

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150104		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/12/2012	
NAME OF PROVIDER OR SUPPLIER WITHAM HEALTH SERVICES				STREET ADDRESS, CITY, STATE, ZIP CODE 2605 N LEBANON ST LEBANON, IN 46052			
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S0000	<p>This visit was for a State hospital licensure survey.</p> <p>Dates: 4/10/2012 through 4/12/2012</p> <p>Facility Number: 005093</p> <p>Surveyors: Albert Daeger, CFM, SFPIO Medical Surveyor</p> <p>Saundra Nolfi, RN PH Nurse Surveyor</p> <p>QA: cloughlin 04/20/12</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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S0102	<p>410 IAC 15-1.2-1 COMPLIANCE WITH RULES 410 IAC 15-1.2-1 (a)</p> <p>(a) All hospitals shall be licensed by the department and shall comply with all applicable federal, state, and local laws and rules.</p> <p>Based on document review the facility failed to comply with all applicable state laws for 1 of 2 unlicensed nursing assistant employee files reviewed.</p> <p>Findings include:</p> <p>1. IC 16-28-13-4: a health care facility shall apply within three (3) business days from the date a person is employed as a nurse aide or other unlicensed employee for a copy of the person's state nurse aide registry report from the state department and a limited criminal history from the Indiana central repository for criminal history information under IC 5-2-5 or another source allowed by law.</p> <p>2. Review of employee P16's employee file indicated that he/she was hired on 5/23/08 as a Patient Care Tech and employee P16's file lacked documentation of a nurse aide registry report and this was confirmed by staff member #24.</p>	S0102	The Human Resource (HR) personnel were reeducated on the process for verifying the registry by the HR Director, and a "checklist" was created to ensure the process is completed on all new hires. All patient care technician/nurse aide personnel files were reviewed and identified as having appropriate nurse aide registry verification by the Director of Human Resources. An audit tool of 100% of nurse aide files will be reviewed by the Director of Human Resources and the VP of HR. The report will be established as a quality improvement indicator for the department and reported out monthly to the Quality Council for the next 6 months and then quarterly if not corrected.	05/04/2012			

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S0308	<p>410 IAC 15-1.4-1 GOVERNING BOARD 15-1.4-2 (c)(6)(B)</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>(B) Orientation of all new employees, including contract and agency personnel, to applicable hospital, department, service, and personnel policies.</p> <p>Based on interview, the governing board failed to ensure the contracted cleaning staff for their off-site facility received any orientation or education to their job requirements.</p> <p>Findings included:</p> <p>1. At 10:45 AM on 04/12/12, the housekeeping manager, staff member #A32, indicated a contracted service performed the cleaning at the facility's off-site location. He/she indicated he/she regularly met with the owner of the company, but did not know the names of the staff who actually cleaned the off-site facility. He/she indicated he/she observed the results of their work, but did not actually observe the work being done. Staff member #A32 could not provide any</p>	S0308	The Manager and respective Vice President of Housekeeping Services have established a process verifying orientation, training, and evaluation of services. The process mirrors the overall hospital policy related to contracted services. All current cleaning personnel who work at Witham had personnel files verified for documented orientation, training, and performance evaluations. A sign-in process has been established with a monthly audit of personnel files to ensure new people assigned to Witham have appropriate documentation of orientation, training, and evaluations. This audit will be submitted to Quality Council monthly for the remainder of 2012 by the Manage. The Department Manager will conduct random monthly direct observation audits	05/07/2012			

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	documentation of orientation, training, in-servicing, or evaluations for the contracted cleaning staff.		to be documented and reported to Quality Council monthly for the next 6 months.		

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S0330	<p>410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1(c)(6)(K)</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: (K) Maintaining personnel records for each employee of the hospital which include personal data, education and experience, evidence of participation in job related educational activities, and records of employees which relate to post offer and subsequent physical examinations, immunizations, and tuberculin tests or chest x-ray, as applicable.</p> <p>Based on document review and staff interview, the facility failed to ensure documented evidence of immunity to Varicella for 13 of 31 health care workers (#1, 2, 3, 4, 5, 6, 8, 9, 11, 13, P1, P3 and P5).</p> <p>Findings included:</p> <p>1. 31 personnel health care records were reviewed. 13 personnel records lacked documented evidence of Varicella immunity (#1, 2, 3, 4, 5, 6, 8, 9, 11, 13, P1, P3 and P5).</p> <p>2. CDC Prevention of Varicella,</p>	S0330	The Infection Control Prevention Practitioner (ICPP) reeducated the Employee Health Nurse on the appropriate recommendations for post-offer pre-employment health updated screening. The policy was rewritten with information by the ICPP and the Employee Health Nurse and Director was reeducated on updated changes. The Employee Health Nurse reviewed all employee health records for required post- offer pre-screening health information documentation. Employees and their managers were contacted by the COO of any lacking information and requested to comply as required per policy. If	05/07/2012			

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-	<p>Evidence of Immunity, page 14: "U.S. birth before 1980 is considered evidence of immunity except for health-care personnel (HCP), pregnant women, and immunocomprised persons. For these three groups, certainty regarding immunity is desirable..."</p> <p>3. Hospital policy titled Varicella (Chickenpox): Exposure and Screening: "All employees will be screened for a history of Varicella zoster infection at the time of employment. An emphasis will be placed on a verbal history of Varicella in the employee history".</p> <p>4. At 2:00 PM on 4/12/2012, staff member #46 indicated CDC states if a staff member was born before 1980 they are immune to chickenpox, therefore, those individuals will not be tested. The staff member would just ask the new employee if they had it and they would note it in their health care records.</p>		<p>the employee does not comply with policy requirements then the employee risks corrective action including not being allowed to work until completed. The Employee Health Nurse and her Director have created a checklist that is signed by the Employee Health Nurse and submitted to the Director for auditing purposes and reporting compliance rates to the Quality Council monthly for the remainder of 2012.</p>		

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S0332	<p>410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1(c)(6)(L)</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>(L) Demonstrating and documenting personnel competency in fulfilling assigned responsibilities and verifying inservicing in special procedures.</p> <p>Based on document review, the facility failed to ensure 1 of 11 Registered Nurses and 2 of 2 Paramedics had annual competency on blood administration as per policy.</p> <p>Findings included:</p> <p>1. The personnel records failed to evidence documentation that Register Nurse #P9 and Paramedics #15 and #16 were provided annual competency on blood administration. This was reviewed and confirmed with staff member #24.</p> <p>2. A memorandum dated 4/12/2012 from staff member #28 noted that the Paramedics only were provided training on blood administration when they received their Paramedic Certification and</p>	S0332	The appropriate personnel (paramedic and nursing staff) were provided with education related to Blood Administration and IV Therapy by the Clinical Nurse Specialist. This annual education was also added to the appropriate job descriptions by the Director of Human Resources. The Director of EMS and other clinical directors will request and review quarterly Educational Reports from the clinical educator to ensure personnel continue to meet this requirement annually.	05/07/2012			

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	<p>never was provided annual competency on blood administration after their certification.</p> <p>3. Policy Certification Process: Professional Development Expectation states, "It is the responsibility of the employee to ensure that he/she completes all educational and staff development activities in a timely manner. Activities include but are not limited to the following: IV Therapy - annually; Blood Administration - annually."</p>				

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S0408	<p>410 IAC 15-1.4-2 QUALITY ASSESSMENT AND IMPROVEMENT 410 IAC 15-1.4-2 (a)(2)(A)(B)(C)(D)</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>(2) All functions, including but not limited to the following:</p> <p>(A) Discharge planning. (B) Infection control. (C) Medication therapy. (D) Response to emergencies as defined in 410 IAC 15-1.5-5(b)(3)(L)(i).</p> <p>Based on document review and interview, the facility failed to ensure Response to Patient Emergencies was part of the hospital's Patient Care Performance Improvement Goals.</p> <p>Findings included:</p> <p>1. Patient Care Performance Improvement Goals 2012 states, "Witham Health Services strives to deliver patient care which is optimal, customer-focused, and achieves improved patient health outcomes. The Clinical Departments</p>	S0408	The Quality Improvement Nurse and the Director of ED have reeducated staff, managers, and Medical Staff Coordinator on the Code Blue and Rapid Response Evaluations process through review of the written policy. The two above indicators have been made standing agenda items for the ED and Quality Council, which will be forwarded up to Medical Staff Executive Committee and the Board of Trustees by the Medical Staff Coordinator.	04/30/2012			

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	<p>quality improvement program is designed to enhance patient care through systematic assessment and improvement of the quality and appropriateness of care rendered by the department members. Opportunities to improve patient care through evaluation of clinical and operational performance measures will be integrated into ongoing management processes. The plan encompasses relevant dimensions of performance including those that are high volume, high risk, and problem prone." The items that are included in this plan but not limited are: Assessment of Patients, Administration of Medication Safety, patient falls, etc.</p> <p>2. After reviewing the Quality Performance indicators, Response to Patient Emergencies indicator was not evidenced in the documents provided for review.</p> <p>3. At 11:00 AM on 4/12/2012, staff member #4 indicated the quality indicator Response to Patient Emergencies has not been identified as an indicator for evaluation by the Quality Performance Improvement Committee for 2011.</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 observation and document review, and interview, the facility failed to ensure 6 of 6 designated handwashing sinks located in the Laboratory Department are primarily for handwashing and no other purpose and failed to ensure ACL Elite hemostasis system was disposing liquid waste according to the manufacturer's recommendations and failed to ensure a safe environment for patients by checking supplies to prevent outdated usage.</p> <p>Findings included:</p> <p>1. The hospital laboratory was toured at 9:05 AM on 4/11/2012. Five of six designated handwashing sinks throughout the department were observed with waste tubes exiting lab equipment into the drain of the sink basins. One of the five handwashing sinks was also observed with an eye-washing system plumed to the faucets. One of the six hand washing sinks was observed with a plastic tub covering the Faust. The pink plastic tub</p>	S0554	<p>The sinks were cleared of any physical obstruction. Plant Operations installed separate drains, which designate all Laboratory sinks as clean sinks. Staff has been reeducated to the changes by the Director. The Laboratory Director continues to monitor compliance daily by direct observation and review of the Daily Maintenance Log. The Department Directors and Executive Director of Nursing performed a clean sweep of supply areas to ensure that outdated items were not accessible for patient care use.</p> <p>All identified items that were found as outdates were removed, which included:</p> <ul style="list-style-type: none"> · Lab tubes in ED · Glucometer solution in OB · Lab tubes in Transitions · Introducers, Swan-Ganz catheters, Cardiac Output sets, Temporary Pacing Electrodes, Percutaneous Entry Needles in ICU · Cidex OPA test strips in Endoscopy <p>The Clinical Nurse Specialist provided mandatory reeducation</p>	05/07/2012			

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	<p>was draining from being previously cleaned.</p> <p>2. At 9:10 AM on 4/11/2012, staff member #22 indicated the five sinks observed with waste tubes draining into them and the one sink with the faucet covered with the pink plastic tub are all designated hand washing lavatories.</p> <p>3. Evidence of equipment indicated that their waste tubes are draining into the hand washing sinks. Manuals were reviewed. The manufacturer warning for equipment notes the liquid waste from the instrument are to be considered as hazardous waste and are to be treated as such. Therefore, 1 hand washing sink was obstructed by a pink tub and 5 hand washing sinks are handling biohazardous waste.</p> <p>4. One of the six designated handwashing sinks was observed with an ACL Elite hemostasis system in the hospital Laboratory was observed with the waste tube exiting side of the machine into a handwashing sink.</p> <p>5. Section 2.3 of the ACL Elite owner's manual states, "Connect the waste tube to the fitting on the bottom left hand side of the instrument. Cut the tube to suitable length to fit into the waste container</p>		<p>on expiration dates related to items used to provide patient care to appropriate staff and managers. An audit has been added to the monthly departmental safety inspections and environmental rounds to be submitted to the Safety Committee and Quality Council with a report to the Board of Trustees.</p>		

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	<p>which must be situated below the instrument waste outlet port. The liquid waste from the instrument is to be considered contaminated and should be disposed of according to the waste management procedures of the laboratory and in compliance with local regulations."</p> <p>6. During the tour of the Emergency Department (ED) at 11:30 AM on 04/10/12, accompanied by staff members #A2 and A10, the following expired items were observed on the lab carts: A. 5 of 12 pink top lab tubes expired 09/2011. B. 17 of 17 green top lab tubes, 13 expired 02/2012 and 4 expired 09/2011.</p> <p>7. During the tour of the Obstetrical Department (OB) at 12:25 PM on 04/10/12, accompanied by staff members #A2 and A13, 1 of 2 bottles of glucometer control solution was observed open, but not dated. The manufacturer's directions were to date when opened and discard in 90 days.</p> <p>8. During the tour of the Geriatric Transitions Unit at 1:00 PM on 04/10/12, accompanied by staff members #A2 and A14, the following expired items were observed in a drawer in the nurses' station: A. 48 of 50 various lab tubes, 1 expired in 2007, 44 expired in 2008, and 3</p>						

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	<p>expired in 2009.</p> <p>9. During the tour of the Intensive Care Unit at 1:35 PM on 04/10/12, accompanied by staff member #A2 , the following expired items were observed in the treatment cart outside of the med room:</p> <p>A. 3 of 4 Avanti Introducers, 2 expired 05/2011 and 1 expired 04/2010.</p> <p>B. 2 of 2 Swan-Ganz catheters, 1 expired 10/2011 and 1 expired 12/2011.</p> <p>C. 3 of 3 Cardiac Output sets, 1 expired 06/2010 and 2 expired 10/2011.</p> <p>D. 2 of 4 Temporary Pacing Catheter Electrodes expired 03/2012.</p> <p>E. 2 of 2 Percutaneous Entry Needles expired 01/2012.</p> <p>At 1:40 PM, staff member #A16 indicated the treatment cart was checked every time it was opened, but there was no documentation of any checks.</p> <p>10. During the tour of the decontamination room near the endoscopy rooms at 4:20 PM on 04/11/12, accompanied by staff member #A41, a container of Cidex OPA test strips with an expiration date of 02/2012 was observed that had been used for testing the Cidex solution.</p>						

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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.</p> <p>Based on document review and staff interview, the facility failed to ensure the washer/dryer combos located in the hospital's Housekeeping Department and in North Pavilion are removing significant quantities of microorganisms required for a health care facility.</p> <p>Findings included:</p> <ol style="list-style-type: none"> At 10:20 AM on 4/11/2012, the North Pavilion Rehab Unit was toured. The department was observed with a shakable washer/dryer combo. The combo was not observed with any preventive maintenance inspection tag on it. At 10:30 AM on 4/11/2012, staff 	S0612	<p>The Rehab and Laundry washer/dryer were inspected and tagged by the BioMed Technician and placed on the facility preventive maintenance schedule for inspection per policy. The Director of BioMed will conduct random audits of equipment that is preventive maintenance and report to Quality Council monthly for the remainder of 2012. The washer in Rehab will be used for skills assessment only. New policy written and staff reeducated on the process at the department meeting of May 2, 2012 by the Director of Rehab. The washer in laundry area will use chlorine bleach in the wash cycle and mild acid (vinegar) in the rinse cycle to clean and sanitize the mops and cleaning clothes used in the hospital</p>	05/04/2012	

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	<p>member #25 indicated he/she does not use bleach during any of the wash cycles. The staff member indicated Clothesline Fresh Laundry Detergent was used for the washer to wash items that will be used for patients.</p> <p>3. At 11:15 AM on 4/12/2012, staff member #32 indicated the washer and dryer units have never been placed on a preventive maintenance schedule. The staff member indicated bleach was used for the washer and the bleach was placed in the washing machine dispenser.</p> <p>4. At 12:00 PM on 4/12/2012, staff member #6 indicated 120 F hot water was provided to the units located in North Pavilion and 140 F hot water was provided to the washer located in the Housekeeping Department. The washer in the Housekeeping Department was for mops and rags that are used throughout the hospital.</p> <p>5. The Clothesline Fresh Laundry Detergent does not list what it kills in a health care setting. The detergent notes how it provides a deep cleaning.</p> <p>7. The hospital's Infection Control Program recognizes standards of practice guidelines for Centers for Disease Control and Prevention (CDC).</p>		<p>areas. Mops and clothes will be dried at high temperatures. These items are also saturated with disinfectant chemicals prior to use. An eyewash station and goggles have been made available to staff performing these duties. The Housekeeping Manager has also reeducated all staff. The Manager will use random observation audits and submit to their respective vice president to ensure compliance.</p>		

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	<p>8. CDC Guidelines for laundry services in a Health Care Facility states, "The microbicidal action of the normal laundering process is affected by several physical and chemical factors. Although dilution is not a microbial mechanism, it is responsible for the removal of significant quantities of microorganisms. Soaps or detergents loosen soil and also have some microbial properties. Hot water provides an effective means of destroying microorganisms, and a temperature of at least 71 C (160 F) for a minimum of 25 minutes is commonly recommended for hot-water washing. Chlorine bleach provides an extra margin of safety. A total available chlorine residual of 50-150ppm is usually achieved during the bleach cycle. The last action performed during the washing process is the addition of a mild acid to neutralize any alkalinity in the water supply, soap, or detergent. Recent studies have shown that a satisfactory reduction of microbial contamination can be achieved at lower water temperatures of 22-50 C when the cycling of the washer, the wash formula, and the amount of chlorine bleach are carefully monitored and controlled. Instead of the microbial action of hot water, low-temperature laundry cycles rely heavily on the presence of bleach to reduce levels of microbial</p>						

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	contamination."				

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S0674	<p>410 IAC 15-1.5-3 LABORATORY SERVICES 410 IAC 15-1.5-3(f)</p> <p>(f) If sufficient or suitable outside facilities are not provided by undertakers or others, the hospital shall have a morgue or a low temperature body holding room. Policies covering appropriate refrigeration requirements and length of holding bodies shall be approved by the medical staff. If autopsies are performed in the hospital, there shall be a refrigerated storage unit designed for holding bodies, along with hand washing facilities and other necessary personal hygiene facilities available.</p> <p>Based on observation, the facility failed to ensure the shower was maintained sanitary and free of debris necessary for personal hygiene after autopsies.</p> <p>Findings included:</p> <p>1. At 1:00 PM on 4/10/2012, the Morgue was inspected. The shower for the personnel who conducted the autopsy was unavailable for use after the autopsy. The shower stall was observed with two large gray storage boxes in it. The containers had a red biohazard label sticker on each storage unit. The shower stall was located in the Morgue. The shower stall was observed with heavy accumulation of soil and other debris.</p>	S0674	<p>The items placed in the shower were removed and sent to storage. Shower area was hygienically cleaned and signage placed above bathroom shower is identifying that the shower is "NOT A STORAGE AREA". The ED Director in conjunction with the Laboratory Director has reeducated staff personnel regarding the importance of maintaining this area free from storage and kept clean. This area has specifically been added to the monthly Environmental Rounds for Laboratory Services with a report to Safety Committee every other month.</p>	04/13/2012			

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S0912	<p>410 IAC 15-1.5-6 NURSING SERVICE 410 IAC 15-15-6 (a)(2)(B)(i)(ii) (iii)(iv)(v)</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>(2) A nurse executive who is: (B) responsible for the following: (i) The operation of the services, including, but not limited to, determining the types and numbers of nursing personnel and staff necessary to provide care for all patient care areas of the hospital. (ii) Maintaining a current nursing service organization chart. (iii) Maintaining current job descriptions with reporting responsibilities for all nursing staff positions. (iv) Ensuring that all nursing personnel meet annual in-service requirements as established by hospital and medical staff policy and procedure, and federal and state requirements. (v) Establishing the standards of nursing care and practice in all settings in which nursing care is provided in the hospital.</p> <p>Based on policy review, medical record review, and interview, the nurse executive failed to ensure all patients received an accurate fall assessment upon admission and had safety interventions implemented according to their risk assessment in 13 of 17 patients reviewed (#N1, N3, N4, N5, N6,</p>	S0912	The Executive Director in conjunction with the Clinical Nurse Specialist has reeducated appropriate staff on the adult and child fall protocol related to interventions and accurate	05/07/2012			

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	<p>N7, N9, N10, N11, N17, N18, N19, and N20).</p> <p>Findings included:</p> <p>1. The facility policy "Fall Prevention Program: Fall Risk Protocol", effective September 2011, indicated, "...The following guidelines have been established for WHS staff to follow with patient care to prevent patient (adult and children) falls and reduce the injury or harm resulting from a fall. A RN (registered nurse) will assess each patient upon admission and at designated intervals using the established assessment tool. ...The level of fall precautions is driven by the use of the Morse Fall Scoring Tool or the Humpty Dumpty Falls Scales."</p> <p>The policy continued on page 2, "...The nurse managers are responsible for making fall prevention a standard of care, enforcing the responsibilities of our staff to comply with interventions, ensure that equipment is on the unit in working order, and that staff receive ongoing education." Page 3 continued, "...1. The RN/LPN will use the Morse Fall Risk Scoring tool to assess a patient at these times and update needed interventions as appropriate: a. Admission-document on admission assessment. ...2. Add up all the number of points from each of the categories upon the assessment. 3. The patient is then identified as Low, Moderate, or High Risk based on the Total Points Score from the Nursing assessment."</p> <p>The Morse Fall Risk Assessment assigned a score of 15 if the patient had a secondary diagnosis. The assessment designated a score of 0- 24 as Low Risk, 25- 44 as Moderate Risk, and 45 or higher as High Risk. Each category had a list of safety precautions to implement.</p>		<p>assessment of risk level.</p> <p>The monthly open chart review tool has been revised to include verification of fall protocol documentation process to be submitted to Quality Council by the Executive Director on a monthly basis for the remainder of 2012.</p>				

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	<p>The policy designated the Humpty Dumpty Fall Score for the assessment of children with a Low Risk as a score of 7- 11 and a High Risk as a score of 12 and above. Both categories listed interventions to be implemented based on the score.</p> <p>2. The admission assessment from 12/20/11 for patient #N1 documented a 20 for the fall risk and "No" for the secondary diagnosis item. The physician's history and physical listed 5 different diagnoses for the patient. Adding 15 points for a secondary diagnosis would have changed the patient's fall risk from a Low to a Moderate and necessitated additional interventions.</p> <p>3. The admission assessment from 10/18/11 for patient #N3 documented a 20 for the fall risk and "No" for the secondary diagnosis item. The physician's history and physical listed 5 different diagnoses for the patient. Adding 15 points for a secondary diagnosis would have changed the patient's fall risk from a Low to a Moderate and necessitated additional interventions.</p> <p>3. The admission assessment from 12/20/11 for patient #N4 documented a 20 for the fall risk and "No" for the secondary diagnosis item. The physician's history and physical listed 2 different diagnoses for the patient. Adding 15 points for a secondary diagnosis would have changed the patient's fall risk from a Low to a Moderate and necessitated additional interventions.</p> <p>4. The admission assessment from 02/09/12 for patient #N5 documented a 30 for the fall risk and "No" for the secondary diagnosis item. The physician's history and physical listed 4 different diagnoses for the patient. Adding 15 points for a secondary diagnosis would have changed the patient's fall risk from a Moderate to a High and</p>				

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	necessitated additional interventions. 5. The admission assessment from 10/07/11 for patient #N6 indicated a fall risk score of 45, but failed to document the High Risk fall interventions. 6. The admission assessment from 11/05/11 for patient #N7 documented a 35 for the fall risk and "No" for the secondary diagnosis item. The physician's history and physical listed 4 different diagnoses for the patient. Adding 15 points for a secondary diagnosis would have changed the patient's fall risk from a Moderate to a High and necessitated additional interventions. 7. The admission assessment from 01/14/12 for patient #N9 documented a 35 for the fall risk and "No" for the secondary diagnosis item. The physician's history and physical listed 4 different diagnoses for the patient. Adding 15 points for a secondary diagnosis would have changed the patient's fall risk from a Moderate to a High and necessitated additional interventions. 8. The admission assessment from 02/10/12 for patient #N10 indicated a fall risk score of 95, but failed to document the High Risk fall interventions. 9. The admission assessment from 02/21/12 for patient #N11 documented a 20 for the fall risk and "No" for the secondary diagnosis item. The physician's history and physical listed 8 different diagnoses for the patient. Adding 15 points for a secondary diagnosis would have changed the patient's fall risk from a Low to a Moderate and necessitated additional interventions. 10. The admission assessment from 10/03/11 for patient #N17 failed to indicate a fall risk				

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	<p>assessment.</p> <p>11. The admission assessment from 11/10/11 for patient #N18 documented a 20 for the fall risk and "No" for the secondary diagnosis item. The physician's history and physical listed 8 different diagnoses for the patient. Adding 15 points for a secondary diagnosis would have changed the patient's fall risk from a Low to a Moderate and necessitated additional interventions.</p> <p>12. The admission assessment from 12/16/11 for pediatric patient #N19 failed to indicate a fall risk assessment.</p> <p>13. The admission assessment from 01/21/12 for pediatric patient #N20 indicated an incomplete fall risk assessment and no score to determine what interventions should be implemented.</p> <p>14. At 2:00 PM on 04/12/12, staff member #A40, the nurse navigating the electronic medical records, confirmed the fall assessments were not accurate and that they did not indicate what interventions were implemented.</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 document review, policy and procedure review, observation and interview, the facility failed to ensure safety of employees who clean and check batteries for the generator and the battery operated floor scrubbers and personnel who operate the maintenance department's grinding wheel and failed to ensure a safe environment by monitoring the warming cabinets and inspecting the chemical storage areas.</p> <p>Findings included:</p> <ol style="list-style-type: none"> 1. The hospital Safety Management Plan complies with safety standards and regulations which include OSHA and Life Safety Code. 2. 1910.178 does not have a specific requirement for eyewash facilities. The general standard at 1910.151 applies. 	S1118	<p>The Plant Operations Supervisor replaced generator batteries with sealed batteries that eliminate exposure to battery acid. An eye wash station was installed where the scrubber is stored and staff was reeducated on the use of the eye wash. The floor scrubber is serviced in Plant Operation's service area where an eye wash station is immediately available. Staff was reeducated on the use of the eye wash station by the Plant Operations Supervisor. The Plant Operations Supervisor will audit by direct observation the staff involved in battery maintenance.</p> <p>The Plant Operation Supervisor repaired and replaced the grinder according to acceptable standard. The Supervisor has reeducated staff on safety guides, guards, rests and adjustment of such at all times. This area of concern will be reviewed monthly and reported to the Safety</p>	05/04/2012			

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	<p>When necessary, facilities for drenching or flushing the eyes 'shall be provided within the work area for immediate emergency use. In applying these general terms, OSHA would consider the guidelines set by such sources as American National Standards Institute (ANSI) Z358.1 -1998, Emergency Eyewash and Shower Equipment, which states, at section 7.4.4, that eyewash facilities are to be located to require no more than 10 seconds to reach but that where a strong acid or caustic is used, the unit should be immediately adjacent to the hazard."</p> <p>3. At 11:00 AM on 4/11/2012, the outside generator was inspected. The generator was located in a stand alone steel storage unit. The storage unit was observed surrounded by walls of the hospital and the storage unit was centrally located in the court yard. The generator within the steel storage unit was observed with 4 CAT 12-volt acid batteries. The batteries are checked for water levels and corrosion on a weekly basis by the maintenance staff. The steel unit does not have a portable eye washing station in case of acid splash into someone's eyes.</p> <p>4. At 11:00 AM on 4/12/2012, the housekeeping storage room where the battery operated floor scrubbers are stored</p>		<p>Committee by the Director of Plant Operations. The COO revised the Warning Cabinet policy including the establishment of a standardized warming cabinet temperature log sheet to record temperature and the action taken when out of range. The Managers and staff were reeducated by the respective department director. These log sheets were added to the respective department's quality indicator reporting program to be submitted to the Quality Council on a monthly basis for the remainder of 2012 and added to the monthly environment of care rounds. The COO and Safety Director removed all unapproved chemicals from storage to be to be disposed of properly. The department director replaced the unapproved chemicals with hospital approved disinfectants, reeducated staff, rewrote policies related to such, and has established a monthly audit to be submitted to the Quality Council for the remainder of 2012. The Director also added this indicator to the monthly environment of care inspections form to be submitted to the Safety Committee.</p>		

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	<p>was inspected. The battery operated floor scrubbers require weekly battery maintenance which includes proper water levels, proper electrolyte level in each battery cell, wiping excess of water off of top of each battery after they are filled, etc. The storage room was observed without an eye washing station where acid of batteries are exposed.</p> <p>5. OSHA guidelines for bench grinder safety " ...Work rests shall be used to support the work. They shall be of rigid construction and designed to be adjustable to compensate for wheel wear. Work rests shall be kept adjusted closely to the wheel with a maximum opening of one-eighth inch to prevent the work from being jammed between the wheel and the rest, which may cause wheel breakage. The work rest shall be securely clamped after each adjustment."</p> <p>6. At 10:00 AM on 4/11/2012, the Maintenance Department was tour and in the maintenance supply room was a red counter top mounted grinding wheel with an abrasive wheel on the right side of the equipment. The work rest for the abrasive wheel was missing and was a safety concern. This was confirmed by staff member #21.</p> <p>7. The facility policy "Warmers (Blanket/Fluid): Care of the Patient Using</p>						

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	<p>Supplies Stored in These Devices", effective 9/11, indicated, "...Warmers will not be set at a temperature higher than the below temperature for the following items: -Blanket Warmer Temperatures will not be set higher than 130 degrees Fahrenheit and will not exceed 104 degrees Fahrenheit, if placed with IV or irrigation solution as there is only one temperature control. -IV/Irrigation Solutions Warmer Temperatures will not be set higher than 40 degrees C (104 degrees F). Temperature ranges will be posted on the outside of the device (warmer)."</p> <p>The policy continued on page 2, "...A daily temperature log will be maintained for each warmer following the below procedure steps: A Temperature Log Sheet will be posted on the warming cabinet or placed in a binder on the unit, which will be reviewed randomly by the director or designee to ensure compliance. Read and record the temperature about the same time each day. ...The Temperature Log Sheet will include the following information: Warming cabinet and its location, initials of individual performing the monitoring, record of daily temperatures, instructions of actions taken when out of range, identifies Centigrade and/or Fahrenheit, as appropriate."</p>						

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	<p>8. During the tour of the Emergency Department at 11:30 AM on 04/10/12, accompanied by staff members #A2 and A10, a Ready Box Body Temperature Media Warmer displaying a temperature of 34.4 degrees C and a Blickman Blanket Warmer displaying a temperature of 142.0 degrees F were observed in the supply room. The documentation of checks and monitoring for January through March 2012 indicated check marks for the warmers, but no actual temperatures. Also, there was no documentation regarding the current temperature being out of range or any actions taken.</p> <p>9. During the tour of the Obstetrics Department at 12:25 PM on 04/10/12, accompanied by staff members #A2 and A13, a Getinge Castle Warmer displaying a temperature of 137 degrees Fahrenheit was observed in the nursery. The warmer contained blankets and a sticker indicating "Do not exceed 130 degrees" was located next to the temperature display area.</p> <p>Review of the temperature monitoring logs indicated the following: A. January 2012- 5 days not monitored, all other days indicated temperatures of 137 and 138 degrees. B. February 2012- 4 days not monitored,</p>				

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	<p>all other days indicated temperatures of 137 and 138 degrees.</p> <p>C. March 2012- 4 days not monitored, all other days indicated temperatures of 137 and 138 degrees.</p> <p>D. April 2012- 4 of the 10 days not monitored, the other 6 days indicated temperatures of 138 degrees.</p> <p>10. During the tour of the off-site Emergency Department at 9:30 AM on 04/11/12, accompanied by staff members #A3 and A10, a Ready Box Fluid Warmer with a displayed temperature of 91.4 degrees Fahrenheit and an Olympic Warmette Blanket Warmer with a displayed temperature of 35 degrees C were observed in the storage room. Review of the monitoring logs for January through March 2012 indicated temperatures documented for the fluid warmer, but only check marks for the blanket warmer.</p> <p>11. During the tour of the off-site allergy clinic at 10:45 AM on 04/11/12, accompanied by staff members #A1, A3, and A19, a locked closet was observed containing the following:</p> <p>A. (2) half full plastic jugs containing pink liquid with labels of Distilled Water.</p> <p>B. An unopened gallon jug of Cidexplus 28 day high level disinfectant.</p> <p>C. A quart container of Metrizyme with</p>						

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	<p>an expiration date of 03/2012.</p> <p>D. A gallon container of Asepti-zyme enzymatic cleaner.</p> <p>E. (2) spray bottles of Quik-cide RTU disinfectant.</p> <p>F. A gallon of bleach.</p> <p>At 10:50 AM, the director, staff member #A19, indicated the area did not have an eyewash station, but he/she did not know anything about those chemicals.</p> <p>At 10:55 AM, a nurse in the area, staff member #A20, indicated the Asepti-zyme was used to soak any used instruments that were sent to the hospital for actual cleaning.</p> <p>At 10:45 AM on 04/12/12, the housekeeping manager, staff member #A32, indicated the chemicals in that closet were not used by the contracted cleaning staff and he/she did not know where they came from or what they were used for.</p> <p>12. During the tour of Ambulatory Care Unit at 3:40 PM on 04/11/12, accompanied by staff members #A1 and A41, a Blickman Blanket Warmer displaying a temperature of 128 degrees Fahrenheit was observed in the back hallway and a Getinge Blanket Warmer displaying a temperature of 106 degrees</p>						

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	<p>Fahrenheit was observed in the Post Anesthesia Care Unit. An ALM Warmer, located in the substerile area, displayed a temperature of 105 degrees Fahrenheit for the top section containing fluids and a temperature of 102 degrees Fahrenheit for the bottom section containing blankets.</p> <p>At 4:00 PM on 04/11/12, staff member #A41 indicated there was no documentation of temperature monitoring for any of the warmers in those areas.</p>				

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S1162	<p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8(d)(2)(A)</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>(A) All mechanical equipment (pneumatic, electric, or other) shall be on a documented maintenance schedule of appropriate frequency and with the manufacturer's recommended maintenance schedule.</p> <p>Based on document review and staff interview, the facility failed to maintain the manufacturer's required temperature parameters for the two Hydrocollators that are utilized in the North Pavilion off site.</p> <p>Findings included:</p> <ol style="list-style-type: none"> The North Pavilion Rehab Department has 2 different hydrocollators: Chattanooga and Rolyan. The manufacturer's recommended operating temperatures for the Chattanooga is 160 F to 166 F. The manufacturer recommended operating temperature for the Rolyan Hydrocolator is 162 F. At 10:20 AM on 4/11/2012, staff 	S1162	<p>The hydrocollator policy was revised to ensure that the temperature range adheres to manufacturer recommendations of 160-166 degrees F. The temperature is logged on the department monthly environmental sheet and staff was reeducated on the process for "action taken", if out of range. A new thermometer was obtained to ensure accurate readings and the Director of Rehab remains responsible for monitoring and submitting audits to Quality Council monthly for the remainder of 2012.</p>	05/02/2012			

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	<p>member #25 indicated the hydrocollators are maintained between 170 and 176 F.</p> <p>3. The North Pavilion Rehab log for the week 4/2 to 4/6/2012 noted the two hydrocollators maintained a temperature of 170.6 and 170.2 F which both exceeded the manufacturer's recommendations.</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 document review and staff interview, the facility failed to ensure the washer/dryer combos located in the hospital's Housekeeping Department and in North Pavilion were scheduled on a preventive maintenance.</p> <p>Findings included:</p> <ol style="list-style-type: none"> At 10:20 AM on 4/11/2012, the North Pavilion Rehab Unit was toured. The department was observed with a shakable washer/dryer combo. The combo was not observed with any preventive maintenance inspection tag on it. At 11:00 AM on 4/12/2012, the laundry room/biohazard utility room in the hospital was observed with a washer and dryer. The two units were observed without any preventive maintenance sticker on them. 	S1164	The Rehab and Laundry washer/dryers were inspected, tagged and placed on the facility preventive maintenance schedule for inspection per policy. The Department Director reviewed all patient equipment to ensure that all patient care equipment has received PM. The Director of Biomedical Services has established a monthly audit (random sampling of work performed by the contracted service) to be submitted to the Safety Committee.	04/12/2012			

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	3.. At 11:15 AM on 4/12/2012, staff member #32 indicated the washer and dryer units have never been placed on a preventive maintenance schedule. The staff member could not provide documentation of preventive maintenance on the two washer/dryer combo units.				

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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 staff interview, the facility failed to ensure the Ambulance's defibrillators are daily checked and logged per manufacturer's recommendations.</p> <p>Findings included:</p> <ol style="list-style-type: none"> 1. The Defibrillator logs were requested for the ambulances that were housed in the ambulance garage. The document was not provided for review. 2. At 1:45 PM on 4/11/2012, staff member #48 indicated he/she checks the defibrillator each shift but the checks are never recorded for verification. The staff member indicated his/her shift was 24 hour shifts. 3. At 1:55 PM on 4/11/2012, staff member #28 indicate the defibrillators are not on their ambulance shift reports. The shifts for the department are random and 	S1168	<p>The Director of EMS wrote revisions to the following policies: · "Shift Check" · Defibrillators · Ambulance Maintenance, which includes defibrillator checks and documentation of such checks. The Director of EMS reeducated staff on the changes to the "shift check process". A quality indicator was also established using an audit tool to be submitted to the Quality Council monthly for the remainder of 2012.</p>	05/01/2012	

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	<p>it affects the shifts of each ambulance. The ambulance staff operate 8, 10, 12, and even 24 hour shifts. The staff member indicated the department has no documentation of when the defibrillators for each ambulance has been ran through it's pre-shift operation.</p> <p>4. The Ambulances utilizes Zoll M-series defibrillators. Section 9 of the owner's manual states, "Resuscitation equipment must be maintained to be ready for immediate use. The following operational checks should be performed at the beginning of every shift to ensure proper equipment operation and patient safety."</p> <p>5. Staff member #28 provided documentation of routine checks that are recorded. The documentation included 'Ambulance Medication List - last day of the Month' and 'Monthly Truck Maintenance' reports. The staff member provided a daily checklist of supplies each ambulance needs before it can operate that day. The daily check list included; backboards, CO2, BLS Bags, etc. This report never mentioned the defibrilator that was on the ambulance. In fact, none of the three reports noted the defibrillators that are assigned to each ambulance that is owned by the hospital.</p>				

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	6. The hospital Ambulance Maintenance Policy was reviewed. The points of emphasis of the policy includes daly checks, routine maintenance, preventive maintenance, and repairs. The policy did not identify the Defibrilators that are located on the ambulances.				