

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  151304	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/28/2015
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NAME OF PROVIDER OR SUPPLIER  RUSH MEMORIAL HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 1300 N MAIN ST RUSHVILLE, IN 46173
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C000000	<p>This visit was for a re-certification survey.</p> <p>Facility Number: 005082</p> <p>Survey Date: 1-26/28-15</p> <p>Surveyors: Jack I. Cohen, MHA Medical Surveyor</p> <p>Marcia Anness, RN Public Health Nurse Surveyor</p> <p>Cleone Peterson Medical Surveyor</p> <p>QA: cloughlin 02/05/15</p>	C000000		
C000204	<p>485.618(b)(2) EQUIPMENT AND SUPPLIES [The items available must include the following:]</p> <p>Equipment and supplies commonly used in life saving procedures, including airways, endotracheal tubes, ambu bag/valve/mask, oxygen, tourniquets, immobilization devices, nasogastric tubes, splints, IV therapy supplies, suction machine, defibrillator, cardiac monitor, chest tubes, and indwelling urinary catheters.</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 document review and interview, the facility failed to follow the manufacturer's recommendation and facility requirement to make daily checks of 1 automated external defibrillator.</p> <p>Findings:</p> <p>1. Review of an offsite facility (RMH Healthcare Associates Medical Professional Building) document entitled Daily Defibrillator Check Sheet, Month: Dec 1/4 North indicated checks were not made on 10 of 21 days the facility was open, as follows: December 8 through December 12 December 17 through December 19 December 24 December 26</p> <p>2. In interview on 1-28-2015 at 2:00 pm, facility staff confirmed checks were made each day the building was open and the building was not open on weekends. No other documentation was provided prior to exit.</p>	C000204	<p><b>C-0204</b> 1. How are you, the provider, going to correct the deficiency? If already corrected, include the steps taken and the date of correction. <b>ZOLL AEDPlus External Defibrillator - Model 8000-0856 (Located at the Rush Memorial Hospital Health Care Associates North Building) Since the manufacturer's suggested frequency to perform a PM on this piece of equipment is "at a minimum monthly inspections are required", the Maintenance Department will assume responsibility to perform a PM check on this piece of equipment on a weekly basis. The preventative maintenance plan will include the appropriate frequency of the manufacturer's recommended maintenance schedule. It will also include detailed information on what is being checked per the manufacturer's recommendations. The maintenance departments staff will be trained on the changes to assure the PMs are done in an accurate and timely manner.</b></p> <p>2. How are you, the provider, going to prevent the finding and/or deficiency from recurring in the future? <b>The Facility Director (or Maintenance Supervisor) will conduct a monthly check to assure that the PMs have been done and</b></p>	02/26/2015	

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C000224	<p>485.623(b)(3) MAINTENANCE [The CAH has housekeeping and preventive maintenance programs to ensure that--]</p> <p>drugs and biologicals are appropriately stored; Based on observation, it could not be determined the facility followed the manufacturer's instruction to store contrast media within the proper temperature range in 1 instance.</p> <p>Findings:</p> <p>1. On 1-26-2015 at 1:30 pm, in the presence of employee #A6, Director of Maintenance, it was observed in the CT (computerized tomography) Scanner</p>	C000224	<p><b>documented per state regulations. 3. Who is going to be responsible for numbers 1 and 2 above? The Facility Director will be responsible for Items 1 &amp; 2 above. 4. By what date are you, the provider, going to have the finding and/or deficiency corrected? The deficiencies mentioned above are anticipated to be corrected by February 16th 2015. Plan of action: 30 day period (January 26, 2015 through February 26, 2015): PM for the ZOLL AEDPlus external defibrillator will be established and the maintenance department will be trained on the changes.</b></p> <p>SUBJECT: Use of contrast Media Warmer REFERENCE: DEPARTMENT OF IMAGING APPROVED BY: Terry J. Aker, R.T. Effective: February 28, 2015 Revised: Reviewed: PURPOSE: To define the Department of Imaging guidelines for use of contrast media warmers and contrast warmer logs. POLICY: 1. Contrast media warmers are used to warm IV contrast media which may be stored at temperatures up to 37 degrees Celsius for up to one</p>	02/28/2015	

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C000292	<p>Room, there were 9 bottles of Iso-Vue 370 contrast media, 300 ml each, in a warming box. The manufacturer's label on each bottle indicated to store at temperature 68-77 degrees Fahrenheit. It was also observed there was no thermometer or other method to determine the temperature of the warming box.</p> <p>2. In interview on the above date and time, employee #A8, Radiology Director, confirmed the above, provided no temperature log, and no other documentation was provided prior to exit.</p>		<p>month. 2. Contrast media warmers are not used for long-term storage of contrast media. Consult the contrast Media storage for the pertinent package insert for storage recommendation. All bottles/vials/flexible containers must have a use before date sticker on them. 3. The Radiographer should mark each bottle/vial/flexible container as to the date and time the bottle/vial/flexible container was initially placed in the warmer. 4. Minimize "door opening" time to assure that the warmer is maintained at the proper temperature. 5. The contrast warmer will have a log placed by it. The temperature must be logged by the CT Radiographer everyday that the department is open to insure that the warmer is working properly. 6. If the temperature falls into a range that exceeds acceptable, the unit will be unplugged immediately and the Director of Imaging notified. <u>Update: Tag #C224:</u> Contrast media will be monitored on a daily basis to ensure proper temperature per manufacturer's specification. Monitoring will be performed by the Radiology Director and reported quarterly at Quality Improvement Committee meetings. Date of Compliance: February 28, 2015 and ongoing</p>		

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	<p><b>AGREEMENT/ARRANGEMENT</b></p> <p>The person principally responsible for the operation of the CAH under §485.627(b)(2) of this chapter is also responsible for the following:</p> <p>(i) Services furnished in the CAH whether or not they are furnished under arrangements or agreements.</p> <p>(ii) Ensuring that a contractor of services (including one for shared services and joint ventures) furnishes services that enable the CAH to comply with all applicable conditions of participation and standards for the contracted services.</p> <p>Based on document review and interview, the hospital failed to ensure contractors met standards for 2 of 8 services (social services, teleradiologist) provided by the contractors.</p> <p>Findings:</p> <p>1. Review of the facility's QAPI program for calendar year 2014 indicated it did not include monitors and standards for the contracted service of social services.</p> <p>2. In interview, on 1-28-2015 at 10:50 am, employee #A4, VP Operations/Risk &amp; Compliance, confirmed the above for social services and no further documentation was provided prior to exit.</p> <p>3. Review of 6 medical staff credential</p>	C000292	<p><b>PLAN OF CORRECTION:</b> 1. <i>Date this deficiency will be corrected: 2/28/2015</i> 2. <i>Describe what the facility did to correct the deficient practice for each client cited in the deficiency.</i> The Social Services Director was informed of the need for the service to participate in the hospital's QAPI program. The department submitted a minimum of one monitor with corresponding standard which will be included in the hospital's QAPI program, beginning with services provided in January 2014. 3. <i>Describe how the facility reviewed all clients in the facility that could be affected by the same deficient practice, and state, what actions the facility took to correct the deficient practice for any client the facility identified as being affected.</i> The hospital's Quality Improvement Committee reviewed all monitors and</p>	02/28/2015

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	<p>files reviewed indicated file MD#2, a contracted teleradiologist, did not have any documentation of outcome oriented performance evaluation.</p> <p>2. In interview, on 1-27-2015 at 3:20 pm, employee #A7, Medical Staff Coordinator, provided a document for MD#2 which indicated the type and number of procedures interpreted. The document did not indicate any standards to be met by the contractor.</p>		<p>standards included in the hospital's QAPI program which are associated with contracted services to ensure all contracted services are included in the QAPI program. 4. Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur, including any in-services, but this also should include any system changes you made. The hospital's Quality Assurance and Improvement Plan will be amended to include an expectation that monitors and standards for all contracted services will be included in the hospital's QAPI program. 5. Describe how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. a. Monitoring should include: i. Who is responsible ii. The system by which the responsible person(s) will monitor iii. Frequency of monitoring. If "random" monitoring is indicated, a specific time frame needs to be included, i.e., weekly, monthly, etc. iv. Monitoring should be on-going. If you indicate you will monitor for 6 months or less then QA will determine further need for monitoring, you will need to describe the criteria QA will use to determine whether further monitoring is necessary or if the monitoring can be stopped. The annual review of the hospital's</p>	

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			<p>Quality Assurance and Improvement Plan will include a review of all QAPI monitors and standards associated with contracted services as performed by the hospital's Quality Improvement Committee to ensure that all contracted services are included in the QAPI program. The Lead Quality and Safety Programs Liaison will coordinate the review performed by the Committee. If/when contracted services are added to the hospital's service listings, the Vice-President and/or director responsible for the utilization or coordination of the use of the service will be responsible for submitting a minimum of one monitor and standard to be included in the hospital's QAPI program at the time the service is added. Department/program leadership will be responsible for reporting results associated with the monitor and standard on an annual basis at a minimum.</p> <p><u>CITATION:</u> BASED ON DOCUMENT REVIEW AND INTERVIEW, THE FACILITY FAILED TO BIENNIALY REVIEW OUTCOME ORIENTED PERFORMANCE EVALUATION FOR 1 OF 6 MEDICAL STAFF CREDENTIAL FILES REVIEWED. (Teleradiologist)</p> <p>Resolution: This issue will be corrected by accepting a "qualitative and quantitative" report from our contracted radiology group. The report lists the types of reads, the</p>		

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C000301	<p>485.638(a)(1) RECORDS SYSTEMS The CAH maintains a clinical records system in accordance with written policies and procedures. Based on observation, the facility failed to ensure medical records were adequately protected from damage due to water and fire in 1 instance.</p> <p>Findings:</p> <p>1. On 1-26-2015 at 1:45 pm, in the presence of employee #A6, Director of Maintenance, it was observed in the medical record storage area, the room was unsprinklered. It was also observed there were 24 shelves of medical records which were on open shelves and not protected from damage due to water and fire.</p>	C000301	<p>number of reads, problems/concerns, peer review issues. At the time of the SBOH survey, the information could not be retrieved from the contracted group. Upcoming reappointments will include a qualitative report.</p> <p>Fire proof curtains have been purchased. Will install once item arrives. Please see attached. Update: <u>Tag #C301</u>: Fire proof curtains have been purchased. Installation will be conducted once curtains have been received. Maintenance Department Director will ensure the curtains have been installed according to manufacturer's guidelines. Date of Compliance: April 1, 2015</p>	04/01/2015

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C000404	<p>485.645(d)(8) DENTAL SERVICES [The CAH is substantially in compliance with the following SNF requirements contained in subpart B of part 483 of this chapter:]</p> <p>Dental services (§483.55 of this chapter):</p> <p>"The facility must assist residents in obtaining routine and 24-hour emergency dental care."</p> <p>Based on interview, the facility failed to ensure the provision of routine dental services.</p> <p>Findings:</p> <p>1. In interview, on 1-26-2015, employee #A1, President/CEO, indicated the facility did not provide dental services.</p>	C000404	<p><u>CITATION:</u> THE FACILITY DOES NOT PROVIDE DENTAL SERVICES. Resolution: The services of local dentists will be requested and dentist(s) will be credentialed according to Medical Staff Bylaws. Update: <u>Tag #C404:</u> Letters have been issued to two local dentists in an effort to recruit their services. Once an agreement has been reached, a Medical Staff application will be forwarded and the credentialing process will begin. The Medical Staff Coordinator will forward the completed Medical Staff application to the Credentials Committee and to the Board of Trustees for final approval. Date of completion: June 30, 2015. Compliance will be conjunction with the Medical Staff Coordinator and Chief of Staff. Reappointments are conducted every two years to ensure compliance with Medical Staff Bylaws.</p>	06/30/2015			
S000000	This visit was for a standard licensure	S000000					

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S000330	<p>survey.</p> <p>Facility Number: 005082</p> <p>Survey Date: 1-26/28-15</p> <p>Surveyors: Jack I. Cohen, MHA Medical Surveyor</p> <p>Marcia Anness, RN Public Health Nurse Surveyor</p> <p>Cleone Peterson Medical Surveyor</p> <p>QA: claughlin 02/05/15</p> <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:</p> <p>(K) Maintaining personnel records for each employee of the hospital which include personal data, education and</p>			

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	<p>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 interview, the facility failed to ensure that employees had current tuberculosis immunity on 29 of 30 personnel.</p> <p>Finding include:</p> <p>1. Review of EMPLOYEE HEALTH POLICY, revised April 2008, pages 1 and 2, under "<u>PROCEDURE</u>, 1. Pre-Employment Screening (Individual), A. All new individuals are required to have a two-step (1-3 weeks after initial test) Mantoux Skin Test unless he/she has known history of positive reactions or has documentation of a negative test completed within the past year" and "2. Annual Screening (Individual), A. Screening will be required for every (Individual) (Person) each March <u>unless</u> documentation of a negative Mantoux test within the last three (3) months is provided".</p> <p>2. Review of facility personnel records indicated that P1, P2, P3, P4, P6, P7, P8, P9, P10, SP11, SP12, SP13, SP14, SP15, SP16, SP17, SP18, SP19, SP20, N1, N2,</p>	S000330	<p>Citation Text Based on document review and interview, the facility failed to ensure that employees had current tuberculosis immunity on 29 of 30 personnel. Findings include: 1. Review of Employee Health policy, revised April 2008, pages 1 and 2, under "Procedure, 1. Pre-Employment Screening (Individual), A. All new individuals are required to have a two-step (1-3 weeks after initial test) Mantoux Skin Test unless he/she has known history of positive reactions or has documentation of a negative test completed within the past year" and "2. Annual Screening (Individual), A. Screening will be required for every (Individual) (Person) each March unless documentation of a negative Mantoux test within the last three (3) months is provided".</p> <p>2. Review of facility personnel records indicated that P1, P2, P3, P4, P6, P7, P8, P9, P10, SP11, SP12, SP13, SP14, SP15, SP16, SP17, SP18, SP19, SP20, N1, N2, N3, N4, N5, N6, N7, N8, N9 and N10 did not have any documentation of current tuberculosis immunity. 3. In interview, on 1-27-2015 at 1:35pm, employee #A2, Vice</p>	02/28/2015

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	N3, N4, N5, N6, N7, N8, N9 and N10 did not have any documentation of current tuberculosis immunity.  3. In interview, on 1-27-2015 at 1:35 pm, employee #A2, Vice President Human Resources, confirmed the lack of documentation and no further documentation was provided prior to exit.		President Human Resources, confirmed the lack of documentation and no further documentation was provided prior to exit. <b>PLAN OF CORRECTION:</b> 1. <i>Date this deficiency will be corrected:</i> 2/28/2015 2. <i>Describe what the facility did to correct the deficient practice for each client cited in the deficiency.</i> The Employee Health policy with regards to employee tuberculosis testing was reviewed and amended by the Employee Health Committee to eliminate a requirement for annual testing and implement the use of an annual Tuberculosis Risk Assessment to be completed by all employees on an annual basis. Employees who have received the initial TB test or chest x-ray required during the first year of employment will be exempt from this requirement. The Employee Health Committee includes representation from Infection Control, hospital administration, human resources and nursing at a minimum. The policy change(s) will be submitted to the Infection Control Committee for additional input. 3. <i>Describe how the facility reviewed all clients in the facility that could be affected by the same deficient practice, and state, what actions the facility took to correct the deficient practice for any client the facility identified as being affected.</i> The		

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			Employee Health policies included in the Employee Health Policy Manual affect all employees, so the review and amending of tuberculosis testing policy which was performed by the Employee Health Committee should correct the deficient practice for all hospital employees. 4. Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur, including any in-services, but this also should include any system changes you made. The policies in the Employee Health Policy Manual will be reviewed on a triannual basis at a minimum. Policy changes will be shared with the employees as they are made and approved. 5. Describe how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. a. Monitoring should include: i. Who is responsible ii. The system by which the responsible person(s) will monitor iii. Frequency of monitoring. If "random" monitoring is indicated, a specific time frame needs to be included, i.e., weekly, monthly, etc. iv. Monitoring should be on-going. If you indicate you will monitor for 6 months or less then QA will determine further need for monitoring, you will need to describe the criteria QA will use		

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S000406	410 IAC 15-1.4-2 QUALITY ASSESSMENT AND IMPROVEMENT 410 IAC 15-1.4-2(a)(1)  (a) The hospital shall have an effective, organized, hospital-wide, comprehensive quality assessment and improvement program in which all areas		<i>to determine whether further monitoring is necessary or if the monitoring can be stopped.</i> The policies in the Employee Health Policy Manual will be reviewed on a triannual basis at a minimum. The review will be coordinated by the hospital's Infection Preventionist. An audit will be performed of a minimum of 5% of the hospital's individual Employee Health records to assess for the presence of completed Tuberculosis Risk Assessments before February 28, 2016. Update: <u>Tag #S-0330</u> : At the recommendation of the Employee Health Committee, the Employee Health policy was amended to require all employees complete a Tuberculosis Risk Assessment on an annual basis. Deb Hummel, Quality Improvement Director will be responsible to ensure policy is followed. Date of compliance February 28, 2015.	

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	<p>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. Based on document review and interview, the hospital failed to include monitors and standards for 1 service provided by a contractor as part of its comprehensive quality assessment and performance improvement (QAPI) program for calendar year 2014.</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>1. Review of the facility's QAPI program for calendar year 2014 indicated it did not include monitors and standards for the contracted service of social services.</li> <li>2. In interview, on 1-28-2015 at 10:50 am, employee #A4, VP Operations/Risk &amp; Compliance, confirmed the above for social services and no further documentation was provided prior to exit.</li> </ol>	S000406	<p>Citation Text</p> <p>Based on document review and interview, the hospital failed to include monitors and standards for 1 service provided by a contractor as part of its comprehensive quality assessment and performance improvement (QAPI) program for calendar year 2014.</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>1. Review of the facility's QAPI program for calendar year 2014 indicated it did not include monitors and standards for the contracted service of social services.</li> <li>2. In interview, on 1-28-2015 at 10:50am, employee #A4, VP Operations/Risk &amp; Compliance, confirmed the above for social services and no further documentation was provided prior to exit.</li> </ol> <p><b>PLAN OF CORRECTION:</b></p>	02/28/2015	

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			<p>1. <i>Date this deficiency will be corrected:</i> 2/28/2015</p> <p>2. <i>Describe what the facility did to correct the deficient practice for each client cited in the deficiency.</i></p> <p>The Social Services Director was informed of the need for the service to participate in the hospital's QAPI program. The department submitted a minimum of one monitor with corresponding standard which will be included in the hospital's QAPI program, beginning with services provided in January 2014.</p> <p>3. <i>Describe how the facility reviewed all clients in the facility that could be affected by the same deficient practice, and state, what actions the facility took to correct the deficient practice for any client the facility identified as being affected.</i></p> <p>The hospital's Quality Improvement Committee reviewed all monitors and standards included in the hospital's QAPI program which are associated with contracted services to ensure all contracted services are included in the QAPI program.</p>	

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			<p>4. Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur, including any in-services, but this also should include any system changes you made.</p> <p>The hospital's Quality Assurance and Improvement Plan will be amended to include an expectation that monitors and standards for all contracted services will be included in the hospital's QAPI program.</p> <p>5. Describe how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.</p> <p>a. Monitoring should include:</p> <p>i. Who is responsible</p> <p>ii. The system by which the responsible person(s) will monitor</p> <p>iii. Frequency of monitoring. If "random" monitoring is indicated, a specific time frame needs to be included, i.e., weekly, monthly, etc.</p>	

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			<p>iv. <i>Monitoring should be on-going. If you indicate you will monitor for 6 months or less then QA will determine further need for monitoring, you will need to describe the criteria QA will use to determine whether further monitoring is necessary or if the monitoring can be stopped.</i></p> <p>The annual review of the hospital's Quality Assurance and Improvement Plan will include a review of all QAPI monitors and standards associated with contracted services as performed by the hospital's Quality Improvement Committee to ensure that all contracted services are included in the QAPI program. The Lead Quality and Safety Programs Liaison will coordinate the review performed by the Committee.</p> <p>If/when contracted services are added to the hospital's service listings, the Vice-President and/or director responsible for the utilization or coordination of the use of the service will be responsible for submitting a minimum of one monitor and standard to be included in the hospital's QAPI program at the time the service is added. Department/program leadership will be responsible for reporting results associated with the monitor and standard on an annual basis at a minimum.</p>		

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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, it could not be determined the facility followed the manufacturer's instruction to store contrast media within the proper temperature range in 1 instance.</p> <p>Findings:</p> <p>1. On 1-26-2015 at 1:30 pm, in the presence of employee #A6, Director of Maintenance, it was observed in the CT (computerized tomography) Scanner Room, there were 9 bottles of Iso-Vue 370 contrast media, 300 ml each, in a warming box. The manufacturer's label on each bottle indicated to store at temperature 68-77 degrees Fahrenheit. It was also observed there was no thermometer or other method to determine the temperature of the warming box.</p>	S000554	<p>SUBJECT: Use of contrast Media Warmer REFERENCE: DEPARTMENT OF IMAGING APPROVED BY: Terry J. Aker, R.T. Effective: February 28, 2015 Revised: Reviewed: PURPOSE: To define the Department of Imaging guidelines for use of contrast media warmers and contrast warmer logs. POLICY: 1. Contrast media warmers are used to warm IV contrast media which may be stored at temperatures up to 37 degrees Celsius for up to one month. 2. Contrast media warmers are not used for long-term storage of contrast media. Consult the contrast Media storage for the pertinent package insert for storage recommendation. All bottles/vials/flexible containers must have a use before date sticker on them. 3. The Radiographer should mark each</p>	02/28/2015

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S000804	<p>2. In interview on the above date and time, employee #A8, Radiology Director, confirmed the above, provided no temperature log, and no other documentation was provided prior to exit.</p> <p>410 IAC 15-1.5-5 MEDICAL STAFF 410 IAC 15-1.5-5(a)(1)</p> <p>(a) The hospital shall have an organized medical staff that operates under bylaws approved by the governing</p>		<p>bottle/vial/flexible container as to the date and time the bottle/vial/flexible container was initially placed in the warmer.</p> <p>4. Minimize "door opening" time to assure that the warmer is maintained at the proper temperature. 5. The contrast warmer will have a log placed by it. The temperature must be logged by the CT Radiographer everyday that the department is open to insure that the warmer is working properly. 6. If the temperature falls into a range that exceeds acceptable, the unit will be unplugged immediately and the Director of Imaging notified.</p> <p>Update: <u>Tag #S-0554:</u> Contrast media will be monitored on a daily basis to ensure proper temperature per manufacturer's specification. Monitoring will be performed by the Radiology Director and reported quarterly at Quality Improvement Committee meetings. Date of Compliance: February 28, 2015 and ongoing.</p>				

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	<p>board and is responsible to the governing board for the quality of medical care provided to patients. The medical staff shall be composed of two (2) or more physicians and other practitioners as appointed by the governing board and do the following:</p> <p>(1) Conduct outcome oriented performance evaluations of its members at least biennially.</p> <p>Based on document review and interview, the facility failed to biennially review outcome oriented performance evaluation for 1 (MD#2) of 6 medical staff credential files reviewed.</p> <p>Findings:</p> <p>1. Review of 6 medical staff credential files reviewed indicated file MD#2, a teleradiologist, did not have any documentation of outcome oriented performance evaluation.</p> <p>2. In interview, on 1-27-2015 at 3:20 pm, employee #A7, Medical Staff Coordinator, provided a document for MD#2 which indicated the type and number of procedures interpreted. The document indicated only quantitative and not qualitative data, because there were no outcomes.</p>	S000804	<p><u>CITATION</u>: BASED ON DOCUMENT REVIEW AND INTERVIEW, THE FACILITY FAILED TO BIENNIALLY REVIEW OUTCOME ORIENTED PERFORMANCE EVALUATION FOR 1 OF 6 MEDICAL STAFF CREDENTIAL FILES REVIEWED. (Teleradiologist) Resolution: This issue will be corrected by accepting a "qualitative and quantitative" report from our contracted radiology group. The report lists the types of reads, the number of reads, problems/concerns, peer review issues. At the time of the SBOH survey, the information could not be retrieved from the contracted group. Upcoming reappointments will include a qualitative report.</p> <p>Update: <u>Tag #S804</u>: The Medical Staff Coordinator, in conjunction with the contracted teleradiologist groups, will collect quality as well as quantitative information on a quarterly</p>	02/13/2015	

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S000952	<p>410 IAC 15-1.5-6 NURSING SERVICE 410 IAC 15-1.5-6(d)</p> <p>(d) Blood transfusions and intravenous medications shall be administered in accordance with state law and approved medical staff policies and procedures. If the blood transfusions and intravenous medications are administered by personnel other than physicians, the personnel shall have special training for these procedures in accordance with subsection (b)(6). Based on policy/procedure review, transfusion record review, and staff interview, the facility failed to follow approved medical staff policies/procedures for the administration of blood transfusions for 2 (T#5, T#6) of 7 of the patient transfusions records reviewed.</p> <p>Findings included: 1. Review of the "Rush Memorial</p>	S000952	<p>basis. This information will be included in a physician profile, which will be reviewed quarterly and used at the time of reappointment to determine appropriate quality of care given. Date of compliance: February 13, 2015 and ongoing.</p> <p>Citation Based on policy/procedure review, transfusion record review, and staff interview, the facility failed to follow approved medical staff policies/procedures for the administration of blood transfusions Resolution: Continue to educate staff on current policy regarding blood transfusion. Discuss with Cerner/electronic health record to the possibility of more clearly defining vital sign times.</p>	03/02/2015

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S001168	<p>Hospital Blood and Blood Product Administration Policy, Section Number: 115, Revision Date: 11/20/14," revealed: "Procedure, Obtain vital signs and record on transfusion form, Recheck vital signs 15 minutes after starting transfusion, Recheck vital signs 30 minutes after starting transfusion,, Continue to check and record vital signs according to the paper Blood Product Transfusion Form, "(each hour until completion and 1 hour post completion).</p> <p>2. Review of 7 patient transfusion records indicated there was no documentation of the vital signs labeled according to policy, or the paper Blood Product Transfusion form for T#5 and T#6.</p> <p>3. In interview on 1/27/15, SP#6, lab director, acknowledged the facility went to electronic records recently and did not realize the electronic record did not properly document the vitals times in the transfusion records.</p> <p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 150-1.5-8 (d)(3)</p>		<p>Update: <u>Tag S-0952</u>: Blood transfusions are given according to policy, however, with the new electronic medical record, the program does not time stamp the transfusion. We have spoken with the software developer, Cerner, who is looking into a program that would clearly define blood transfusion times. We have since implemented a work flow process to include documentation of blood transfusion time when documenting vital signs. Audits will be performed by the VP of Nursing to ensure this process is being completed. This process will also become a routine monitor for our Quality Improvement program, which will be reported quarterly by the VP of Nursing at Quality Improvement Committee meetings. Date of compliance is March 2, 2015 and ongoing.</p>		

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	<p>(d) The equipment requirements are as follows:</p> <p>(3) Defibrillators shall be discharged at least in accordance with manufacturers recommendations and a discharge log with initialed entries shall be maintained.</p> <p>Based on document review and interview, the facility failed to follow the manufacturer's recommendation and facility requirement to make daily checks of 1 automated external defibrillator.</p> <p>Findings:</p> <p>1. Review of an offsite facility (RMH Healthcare Associates Medical Professional Building)document entitled Daily Defibrillator Check Sheet, Month: Dec 1/4 North indicated checks were not made on 10 of 21 days the facility was open, as follows: December 8 through December 12 December 17 through December 19 December 24 December 26</p> <p>2. In interview on 1-28-2015 at 2:00 pm, facility staff confirmed checks were made each day the building was open and the building was not open on weekends. No other documentation was provided prior to exit.</p>	S001168	<p>Tag # C1168</p> <p>1. How are you, the provider, going to correct the deficiency? If already corrected, include the steps taken and the date of correction.</p> <p><b>ZOLL AEDPlus External Defibrillator - Model 8000-0856</b></p> <p><b>(Located at the Rush Memorial Hospital Health Care Associates North Building)</b></p> <p>Since the manufacturer's suggested frequency to perform a PM on this piece of equipment is "at a minimum monthly inspections are required", the Maintenance Department will assume responsibility to perform a PM check on this piece of equipment on a weekly basis.</p> <p>The preventative maintenance plan will include the appropriate frequency of the</p>	02/26/2015

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			<p><b>manufacturer's recommended maintenance schedule. It will also include detailed information on what is being checked per the manufacturer's recommendations. The maintenance departments staff will be trained on the changes to assure the PMs are done in an accurate and timely manner.</b></p> <p>2. <i>How are you, the provider, going to prevent the finding and/or deficiency from recurring in the future?</i></p> <p><b>The Facility Director (or Maintenance Supervisor) will conduct a monthly check to assure that the PMs have been done and documented per state regulations.</b></p> <p>3. <i>Who is going to be responsible for numbers 1 and 2 above?</i></p> <p><b>The Facility Director will be responsible for Items 1 &amp; 2 above.</b></p> <p>4. <i>By what date are you, the provider, going to have the finding and/or deficiency corrected?</i></p> <p><b>The deficiencies mentioned above are anticipated to be corrected by February 16th 2015.</b></p> <p>Plan of action:</p> <p><b>30 day period (January 26, 2015 through February 26,2015): PM for</b></p>	

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			the ZOLL AEDPlus external defibrillator will be established and the maintenance department will be trained on the changes.		