

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152013	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 06/11/2015
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S 0000 Bldg. 00	This visit was for a standard licensure survey. Facility Number: 008900 Survey Date: 06-10/11-2015 QA: cjl 06/30/15	S 0000		
S 0308 Bldg. 00	410 IAC 15-1.4-1 GOVERNING BOARD 15-1.4-2 (c)(6)(B) (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: (B) Orientation of all new employees, including contract and agency personnel, to applicable hospital, department, service, and personnel policies. Based on document review and interview, the hospital failed to ensure a policy to orient new employees to applicable department policies and failed to orient 6 of 9 employees to applicable department policies.	S 0308	S 0308 410 IAC 15-1.4-1 Governing Board 1. On July 7, 2015 Policy and Procedures were reviewed regarding orientation and unit based competency expectations. The organization has a General Orientation Policy that applies to all newly hired	07/07/2015

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>Findings:</p> <ol style="list-style-type: none"> 1. In interview, on 6-11-2015 at 2:50 pm, employee #A5, Health Information Credentialing, indicated the hospital had no policy on orientation of new employees to applicable department policies. 2. Review of 9 personnel files indicated files PF1, radiology tech, PF2, medical records director, PF5, speech pathologist, PF7, plant operations director, PF8, housekeeper, and PF9, pharmacist had no documentation to applicable department policies. 3. In interview, on the above date and time, employee #A5 confirmed all the above and no other documentation was provided prior to exit. 		<p>employees. The policy is readily accessible on the hospital intranet under HR – Section III / Orientation – General. Additionally, all employees have unit specific requirements for orientation. New employees will be instructed during general orientation regarding compliance with check-off lists and competencies by the Human Resources Coordinator. Every employee is required to abide by this policy and practice. The training checklists are maintained in the employee personnel files and follow-up will be conducted within areas of deficiency beginning with the 43 employees who have come through orientation since May of 2015. The Chief Nursing Officer (CNO) and the Human Resources Coordinator (HRC) will track orientation progress each month following orientation and at 90 days. Individual action plans will be developed with the employee for areas of deficiency to ensure completion by 90 days. Results will be reported at the monthly Quality Assurance Performance Improvement (QAPI) meetings, and the quarterly meetings of the Organizational Improvement Committee (OIC) and to the Governing Board (GB). ·Responsible Parties: Chief Nursing Officer (CNO), Human Resource Coordinator (HRC) and the Chief Executive Officer (CEO).</p>		

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S 0330 Bldg. 00	410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1(c)(6)(K) (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		2. All department managers have been educated on the General Orientation Policy and the expectations regarding unit based competency training during a QAPI / Administrative Team Meeting (ATM) on June 16, 2015. Additionally, all employees have annual Mandatory Training Requirements. These are discipline specific. Since May 2015, all new employees (43) have had their unit based competencies reviewed and placed in their files. The Chief Nursing Officer (CNO) and the Human Resources Coordinator (HRC) will track orientation progress each month following orientation and at 90 days. Individual action plans will be developed with the employee for areas of deficiency to ensure completion by 90 days. Results will be reported and the monthly QAPI meetings, and the quarterly meetings of the OIC and the GB. ·Responsible Parties: Human Resources Coordinator and Chief Executive Officer.	

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	<p>for the following:</p> <p>(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 interview, the facility failed to ensure that employees had current tuberculosis immunity on 2 (N5 and N8) of 10 personnel.</p> <p>Finding:</p> <ol style="list-style-type: none"> 1. Review of facility personnel records indicated that N5 and N8 did not have any documentation of current (within 1 year) tuberculosis immunity. 2. In interview, on 6/11/2015 at 1000 hours, employee #N4 (Infection Control Practitioner) confirmed the lack of documentation and no further documentation was provided prior to exit. 	S 0330	<p>S 0330 410 IAC 15-1.4-1 GOVERNING BOARD</p> <p>The documentation in question is not required by our policy or our TB Control Plan. Per the annual TB Risk Assessment, our facility is deemed low risk. The local process of having each employee fill out a yearly questionnaire is in excess of the standard and was only non-compliant with our internal practice. We have discontinued the practice of having employees fill out questionnaires as of June 12, 2015 except in the case of exposure or outbreaks. The Infection Control nurse will administer the two-step TST upon hire as required and will follow-up in the case of outbreaks or exposure. Results will be reported to the monthly QAPI meetings, and the quarterly meetings of the OIC and GB.</p> <p>-Responsible Person: Infection</p>	06/12/2015	

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S 0554 Bldg. 00	<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, the facility created 5 conditions which failed to provide a healthful environment that minimized infection exposure and risk to patients, employees and visitors.</p> <p>Findings:</p> <p>1. On 6-10-2015 at 10:50 am in the presence of employee #A4, Director of Plant Operations, it was observed in the patient care dialysis room there was a renal dialysis machine with a drain hose. The tip of the hose was placed in the drain hole below the top plane of the hole. Thus, the space for air circulation was reduced, thereby potentially causing an environment for bacterial growth.</p> <p>2. On 6-10-2015 at 11:05 am, in the presence of employee #A4, it was observed in the Materials Management area, there were 14 packages of handtowels stored on an open shelf. The</p>			S 0554	<p>Control Nurse</p> <p>S 0554 410 IAC 15-1.5-2 INFECTION CONTROL 1. The Director of Plant Operations will reconfigure the water lines in the patient care dialysis unit to be in compliance with the standard by august 11, 2015. Completion of the work will be reported to the monthly QAPI meetings, and the quarterly meetings of the OIC and GB. Responsible Person: Director of Plant Operations, Infection Control Nurse 2. The manner of storing of paper hand towels has been changed. The packages will remain inside their original boxes with the flaps closed to protect them until issued for use. Plant Operations / EVS employees were educated on June 12, 2015 regarding this process by the Director of Plant Operations. Compliance will be monitored during Environment of Care (EOC) monthly rounding, and reported to the monthly QAPI meetings, and the quarterly meetings of the OIC and GB. Responsible Person: Director of Plant Operations. 3. The</p>		08/11/2015

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	<p>ends of the packages were not covered or enclosed while on the shelf. This posed the potential for cross-contamination of the items used on patients, employees and visitors.</p> <p>3. On 6-10-2015 at 11:15 am, in the presence of employee #A4, it was observed in the Materials Management area, there were 15 6.8 ounce containers of Ensure Therapeutic Nutrition, each having an expiration date of 1 Jun 2015. This posed the potential to administer expired supplement to patients.</p> <p>4. On 6-10-2015 at 11:35 am, in the presence of employee #A4, it was observed in room #1238, female locker room, and room #1237, male locker room, there was considerable dust on the top of the lockers.</p>		<p>Materials Manager has revised the process for checking the expiration dates on slower moving inventory. Expiration dates on existing inventory is now checked with every new delivery. On June 12, 2015, expiration dates were checked by Materials Management on existing inventory and then twice weekly thereafter with each new delivery. Audits will be checked monthly by the Materials Manager. The results will be reported to the monthly QAPI meetings, and the quarterly meetings of the OIC and GB Responsible Person: Materials Manager; Infection Control Nurse</p> <p>4. The Director of Plant Operations educated the lead housekeeper regarding locker cleanliness on June 12, 2015. The new protocol is to do a high clean three times a week. Locker inspections have been added to the monthly Environment of Care Rounds. Monthly EOC Rounds will now also be attended by The IC Nurse, CNO or DQM. Quarterly EOC rounds will be attended by the CEO. The results will be reported to the monthly QAPI meetings, and the quarterly meetings of the OIC and GB. Responsible Person: Director of Plant Operations, Infection Control Nurse</p>		

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S 1164 Bldg. 00	<p>410 IAC 15-1.5-8 PHYSICAL PLANT</p> <p>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. Based on interview, the hospital failed to provide evidence of preventive maintenance (PM) for 1 piece of equipment.</p> <p>Findings:</p> <p>1. On 6-10-2015 at 10:30 am, employee #A4, Director of Plant Operations, was requested to provide documentation of PM on the nurse emergency call (code) system.</p> <p>2. In interview, on 6-11-2015 at 9:10 am, employee #A4 indicated there was no documentation of PM on the above equioment and no documentation was provided prior to exit.</p>	S 1164	<p>S 1164 410 IAC 15-1.5-8 PHYSICAL PLANT In coordination with the Corporate Director of Plant Operations along with the Hospital Director of Plant Operations, a system for conducting semi-annual PM testing on the nurse emergency call system has been put into place. The PM has been added to the corporate master electronic PM schedule which will be monitored by the Director of Plant Operations. The first official PM testing of this system will be held by August 11, 2015. The manufacturer has also been consulted regarding standards and this process. The results will be reported to the monthly QAPI meetings, and the quarterly meetings of the OIC and GB. Responsible Party: Director of Plant Operations</p>	08/11/2015

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S 1186 Bldg. 00	<p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8 (f)(3)(A)(B)(C)(D)(E) (i)(ii)(iii)(iv)(v)</p> <p>(f) The safety management program shall include, but not be limited to, the following: (3) The safety program that includes, but is not limited to, the following:</p> <p>(A) Patient safety. (B) Health care worker safety. (C) Public and visitor safety. (D) Hazardous materials and wastes management in accordance with federal and state rules. (E) A written fire control plan that contains provisions for the following: (i) Prompt reporting of fires. (ii) Extinguishing of fires. (ii) Protection of patients, personnel, and guests. (iv) Evacuation. (v) Cooperation with firefighting authorities.</p> <p>Based on document review and interview, the facility failed to conduct fire drills in accordance with facility policy in 1 instance and the fire control plan failed to contain a provision for cooperation with firefighting authorities in 1 instance.</p> <p>Findings:</p> <p>1. Review of facility policy NUMBER: 228, entitled FIRE PLAN, Management</p>	S 1186	<p>S 1186 410 IAC 15-1.5-8 PHYSICAL PLANT 2 The organization missed one afternoon / evening shift fire drill as a result of an electronic scheduling problem. The Corporate Director of Plant Operations has verified that the system has been corrected and electronic work orders will now be generated for each fire drill on July 7, 2015. Two fire drills have taken place since the survey with appropriate documentation for each shift. The Director of Plant</p>	07/07/2015	

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S 1197 Bldg. 00	<p>Plan, Effective Date: 11-2812, indicated there will be a minimum of one (1) drill per shift per quarter.</p> <p>2. Review of a document entitle Environment of Care Preparedness Index 2014, indicated there was no fire drill conducted on the night shift in the third quarter (July, August, September).</p> <p>3. Review of the above-stated document indicated it contained no provision for cooperation with firefighting authorities.</p> <p>4. In interview, on 6-10-2015 at 3:55 pm, employee #A4, Director of Plant Operations, confirmed all the above and no further documentation was provided prior to exit.</p> <p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5 (f)(3)(F)</p> <p>(f) The safety management program shall include, but not be limited to, the following: (3) The safety program that includes, but is not limited to, the following:</p> <p>(F) Maintenance of written evidence of regular inspections and approval by state or local fire control agencies.</p>		<p>Operations will verify completion of required fire drills prior to the end of the quarter in the event of an electronic scheduling issue. The results will be reported to the monthly QAPI meetings, and the quarterly meetings of the OIC and GB. Responsible Party: Director of Plant Operations</p> <p>3. The Director of Plant Operations has requested both telephonically and electronically, the local Fire Department to participate in fire drills conducted at the hospital on July 7, 2015. This communication will be reported quarterly to the OIC and GB. Responsible Party: Director of Plant Operations</p>	

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	<p>Based on document review and interview, the hospital failed to have written documentation of a regular state or local fire inspection, or request of same, for calendar year 2014.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. Review of documentation indicated the last time the facility had written documentation of a regular state or local fire inspection, or request of same, was 11-9-2012. 2. In interview, on 6-10-2015 at 2:30 pm, employee #A4, Director of Plant Operations, indicated there was no request for a state or local fire inspection in calendar year 2014 and no further documentation was provided prior to exit. 	S 1197	<p>S 1197 410 IAC 15-1.5-8 PHYSICAL PLANT On July 8, 2015, The Fire Marshall was onsite to conduct a fire inspection of the facility. The report stated that there were no findings of deficiencies or violations. Plans have been scheduled with the Fire Marshall for annual inspections. Results will be reported annually to OIC and Governing Board. Responsible Party: Director of Plant Operations</p>	07/08/2015	