

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150075	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/27/2013
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NAME OF PROVIDER OR SUPPLIER BLUFFTON REGIONAL MEDICAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 303 S MAIN ST BLUFFTON, IN 46714
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S000000	<p>The visit was for a Licensure survey.</p> <p>Facility Number: 005069</p> <p>Survey Date: 3-25-13 to 3-27-13</p> <p>Surveyors: Brian Montgomery, RN Public Health Nurse Surveyor</p> <p>Linda Plummer, RN Public Health Nurse Surveyor</p> <p>Steve Poore, BS MLT Medical Surveyor 3</p> <p>QA: claughlin 04/04/13</p>	S000000		

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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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> <p>Based upon observation and interview, the facility failed to post a copy of the State license in a common public area for one hospital off-site location.</p> <p>Findings:</p> <p>1. During a tour on 3-25-13 at 1445 hours of the hospital radiology and rehabilitation outpatient services, the following condition was observed: a copy of the hospital license was not posted in the common public areas of the outpatient location.</p> <p>2. During an interview on 3-27-13 at 1505 hours, staff A2 and A11 confirmed that the off-site location failed to display a copy of the State license in the common area of the building.</p>	S000178	<p>A copy of the hospital state license was placed in the waiting room of the outpatient rehabilitation department at the south campus. The responsible person for posting of hospital state license is the plant operations director.Measures to prevent reoccurrence. The Plant Operations director will conduct weekly observations of the posted license for three months or until 100% compliance is met. Findings will be presented to Quality Council with reports forwarded to Medical Executive committee and Board of Trustees.</p>	03/27/2013			

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S000332	<p>410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1(c)(6)(L)</p> <p>(c) The governing board is responsible for managing the hospital. The governing board shall do the following: (6) Require that the chief executive officer develops policies and programs for the following:</p> <p>(L) Demonstrating and documenting personnel competency in fulfilling assigned responsibilities and verifying inservicing in special procedures.</p> <p>Based on document review and interview, the hospital failed to require and document housekeeping personnel competency for Operating Room (OR) cleaning and disinfecting for 1 housekeeping personnel.</p> <p>Findings:</p> <p>1. The policy/procedure Surgery Department Cleaning (reviewed 1-11) failed to ensure that housekeeping personnel files contain documentation of competency for cleaning the surgical care areas as indicated by the Association of PeriOperative Registered Nurses (AORN) 2008 Recommended Practices for Environmental Cleaning in the Perioperative Setting.</p>	S000332	<p>The surgery director, infection control nurse, and housekeeping management staff met to revise Operating Room (OR) terminal cleaning policy on 04/18/2013. The OR terminal cleaning policy will be reviewed at Infection control committee on 05/07/2013. The surgery director will educate housekeeping staff on OR terminal cleaning policy and have OR cleaning staff demonstrate competency of cleaning OR. The responsible person for policy, education, and competency is the surgery director. Measures to prevent reoccurrence. The Human Resource director will conduct weekly audit of orientation and competency for OR housekeeping staff for three months or until 100% compliance is met. Findings will be presented to Quality Council with reports</p>	05/09/2013
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	<p>2. On 3-25-13 at 1130 hours, staff A2 and A3 was requested to provide documentation of competency for the housekeeping staff providing OR cleaning services at the hospital and none was provided prior to exit.</p> <p>3. The personnel file for housekeeper A20 failed to indicate documentation of competency validation according to specific criteria for cleaning and disinfecting the OR Rooms.</p> <p>4. During an interview on 3-27-13 at 1450 hours, staff A19 confirmed that the personnel file lacked documentation of competency validation.</p> <p>5. During an interview on 3-27-13 at 1545 hours, surgery manager A15 confirmed that they had not oriented and instructed A20 regarding acceptable standards of practice for cleaning and disinfecting the OR Rooms.</p>		forwarded to Medical Executive committee and Board of Trustees.		

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S000394	<p>410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1(f)(3)</p> <p>(f) The governing board is responsible for services delivered in the hospital whether or not they are delivered under contracts. The governing board shall insure the following:</p> <p>(3) That the hospital maintains a list of all contracted services, including the scope and nature of the services provided.</p> <p>Based on document review and interview, the facility failed to maintain a list of all contracted services, including the scope and nature of services provided for 7 contracted services.</p> <p>Findings:</p> <p>1. On 3-25-13 at 1530 hours, a list of all contracted services was received from staff A3. The list of services failed to indicate a service provider for air exchange testing, exhaust hoods, 2 fire services, laundry, pest control and ventilator service.</p> <p>2. Review of facility documentation indicated the following: air exchange testing by CS1, exhaust hoods were inspected by CS2, fire service providers included CS3 and CS4, laundry service by CS5, pest control by CS6 and ventilator service by CS7.</p>	S000394	<p>A complete list of contract services was compiled by Biomed manager and administration to include the scope and nature of the services. Measures to prevent reoccurrence. The Quality Director will review the list of contract services weekly to ensure all contracted services are current for three months or until 100% compliance is met. Findings will be presented to Quality Council with reports forwarded to Medical Executive committee and Board of Trustees.</p>	04/15/2013

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	3. On 3-27-13 at 1605 hours, staff A3 confirmed the list of contracted services failed to include the indicated service providers and confirmed that the list lacked a description of the scope and nature of services provided.			

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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. Based on document review and interview, the facility failed to include 2 direct services and 8 contracted services in its Quality Assessment and Performance Improvement (QAPI) program</p> <p>Findings:</p> <p>1. The Fourth Quarter 2012 Quarterly Outcomes report failed to indicate ongoing monitoring for the direct services of housekeeping and outpatient infusion therapy and the contracted services of air exchange testing, anesthesia machine service, exhaust hood certification, fire alarm maintenance and monitoring and fire sprinkler maintenance services, pest control, radiology equipment maintenance service and ventilator service.</p>	S000406	<p>The quality director added the two direct services and the eight contracted services into the Quality Assessment and Performance Program. Measures to prevent reoccurrence. The quality director will conduct an in-service on the appropriate evaluation of direct services and contracted services of the quality assessment and performance improvement program per policy. The quality director will conduct monthly monitoring of program for six months or until 100% compliance is met. Findings will be presented to Quality Council with reports forwarded to Medical Executive committee and Board of Trustees.</p>	04/24/2013			

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	<p>2. During an interview on 3-26-13 at 1510 hours, staff A14 confirmed that the contracted biomedical equipment service providers including anesthesia equipment and ventilator maintenance were not being evaluated and reviewed through the QAPI program.</p> <p>3. During an interview on 3-27-13 at 1605 hours, staff A3 confirmed that the QAPI program quarterly outcomes report lacked documentation of ongoing monitoring for the direct services of housekeeping and infusion therapy and the contracted services of air exchange testing, exhaust hoods, fire alarm and fire sprinkler services, pest control and radiology equipment service.</p>			

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S000556	<p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(b)</p> <p>(b) There shall be an active, effective, and written hospital-wide infection control program. Included in this program shall be system designed for the identification, surveillance, investigation, control, and prevention of infections and communicable diseases in patients and health care workers.</p> <p>Based on review of the 2012 (and February 2013) infection control committee meeting minutes and staff interview, the facility failed to ensure the infection control program was active and effective in relation to follow up to a concern addressed in the February and May 2012 meeting minutes.</p> <p>Findings:</p> <p>1. at 12:15 PM on 3/25/13, review of the infection control committee meeting minutes from 2/2012 through 2/2013 indicated:</p> <p>a. the first meeting of 2012 was on 2/7/12 and indicated in the section titled "Other", that there was a topic "Cleaning of Ice Machines" in which the ICP (infection control preventionist) noted "[ICP] reported concerns noted with cleaning the ice machines on a routine basis." "Recommendations/Action" was listed as: "Recommendation made to</p>	S000556	<p>The infection control preventionist has followed up on ice machine cleaning at Bluffton Regional Medical Center with the Plant operations director on 04/08/2013. The infection control preventionist will present her findings at the next Infection Control/Pathology committee meeting. Measures to prevent reoccurrence. The quality director will provide an in-service to quality staff (including infection control preventionist) on committee follow through. The in-service included the format of meetings, writing committee minutes, follow through, and agendas. The quality director will conduct monthly monitoring of committee minutes for six months or until 100% compliance is met. Findings will be presented to Quality Council with reports forwarded to Medical Executive committee and Board of Trustees.</p>	05/07/2013			

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	<p>discuss concerns with [physical plant manager] regarding cleaning of ice machines throughout the hospital." "Follow-up" indicated: "Place item of business on next agenda".</p> <p>b. the next committee meeting, on May 1, 2012, indicated in the section "Old Business" in the "Topic" section: "Ice Machines" with "Findings/Conclusions" reading: "[director of EVS (environmental services)] stated maintenance cleans ice machines on a quarterly basis. EVS cleans the outside of the machine. The company has a cleaner for the ice machine." In the "Recommendations/Action section , it reads: "Waiting arrival of ice machine cleaner from the company." And in the "Follow-up" section, it reads: "Continue to report quarterly."</p> <p>c. meetings were held August 7, 2012; November 6, 2012; and February 5, 2013 without any further documentation related to cleaning the ice machines on a routine basis and follow-up</p> <p>2. interview with staff member # 51, the director of quality, at 3:50 PM on 3/27/13, indicated:</p> <p>a. the May 1, 2012 infection control committee meeting minutes indicate there will be quarterly follow up to ice machine cleaning (and that the cleaning is also to occur quarterly)</p>						

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	<p>b. the first documented ice machine cleaning was 12/27/12 (the next was performed 3/1/13)</p> <p>c. the infection control committee failed to follow through with follow up related to the quarterly cleaning of the ice machines, as was indicated would happen in the 5/2012 meeting minutes</p>			

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S000596	<p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(f)(3)(D)(iii)</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>(iii) Cleaning, disinfection, and sterilization.</p> <p>Based on document review and interview, the infection control (IC) committee failed to document review and approval of housekeeping policies for cleaning and disinfecting related to operating room (OR) and sterile processing and ensure that the surgery area cleaning and disinfecting was performed in a safe and effective manner.</p> <p>Findings:</p> <p>1. The Infection Prevention Plan 2013 (approved 2-13) indicated the following: " The surveillance, prevention and control of infection cover processes and activities both in direct patient care and in patient care support coordinated and carried out by the hospital. "</p>	S000596	The surgery director, infection control nurse, and housekeeping management staff met to revise OR terminal cleaning policy on 04/19/2013. The OR terminal cleaning policy will be reviewed at the next Infection control committee. Measures to prevent reoccurrence. The quality director will providee an in-service to management staff on policy reviews. The quality director will conduct monthly monitoring of program for six months or until 100% compliance is met. Findings will be presented to Quality Council with reports forwarded to Medical Executive committee and Board of Trustees.	05/07/2013			

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	<p>2. The Environmental Services policy/procedure Surgery Department Cleaning (reviewed 1-11) failed to indicate the IC committee had reviewed and approved or revised the procedures for performing the terminal cleaning and disinfecting by housekeeping personnel and minimize the potential for contaminating previously disinfected surfaces in the OR.</p> <p>3. During an interview on 3-27-13 at 1030 hours, staff A12 confirmed that the policy/procedure lacked documentation of periodic review by the Infection Control / Patient Care Committee.</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 policy and procedure review, observation, patient medical record review and staff interview, the nurse executive failed to ensure the implementation of policies related to:</p>	S000912	The Medical-Surgical Pediatric (MSP) director will educate MSP staff on fall risk policy, assessment and interventions for patients. Measures to prevent reoccurrence. The MSP director	05/01/2013

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	<p>implementation of fall precautions and 8 hour fall re assessment for one patient--pt. #2; notation of expiration dates for glucometer test strips in the ED (emergency department); and documentation by nursing staff of contact with IOPO (Indiana Organ Procurement Organization) within one hour of death for one patient--pt. #13.</p> <p>Findings:</p> <p>1. at 3:55 PM on 3/25/13, review of the policy and procedure "Fall Risk (Re) Assessment and Interventions, Fall Alert Program", policy number PC 23 with a most recent reviewed/revised date of 7/12, indicated:</p> <p>a. under section "III. Responsibility:", it reads: "...C...An At Risk to Fall patient is to be reassessed at least every 8 hours."</p> <p>b. on page 4, in the description for "At Risk to Fall (25 to 50)" scoring area it reads: "Includes Low Risk to Fall Interventions above, plus: Apply At Risk to Fall yellow sticker on armband. Apply At Risk to Fall yellow star magnet on door rim. Place At Risk to Fall yellow sticker on chart..."</p> <p>2. while on tour of the medical/surgical nursing unit at 1:30 PM on 3/26/13 in the company of staff member # 57, the director of the med/surg/peds nursing unit, it was observed that pt. #2, who was</p>		<p>will conduct weekly observations for fall risk interventions for six months or until 100% compliance is met. Findings will be presented to Quality Council with reports forwarded to Medical Executive committee and Board of Trustees. The Medical-Surgical Pediatric (MSP) director educated MSP staff on IOPO notification. Measures to prevent reoccurrence. The MSP director will conduct weekly monitoring of death records for appropriate IOPO notification for six months or until 100% compliance is met. Findings will be presented to Quality Council with reports forwarded to Medical Executive committee and Board of Trustees. The death protocol and autopsy criteria policy was revised by the Chief Nursing Officer and approved at Quality Council. The ED/ICU director will educate ED staff on appropriate dating of Nova Statstrip Glucose strips. Signage was placed as an additional reminder by 04/27/2013. Measures to prevent reoccurrence. The ED/ICU director will conduct weekly observations for dating of Glucometer strips for six months or until 100% compliance is met. Findings will be presented to Quality Council with reports forwarded to Medical Executive committee and Board of Trustees. The responsible party for all corrections and measures to prevent reoccurrence is the</p>				

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NAME OF PROVIDER OR SUPPLIER BLUFFTON REGIONAL MEDICAL CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 303 S MAIN ST BLUFFTON, IN 46714			
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	<p>admitted on 3/24/13:</p> <ul style="list-style-type: none"> a. was care planned for high risk for falls with scores of 60 and 65 b. lacked a yellow sticker on their armband c. lacked a yellow star magnet on the door rim of their room d. lacked a yellow sticker on their chart <p>3. a more complete review of the medical record for pt. #2 at 3:50 PM on 3/27/13 indicated:</p> <ul style="list-style-type: none"> a. a fall risk re assessment was performed at 0002 hours on 3/25/13 with the next fall risk re assessment performed at 1800 hours on 3/25/13 <p>4. interview with staff members #51, the quality director, and staff member # 56, a quality coordinator, at 3:50 PM on 3/27/13 indicated:</p> <ul style="list-style-type: none"> a. the 8 hour fall risk re assessment should have been accomplished at 8 AM on 3/25/13 b. the time between the 0002 hours fall risk re assessment and the 1800 hours fall risk re assessment was 18 hours, not 8 hours as per policy requirements <p>5. at 11:25 AM on 3/26/13, review of the policy "Death Protocol & Autopsy Criteria", policy number PC 85, with a most recent review/revision date of 2/12 indicated:</p>		Chief Nursing Officer.				

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NAME OF PROVIDER OR SUPPLIER BLUFFTON REGIONAL MEDICAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 303 S MAIN ST BLUFFTON, IN 46714
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	<p>a. under "Policy", it reads: "Charge nurse will notify:...3. IOPO...within 1 hour of death (see Organ Tissue Donation Policy APPM PC 16)"</p> <p>6. at 2:55 PM on 3/27/13, review of the policy and procedure "Organ and Tissue Donation", policy number PC 16, with a most recent revised date of 2/13/12, indicated:</p> <p>a. under "Procedure", it reads: "1. When a patient dies or death is imminent a Registered Nurse of [the facility] will call the Indiana donation Alliance (IDA) hotline...within one hour of cardiac death...2. Document that the call to the Indiana donation Alliance has been placed..."</p> <p>7. review of patient record #13 at 10:15 AM on 3/27/13 indicated the notification of the IDA/IOPO was not documented by nursing staff after the patient's death on 1/13/13</p> <p>8. interview with staff member #56, a quality coordinator, at 1:15 PM on 3/27/13 indicated:</p> <p>a. after a thorough review of patient medical record #13, it is determined that there is no documentation by nursing staff of contact with IDA/IOPO</p> <p>b. it cannot be determined that the IDA/IOPO was contacted within one hour</p>			

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NAME OF PROVIDER OR SUPPLIER BLUFFTON REGIONAL MEDICAL CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 303 S MAIN ST BLUFFTON, IN 46714			
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	<p>of death, as per policy, without the needed documentation by nursing</p> <p>9. at 2:55 PM on 3/25/13, review of the package insert for the Nova StatStrip glucose testing strips indicated:</p> <p>a. in the "Expiration" section, it reads: "The expiration date is printed on the vial of test strips. Once opened, the StatStrip test strips are stable when stored as indicated for up to 180 days or until the expiration date, whichever comes first."</p> <p>10. at 3:55 PM on 3/25/13, review of the policy and procedure "Nova StatStrip Glucose Meter", policy number PC 59, with a last reviewed/revised date of 9/13/12 indicated:</p> <p>a. under section "V. Equipment/Material/Reagents:", it reads: "...C. Materials...2. StatStrip glucose test strips...Opened StatStrip Test strips are stable for 6 months (or 180 days)..."</p> <p>b. under section "Xiii. Procedure Notes", it reads: "...B. do not use test strips or controls beyond the manufacturer's expiration date printed on the vials or beyond the "opened" expiration date..."</p> <p>11. while on tour of the ED in the company of staff member staff member #53, the ED Director, at 1:55 PM on 3/25/13 it was observed in the trauma</p>						

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NAME OF PROVIDER OR SUPPLIER BLUFFTON REGIONAL MEDICAL CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 303 S MAIN ST BLUFFTON, IN 46714		
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	<p>room that:</p> <p>a. the Nova StatStrips lacked an opened date or a 180 day expiration date to have been written on the strip vial by nursing staff</p> <p>12. interview with staff member #53 at 1:55 PM on 3/25/13 indicated:</p> <p>a. it cannot be determined that the Nova StatStrips are within the 180 days of opening without marking this on the strip vial</p> <p>b. facility protocol is to document the 180 day expiration date (after opening) on the strip vial--this is lacking</p>				

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S001118	<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, document review and interview, the facility failed to ensure that no condition was created that might result in a hazard to patients, in regard to patient refrigerator and microwave cleanliness; dusty blanket warmers; the possibility of inaccurate lab results, and lack of immediate availability of eye wash station equipment in 5 areas toured: peds; OB (obstetrics); surgery; PACU (post anesthesia care unit) and surgery disinfection areas of central sterile and endoscopy.</p> <p>Findings: 1. while on tour of the pediatric unit on 3/26/13 in the company of staff members #51, the Quality Director, and #57, the director of med/surg and peds, it was observed at 1:55 PM that: a. the nourishment refrigerator was dirty under the bottom drawer and sticky</p>	S001118	The nursing directors delegated staff to clean the nourishment refrigerator, microwave, blanket warmer. Measures to prevent reoccurrence. The nursing directors established a cleaning schedule process and will educate staff on process. The nursing directors will conduct weekly monitoring of cleaning clinical units for six months or until 100% compliance is met. Findings will be presented to Quality Council with reports forwarded to Medical Executive committee and Board of Trustees. The surgery director removed the expired tubes and replaced with current tubes prior to the completion of the survey. Measures to prevent reoccurrence. The surgery director placed lab tubes on the checklist for each cart. The surgery director will educate staff on process for checking expired items. The surgery director will	04/27/2013			

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NAME OF PROVIDER OR SUPPLIER BLUFFTON REGIONAL MEDICAL CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 303 S MAIN ST BLUFFTON, IN 46714			
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	<p>with juice residue on one shelf</p> <p>b. the microwave had splattered food on the sides and glass rotating base</p> <p>2. staff members #51 and #57 were interviewed at 2:00 PM on 3/26/13 and indicated:</p> <p>a. it was observed that the peds refrigerator and microwave needed cleaning</p> <p>b. currently there is no routine/scheduled cleaning of these patient food appliances</p> <p>3. at 10:00 AM on 3/26/13, interview with staff member #67, the director of nutritional services, indicated:</p> <p>a. nursing is responsible for cleaning unit refrigerators</p> <p>b. at times the dietary staff has cleaned the refrigerators for nursing staff to maintain cleanliness</p> <p>4. while on tour of the OB unit on 3/26/13 in the company of staff members #56, quality coordinator, and #58, OB registered nurse, it was observed at 3:05 PM that:</p> <p>a. the bottom shelf (under the plenum) of the Amsco/Steris blanket warmer was covered with lint/dust (top cabinet of the two door/cabinet unit)</p> <p>5. interview with staff members #56 and</p>		<p>conduct weekly observation on expired items for six months or until 100% compliance is met. Findings will be presented to Quality Council with reports forwarded to Medical Executive committee and Board of Trustees. The responsible person for correction and measures to prevent reoccurrence is the Surgery Director. The plant operation director had an eye wash stations installation completed prior to the end of the survey for central sterile area The Plant Operations Director had an eye wash station installed for endo area. The Plant Operations co-director delegated staff to replace the missing ceiling tiles in the central sterile department. The missing ceiling tiles were placed prior to the end of the survey. Measures to prevent reoccurrence. The Plant Operation Director educated staff on missing ceiling tile deficiency. The Plant Operations Director will conduct monthly observations on missing ceiling tiles for six months or until 100% compliance is met. Findings will be presented to Quality Council with reports forwarded to Medical Executive committee and Board of Trustees. The responsible person for correction and measures to prevent reoccurrence is the Plant Operations Director.</p>				

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NAME OF PROVIDER OR SUPPLIER BLUFFTON REGIONAL MEDICAL CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 303 S MAIN ST BLUFFTON, IN 46714		
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	<p>#58 at 3:10 PM on 3/26/13 indicated:</p> <ul style="list-style-type: none"> a. it was unknown that lint from the blankets would cause a dusty buildup b. the blanket warmer is currently not on a routine cleaning schedule <p>6. while on tour of the surgery area on 3/27/13 in the company of staff members #56, quality coordinator, and #61, the surgery director, at 9:35 AM indicated:</p> <ul style="list-style-type: none"> a. lab tubes in the malignant hyperthermia cart were expired as follows: <ul style="list-style-type: none"> I. one Blue top expired 8/12 II. one Green top expired 9/12 III. one Gold top and one Red top with both expired 10/12 <p>7. interview at 9:35 AM on 3/27/13 with staff members #56 and #61 indicated the checklist used for monthly checks of the malignant hyperthermia cart does not currently include checking the expiration dates on the lab tubes</p> <p>8. while on tour of the PACU area in the company of staff members #56, quality coordinator, and #61, the surgery director, at 9:50 AM on 3/27/13, it was observed in the code/crash cart that:</p> <ul style="list-style-type: none"> a. one green top lab tube expired 1/13 <p>9. interview at 9:50 AM on 3/27/13 with staff members #56 and #61, indicated the</p>				

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NAME OF PROVIDER OR SUPPLIER BLUFFTON REGIONAL MEDICAL CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 303 S MAIN ST BLUFFTON, IN 46714		
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	<p>monthly check of the code/crash cart does not currently include the checking of expiration dates on the lab tubes</p> <p>10. Review of the Occupational Safety and Health Administration (OSHA) general requirements for emergency showers and eye wash station equipment in 29 Code of Federal Regulations (CFR) 1910.151(c) indicated the following: "When the eyes or body of any person may be exposed to injurious corrosive materials, suitable facilities for quick drenching or flushing of the eyes and body shall be provided within the work area for immediate emergency use."</p> <p>11. During a tour on 3-26-13 at 1240 hours, no available eyewash equipment was observed in the area where endoscope decontamination and high level disinfecting was performed.</p> <p>12. During an interview on 3-26-13 at 1240 hours, staff A14 confirmed that an eyewash station was not immediately available in the area if needed.</p> <p>13. During a tour on 3-26-13 at 1345 hours, the following conditions were observed in the gross decontamination area of the Central Sterile department: two ceiling tiles [12"x 12"and 12"x 24"estimated] were missing from the ceiling grid and no available eyewash</p>				

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NAME OF PROVIDER OR SUPPLIER BLUFFTON REGIONAL MEDICAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 303 S MAIN ST BLUFFTON, IN 46714
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	<p>equipment was observed in the area if needed.</p> <p>14. During an interview on 3-26-13 at 1350 hours, staff A14 confirmed that the area ceiling had not been maintained and confirmed that an eyewash station was not immediately available.</p>			

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NAME OF PROVIDER OR SUPPLIER BLUFFTON REGIONAL MEDICAL CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 303 S MAIN ST BLUFFTON, IN 46714			
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S001164	<p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8(d)(2)(B)</p> <p>(d) The equipment requirements are as follows: (2) There shall be sufficient equipment and space to assure the safe, effective, and timely provision of the available services to patients, as follows:</p> <p>(B) There shall be evidence of preventive maintenance on all equipment.</p> <p>Based on observation and interview, the facility lacked documentation of preventive maintenance (PM) on all equipment for 5 items observed on tour at the hospital and one off-site.</p> <p>Findings:</p> <p>1. During a tour on 3-25-13 at 1450 hours, in the outpatient rehabilitation department, the following condition was observed: a set of adjustable wooden and metal parallel bars and a 'Rollator' rolling walker without an asset tag or evidence of periodic PM. Staff A2 and A11 were requested to provide documentation of PM and none was provided prior to exit.</p> <p>2. During an interview on 3-25-13 at 1500 hours, staff A11 confirmed that the equipment was not receiving PM.</p>	S001164	The Biomed engineer delegated staff to perform preventative maintenance (PM) on the following equipment: wooden and metal parallel bars, rollator, wheelchairs, Tennant floor buffer, and wooden stair steps. The Biomed engineer, plant operations director, administration and rehab director met and developed a process for PM of all appropriate hospital equipment. The wooden stair crack was repaired by Biomed manager. Measures to prevent reoccurrence. The quality director will educate the management staff on the PM process for all equipment. The quality director will conduct weekly monitoring on PM equipment for six months or until 100% compliance is met. Findings will be presented to Quality Council with reports forwarded to Medical Executive committee and Board of Trustees. The responsible person	04/24/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150075	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/27/2013
NAME OF PROVIDER OR SUPPLIER BLUFFTON REGIONAL MEDICAL CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 303 S MAIN ST BLUFFTON, IN 46714		
(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 a tour on 3-26-13 at 1215 hours, in the 2nd floor medical surgical nursing unit, the following condition was observed: a wheelchair without an asset tag or evidence of periodic PM.</p> <p>4. During an interview on 3-26-13 at 1215 hours, staff A14 confirmed that documentation of periodic inspection and PM was not available for the wheelchair.</p> <p>5. During a tour of the environmental services department on 3-26-13 at 1340 hours, a Tennant 170 rpm floor buffer [asset #6142] was observed without evidence of recent PM.</p> <p>6. During an interview on 3-26-13 at 1340 hours, staff A14 confirmed that the floor buffer was not receiving periodic PM.</p> <p>7. During a tour on 3-27-13 at 1245 hours in the rehabilitation department, the following condition was observed: a wooden stair steps without an asset tag or evidence of periodic PM. One inside corner handrail was observed to have a full-thickness crack through the union with the vertical support attached to the upper landing.</p> <p>8. During an interview on 3-27-13 at 1245 hours, staff A18 confirmed that the</p>		for corrections is the Biomed Engineer. The responsible person for measures to prevent reoccurrence is the Quality Director.		

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NAME OF PROVIDER OR SUPPLIER BLUFFTON REGIONAL MEDICAL CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 303 S MAIN ST BLUFFTON, IN 46714		
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S001906	<p>wooden stair equipment lacked evidence of periodic PM and had not been maintained.</p> <p>410 IAC 15-1.6-6 REHABILITATION SERVICES 410 IAC 15-1.6-6(b)</p> <p>(b) The services shall be under the direction of a physician qualified by training or experience and supervised by a qualified person or persons. Based on document review and interview, the facility lacked documentation indicating that the rehabilitation services were provided under the direction of a physician qualified by training and experience.</p> <p>Findings:</p> <ol style="list-style-type: none"> On 3-25-13 at 1130 hours, staff A2 and A3 were requested to provide documentation that the rehabilitation services were under the direction of a qualified physician approved by the medical staff and none was provided prior to exit. During an interview on 3-25-13 at 1650 hours, staff A3 confirmed that the facility failed to appoint a medical director for its rehabilitation services. 	S001906	The Chief Executive Director (CEO) has contacted Dr. L Landman to become the medical director for rehabilitation services. The Medical Executive Committee (MEC) approved Dr. Landman as medical director of rehabilitation services at MEC meeting.	04/24/2013	