

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  150048	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/30/2012
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NAME OF PROVIDER OR SUPPLIER  REID HOSPITAL & HEALTH CARE SERVICES	STREET ADDRESS, CITY, STATE, ZIP CODE 1100 REID PKWY RICHMOND, IN 47374
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S0000	<p>This visit was for a standard licensure survey.</p> <p>Facility Number: 005044</p> <p>Survey Date: 8-27/30-12</p> <p>Surveyors: Jack I. Cohen, MHA Medical Surveyor</p> <p>John Lee, RN Public Health Nurse Surveyor</p> <p>Cleone Peterson Medical Surveyor</p> <p>QA: cloughlin 09/06/12</p>	S0000		

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

TITLE

(X6) DATE

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

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S0270	<p>410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1(a)(6)</p> <p>(a) The governing board is legally responsible for the conduct of the hospital as an institution. The governing board shall do the following:</p> <p>(6) Review, at least quarterly, reports of management operations, medical staff actions, and quality monitoring, including patient services provided, results attained, recommendations made, actions taken and follow-up.</p> <p>Based on document review and interview, the governing board failed to review reports of quality monitoring activities for 1 directly-provided service (pet therapy services) and 2 contracted services (biohazardous waste and tissue transplant services).</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>Review of the governing board minutes for calendar year 2011 indicated they did not include review of reports for the directly-provided pet therapy services.</li> <li>In interview, on 8-30-12 at 4:45 pm, employee #A1 indicated no report for the directly-provided pet therapy service was reviewed by the governing board in calendar year 2011 and no further</li> </ol>	S0270	<p>S410 IAC 15-1.4-1(a)(6) Governing Board1.) This deficiency will be corrected by adding Pet Therapy quality indicators to the departmental quality indicators under Volunteer Services and by adding quality reports and clinical contract reviews for our biohazardous waste and tissue transplant services to the Clinical Contract Grid for the Quality Committee, and ultimately, the Governing Board.2.) The quality indicators for Pet Therapy will be added to the Quarterly Department QA spreadsheet. The biohazardous waste and tissue transplant services contracts will be added to the Clinical Contract Grid and assigned a month for annual review.3.) Pet Therapy will be monitored by the Director of Volunteer Services, whom will be responsible for data collection</p>	11/30/2012	

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	<p>documentation was provided prior to exit.</p> <p>3. Review of the governing board minutes for calendar year 2011 indicated they did not include review of reports for the contracted biohazardous waste and tissue transplant services.</p> <p>4. In interview, on 8-30-12 at 4:45 pm, employee #A1 indicated no report for the contracted biohazardous waste and tissue transplant services was reviewed by the governing board in calendar year 2011 and no further documentation was provided prior to exit.</p>		<p>and submission to the Quality Department. Biohazardous Waste will be monitored by the Director of Environmental Services, whom will be responsible for data collection and submission to the Quality Department. Tissue Transplant will be monitored by the Director of Surgical Services, whom will be responsible for data collection and submission to the Quality Department. The Director of Quality will be responsible for including data on the Quality Reports and for presenting data to the Quality committee and Governing Board.4.) Implementation dates - By September 30, 2012, contact will be made with Volunteer Services and the two vendors (biohazardous waste and tissue transplant) to discuss QA data needs.By October 30, 2012, quality indicators will be finalized.By November 30, 2012 the first report will have been submitted to the Director of Quality, the first QA reports will have been taken to the Quality Committee (November 13, 2012) and the Governing Board (November 26, 2012).</p>		

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S0322	<p>410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1(c)(6)(H)</p> <p>(c) The governing board is responsible for managing the hospital. The governing board shall do the following: (6) Require that the chief executive officer develops policies and programs for the following:</p> <p>(H) Requiring all services to have policies and procedures that are updated as needed and reviewed at least triennially.</p> <p>Based on review of documents and interview, the hospital failed to have policies and procedures reviewed at least triennially for Massage Therapy services.</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>1. Review of Massage Therapy policies and procedures indicated they had not been reviewed at least triennially.</li> <li>2. In interview, on 8-30 at 11:15 am, employee #A1 indicated the Massage Therapy policies and procedures had not been reviewed at least triennially and no further documentation was provided prior to exit.</li> </ol>	S0322	<p>S322 410 IAC 15-1.4-1(c)(6)(H) Governing Board1.) New format for massage therapy policies established. All policies have been reviewed and will continue to be reviewed at least every three years.2.) Signature sheet established and policies added to rotation of policies reviewed at least every three years. 3.) Department Manager and Director4.) Deficiency corrected 9/19/2012</p>	09/19/2012			

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S0406	<p>410 IAC 15-1.4-2 QUALITY ASSESSMENT AND IMPROVEMENT 410 IAC 15-1.4-2(a)(1)</p> <p>(a) The hospital shall have an effective, organized, hospital-wide, comprehensive quality assessment and improvement program in which all areas of the hospital participate. The program shall be ongoing and have a written plan of implementation that evaluates, but is not limited to, the following:</p> <p>(1) All services, including services furnished by a contractor.</p> <p>Based on document review and interview, the hospital failed to include monitors and standards for 1 service directly-provided (pet therapy) by the hospital and 2 services provided by a contractor (biohazardous waste and tissue transplant services) as part of its comprehensive quality assessment and performance improvement (QAPI) program.</p> <p>Findings:</p> <p>1. Review of the facility's QAPI program indicated it did not include monitors and standards for the directly-provided services of pet therapy.</p> <p>2. On 8-30-12 at 3:45 pm, upon interview, employee #A3 indicated there was no documentation for the</p>	S0406	S406 410 IAC 15-1.4-2(a)(1) Quality Assessment and Improvement 1.) This deficiency will be corrected by adding Pet Therapy quality indicators to the departmental quality indicators under Volunteer Services and by adding quality reports and clinical contract reviews for our biohazardous waste and tissue transplant services to the Clinical Contract Grid for the Quality Committee, and ultimately, the Governing Board.2.) The quality indicators for Pet Therapy will be added to the Quarterly Department QA spreadsheet. The biohazardous waste and tissue transplant services contracts will be added to the Clinical Contract Grid and assigned a month for annual review.3.) Pet Therapy will be monitored by the Director of Volunteer Services, whom will be	11/30/2012	

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	<p>directly-provided pet therapy service and no documentation was provided prior to exit.</p> <p>3. Review of the facility's QAPI program indicated it did not include monitors and standards for the contracted services of biohazardous waste and tissue transplant.</p> <p>4. On 8-30-12 at 3:45 pm, upon interview, employee #A3 indicated there was no documentation for the contracted biohazardous waste and tissue transplant services and no documentation was provided prior to exit.</p>		<p>responsible for data collection and submission to the Quality Department. Biohazardous Waste will be monitored by the Director of Environmental Services, whom will be responsible for data collection and submission to the Quality Department. Tissue Transplant will be monitored by the Director of Surgical Services, whom will be responsible for data collection and submission to the Quality Department. The Director of Quality will be responsible for including data on the Quality Reports and for presenting data to the Quality committee and Governing Board.4.) Implementation dates - By September 30, 2012, contact will be made with Volunteer Services and the vendors (biohazardous waste and tissue transplant) to discuss QA data needs.By October 30, 2012, quality indicators will be finalized.By November 30, 2012 the first report will have been submitted to the Director of Quality, the first QA reports will have been taken to the Quality Committee (November 13, 2012) and the Governing Board (November 26, 2012).</p>		

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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 provide a safe and healthful environment that minimizes infection exposure and risk to patients for 1 Emergency Department and 1 Outpatient Surgery Area.</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>1. Review of policy/procedure Cleaning Procedures Emergency Room, Fast Track and OCC Health indicated the following: "2. Sweep and mop all of the floors inside Emergency, Fast Track and OCC Health with approved disinfectant." This policy/procedure was last reviewed/revised on 03/12.</li> <li>2. On 08-27-12 at 1235 hours, staff #60 confirmed that he/she uses GP Forward Diversy on the Emergency Department patient room floors.</li> <li>3. Review of the GP Forward Diversy manufacturer's label lacked documentation of being a disinfectant.</li> </ol>	S0554	<p>S554 410 IAC 15-1.5-2 (a) Infection Control1.) At the September 7, 2012 Reid Orthopedic Center (ROC) Surgery Committee meeting a unanimous decision was made to allow skull caps to be worn only if a bouffant cap is worn over it. This plan was implemented immediately.2.)This rule will be monitored on an ongoing daily basis by the OR circulating RN. A detailed compliance report will be generated on a monthly basis. 3.)It will be the responsibility of the Medical Director to ensure that all staff members are compliant. He will report any non-compliance at the ROC Surgery Committee monthly meetings.4.) September 8, 2012</p>	09/08/2012			

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	<p>4. Review of policy/procedure Surgical Attire indicated the following: "9. Restricted Areas - All head and facial hair must be covered with hair cover or hood. If male skull cap does not cover all hair, a bouffant cap or hood should be worn." This policy/procedure was last reviewed/revised on 04-2011.</p> <p>5. During the tour of the Reid Outpatient Center (ROC) on 08-28-12 at 1330 hours, the following was observed in operating room #1 during a surgical case: 2 male staff members wearing skull caps with hair exposed from the top of the ears and down.</p> <p>6. On 08-28-12 at 1330 hours, staff #61 confirmed the hair was exposed and the two male staff members were the physician and the physician's assistant.</p>				

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S0952	<p>410 IAC 15-1.5-6 NURSING SERVICE 410 IAC 15-1.5-6(d)</p> <p>(d) Blood transfusions and intravenous medications shall be administered in accordance with state law and approved medical staff policies and procedures. If the blood transfusions and intravenous medications are administered by personnel other than physicians, the personnel shall have special training for these procedures in accordance with subsection (b)(6). Based on policy/procedure review, transfusion record review and staff interview, the facility failed to follow approved medical staff policies/procedures for seven of seven (# 1 through #7) transfusions reviewed on 8/28/12.</p> <p>Findings included:</p> <ol style="list-style-type: none"> <li>Review of the policy/procedure labeled "REID HOSPITAL &amp; HEALTH CARE SERVICES NURSING BLOOD COMPONENTS ADMINISTRATION" Page 17A revealed the following statement: "26. Document vital signs (EXCEPTIONS: IM, slow IVP, Albumin, Immunoglobulin) <ul style="list-style-type: none"> <li>A. Prior to infusing."</li> </ul> </li> <li>On 8/28/12 review of transfusions # 1 through #7 revealed all transfusions were started at the same time as the prior vitals were taken. <ul style="list-style-type: none"> <li>T# Prior vitals T Start</li> </ul> </li> </ol>	S0952	S952 410 IAC 15-1.5-6(d) Nursing Service1.) Design and implement "pre transfusion vital signs" documentation in Soarian. 2.) Pre transfusion vital signs discrete data fields have now been developed and are located on the blood scanning flowsheet. Pre transfusion vitals will be taken and documented on the blood scanning flowsheet prior to the onset of transfusion. These fields are a "hard stop" in that the vital signs must be entered before the nurse is able to advance to the blood scanning screens in order to administer the blood. We will monitor the effectiveness of this correction as part of our regular quality monitoring of our blood transfusion process on an on-going basis. 3.) Director of Nursing Practice4.) September 25, 2012	09/25/2012			

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1	01:30 01:30			
2	08:20 08:20			
3	00:15 0015			
4	01:00 01:00			
5	01:45 01:45			
6	03:19 03:19			
7	10:10 10:10 where T means transfusion.			
	3. In interview on 8/28/12 between 2:30 and 3:30 p.m. staff persons #6 and #8 agreed these were the recorded times in the electronic record. Staff person #3 indicated the nurses were doing the prior vitals before the start of the transfusion but they were unable to open the electronic record until the blood was scanned, so it appeared that is when the prior vitals were done.			

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S1022	<p>410 IAC 15-1.5-7 PHARMACEUTICAL SERVICES 410 IAC 15-1.5-7 (d)(2)(B)</p> <p>(d) Written policies and procedures shall be developed and implemented that include the following:</p> <p>(2) Ensure the monthly inspection of all areas where drugs and biologicals are stored and which address, but are not limited to, the following:</p> <p>(B) Appropriate storage conditions. Based on documentation, observation and interview, the hospital failed to follow its policy to securely store medications in 1 instance.</p> <p>Findings:</p> <p>1. Review of a hospital policy entitled Controlled Substance Management, reviewed 6-10-2011, indicated CII [medications] are stored in the Omnicell SecureVault cabinetry.</p> <p>2. On 8-28-12 at 10:15 am, in the presence of employee #A5, it was observed in the Pharmacy there was a refrigerator with a lock hasp and no lock. Pharmacy personnel were asked if there were any CII's stored in the refrigerator. The hospital staff indicated there were. It was then observed there were 38 3 mg suppositories each (CII's) stored in the refrigerator.</p>	S1022	<p>S1022 410 IAC 15-1.5-7 Pharmaceutical Services1.) A lock was added within 15 minutes of discovery on 8/28/12 at 1030AM. The key to the lock is located in the Omnicell Securevault in the Pharmacy. 2.) A check of the lock will be added to Pharmacy's monthly Safety Inspection, which is currently completed by the Pharmacy Safety Rep. 3.) All variances will be reported to the Director of Pharmacy. 4.) September 28, 2012</p>	08/30/2012	

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	3. In interview, on 8-28-12 at 10:15 am, several Pharmacy staff indicated they were unaware the refrigerator was to be locked.			

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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 observation, the hospital created conditions which resulted in a hazard to patients, public or employees in 1 instance.</p> <p>Findings:</p> <p>1. On 8-28-12 at 10:30 am in the presence of employee #A5, it was observed in a mechanical room, there was 1 fire extinguisher on the floor unsecured by chain or holder.</p> <p>2. If the above extinguisher was knocked over and broke the head off the compressed cylinder, it could result in harm to people and/or property.</p>	S1118	<p>S1118 410 IAC 15-1.5-8 Physical Plant1.) Develop a policy in regards to storage of Fire Extinguishers in the Engineering Department.2.) Policy will be reviewed by Engineering Staff. Department Director or designee will conduct regular monitoring. Deviations from the criteria set forth in policy will result in disciplinary actions.3.) Director of Engineering4.) Deficiency was corrected immediately, policy mentioned above will be implemented 9/25/12.</p>	09/25/2012			