

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150023	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/24/2012
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NAME OF PROVIDER OR SUPPLIER UNION HOSPITAL INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1606 N SEVENTH ST TERRE HAUTE, IN 47804
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S0000	<p>This visit was for a State licensure survey.</p> <p>Facility #: 005022</p> <p>Survey Dates: 10-22/24-12</p> <p>Surveyors:</p> <p>Billie Jo Fritch RN, BSN, MBA Public Health Nurse Surveyor</p> <p>Jennifer Hembree RN Public Health Nurse Surveyor</p> <p>Ken Zeigler Laboratorian</p> <p>QA: cloughlin 11/09/12</p>	S0000		

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

TITLE

(X6) DATE

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

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S0744	<p>410 IAC 15-1.5-4 MEDICAL RECORD SERVICES 410 IAC 15-1.5-4 (e)(1)</p> <p>(e) All entries in the medical record shall be:</p> <p>(1) legible and complete; Based on document review and staff interview, the facility failed to ensure emergency department (ED) records for transfer patients were complete for 1 of 2 patients transferred.</p> <p>Findings include:</p> <p>1. Review of patient #N24 medical record indicated the following: (A) He/she was transferred from the ED on 10/11/12. (B) The risks section of the emergency department certification for transfer form was left blank.</p> <p>2. Staff member #8 verified the risks section was left blank on the medical record of patient #N24 beginning at 8:55 a.m. on 10/24/12.</p>	S0744	<p>a. All physicians will receive additional education on completing the transfer form in its entirety by 12/20/12b. All transfers from our facility will have a form completed.c. All transfer charts will be audited each day for completeness beginning 11/12/2012d. The ED abstractor will review transfer forms daily in HPF to verify transfer forms have been scanned into the medical record (HPF) and are completed. Any deficiencies will be reported weekly to management for employee and physician follow-up effective 11/26/12.Process Owner - ED Director</p>	12/20/2012	

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S0930	<p>410 IAC 15-1.5-6 NURSING SERVICE 410 IAC 15-1.5-6 (b)(3)</p> <p>(b) The nursing service shall have the following:</p> <p>(3) A registered nurse shall supervise and evaluate the care planned for and provided to each patient.</p> <p>Based on document review and staff interview, the facility failed to ensure physician orders were followed by the nursing staff for 1 of 3 critical care patients, 1 of 1 prison unit patient, and 2 of 2 ortho/neuro patients.</p> <p>Findings include:</p> <p>1. Review of critical care unit patient #N1 medical record indicated the following: (A) An order was written at 2145 on 6/30/12 for Lovenox stat. (B) Per review of the medical administration record, the Lovenox was not administered until 2336.</p> <p>2. Review of prison unit patient #N12 medical record indicated the following: (A) An order was written at 1407 on 7/24/12 for vital signs every 15 minutes until stable and then every hour for 8 hours. (B) Nursing documentation indicated the vital signs were taken at 1415 and were</p>	S0930	<p>1. A. and B. - Stat Order for LovenoxPhase I (to be done (12/3/2012)a. Pharmacy is building and implementing a plan to enter medications in to Pharmacy as STAT when written order indicates.b. STAT will appear on the order in medication Administration check System. Phase II (to be done 12/17/2012)a. Pharmacy building within pharmacy system/Medication Administration Check system to indicated all STAT medications, order start/date/time and administration date/time given for specified time period.b. Report distributed to clinical informatics and/or clinical managers for monitoring/counseling.c. Clinical Informatic to report to Vice President of Patient Care Services compliance results for a minimum 3 month period. Process owner - System Director, Pharmacy2. A. and B. Prison Unit vital signsPhase I (implementation date 11/27/2012)a. Clinical Managers or designee will manually audit 10 random charts a month for a</p>	07/16/2013	

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	<p>stable. The vitals were taken at 1557 and 2317 only on 7/24/12 and not every hour per physician order.</p> <p>3. Review of ortho/neuro unit patient #N4 indicated the following: (A) An order was written at 1430 on 6/15/12 for vital signs with neurological check to lower extremities every 2 hours x 4, then every 4 hours x 2, then routinely. (B) Nursing documentation indicated the neurological checks were completed at 2000 and midnight on 6/15/12 and 0800, 1305, and 2000 on 6/16/12 and not per physician order. (C) Nursing documentation indicated the vital signs were completed at 1610, 2021, and midnight on 6/15/12 and 0348, 0744, 1556, 1946, and 2341 on 6/16/12 and not per physician order.</p> <p>4. Review of ortho/neuro unit patient #N18 medical record on 10/23/12 indicated the following: (A) An order was written at 1300 on 10/22/12 for neurocirculatory checks of affected extremity every hour x 4 hours; every 2 hours x 8, then every 4 hours. (B) Nursing documentation indicated a neurocirculatory check had been conducted at 1505 on 10/22/12 only.</p> <p>5. RN #1 verified the medical record documentation for patient #N18 at 9:30</p>		<p>minimum of 3 months or until improved documentation of vital signs as ordered. Each month must be submitted by the end of the last calendar day for the month starting December 2012.b. Reports will be submitted to Clinical Informatics.c. Clinical Infomratics will report to the Vice President of patient care Services compliance results for a minimum of 3 month period. Process owners - Clinical Informatics Director/ Clinical Nursing Unit ManagersPhase II (implementation date 12/31/2012)a. Standardization of Vital Signs orders to be determined by apporpiate approval bodies and care councils.Process owners - Clinical Informatics Director/Clinical Nursing Unit ManagersPhase III (implementation date 7/16/2013)a. Building ordersets/orders to standardization within the electronic medical record.b. Downtime CPOE paper Ordersets will be revised with new standard.c. Build CPOE orders to include a link to the online documentation worklist specific for Vital Sign Documentation.Process owners - Clinical Informations Director/Clinical Nursing Unit Managers3. and 4. 5, and 6 A. and B. Ortho - Neuro Unit Neuro ChecksTarget implementation date 11/27/12a. Educational</p>		

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	a.m. on 10/23/12. 6. Staff member #8 verified the medical record documentation for patients #N1, N4, and N12 beginning at 8:55 a.m. on 10/24/12.		materials distributed to nursing staff on definitions, and field related to a neurological check vs. neurovascular check.b. Nursing order modified to include a link to the online documentation worklist specific for Neurovascular Checks documentation.c. Clinical Managers or designn will manually audit 10 radom charts a month for a minimum 3 months or until improved documetation of neurological checks as ordered. Each month must be submitted by the end of the last calendar day for the month starting December 2012.d. Reports submitted to Clinical Informatics Committee and this committee will report the compliance results to the Vice President of patient Care Services for a minimum of 3 months. Process Owner - Clinical Informatics Director/Clinica Nursing Unit Managers3. C - Ortho - Neuro Unit Vital SignsPhase I (implementation date 11/27/2012)a. Clinical Managers or designee will manually audit 10 random charts a month for a minimum of 3 months or until improved documentation of vital signs as ordered. Each month must be submitted by the end of the last calendar day for the month starting December 2012.b. Reports will be submitted to Clinical Informatics.c. Clinical Infomratics will report to the Vice President of patient care Services		

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			<p>compliance results for a minimum of 3 month period. Process owners - Clinical Informatics Director/ Clinical Nursing Unit ManagersPhase II (implementation date 12/31/2012)a. Standardization of Vital Signs orders to be determined by appropriate approval bodies and care councils.Process owners - Clinical Informatics Director/Clinical Nursing Unit ManagersPhase III (implementation date 7/16/2013)a. Building ordersets/orders to standardization within the electronic medical record.b. Downtime CPOE paper Ordersets will be revised with new standard.c. Build CPOE orders to include a link to the online documentation worklist specific for Vital Sign Documentation.Process owners - Clinical Informations Director/Clinical Nursing Unit ManagersPhase I (implementation date 11/27/2012)a. Clinical Managers or designee will manually audit 10 random charts a month for a minimum of 3 months or until improved documentation of vital signs as ordered. Each month must be submitted by the end of the last calendar day for the month starting December 2012.b. Reports will be submitted to Clinical Informatics.c. Clinical Infomratcs will report to the Vice</p>		

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			<p>President of patient care Services compliance results for a minimum of 3 month period. Process owners - Clinical Informatics Director/ Clinical Nursing Unit ManagersPhase II (implementation date 12/31/2012)a. Standardization of Vital Signs orders to be determined by appropriate approval bodies and care councils.Process owners - Clinical Informatics Director/Clinical Nursing Unit ManagersPhase III (implementation date 7/16/2013)a. Building ordersets/orders to standardization within the electronic medical record.b. Downtime CPOE paper Ordersets will be revised with new standard.c. Build CPOE orders to include a link to the online documentation worklist specific for Vital Sign Documentation.Process owners - Clinical Informations Director/Clinical Nursing Unit Managers</p>		

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S0952	<p>410 IAC 15-1.5-6 NURSING SERVICE 410 IAC 15-1.5-6(d)</p> <p>(d) Blood transfusions and intravenous medications shall be administered in accordance with state law and approved medical staff policies and procedures. If the blood transfusions and intravenous medications are administered by personnel other than physicians, the personnel shall have special training for these procedures in accordance with subsection (b)(6).</p> <p>Based on blood transfusion policy review, transfusion document chart reviews and staff interview, the hospital failed to administer blood transfusions in accordance with approved medical staff policies and procedure for two of twenty patients.</p> <p>Findings include:</p> <p>1. On 10/23/12 at 10:15 a.m., the policy, "Blood Administration/Reactions", policy #RX 25.020 (D), revised 11/10, read: "Blood should not hang for more than four hours. The four hour time limit begins at the time a unit is</p>	S0952	<p>1. Blood Administration Documentations. As soon as blood has been infused and the Blood Transfusion Record form is complete, it is to be given to the charge nurse. The charge nurse will review the record to see that documentation is completed according to policy and will initial the top left hand corner showing that the form has been reviewed.c. If there are any missing documentation elements that need addressed/corrected, it will be addressed at that ime with the individual responsible for the transfusion. If another unit is involved the charge nurse will cal the other charge nurse on that unit or department to address issues.d. The charge nurse will fill out a Blood Slip compliance form for any unfinished documentation or written error and go over this with the person involved with the error as education and training. This will be igned by the person involved that education had been</p>	11/23/2012	

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	<p>signed out of Blood Bank. Blood Bank will document time signed out on the Transfusion Record. Assess the vital signs after the first fifteen minutes of transfusion, and upon completion. (sic) Document the date, time and values on the Transfusion Record."</p> <p>2. On 10/23/12 at 10:15 a.m., review of two patients receiving blood units, indicated two of these received-units did not have complete documentation, per policy, on the Blood Transfusion Record form including:</p> <p>Patient #6 --Unit administered on 10/19/12 at 2305: The unit was released from the blood bank at 2237 and completed at 0245 which was 4 hours and 8 minutes in lieu of within 4 hours.</p> <p>Patient #10 --Unit administered on 10/20/12 at 2205: The unit was completed at 0045; however, there was no signature documentation for who completed</p>		<p>done. This copy is given to the Nursing Care manager to track for any patterns of non-compliance of policies and further disciplinary action may occur.e. The "yellow" copy Blood Transfusion Record will be sent by the pneumatic tube system back to The Med Lab. If the rube system is down or it is a department that does not have access to the pneumatic tube system the charge nurse is repsonsible to make sure all yellow copies of the Blood Transfusion Record is taken to The Med lab by the end of the shift.f. The white copy of the form will be placed on the patient's chart.Education will be completed with the charge nurses and staff by November 23, 2012. Process of auditing will begin November 24, 2012.Process Owners - Nursing Unit Charge Nurses; Vice President, Patient Care Services.</p>				

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	<p>the administered unit.</p> <p>3. On 10/23/12 at 10:15 a.m., staff member #19 indicated that the two above-listed patients had received blood without benefit of complete documentation, per policy, as required.</p>				

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S1028	<p>410 IAC 15-1.5-7 PHARMACEUTICAL SERVICES 410 IAC 15-1.5-7 (d)(2)(E)</p> <p>(d) Written policies and procedures shall be developed and implemented that include the following:</p> <p>(2) Ensure the monthly inspection of all areas where drugs and biologicals are stored and which address, but are not limited to, the following:</p> <p>(E) Security of and authorized access to all drug storage areas within the hospital, as approved by the medical staff, when the pharmacist is absent.</p> <p>Based on document review and observation, the facility failed to prevent unauthorized access to medications for 1 prison unit toured.</p> <p>Findings include:</p> <p>1. Facility policy titled "Pharmacy Services/Medication Use" last reviewed/revised 1/12 states on page 5 of 9: "8. Medications will be stored in locked or otherwise secured areas in accordance with applicable law and regulation."</p> <p>2. During tour of the locked federal prison unit beginning at 2:00 p.m. on 10/23/12 and accompanied by staff members #1 and #11 the following was observed:</p>	S1028	<p>Unsecured meds on Prison Unit. Education to be done with the nursing staff in the Prison Unit regarding: 1. MAK carts must be locked at all times and never left unattended; 2. A nurse will take the MAK cart with her when washing hands in between patients; 3. Pill splitters will be secured in the medication room and not put on the MAK carts.b. This education will be with all charge nurses and 80 % of staff by 11/23/2012 and 100% of staff by 12/5/2012.c. Formal plan of action: 1. nurse will prepare medications for dispensing in secured medication room; 2. pill splitter will be secured and used only in medication room; 3. medications will be clearly labeled for each patient and locked in MAK cart; 4. nurse will take MAK cart to bedside for armband scanning and will ensure that</p>	12/05/2012			

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	(A) RN #1 had medications including numerous pills as well as a bag of I.V. solution on top of his/her medication cart. He/she then walked away leaving the cart unattended. (B) Unauthorized personnel in the area included nine (9) officers.		drawers of MAK are locked and nothing is on top of the cart; 5. nurse will take MAK cart with her when washing hands between patients, never leaving the cart unattended.d. Through observations by the nursing care managers and charge nurses, staff will be held accountable if not following policy and the steps of disciplinary action will be followed for those who are not compliant.Process owners - Unit's manager and charge nurses		

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S1118	<p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8 (b)(2)</p> <p>(b) The condition of the physical plant and the overall hospital environment shall be developed and maintained in such a manner that the safety and well-being of patients are assured as follows:</p> <p>(2) No condition shall be created or maintained which may result in a hazard to patients, public, or employees.</p> <p>Based on observation and interview, the hospital created/maintained conditions that could result in a hazard to patients, public, and staff in 3 instances.</p> <p>Findings included:</p> <ol style="list-style-type: none"> 1. While touring the kitchen on 10/22/12 at 11:45, six loosely chained and unsecured soda gas cylinders capable of falling over were observed. 2. On 10/22/12 at 11:45 a.m. staff member #6 indicated the above-mentioned six soda gas cylinder were not tightly chained and secured. 	S1118	<p>1. and 2. Unsecured soda gass cylinersOn the day of the inspection (10/22/2012) the cyclinders were tightly secured to the corner of the wall with an eye bolt and chain. On Octoer 23, 2012, Coca Cola was notified to reduce the number of cylinders on the site to three and that they myust be secured to the wall. The manager of food services is responsible to ensure the cylinders stay at three and are tightly secured.Process owner - Manager of Food Services3. Unsecured meds on Prison Unita. Education to be done with the nursing staff in the Prison Unit regarding: 1. MAK carts must be locked at all times and never left unattended; 2. A nurse will take the MAK cart with her when washing hands in between patients; 3. Pill splitters will be secured in the medication room and not put on the MAK carts.b. This education will be with all</p>	11/24/2012	

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			charge nurses and 80 % of staff by 11/23/2012 and 100% of staff by 12/5/2012.c. Formal plan of action: 1. nurse will prepare medications for dispensing in secured medication room; 2. pill splitter will be secured and used only in medication room; 3. medications will be clearly labeled for each patient and locked in MAK cart; 4. nurse will take MAK cart to bedside for armband scanning and will ensure that drawers of MAK are locked and nothing is on top of the cart; 5. nurse will take MAK cart with her when washing hands between patients, never leaving the cart unattended.d. Through observations by the nursing care managers and charge nurses staff will be held accountable if not following policy and the steps of disciplinary action will be folloed for those who are not compliant.Process owners - Unit's manager and charge nurses4. and 6. - Hazardous Waste Container in CTa. Clarification was reviewed with staff about what goes in the black boxes.b. Clarification done with staff about when box is half full they are to request for the box to be replaced instead of waiting until it is full.Education done 10/23/2012Process owner - System Director Imaging Services5. Eye station in boiler rooma. New eye was station was installed beside the testing area (installed 10/26/2012)b. Staff	

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NAME OF PROVIDER OR SUPPLIER UNION HOSPITAL INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1606 N SEVENTH ST TERRE HAUTE, IN 47804
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>3. During tour of the locked prison unit beginning at 2:00 p.m. on 10/23/12, RN #1 was observed leaving the medication cart next to an offenders bed and went out of site of the cart to wash his/her hands. A pill splitter with a metal blade was observed on top of the cart.</p> <p>4. While touring the Radiology Department on 10-23-12 with B#15, B#16, B#22, B#20, B#21, and B#23 at 1015 hours, the Hazardous Waste container in Computed Tomography (CT) Room #2 was observed to be overflowing with hazardous waste and the lid could not be closed.</p> <p>5. While touring the boiler room area on 10-23-12 with B#15, B#16, B#22, and B#23 at 1115 hours, it was observed that the area where caustic chemicals are used for water testing did not have an eye wash station in that area.</p> <p>6. Interviews with B#20 and B#21 on 10-23-12 at 1015 hours in the CT Room #2 confirmed the hazardous waste container located in CT Room #2 was overflowing with hazardous waste, the lid could not be closed, and the container should not be over-filled.</p> <p>7. Interview with B#15 on 10-23-12 at 1115 hours in the boiler room area of the hospital confirmed there is no eye wash</p>		provided education regarding its use.Process owner - CEP Manager	

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	station in the area where water testing is done using caustic chemicals.				