Specialty Representative will follow up with anesthesiologists concerning the need to complete all applicable documentation on the anesthesia record. 7/6/2012How are you going to prevent the deficiency from recurring in the future?The Quality Management Department performs ongoing monitoring of the anesthesia record and will report non-compliance to the</p>	07/06/2012	

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	<p>Documentation in the medical record will follow the guidelines set forth in the Medical Staff Rules and Regulations...6. entries must be legible..."</p> <p>3. at 1140 hours on 5/24/12, review of patient medical records indicated:</p> <p>a. pt. #12 lacked completion of a date and time of the postoperative anesthesia note on the "Anesthesia Record" form</p> <p>b. pt. #13:</p> <p>A. had a write over on the date of the "Authorization to Treat" form making it unclear what day the patient was admitted and/or signed the form</p> <p>B. lacked completion of documentation on the "Anesthesia Record" form (page 1) in the "Post Anesthesia Note" area (failed to indicate if the patient went to PACU, SAU or ICU after OR) and lacked a date and time by the anesthesiologist of the post anesthesia evaluation</p> <p>C lacked completion on the "Anesthesia Record" form (page 2) in the "Airway Class" section, and the "Gas off" section</p> <p>4. interview with staff member #51 at 1310 hours on 5/24/12 indicated the legibility and missing documentation in the medical records for pts. #12 and #13 were not in compliance with facility policy and medical staff rules and regulations for legibility and completion</p>		<p>Anesthesia Specialty Representative as needed. Who is going to be responsible for steps A and B above? The Anesthesia Specialty Representative By what date are you going to have the deficiency corrected? 7/6/2012</p>				

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S0871	<p>410 IAC 15-1.5-5 Medical Staff 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: (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>						

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	<p>Based on review of the medical staff rules and regulations, patient medical record review, and staff interview, the facility failed to ensure that the rules and regulations were implemented related verbal/telephone orders, and standing orders/protocols, for 2 of 2 death records reviewed. (pts. # 10 and #11)</p> <p>Findings:</p> <p>1. at 1155 hours on 5/22/12, review of the medical staff rules and regulations, with a last date of approval of 06/14/11, indicated:</p> <p>a. on page 5 under "H. Orders", it reads: "...2. Verbal and telephone orders must include:...f. authentication of a verbal order must occur within 48 hours unless a read back and verify (R/V) process is utilized. When the read back and verify (R/V) is followed, the hospital shall require authentication of the verbal order no later than 30 days after the patient's discharge...4. Orders written subsequent to a dosing protocol must be documented "as per _____ protocol" (ex. as per "Heparin" protocol) and include the first initial, last name, and credentials of the individual writing the order..."</p> <p>2. review of patient medical records at 1140 hours on 5/24/12 indicated:</p> <p>a. pt. #10 had: orders written on 2/20/12</p>	S0871	<p>How are you going to correct the deficiency? A department audit completed 32/32 (100%) VO/TO orders had documentation of Read back and Verify. 6/18/2012The employee involved was provided appropriate follow up and education. 5/24/12The Director of Quality and Accreditation discussed preliminary ISDH survey findings and specifically appropriate documentation for TO/VO read back & verify with Nursing Leadership. 6/5/2012Manager of Clinical Education will provide mandatory education to all nurses on TO/VO Read back & Verify policy/procedure. 7/15/2012How are you going to prevent the deficiency from recurring in the future?Periodic random department audits to assure continued compliance.Who is going to be responsible for steps A and B above?Manager of Clinical Education in conjunction with the Nursing Services Manager.By what date are you going to have the deficiency corrected?6/18/2012 Respiratory Therapy Order per Protocol:How are you going to correct the deficiency? The employee involved was provided appropriate follow up and education. How are you going to prevent the deficiency from recurring in the future? Compliance monitoring is done weekly with issues addressed immediately. Cumulative data will</p>	06/18/2012			

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	<p>at 1500 hours by an RRT that read: "current vent settings: PRUC 26 500 100% peep 5 per Dr.../...RRT", but lacked "Per ___protocol" notation</p> <p>b. pt. #11: A. had orders written at 1247 hours on 1/10/12 as "order clarification...carb gtt ASAP" as a "VO Dr.../K...RN" (order electronically authenticated on 3/7/12, but without the R/V, it was due within 48 hours of the order" B. had orders written at 1335 hours on 2/20/12 for "3 units PRBC's STAT" as a "TO Dr.../K...RN" (this order still lacks authentication by the ordering physician) C. had orders written at 1532 hours on 2/20/12 that read: "give 2 amps Calcium Chloride" as a "TO Dr.../K...RN" (this order is authenticated, but lacks a date and time to determine if it was signed within 48 hours as required by rules and regulations without the R/V by nursing staff</p> <p>3. interview with staff member #53 at 1530 hours on 5/24/12, indicated: a. the RRT (respiratory therapist) failed to write "per protocol" for the orders written on pt. #10, as listed in 2. a. above, per medical staff rules and regulations b. the RN failed to write R/V with the orders for pt. #11 as written in 2. b. above--without the R/V, the</p>		<p>be shared with all therapists weekly. Who is going to be responsible for steps A and B above? The Director of Respiratory Therapy. By what date are you going to have the deficiency corrected? 5/25/2012.</p>				

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	authentication by the practitioner should have been within 48 hours, as per medical staff rules and regulations			

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S0904	<p>410 IAC 15-1.5-6 NURSING SERVICE 410 IAC 15-1.5-6(a)(1)</p> <p>(a) The hospital shall have an organized nursing service that provides twenty-four (24) hour nursing service furnished or supervised by a registered nurse. The service shall have the following:</p> <p>(1) An organizational plan which delineates the responsibilities for patient care.</p> <p>Based on document review and interview, the nursing organizational chart was lacking clarity in lines of authority for the nursing director.</p> <p>Findings:</p> <p>1. at 1340 hours on 5/23/12, review of the facility organizational chart dated 9/11/11 indicated nursing is intermingled with other department managers and directors making it difficult to determine clear lines of authority for this staff member</p> <p>2. at 1035 hours on 5/24/12 an updated organizational chart was provided and dated 5/23/12, with nursing director areas highlighted but still not with clear lines of authority for the nursing director</p> <p>3. interviews with staff members #50 and #51 at 1035 hours on 5/24/12 indicated the "PVH (Parkview Hospital) &</p>	S0904	<p>How are you going to correct the deficiency? The Nursing Organization Chart was developed by the Senior Vice President of Nursing on 6/25/12 and shared with Nursing Leadership on 7/2/2012. How are you going to prevent the deficiency from recurring in the future? The Senior Vice President of Nursing will perform at minimum an annual review of the organization chart for changes in the nursing reporting structure. Who is going to be responsible for steps A and B above? Senior Vice President of Nursing By what date are you going to have the deficiency corrected? 7/2/2012</p>	07/02/2012			

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	<p>Affiliates Organizational Chart:</p> <ul style="list-style-type: none"> a. includes nursing services within all of the areas of their "service line" b. it was unknown by these staff members that a stand alone nursing organizational chart would better explain and show the clear lines of authority for the nursing executive 			

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S0954	<p>410 IAC 15-1.5-6 NURSING SERVICE 410 IAC 15-1.5-6(e)</p> <p>(e) Emergency equipment and emergency drugs shall be available for use on all nursing units.</p> <p>Based on document review and interview, emergency equipment and medications were not maintained and available for use if needed for 1 outpatient imaging department</p> <p>Findings:</p> <p>1. The policy/procedure Crash Cart/Defibrillator/AED Checks (reviewed 10-08) indicated the following: " Outdates should be checked on all supplies, equipment and medication ...Nursing/Ancillary Departments: It is the responsibility of that area where the cart is normally located to [-?-] all outdates of the code cart. "</p> <p>3. Facility documentation titled " Parkview Health AED and Code Cart Checklist " and dated May 2011 for the NV outpatient imaging area failed to indicate a staff entry following ' Cart Expiration Date ' to ensure that all equipment, supplies and medications were not expired.</p> <p>4. During a tour on 5-21-12 at 1610</p>	S0954	<p>How are you going to correct the deficiency? A locked drug box containing saline was provided by pharmacy on 6/20/2012. In addition, an AED monitoring log and supply check is now on the cart. Inservice and the department assignment schedule was shared with all Imaging staff at a meeting 6/30/2012. How are you going to prevent the deficiency from recurring in the future? Staff were assigned to check the cart and the schedule was posted. 6/30/2012. Who is going to be responsible for steps A and B above? The Director of Diagnostic Imaging By what date are you going to have the deficiency corrected? 6/30/2012.</p>	06/30/2012			

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	<p>hours at the NV outpatient imaging department, during a check of the Code Cart equipment, the following conditions were observed:</p> <p>A. (1) 1000 ml 0.9% Normal Saline IV bag expired 4-01-2012</p> <p>B. (2) 500 ml 0.9% Normal Saline IV bags expired 3-01-2012</p> <p>5. During an interview on 5-21-12 at 1615 hours, staff A10 confirmed that the equipment had not been maintained by staff.</p>			

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S1118	<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 policy and procedure review, observation, and staff interview, the facility failed to ensure conditions that would not result in a hazard to its' patients or employees in regards to expired lab tubes, non dated glucometer control solutions, missing eye wash station checks in 4 areas toured and the lack of dantrium and malignant hyperthermia kit in one OB (obstetric) C-Section area.</p> <p>Findings:</p> <p>1. at 1155 hours on 5/22/12, review of the policy and procedure "Whole Blood Glucose - AccuChek Inform Meter", with a last revised date of 2/20/12, indicated:</p> <p>a. on page 3 in the section "III. Equipment and Materials", it reads in item E. "Storage Requirements:...Glucose Control Solutions and Linearity Test Kits are stable for three months after</p>	S1118	<p>Expired Lab Tubes - How are you going to correct the deficiency? The Emergency Department implemented a process to review the inventory for outdates the last Friday of every month. The SCORE (Supply Chain Operational Resource eNovation) has a policy to not receive product within 6 months of product expiration. Product expiration dates are monitored during the weekly cycle count function. Expired or close to expired product will be removed. SCORE software has a lot/expiration date notification feature. These tubes were added as date sensitive items to be monitored. This feature will alert the staff at 30 days before expiration and will not allow the item to be shipped from the SCORE distribution center. How are you going to prevent the deficiency from recurring in the future?All preventative measures</p>	07/01/2012			

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	<p>opening...Three month expiration date must be written on vials after opening."</p> <p>2. at 1457 hours on 5/21/12, while on tour of the ED (emergency department) trauma room #20, in the company of staff members #51 and #59, it was observed that:</p> <p>a. two blue top lab tubes expired 2/2012</p> <p>b. the Glucometer control solutions (Hi and Lo bottles) had a date opened noted as 5/6/12, but lacked a notation of the 3 month discard date</p> <p>3. at 1600 hours on 5/21/12, while on tour of the PHI (Parkview Heart Institute) and cardiovascular patient room areas in the company of staff members #51, #60, and #61 it was observed that:</p> <p>a. the soiled utility room eye wash station weekly check log was not completed for 3 of 10 weeks the unit had been occupied (opened the unit on March 17, 2012)</p> <p>b. the Glucometer control solutions (Hi and Lo bottles) in the nursing station outside room 2204 had unreadable dates of opening and discard (dates were smudged and unreadable by the surveyor and facility staff)</p> <p>4. interview with staff member #61 indicated that the techs are to log the</p>		<p>listed above will prevent the deficiency in SCORE managed areas. Also, the last Friday of each month, the Emergency Department has a process to review inventory for expired tubes. Who is going to be responsible for steps A and B above? The Vice President of SCORE and the Emergency Department Director. By what date are you going to have the deficiency corrected? 6/29/2012</p> <p>Glucometer Control Solution - How are you going to correct the deficiency? Nursing managers ensured that opened and expiration dates are marked on each vial. Additionally, tape was applied after this labeling to help keep the dates readable and avoid disintegration or smudging of dates. Lab will continue it's periodic audits to ensure this is being completed. All vials were rechecked by the Laboratory to ensure smudged dates were addressed at the time of the survey. Infection Prevention was contacted to ensure the application of tape to the control vials was acceptable as well. Application of tape has been trialed and appears to work very well. Completed 6/26/2012</p> <p>How are you going to prevent the deficiency from recurring in the future? Periodic audits are performed with aid of nursing managers in addition to laboratory audits. Data from audits will be compiled by</p>				

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	<p>weekly eye wash station checks, but this staff member follows up and does it if it gets missed by techs, however 3 weeks of logging are missing</p> <p>5. at 0945 hours on 5/22/12, while on tour of the Randallia (main) hospital OR (operating room) area, interview with staff members #57 and #62 indicated:</p> <p>a. the OR staff is responsible for staffing and supplying the OB C-Section room(s)</p> <p>b. there is no dantrium or malignant hyperthermia kit in the OB C-Section area</p> <p>c. in the event of a malignant hyperthermia patient, someone would have to retrieve, or call for, the needed emergency items possibly causing a delay in emergency care for the patient</p>		<p>laboratory and retained in grid format with expiration dates. This allows for ongoing assessment and random audits to be performed. The process was effective 7/1/2012. Who is going to be responsible for steps A and B above? Laboratory Point of Care Testing Department in conjunction with nursing managers. By what date are you going to have the deficiency corrected? 7/1/2012</p> <p>Eyewash Station Weekly Checks - How are you going to correct the deficiency? The eyewash station was checked and logged during the survey on 5/22/12. The Nursing Manager concluded education to PHI Tech staff on 6/26/12 regarding the need for weekly checks, the process for conducting checks and how to document checks. Compliance with weekly checks and documentation was validated during the 6/26/12 audit which noted that the log was up to date for the past five weeks with 100% compliance. How are you going to prevent the deficiency from recurring in the future? Annually, and on an ongoing basis, training is provided to departments regarding eyewash station checks via the Safety Department and Netlearning. Additionally, the Safety Coordinator conducts surveillance rounds to ensure that departmental eyewash stations are checked in accordance with hospital policy. Who is going to</p>		

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			<p>be responsible for steps A and B? The PHI Nursing Manager is responsible for ensuring eyewash station checks occur per policy. The Safety Coordinator validates via the Environment of Care surveillance rounds. By what dates are you going to have the deficiency corrected? 6/26/2012 Randalia - OB Department C-section room(s) How are you going to correct the deficiency? Randalia (main) hospital OB department C-section area was stocked with Dantrium. Completed 6/6/2012. How are you going to prevent the deficiency from recurring in the future? Pharmacy maintains and monitors levels and expiration dates of Dantrium through the Pyxis medication dispensing system. The unit par levels are adjusted as necessary. Who is going to be responsible for steps A and B? The Pharmacy Director. By what dates are you going to have the deficiency corrected? 6/6/2012 Boiler room at Randallia Eyewash Station How are you going to correct the deficiency? An eyewash station was added to the boiler room on 5/22/12. How are you going to prevent the deficiency from recurring in the future? Risk assessments determine the need for eyewash station installation and are conducted by the Safety Coordinator and in conjunction with departmental managers. Risk assessments are triggered</p>	

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	<p>6. Review of the Occupational Safety and Health Administration (OSHA) general requirements for emergency showers and eye wash station equipment in 29 Code of Federal Regulations (CFR) 1910.151(c) indicated the following: " When the eyes or body of any person may be exposed to injurious corrosive materials, suitable facilities for quick drenching or flushing of the eyes and body shall be provided within the work area for immediate emergency use. "</p> <p>7. During a tour on 5-22-12 at 1145 hours, the following condition was observed: no available eyewash equipment in the boiler room area where water quality testing was performed.</p> <p>8. During an interview on 5-01-12 at 1605 hours, staff A14 confirmed that an eyewash station was not immediately available in the water quality testing area if needed.</p>		<p>by surveillance rounds, work orders and department requests. Who is going to be responsible for steps A and B? The Facilities Director and the Safety Coordinator are responsible for ensuring the installation of eyewash stations are in appropriate locations. By what dates are you going to have the deficiency corrected? 5/25/2012</p>		

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S1125	<p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8 (b)(5)(B)</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>(5) Provision shall be made for the periodic inspection, preventive maintenance, and repair of the physical plant and equipment by qualified personnel as follows:</p> <p>(B) Operational and maintenance control records shall be established and analyzed periodically. These records shall be readily available on the premises.</p> <p>Based on observation and interview, the facility failed to follow its policy/procedure ensuring that preventive maintenance (PM) was documented and equipment maintained in good working order for 6 of 6 physical plant equipment sampled for program compliance.</p> <p>Findings:</p> <p>1. The Facilities Engineering Procedure P72004 Quarterly Medical Air Compressor Inspection Procedure (reviewed 12-20-12) indicated the following: " Measure and record motor current. Should be within 5% of previous</p>	S1125	<p>How are you going to correct the deficiency? Review of the medical gas compressors was added to the preventative maintenance schedule and was updated to include the electrical current value observed.How are you going to prevent the deficiency from recurring in the future?The preventative maintenance standard work was modified to include logging of the observed values. The facility tech performing the preventative maintenance is responsible for completing the updated standard work.Who is going to be responsible for steps A and B above?The Facilities Director is responsible for validating that</p>	06/15/2012			

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	<p>readings. "</p> <p>2. PM documentation dated 3-16-12, 1-04-12, 10-03-11, 6-29-11, and 4-05-11 failed to indicate a record of electric current measurements for Med Air Compressor Units #1, #2, and #3 to validate a comparison with the previous readings by facilities personnel.</p> <p>3. The Facilities Engineering Procedure P75001 Annual Vacuum Pump Inspection Procedure (reviewed 12-20-12) indicated the following: " Measure and record motor current. Should be within 5% of previous readings. "</p> <p>4. PM documentation dated 1-06-12 and 2-10-11 failed to indicate a record of electric current measurements for Medical Vacuum Pumps #1, #2, and #3 to validate a comparison with the previous readings by facilities personnel.</p> <p>5. During an interview on 5-24-12 at 1305 hours, staff A4 confirmed that the PM documentation lacked an indication of electric current measurements in accordance with the PM policy/procedure.</p>		<p>corrective actions are sustained. By what date are you going to have the deficiency corrected? 6/15/12</p>		

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S1164	<p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8(d)(2)(B)</p> <p>(d) The equipment requirements are as follows: (2) There shall be sufficient equipment and space to assure the safe, effective, and timely provision of the available services to patients, as follows:</p> <p>(B) There shall be evidence of preventive maintenance on all equipment.</p> <p>Based on observation and interview, the facility lacked evidence of preventive maintenance on equipment in use in all areas including off-site locations for 5 equipment items.</p> <p>Findings:</p> <p>1. The policy/procedure Equipment Inspection and Maintenance (revised 5-11) indicated the following: " All equipment must be clean and inspected for safety prior to use within the hospital ...department managers and supervisors are responsible for assuring that clinical, diagnostic, therapeutic, and patient transport equipment in their area is tagged with the appropriate barcoded asset tag ...all patient transport equipment, which includes wheelchairs ...must be inspected at least annually ...departments are responsible for inspections for</p>	S1164	<p>How are you going to correct the deficiency? Review of tables and stairs was added to the preventative maintenance schedule for all of the wooden physical therapy equipment. The ice machine was activated on the preventative maintenance schedule. Wheelchairs are not tracked by asset tags but rather are tracked by tag number in the AIMS system (Asset Information Management System). Wheelchairs are safety inspected annually by department users. Any deficiencies are submitted via work order to maintenance for repair. How are you going to prevent the deficiency from recurring in the future?An asset tag was placed on all wooden equipment on 6/25/12. Preventative maintenance standard work was developed to ensure wooden equipment is safe for patient use and will be documented in the AIMS. The</p>	06/25/2012

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	<p>non-motorized equipment. "</p> <p>2. During a facility tour of an outpatient physical therapy department on 5-21-12 at 1440 hours, the following equipment was observed without evidence of an asset tag or indication of preventive maintenance:</p> <p>A. a wooden exam table in an open exam room off the main therapy department area</p> <p>B. a Follett LC 25 ice machine in the main therapy area</p> <p>C. wooden steps with attached metal hand rails in the main therapy area.</p> <p>3. On 5-21-12 at 1440 hours, staff A4 was requested to provide documentation of PM for the indicated equipment and none was provided prior to exit.</p> <p>4. During an interview on 5-21-12 at 1445 hours, staff A10 confirmed that the equipment lacked evidence of preventive maintenance.</p> <p>5. During a facility tour of an emergency department (ED) on 5-22-12 at 0850 hours, the following equipment was observed without evidence of an asset tag or indication of preventive maintenance: 1 of 5 wheelchairs adjacent to the pedestrian ED entrance with the identifier '4E' stenciled on the seat back.</p>		<p>facility tech performing the preventative maintenance is responsible for completing the standard work. Wheelchairs are safety inspected annually by department users for deficiencies. Who is going to be responsible for steps A and B above? The Department Managers are responsible for submitting repair orders. The Facilities Director is responsible for validating that corrective actions are sustained. By what date are you going to have the deficiency corrected? 6/25/12</p>				

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	<p>6. On 5-22-12 at 0850 hours, staff A4 was requested to provide documentation of PM for the wheelchair and none was provided prior to exit.</p> <p>7. During an interview on 5-22-12 at 0850 hours, staff A10 confirmed that the equipment lacked evidence of preventive maintenance.</p> <p>8. During a facility tour of an inpatient physical therapy department on 5-22-12 at 1245 hours, the following equipment was observed without evidence of an asset tag or indication of preventive maintenance: wooden steps with attached wooden hand rails in the main therapy area.</p> <p>9. On 5-22-12 at 1245 hours, staff A15 was requested to provide documentation of PM for the indicated equipment and none was provided prior to exit.</p> <p>10. During an interview on 5-22-12 at 1245 hours, staff A15 confirmed that PM was not being performed on the wooden therapy tables and wooden therapy steps used for patient care in the inpatient and outpatient departments.</p>			

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S1168	<p>410 IAC 15-1.5-8 PHYSICAL PLANT 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 and interview, the facility failed to follow its policy/procedure and perform defibrillator inspection and testing per manufacturer's recommendations for 1 defibrillator/AED.</p> <p>Findings:</p> <p>1. The Phillips HeartStart FR2+ Instructions for Use (edition 15) indicated the following: " Check supplies, accessories, and spares for damage and expiration dating. "</p> <p>2. The policy/procedure Crash Cart/Defibrillator/AED Checks (reviewed 10-08) indicated the following: " Outdates should be checked on all supplies, equipment and medication ...Nursing/Ancillary Departments: It is the responsibility of that area where the cart is normally located to [-?-] all outdates of the code cart. "</p>	S1168	<p>How are you going to correct the deficiency? A locked drug box was provided by pharmacy on 6/20/2012. In addition, an AED monitoring log and supply check is now on the cart. Inservice and the department assignment schedule was shared with all Imaging staff at a meeting 6/30/2012. How are you going to prevent the deficiency from recurring in the future? Staff were assigned to check the cart and the schedule was posted. 6/30/2012. Who is going to be responsible for steps A and B above? The Director of Diagnostic Imaging By what date are you going to have the deficiency corrected? 6/30/2012.</p>	06/30/2012	

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	<p>3. Facility documentation titled " Parkview Health AED and Code Cart Checklist " and dated May 2011 for the NV outpatient imaging area failed to indicate a staff entry following ' Cart Expiration Date ' to ensure that all equipment, supplies and medications were not expired.</p> <p>4. During a tour on 5-21-12 at 1610 hours at the NV outpatient imaging department, the following conditions were observed: a Heartstart AED with electrode pads expired 4-2012.</p> <p>5. During an interview on 5-21-12 at 1615 hours, staff A10 confirmed that the equipment had not been maintained by staff.</p>			

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S1186	<p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8 (f)(3)(A)(B)(C)(D)(E) (i)(ii)(iii)(iv)(v)</p> <p>(f) The safety management program shall include, but not be limited to, the following: (3) The safety program that includes, but is not limited to, the following:</p> <p>(A) Patient safety. (B) Health care worker safety. (C) Public and visitor safety. (D) Hazardous materials and wastes management in accordance with federal and state rules. (E) A written fire control plan that contains provisions for the following: (i) Prompt reporting of fires. (ii) Extinguishing of fires. (ii) Protection of patients, personnel, and guests. (iv) Evacuation. (v) Cooperation with firefighting authorities.</p> <p>Based on document review and interview, the safety program failed to ensure that quarterly fire drills were performed at all locations listed on the State license for 13 of 16 locations.</p> <p>Findings:</p> <p>1. The policy/procedure Conducting Fire Drills (reviewed 1-12) indicated the following: " For hospital buildings (Parkview Hospital, Parkview Behavioral Health, Parkview Regional Medical Center and the Parkview Orthopedic Hospital) a drill will be run once per shift, per quarter. For other buildings listed as Business Occupancies, one fire drill will be run each calendar year. " The policy/procedure failed to require quarterly drills</p>	S1186	How are you going to correct the deficiency? A current site listing was provided to Security on 6/8/12 and a process was established to ensure updated site listing information is provided to Security on a regular basis. Contact was made with each HOPD (Hospital Out Patient Department) office manager advising them of the new drilling requirements of once per quarter per shift on 6/25/12. A schedule for each location's quarterly drills was developed to include all HOPD sites on 6/28/12. Missing	06/28/2012			

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	<p>for all locations listed under the State hospital license.</p> <p>2. Fire drill documentation for hospital off-site locations indicated the following:</p> <p>A. Offsite 1 conducted a fire drill on 5-11-11 and 9-30-11 and no drill 2012</p> <p>B. Offsite 2 and 13 conducted a fire drill on 11-08-11 and no drill 2012</p> <p>C. Offsite 8 conducted a fire drill on 6-23-11 and no drill in 2012</p> <p>D. Offsite 10, 11 and 14 conducted a fire drill on 6-14-11 and no drill 2012</p> <p>E. Offsite 12 conducted a fire drill on 10-12-11 and no drill 2012</p> <p>F. Offsite 15 conducted a fire drill on 10-18-11 and no drill 2012</p> <p>G. Offsite 4, 5, 6 and 7 failed to conduct any fire drill in 2011 and 2012</p> <p>3. During an interview on 5-23-12 at 1705 hours, staff A11 confirmed that the listed off-site locations failed to conduct quarterly fire drills.</p>		<p>fire drills were conducted at the Minnich Road location on 6/13/2012, the New Vision office on 6/20/2012 and the Scott Road location on 6/25/2012. The completion of the annual fire drill at Parkview First Care on New Vision Drive occurred 6/29/2011 via an actual alarm for which documentation was not provided during the annual survey. How are you going to prevent the deficiency from recurring in the future? A schedule for conducting drills was developed to include all HOPD sites. Prompts to the HOPD sites reminding them of their upcoming drills to be sent by Security personnel as part of standard work. Validation that drills occur as required and scheduled will be ongoing via document review by the Security Director and the Safety Coordinator. Who is going to be responsible for steps A and B above? The Security Director ensures that drills are run per the scheduled plan. By what date are you going to have the deficiency corrected? 6/28/12</p>		