

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150046	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/06/2014
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NAME OF PROVIDER OR SUPPLIER TERRE HAUTE REGIONAL HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 3901 S SEVENTH ST TERRE HAUTE, IN 47802
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S000000	<p>This visit was for a State hospital licensure survey.</p> <p>Dates: 2/3/2014 through 2/6/2014</p> <p>Facility Number: 005042</p> <p>Surveyors: Albert Daeger, CFM, SFPIO Medical Surveyor</p> <p>Saundra Nolfi, RN PH Nurse Surveyor</p> <p>QA: claughlin 02/14/14</p>	S000000		
S000178	<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>			

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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	<p>Based on observation and staff interview, the hospital failed to ensure the hospital license was conspicuously posted for patient and public viewing when entering the premises during all hours of operation.</p> <p>Findings included:</p> <ol style="list-style-type: none"> The hospital was toured at 11:00 AM on 2/4/2014. The hospital license was observed located outside of the administrative offices. The posted sign was located northwest of the hospital across from the dining room. The hospital did not have a license posted in the main lobby or the Emergency Room. The Emergency Department entrance was located at the far east end of the hospital building. Only access to the viewing of the state license after entering the main entrance would be to pass the Cafeteria. Terre Haute Regional Hospital First Floor Composite Plan 	S000178	<p>S 178 410 IAC 15-1.3-2 POSTING OF LICENSE410 IAC 15-1.3-2(a) Discussion Tag S 178:The hospital failed to ensure the hospital license was conspicuously posted for patient and public viewing when entering the premises during all hours of operation. Corrective Action: Current posting of Licensure was reviewed by the VP of Quality Management, Regulatory Survey Coordinator, and Director of Plant Operations on February 14, 2014. Four additional copies of State Licensure were posted in (1) The Hospital Main Entrance (2) Hospital Outpatient Surgery Entrance (3) Emergency Department Entrance and (4) Outpatient Services Entrance. This was completed on February 28, 2014. See Attachment A. Compliance Monitoring Observation of Licensure displays will be evaluated monthly times 3 months by the Regulatory Survey Coordinator to ensure that State License remains conspicuously posted. Aggregate data will be submitted to Hospital Leadership, Medical Executive Committee, and the Board of Trustees monthly times three months. See Attachment B. Implementation Date: March 1, 2014 Responsible Person: Director of Plant Operations, Vice President of Quality, and Regulatory Survey Coordinator.</p>	03/01/2014	

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	<p>revealed the only posted licensure sign was located at the northwest end of the hospital outside Administration and across the hallway from the Cafeteria. The Emergency Department was located at the far east end of the hospital and the Main Entrance was located at the far southwest end of the hospital. Patient and/or public entering either area of the hospital may walk hallways that would never pass the posted licensure sign.</p> <p>3. At 10:30 AM on 2/6/2014, staff member #1 indicated the main lobby is closed during the evening. Patients must enter through the Emergency Department. The Emergency Department does not have a licensure replica posted upon entrance to the hospital. The staff member confirmed that patients can enter the hospital without easy availability of viewing the hospital state license.</p>						

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S000406	<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 staff interview, the facility failed to ensure 5 services were part of its comprehensive quality assessment and improvement (QA&I) program: Hyperbaric Chamber, Emergency Psychiatric, Internal Laundry, Foodservice Management, and Audiology.</p> <p>Findings included:</p> <p>1. Terre Haute Regional Hospital 2013 Performance Improvement and Patient Plan implements all service with direct or indirect</p>	S000406	<p>S 406 410 IAC 15-1.4-2 QUALITY ASSESSMENT ANDIMPROVEMENT410 IAC 15-1.4-2(a)(1) Discussion Tag S406:The Hospital failed to ensure 5 services were part of its comprehensive quality assessment and improvement (QA&I) program: Hyperbaric Chamber, Emergency Psychiatric, Internal Laundry, Food Service Management, and Audiology. Corrective Action:1. Hyperbaric ChamberThe Wound Care Center Program Manager and Regulatory Survey Coordinator met on February 27, 2014 to discuss appropriate quality indicators for Hyperbaric Chamber Services. For 2014 and beyond, The Wound Care Center Program Manager will assess the average number of hyperbaric</p>	03/01/2014	

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	<p>impact on patient care quality shall be reviewed under the quality improvement program.</p> <p>2. Review of the hospital Quality Reports provided no evidence that Hyperbaric Chamber, Emergency Psychiatric, Internal Laundry, Foodservice Management, and Audiology services were part of its comprehensive quality assessment and improvement (QA&I) program.</p> <p>3. At 2:00 PM on 2/3/2014, staff member #2 confirmed that the facility does not have evidence that 5 services were made part of the QA&I program.</p>		<p>oxygen treatments completed per discharged patient with a diagnosis of diabetic foot ulcer(s). The benchmark used for this metric will be the recommended number of hyperbaric oxygen treatments for patients with a diabetic foot ulcer(s) which is 30-60 treatments. This monthly data will be collected by Wound Care Center Program Director (or designee) and will be entered on the Quality Dashboard departmental report. It will be shared with The Quality Department, Administration, and reported to the Medical Executive Committee and Board of Trustees at least quarterly. If the average number of hyperbaric oxygen treatments completed is under the 30 visit benchmark, a review will ensue to determine the cause of extended hold hours and to verify if any opportunities exist for improvements in process. See Attachment C. 2. Emergency PsychiatricThe ED has been monitoring and reporting the number of "hold hours" of psychiatric patients in the Emergency Department since July of 2013. This data is collected, and then shared via electronic format with the quality department. For 2014 and beyond, the Director of Emergency Services or designee will continue to collect the number of hours each month that psychiatric patients are held</p>		

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			<p>within our ED before being admitted to inpatient or transferred to an appropriate facility. Based on previous year's average data, the facility has chosen a benchmark of 40 hours or less per month for hold hours for psychiatric patients in the ED. This monthly data will be collected by ED Director (or designee) and will be entered on the quality dashboard departmental report. It will be shared with Inpatient Psychiatric Services Director, Quality Department, Administration, and reported to the Medical Executive Committee and Board of Trustees at least quarterly. If the hold hours are over the 40 hour benchmark, a review will ensue to determine the cause of extended hold hours and to verify if any opportunities exist for improvements in process. See Attachment D. 3. Internal Laundry For 2014 and beyond, the Behavioral Health Unit, responsible for the internal laundry service, will log temperature of wash, amount of detergent used and cleaning of both washer and dryer between every use. The average monthly temperature of every wash will be entered on the quality dashboard departmental report monthly. It will be shared with Inpatient Psychiatric Services Director, Quality Department, Administration, and reported to the Medical Executive Committee</p>	

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			and Board of Trustees at least quarterly. If the temperature average falls below CDC regulation for infection control purposes, a cause will be determined to verify if any opportunities exist for improvements in process. See Attachment E. 4. Food Service Management a) The Director of Food and Nutrition Services, Infection Preventionist, and Regulatory Survey Coordinator met on February 20, 2014 to discuss appropriate quality indicators for the department. Meal round survey questions were reviewed, revised, and incorporated into the Quality Dashboard for 2014. Meal round surveys will be conducted by the dietitians, Food Production Manager, and General Manager or designee. b) Weekly Kitchen Sanitation survey will be performed; the following quality measures will be reported as a monthly average on the Quality Dashboard: 1. Milk in the physician lounge refrigerator is below 41 degrees F. 2. Milk on the trayline is below 41 degrees F. c. The Infection Preventionist will perform a monthly follow up kitchen survey. d. Clinical Performance Improvement will focus on whether or not physicians follow dietitian recommendations for oral nutrition supplements, diet changes, and enteral/parenteral nutrition recommendations. e.		

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			Data from meal rounds, weekly sanitation reports, follow up surveys, and Clinical Performance Improvement will be documented on The Quality Dashboard. This data will be shared with the Quality Department, Administration, and reported to the Medical Executive Committee and Board of Trustees at least quarterly. If expectations do not meet benchmark, a review will ensue to determine the cause and to verify if any opportunities exist for improvements in process. See attachment F. 5. Audiology The Director of Occupational Health Services, Director of Plant Operations, and Regulatory Survey Coordinator met on February 12, 2014 to discuss appropriate quality indicators for Audiology Services. For 2014 and beyond, Occupational Health Services, responsible for the Audiology Services, will log results of calibration testing each day the clinic is open. The total results of calibrations will be entered on the Quality Dashboard departmental report monthly. It will be shared The Quality Department, Administration, reported to the Medical Executive Committee and Board of Trustees at least quarterly. If the calibration results are out of range, a cause will be determined to verify if any opportunities exist for improvements in process. See Attachment E. Compliance	

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S000554	<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, document review, and interview, the facility failed to ensure chemical Cidex OPA was properly rinsed from health care equipment that comes in direct contact with patients in Surgical Decontamination Room and Women</p>	S000554	<p>MonitoringThe Quality Dashboard will be evaluated monthly times 3 months by the Regulatory Survey Coordinator to ensure that all five areas (Hyperbaric Chamber, Emergency Psychiatric, Internal Laundry, Food Service Management, and Audiology) have entered Quality data in a timely fashion. Aggregate data will be submitted to Hospital Leadership, Medical Executive Committee, and the Board of Trustees monthly times three months. See Attachment B. Implementation Date: March 1, 2014 Responsible Person:Director of Wound Care center, Director of Emergency Services, Director of Behavioral Health Services, Director of Food and Nutrition Services, and Director of Occupational Medicine Clinic.</p> <p>S 554 410 IAC 15-1.5-2 INFECTION CONTROL410 IAC 15-1.5-2(a) Discussion Tag S554:The Hospital failed to: 1. Ensure chemical Cidex OPA was properly rinsed from health care equipment that comes in direct contact with patients in Surgical Decontamination Room 2.</p>	03/01/2014

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	<p>Imaging and failed to ensure a safe environment for patients by checking supplies to prevent outdated usage and failed to ensure clean supplies and equipment were protected from contamination in patient care areas.</p> <p>Findings included:</p> <p>1. The hospital was using Ortho-phthalaldehyde Solution (Cidex OPA), high level disinfectant for semi-critical devices, in the Women Imaging Department and The Heart and Vascular Center. Cidex OPA manufacturer sheet requires: Manual processing - Immerge device completely, filling all lumens and eliminating air pockets in Cidex OPA solution for a minimum of 12 minutes at 68 degrees F or higher; Manual rinsing procedure - thoroughly rinse the semi-critical medical device by immersing it completely in 2 gallons of water 3 times. Each time should be done for a minimum of 1 minute. Always use fresh water each time this step is done.</p> <p>2. During the tour of the surgical decontamination room at 2:00 PM on 02/03/14, accompanied by staff members #11 and #15, a container of Cidex solution was observed on the</p>		<p>Ensure a safe environment for patients by checking supplies to prevent outdated usage in the Post-partum and Pediatric Department. 3. Ensure clean supplies and equipment were protected from contamination in patient care areas. Corrective Action:1) Cidex Rinse Processa. Policy, ADM.INF.012, High Level Disinfection with Cidex OPA, and the Cidex OPA solution daily log was reviewed by the VP of Quality Management, Director of Surgical Services, Director of Radiology Services, and Infection Preventionist on February 12, 2014. No revisions were necessary to the policy. The policy states that following removal from the Cidex Plus OPA solution, the device must be rinsed in a clean container with sterile water or water that has been through a bacterial retentive 0.2 micron filter system. The device must be rinsed for a period of one minute duration. Discard the water, and repeat this procedure two additional times for a total of three rinses. See Attachment H1. The Cidex OPA Solution log for Central Sterile Supply and Ultrasound was revised on February 19, 2014 by VP of Quality Management to clarify the rinse instruction as reflected in the policy. See Attachment H2 and H3. b. Education and review of policy ADM.INF.012 was provided to Central Sterile Supply and</p>		

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	<p>counter, labeled and dated appropriately. At 2:15 PM, staff member #15 indicated glidescopes were soaked in the solution for 12 minutes and a timer was set to monitor the time. He/she indicated the scopes were then rinsed with the sprayer in the sink for about 12 seconds before drying and packaging.</p> <p>3. At 11:45 AM on 2/3/2014, staff member #45, an Ultrasound Technician from Women Imaging described the procedures on rinsing off the excess Cidex OPA from their vaginal probes. The staff member indicated he/she submerges the probe into distilled water for 1 minute and for only one time. Then the staff member would rinse the probe in the sink for another couple of minutes.</p> <p>4. High Level Disinfection with Cidex OPA policy #382059 (Last revised April 2013) states, "Following removal from the Cidex Plus OPA solution, the device must be rinsed in a clean container with sterile water or water that has been through a bacterial retentative 0.2 micron filter system. The device must be totally immersed in for a period of one minute in duration, unless longer time is specified by the manufacturer. Remove the device and discard the rinse water. Repeat the procedure two</p>		<p>Ultrasound staff. It was completed on February 21, 2014 by the Director of Surgical Services and Director of Radiology. This education was to re-enforce the requirement that devices disinfected with Cidex OPA requires three separate rinses for one minute each in sterile or water filtered through a bacterial retentive 0.2 micron filter system. See Attachment H4.2) Expired Supplies in Post-partum and Pediatrics. All expired items were removed from all treatment carts, treatment rooms, and store rooms on Pediatrics and Post-Partum, in addition to all items under the sink in Pediatric Treatment room on Feb 19th by staff as directed by The Director of Women's Services. The cabinet under the sink in the Pediatric treatment room was locked shut to avoid further storage on February 20, 2014 by Plant Operations Staff. See Attachment I1b. Policy, ADM.INF.037 Managing Products with Expiration Dates, was reviewed by the Director of Women's Services on February 12, 2014. No revisions were necessary to the policy. See Attachment I2c. A monthly log was created on February 20, 2014 by the Director of Women's Services. The log will be kept on Post-Partum and Pediatrics, outlining those areas that need to be checked. All areas will be checked for outdates monthly.</p>				

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	additional times for a total of three times.		See Attachment I3d. Education was provided to Obstetric and Pediatric Staff by the Women's Services Clinical Coordinator on February 23, 2014 regarding the new monthly log, compliance requirements, and review of Policy ADM.INF.037. See Attachment I43) Presence of Shipping Boxes near unpackaged clean patient suppliesa. All outside shipping boxes were removed from clean supply rooms on February 5, 2014 by Supply Chain Staff at the direction of the Director of Supply Chain Operations. b. Education was provided to Supply Chain staff on February 11, 2014 by the Director of Supply Chain Services of the proper practice of storing supplies in clean patient areas. Plastic totes were purchased and placed in clean supply areas for storage needs on February 11, 2014 by the Director of Supply Chain Services. See Attachment J1 Compliance Monitoring1. Cidex Rinse Process Random Observations of 10 staff members performing high level disinfection will be performed by the Manager of Radiology Services and Manager of Central Sterile Supply monthly. Outcomes of these observations will be evaluated monthly times 3 months by the Regulatory Survey Coordinator to ensure that staff perform high level disinfection with Cidex OPA according to policy. Aggregate data will be		

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			submitted to Hospital Leadership, Medical Executive Committee, and the Board of Trustees monthly times three months. See Attachment B.2. Expired supplies in Post-partum and Pediatrics 100% of logs for patient supply rooms and carts on Post-Partum and Pediatrics will be reviewed monthly times three months by the Women's Services Director or her designee for compliance with Policy, "Managing Products with Expiration Dates", ADM.INF.037, to ensure no expired items are present in patient care areas and that all areas are checked monthly. Aggregate data will be submitted to hospital leadership, Medical Executive Committee, and the Board of Trustees monthly times three months. See Attachment B.3. Shipping Boxes near unpackaged clean patient supplies 100% of patient care areas will be inspected by The Director of Supply Chain Services monthly times three months to ensure no outside shipping boxes are kept near clean unpackaged patient supplies. Aggregate data will be submitted to hospital leadership, Medical Executive Committee, and the Board of Trustees monthly times three months. See Attachment B. Implementation Date: March 1, 2014 Responsible Person: 1. Cidex Process: Director of Radiology Services, Director of Surgical Services 2. Expired		

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	<p>5. During the tour of the out-patient surgery area at 12:50 PM on 02/03/14, accompanied by staff members A3, A11, and A12, several cardboard shipping boxes were observed stored alongside clean unpackaged products in the supply room.</p> <p>6. During the tour of the Emergency Department at 9:00 AM on 02/4/14, accompanied by staff members A3 and A27, several cardboard shipping boxes were observed stored alongside clean unpackaged products in the supply room.</p> <p>7. During the tour of the Intensive Care Unit at 9:45 AM on 02/4/14, accompanied by staff members A3, A28, and A29, several cardboard shipping boxes were observed stored alongside sterile packs in the oxygen room.</p> <p>8. During the tour of the Behavioral Health Unit at 12:50 PM on 02/04/14, accompanied by staff members A3, A32, and A33, several cardboard shipping boxes were observed stored alongside clean unpackaged products in the supply room.</p>		Supplies: Director of Women's Services 3. Shipping boxes in Clean Patient areas: Director of Supply Chain Services	

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	<p>9. During the tour of the Post-Partum Unit at 1:45 PM on 02/04/14, accompanied by staff members A3 and A34, the cart containing emergency supplies for post-partum hemorrhage was observed with two of two purple-top lab tubes with an expiration date of 01/14.</p> <p>10. During the tour of the Pediatric Unit at 3:10 PM on 02/04/14, accompanied by staff members A8, A34, and A36, the following observations were made:</p> <p>A. Five of five packages of Quik-Combo RTS electrodes, with an expiration date of 09/28/13, on top of the crash cart in the medication room.</p> <p>B. Five of seven BD Bactec Peds culture bottles, with an expiration date of 11/30/13, in a cabinet in the treatment room.</p> <p>C. One of one Lumbar Puncture kit, with an expiration date of 08/2012, in a cabinet in the treatment room.</p> <p>D. One of one spinal needle, with an expiration date of 01/2012, in a cabinet in the treatment room.</p> <p>E. One of one Trocar Catheter, with an expiration date of 09/2011, in a cabinet in the treatment room.</p> <p>F. One of two 250 milliliter bottles of sterile water, with an expiration date of May 1, 2012, in a cabinet in the treatment room.</p>						

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S000612	<p>G. A plastic basin of clean and sterile packages of supplies was stored under the sink in the treatment room.</p> <p>11. At 4:00 PM on 02/04/14, staff members A3 and A8 confirmed all of the areas were not checked for outdates and the clean supplies were in close proximity to outside shipping boxes, which put them at risk for contamination.</p> <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 documentation review, observation, and staff interview, the facility failed to ensure the internal laundry for Behavioral Health and Inpatient Rehab were</p>	S000612	S 612 410 IAC 15-1.5-2 INFECTION CONTROL410 IAC 15-1.5-2(f)(3)(D)(xi) Discussion Tag S612The facility failed to ensure the internal laundry for Behavioral Health and Inpatient Rehab were in compliance with	03/01/2014

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	<p>complying with policies and procedures.</p> <p>Findings included:</p> <ol style="list-style-type: none"> 1. Terre Haute Regional Hospital Washing Machine and Dryer Guidelines for Mehta Behavioral Health and Acute Rehabilitation Unit policy #284606 (Last revised May 2012) recommends to follow Centers for Disease Control and Prevention (CDC) 2003. related to health care laundry services. The added precaution listed in the policy was to remove patient clothes from the dryer under staff supervision and spray a hospital-approved disinfectant. 2. CDC guidelines for laundry services in health care facilities states, "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 		<p>policies and procedures. Corrective Action: (a) Policy, ADM.INF.042, Washing Machine and Dryer Guidelines for Mehta Behavioral Health Unit and Acute Rehabilitation Unit, was reviewed by the VP of Quality Management, the Infection Preventionist, the Behavioral Health Program Director, Director of Rehabilitation Services and Director of Plant Operations on February 17, 2014 and needed revisions were discussed. The policy was revised on February 27, 2014 by the Infection Preventionist. It now states that no patient clothing may be laundered on the Inpatient Rehabilitation Unit. The Inpatient Rehabilitation Unit (IRU) washer and dryer will be kept on the unit to perform Occupational Therapy Independent Activities of Daily Living (IADL) training only. Any patient clothing will be laundered by the family or by the Inpatient Rehabilitation Staff on the BHU unit. The policy was also revised to reflect the use of use of high efficiency detergents and the log monitoring needed to track temperature on the laundry unit located in Behavioral Health. See Attachment K1. (b) A new, Commercial Grade High Efficiency washer with installed water temperature gauge was installed on the Behavioral Health Unit on February 24, 2014 by the direction of the Director of Plant Operations. This washer will meet</p>		

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	<p>commonly recommended for hot-water washing. A satisfactory reduction of microbial contamination can be achieved at lower water temperatures of 22-50 C (71.6 to 122 F) when the cycling of the washer, the wash formula, and the amount of chlorine bleach are carefully monitored and controlled at a residual of 50-150 ppm during the chlorine bleach cycle."</p> <p>3. At 1:25 PM on 2/4/2014, the Behavioral Health Laundry Room was toured. The dryer was observed off and a patient's pajama bottoms had been left in the dryer. The dryer drum was cooled indicating the bottoms was left in the dryer for awhile without being transported to a patient's room as required per policy.</p> <p>4. At 1:35 PM on 2/4/2014, the In-patient Rehab Unit was toured. The unit did not have a hospital-approved disinfectant (Bleach) available on the unit to</p>		<p>CDC guidelines. See Attachment K2. (c) The article of clothing found in the dryer during the onsite ISDH survey was immediately removed and the dryer disinfected with a hospital approved disinfectant on February 4, 2014 by the Behavioral Health Program Director. Policy, ADM.INF.042, Washing Machine and Dryer Guidelines for Mehta Behavioral Health Unit and Acute Rehabilitation Unit, was reviewed by the VP of Quality Management, the Infection Preventionist, the Behavioral Health Program Director, the Director of Rehabilitation Services and Director of Plant Operations on February 17, 2014 and no revisions were necessary related to the removal of clothing and disinfection of the dryer. (b) Education was provided to Behavioral Health Staff and Rehabilitation Staff on February 27, 2014 and February 28, 2014 by the Behavioral Health Program Director and Director of Rehabilitation Services via email and unit notices. This education was to re-enforce the requirement that staff complete the washer and dryer log with each wash in compliance with CDC guidelines when washing patient clothing in the Behavioral Health Unit as well as the directive that no patient clothing will be laundered on the Inpatient Rehabilitation Unit. See Attachment K3. Compliance</p>		

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	<p>disinfect the washer and dryer between patient use.</p> <p>5. At 1:45 PM on 2/4/2014, staff member #24 indicated the nursing staff will wash patient clothes for patients that are stroke patients or other patients that cannot at the present time wash their own clothes.</p> <p>6. At 1:55 PM on 2/4/2014, staff member #20 indicated the washers are low-temperature units and each department is using detergent single-use packs. The staff member did not know if the detergent kills all the pathogens required for use in a health care facility. The staff member indicated he/she was told before that both internal laundry services (Behavioral Health and Inpatient Rehab) must comply with CDC guidelines for laundry services in a health care facility.</p>		<p>Monitoring(a) 10 random observations of the washer and dryer unit on the Inpatient Rehabilitation unit will be performed monthly times 3 months by the Regulatory Survey Coordinator to ensure that no patient clothing is contained in the Inpatient Rehabilitation laundry Facility. In addition, 10 random observations of the dryer unit on the Behavioral Health unit will be performed monthly times 3 months by the Regulatory Survey Coordinator to ensure that no patient clothing remains in the dryer once dry. Aggregate data will be submitted to Hospital Leadership, Medical Executive Committee, and the Board of Trustees monthly times three months. See Attachment B.(b) 100% of entries on the Behavioral Health Unit Laundry Log will be reviewed for correct and thorough completion according to Hospital Policy by the Behavioral Health Program Director monthly times 3 months. Aggregate data will be submitted to Hospital Leadership, Medical Executive Committee, and the Board of Trustees monthly times three months. See Attachment B.Implementation Date: March 1, 2014 Responsible Person:Infection Preventionist, Behavioral Health Program Director, Director of Rehabilitation Services and Director of Plant Operations.</p>		

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S000912	<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 medical record review, policy and procedure review, and interview, the nurse executive failed to ensure assessments were done according to policy and protocol for 3 of 3 pediatric</p>	S000912	S 912 410 IAC 15-1.5-6 NURSING SERVICE410 IAC 15-15-6 (a)(2)(B)(i)(ii)(iii)(iv)(v) Discussion Tag S 912:The nurse executive failed to ensure assessments were done	03/01/2014			

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	<p>patients (#N9, N11, and N25), for 1 of 1 newborns (#N15), and for 5 of 7 patients receiving pain medication (#N1, N3, N5, N12, and N16).</p> <p>Findings included:</p> <ol style="list-style-type: none"> 1. The medical record for patient N9, a 12-month old admitted 12/06/13, lacked documentation of a head circumference measurement. 2. The medical record for patient N11, an 18-month old admitted 08/30/13, lacked documentation of a head circumference measurement. 3. The medical record for patient N25, an 22-month old admitted 02/03/14 to the Pediatric Unit, lacked documentation of a head circumference measurement. 4. At 3:15 PM on 02/04/14, staff member A36 on the Pediatric Unit indicated head circumferences were only done on infants aged six months or younger. 5. The facility policy "Assessment and Reassessment of Patients", last revised 09/2013, indicated, "d. Bio-Physical System Data: ...ii. Height and weight, including head circumference on children up to 24 months of age and/or 		<p>according to policy and protocol for:</p> <ol style="list-style-type: none"> 1. Pediatric patients who required assessment of head circumference 2. Newborn males who required post circumcision assessment 3. Patients requiring pain reassessments <p>Corrective Action:</p> <ol style="list-style-type: none"> 1) Assessment of Pediatric Head Circumference (a) Policy, IPC.DIR.005, Assessment and Reassessment of Patients, was reviewed by the VP of Quality Management, Director of Women's Services and Regulatory Survey Coordinator on February 13, 2014 and no revisions were necessary. The policy states the collection of health data will include head circumference on children up to 24 months of age. See Attachment L 1.(b) Computer Documentation screen changes were made by The Clinical Documentation Specialist on February 19, 2014 to prompt nursing staff to assess head circumference on all children less than 24 months of age in compliance with policy IPC.DIR.005. See Attachment L2. (c) Education was provided to Pediatric Nursing staff on February 27, 2014 by the Women's Services Clinical Coordinator via direct education and unit notices. This education re-enforces the requirement that head circumference shall be assessed on children less than 24 months. See Attachment L3. 2) Post Circumcision Assessment 				

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	<p>any child with a suspicious-sized head."</p> <p>6. The medical record for patient N15, a male born 12/08/13, indicated a circumcision was performed at 9:00 AM on 12/09/13. The record indicated circumcision checks were done at 0925 on 12/09/13, at 2015 on 12/09/13, at 2040 on 12/10/13, and at 0830 on 12/11/13.</p> <p>7. A copy of "Lippincott Procedures-Neonatal Circumcision, assisting" was provided as the protocol the facility followed for newborn circumcisions. The protocol indicated, "Providing Aftercare- Remove the neonate from the positioning board and assess him for bleeding every 30 minutes for 1 hour, then hourly for 2 hours, and then with diaper changes until discharge."</p> <p>8. The medical record for patient N1 indicated medication was given at 0458 on 08/31/13 for a stated pain level of 5 out of 10, but the record lacked documentation of a reassessment for effectiveness of the medication.</p> <p>9. The medical record for patient N3 indicated medication was given at 2155 on 10/28/13 for a stated pain level of 10 out of 10, but the record lacked documentation of a reassessment for</p>		<p>(a) "Lippincott Procedures-Neonatal Circumcision, assisting", which is the facility approved evidence-based practice guidelines, along with Policy, IPC.DIR.005, Assessment and Reassessment of Patients, was reviewed by the VP of Quality Management, Director of Women's Services, Chief Nursing Officer, and Regulatory Survey Coordinator on February 13, 2014 and no revisions were necessary. Lippincott's states that newborns should be assessed for bleeding post circumcision every 30 minutes times two, then every hour times two, then as needed until discharge. See Attachment M1.(b) Physician Standing Order Set, "Routine Pre and Post Circumcision Orders", was revised to reflect appropriate Circumcision care. See Attachment M2 (c) Education was provided to Newborn Nursery staff on February 27, 2014 by the Women's Services Clinical Coordinator via direct education and unit notices. This education re-enforces the requirement that newborns must be assessed post circumcision according to Lippincott's Standards and the revised Post Circumcision Standing orders. See Attachment M3. 3) Pain Reassessments (a) Policy, IPC.DIR.002, Pain Management Guidelines, was reviewed by the VP of Quality Management, Director of Medical Surgical/ Oncology, Director of</p>		

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	<p>effectiveness of the medication.</p> <p>10. The medical record for patient N5 indicated a pain medication pump was in place on 12/01/13 for an initial stated pain level of 10 out of 10, but the record lacked documentation of every 2 hour reassessments for effectiveness of the medication.</p> <p>11. The medical record for patient N12 indicated medication was given at 0951 on 09/01/13 for a stated pain level of 7 out of 10, but the record lacked documentation of a reassessment for effectiveness of the medication.</p> <p>12. The medical record for patient N16 indicated medication was given at 1043 on 10/19/13 for a stated pain level of 1 out of 10, but the record lacked documentation of a reassessment for effectiveness of the medication.</p> <p>13. The facility policy "Pain Management Guidelines", last revised 08/2013, indicated, "8. Documentation: A. All patients must have a pain assessment documented on admission and once per shift. B. All patients will have a reassessment of pain. C. If patient complains of pain or behavior indicates he/she is having pain: 1. Pain assessment must be documented in</p>		<p>Intensive Care, Chief Nursing officer, and Regulatory Survey Coordinator on February 13, 2014. No revisions were necessary. The policy states that all patients will have a reassessment of pain and that timing requirement for pain reassessment is two hours. See Attachment N 1. (b)Education was provided to nursing staff on February 21, 2014 by the Director of Medical Surgical / Oncology via Healthstream Education. This education was to re-enforce the requirement that all patients who require an intervention for pain must be reassessed within two hours. See Attachment N2. Compliance Monitoring(1) 100% of all Pediatric inpatients less than 24 months will be reviewed monthly times three months by the Women's Services director or her designee for compliance with policy "Assessment and Reassessment of Patients", IPC.DRI.005, to ensure these patients have head circumference assessed during their admission assessment. Aggregate data will be submitted to Hospital Leadership, Medical Executive Committee, and the Board of Trustees monthly times three months. See Attachment B. (2) 100% of all Newborn male medical records meeting criteria will be reviewed monthly for three months by the Women's Services Director or her designee for compliance with Policy</p>		

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	<p>Medication Administration Record (MAR) prior to medication administration. 2. Pain reassessment must be documented in Pain Assessment/Med Management screen post pain medication. ...5. The timing requirement for pain reassessment is two hours."</p> <p>14. At 4:30 PM on 02/05/14, staff members A1, A3, and A37 confirmed the medical record findings and indicated the assessments were not performed according to hospital policy and protocol.</p>		<p>"Assessment and Reassessment of Patients", IPC.DIR.005, to ensure these patients have appropriate assessment post circumcision according to guidelines present on physician standing order sets for Newborn circumcision. Aggregate data will be submitted to Hospital Leadership, Medical Executive Committee, and the Board of Trustees monthly times three months. See Attachment B.(3) At least 80% of inpatients who require an intervention for pain will be reviewed monthly for three months by the Chief Nursing Officer or her designee for compliance with Policy "Assessment and Reassessment of Patients", IPC.DIR.005, to ensure these patients have appropriate assessment post pain intervention. Aggregate data will be submitted to Hospital Leadership, Medical Executive Committee, and the Board of Trustees monthly times three months. See Attachment B. Implementation Date:March, 1 2014Responsible Person:(1) Director of Women's Services, Chief Nursing Officer(2) Director of Women's Services, Chief Nursing Officer(3) Chief Nursing officer and Directors of all Patient care Units.</p>		