

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151320	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/06/2013
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NAME OF PROVIDER OR SUPPLIER JAY COUNTY HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 500 W VOTAW ST PORTLAND, IN 47371
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S000000	<p>The visit was for a licensure survey.</p> <p>Facility Number: 005029</p> <p>Survey Date: 6-05-13 to 6-06-13</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 06/13/13</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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S000102	<p>410 IAC 15-1.2-1 COMPLIANCE WITH RULES 410 IAC 15-1.2-1 (a)</p> <p>(a) All hospitals shall be licensed by the department and shall comply with all applicable federal, state, and local laws and rules.</p> <p>Based on personnel file review, document review, and interview, the facility failed to ensure that state rules and regulations were complied with in reference to IC 16-28-13 for 2 of 2 PCT (patient care technician)/nurse aide files reviewed (staff members N4 and N5).</p> <p>Findings: 1. review of IC 16-28-13-4 indicated that: a. "Except as provided in subsection (b), a person who: (1) operates or administers a health care facility; or (2) operates an entity in the business of contracting to provide nurse aides or other unlicensed employees for a health care facility; shall apply within three (3) business days from the date a person is employed as a nurse aide or other unlicensed employee for a copy of the person's state nurse aide registry report from the state department and a limited criminal history from the Indiana central repository for criminal history information under IC 10-13-3 or another source by law."</p>	S000102	<p>1. This item was completed on 6/17/2013. All PCT's (unlicensed nurse aides) were checked with the nurse aid registry and verification was placed in the employee's personnel file.2. The nurse aid registry will be checked for all PCT's upon hire.3. The Director of Human Resources will be responsible for No. 2 above.</p>	06/17/2013			

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	<p>2. review of personnel files at 2:00 PM on 6/6/13 indicated:</p> <p>a. staff member N4 was a PCT hired 2/20/12 whose file lacked documentation of nurse aide registry check upon hire</p> <p>b. staff member N5 was a PCT hired 2/21/12 whose file lacked documentation of nurse aide registry check upon hire</p> <p>3. interview with staff member #59, the human resources director, at 3:15 PM on 6/6/13 indicated:</p> <p>a. it was unknown that the nurse aide registry check at the time of hire for nurse aides was required</p> <p>b. a nurse aide registry check for unlicensed patient care givers is not being completed at the facility</p>			

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S000270	<p>410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1(a)(6)</p> <p>(a) The governing board is legally responsible for the conduct of the hospital as an institution. The governing board shall do the following:</p> <p>(6) Review, at least quarterly, reports of management operations, medical staff actions, and quality monitoring, including patient services provided, results attained, recommendations made, actions taken and follow-up.</p> <p>Based on document review and interview, the governing board meeting documentation failed to indicate a review of the quality assessment and performance improvement (QAPI) monitoring for 12 of 12 monthly board meeting reports provided for review.</p> <p>Findings:</p> <p>1. On 6-05-13 at 1130 hours, staff A1 was requested to provide the governing board meeting minutes including evidence of quarterly QAPI monitoring reports for the past 12 months and none was provided prior to exit.</p> <p>2. The monthly board meeting documentation dated 6-27-12 thru 4-24-13 failed to indicate that quarterly</p>	S000270	<p>1. The hospital currently presents, on a quarterly basis, the Quality Improvement reports to the Finance and HR/Facilities subcommittees of the Board of Directors as well as the Medical Staff. The minutes for the Finance and HR/Facilities committee meetings indicate what was reviewed and any discussion or action items for follow up. The minutes of the HR/Facilities and Finance committees are sent to full board for review prior to their meeting. We will begin to attach the presentations from the HR/Facilities and Finance committees to the minutes of the committees so that the full board can review that data prior to the meeting. The minutes of the full board meetings will reflect that the Board reviewed the minutes from the HR/Facilities and Finance Committee.</p>	09/06/2013

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	<p>QAPI reports were attached and reviewed or indicate that QAPI committee minutes with reports were attached and reviewed.</p> <p>3. During an interview on 6-06-13 at 0935 hours, staff A1 confirmed that the governing board meeting documentation failed to indicate a discussion of quarterly QAPI monitoring reports or otherwise validate that QAPI committee reports (including results, recommendations, actions taken and follow-up) were reviewed.</p>		<p>2. As stated in the response to question 1, the Quality Improvement data will be a quarterly standing agenda item on the Finance, HR/Facilities, and Medical Staff meeting agendas. We will develop a meeting calendar that will outline what months of the year each committee will receive the quality improvement data.</p> <p>3. The CEO, Dave Hyatt, is ultimately responsible for the data reported to the board. Dave will ensure that the administrative assistant to the CEO and Board, Beth Auker, works with our Chief Nursing Officer, Lisa Craiger, to plan the Quality Improvement data presentation timeline.</p> <p>4. Due to the interaction with the board, the CEO will work with the Hospital attorney as well as the Board Chairman to have this plan outlined and presented to the Board of Trustees within 90 days of the initial survey. In the first 30 days the CEO, Hospital Attorney, and Board Chair will review the requirements and state survey, days 30-60 the group will recommend a solution to the board of trustees, and in day 60-90 will seek an official approval from the Board for a new plan for QI presentation. The official date of resolution will be September 6 th , 2013.</p>		

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S000312	<p>410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1(c)(6)(D)</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>(D) Annual performance evaluations, based on a job description, for each employee providing direct patient care or support services, including contract and agency personnel, who are not subject to a clinical privileging process.</p> <p>Based on policy and procedure review, employee file review, and staff interview, the governing board failed to ensure that annual performance evaluations were completed per facility policy for 2 of 2 radiology staff members (staff members N7 and N9).</p> <p>Findings: 1. at 4:25 PM on 6/6/13, review of the policy and procedure "Competency", policy number "HRD5-000", with a last revised date of 3/2011, indicated: a. on page 2 under section "B. Performance Appraisal and Competency Assessment", it reads: "Performance Appraisal Performance appraisals are to be performed annually using criteria base evaluation form...Evaluations are to be</p>	S000312	<p>1. The Director of Radiology will insure annual performance evaluations are completed per the facility policy. Delinquent appraisals will be completed within the next 60 days.2. The Director of Human Resources will review the Director of Radiology's responsibility on a monthly basis to ensure timeliness of the performance evaluations.3. The Director of Radiology will be directly responsible for conducting the performance evaluations and insuring the timeliness of the appraisals. The Director of Human Resources will be responsible for overseeing the Director of Radiology in the accomplishment of that task.</p>	08/06/2013	

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	<p>performed on the following schedule. Employees whose last name begins with:...I or J May K or L June..."</p> <p>2. at 2:00 PM on 6/6/13, review of personnel files indicated:</p> <p>a. staff member N7 (last name begins with I) was an ultrasound technician hired 6/15/98 with a last evaluation of 6/2/10</p> <p>b. staff member N9 (last name begins with K) was a radiology technician hired 6/24/02 with a last evaluation of 1/4/11</p> <p>3. interview with staff member #59, the human resources director, at 3:55 PM on 6/6/13, indicated:</p> <p>a. neither staff member N7 nor N9 have had a performance evaluation since the ones in their files (6/2/10 for N7 and 1/4/11 for N9)</p> <p>b. the director of radiology has not followed facility policy related to annual evaluations</p>				

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S000322	<p>410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1(c)(6)(H)</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>(H) Requiring all services to have policies and procedures that are updated as needed and reviewed at least triennially.</p> <p>Based on document review and interview, the facility failed to follow its policy/procedure and ensure that all services update and/or review all policies and procedures at least annually.</p> <p>Findings:</p> <p>1. The policy/procedure Policy and Procedure Development (revised 2-09) indicated the following: " All [facility] policies and procedures shall be reviewed on an annual basis ...a cover sheet for each manual may be used to indicate the date that the policies/procedures were reviewed." The policy/procedure failed to indicate that it had been reviewed within the past year.</p> <p>2. On 6-05-13 at 1100 hours, staff A1 was requested to provide policies and</p>	S000322	<p>1. We have written an updated policy on policies which state that each manager is responsible for reviewing and updating policies in their areas on an annual basis.</p> <p>2. We are able to monitor the review of policies on our electronic policy manager software.</p> <p>3. The CNO will take responsibility for the assignment of checking policies monthly and notifying the director of each service of policies due for review and will monitor that this task is completed as evidenced by the electronic policy manager software. If deficiencies are not resolved, the CNO will notify the administration leader of the deficiency in their area of responsibility.</p> <p>4. Will present the new policy to the Hospital Manager's Meeting on 06/27/2013. Will expect all managers to have reviewed all policies in their areas by</p>	07/31/2013	

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	<p>procedures including documentation of the most recent periodic review by responsible staff.</p> <p>3. The radiology policy/procedures Equipment Malfunction (reviewed 4-03), Official Interpretation (revised 4-11), MRI Infection Control (approved 1-10) and MRI Safety Policy and Procedures (revised 5-09) lacked evidence of an annual review.</p> <p>4. Radiation Safety Committee minutes dated 12-12 lacked documentation indicating that all department policies and procedures were reviewed by the committee.</p> <p>5. On 6-05-13 at 1245 hours, staff A1 confirmed that the departmental policy/procedures lacked documentation of annual review and no further documentation was available.</p>		07/31/2013.		

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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 12 contracted services.</p> <p>Findings:</p> <p>1. On 6-05-13 at 1630 hours, a list of all contracted services was received from staff A1. The list of services failed to indicate a service provider for anesthesia equipment, generator load testing and transfer switch certification, laboratory instrument maintenance, mammography equipment, a current pest control provider and a medical physicist service. The list of services failed to indicate the scope and nature of services provided for 4 radiology equipment service providers, a food service provider and an endoscope reprocessor provider.</p>	S000394	<p>1. The list of contracted services will be updated by the administrative assistant to the CEO in conjunction with department managers to include service provider for Anesthesia Equipment, Generator Load Testing and Transfer Switch Certification, Laboratory Instrument Maintenance, Mammography Equipment, Pest Control, and a Medical Physicist Service by July 5, 2013. The current list of contracted services will be revised by each department manager to include scope of services to be provided and quality standards to be evaluated for each contracted vendor.</p> <p>2. A policy on contracted services will be created to show that the contracted list of services will be reviewed on a quarterly basis an annual basis by all managers with contracted services. The policy will include how contracts will be added to, reviewed while on, and, when no longer relevant, removed from the</p>	08/30/2013

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	<p>2. Review of facility documentation indicated the following: anesthesia machine service by CS1, generator service by CS2, laboratory instrument service by CS3, mammography equipment service by CS4, computerized tomography (CT scan) service by CS5, MRI service by CS6, bone densitometry service by CS7, ultrasonography service by CS8, pest control by CS9, medical physics by CS10, food service provider by CS11, and endoscope reprocessor service by CS12.</p> <p>3. On 6-06-13 at 0955 hours, staff A1 confirmed that the list of contracted services had not been maintained.</p>		<p>list of contracted services. The policy on contracted services and the revised contract list will be completed by July 31, 2013. 3. Administrative Assistant to the CEO, Beth Auker, will create the policy on contracted services in conjunction with the CEO and maintain the list of contracted services. The CEO, through his administrative assistant, will on a quarterly basis require each manager to review and sign off on each contracted service listed for their span of control. 4. The first quarterly review utilizing the revised contract list will be completed by August 30, 2013.</p>		

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S000406	<p>410 IAC 15-1.4-2 QUALITY ASSESSMENT AND IMPROVEMENT 410 IAC 15-1.4-2(a)(1)</p> <p>(a) The hospital shall have an effective, organized, hospital-wide, comprehensive quality assessment and improvement program in which all areas of the hospital participate. The program shall be ongoing and have a written plan of implementation that evaluates, but is not limited to, the following:</p> <p>(1) All services, including services furnished by a contractor. Based on document review and interview, the facility failed to follow its policy/procedure and ensure that its contracted services were monitored and evaluated through its Performance Improvement (PI) program.</p> <p>Findings:</p> <p>1. The Performance Improvement Plan 2013 (approved 4-13) indicated that the Patient Care Committee was responsible for direct oversight of the PI program and indicated that all providers for clinical engineering services would be monitored.</p> <p>2. PI documentation provided for review indicated 1 service (biomedical engineering) was reviewed through the PI program in 2012. On 6-06-13 at 1400</p>	S000406	<p>1. The current list of contracted services will be revised by each department manager to include scope of services to be provided and quality standards to be evaluated for each contracted vendor to be completed by July 31, 2013. The managers will then conduct their first quarterly review of contracted services in August. To be complete by August 30, 2013. The updated contract list will then be attached to the Performance Improvement document on an annual basis.2. Quality standards for contracted services will be reviewed quarterly by the department managers and will be included in the Performance Improvement Plan on an annual basis.3. Administrative Assistant to the CEO, will maintain the list of contracted services. The CEO, through his administrative</p>	08/30/2013
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	<p>hours, the PI manager A5 was requested to provide documentation indicating additional contracted services including fire protection and radiology equipment service providers were reviewed through the PI program and none was provided prior to exit.</p> <p>3. During an interview on 6-06-13 at 1415 hours, staff A5 confirmed that the facility lacked documentation for evaluating and reporting all contracted services through the PI program.</p>		<p>assistant, will on a quarterly basis require each manager to review and sign off on each contracted service listed for their span of control.</p>		

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S000418	<p>410 IAC 15-1.4-2 QUALITY ASSESSMENT AND IMPROVEMENT 410 IAC 15-1.4-2(b)(1)(2)</p> <p>(b) The hospital shall take appropriate action to address the opportunities for improvement found through the quality assessment and improvement program as follows:</p> <p>(1) The action shall be documented.</p> <p>(2) The outcome of the action shall be documented as to its effectiveness, continued follow-up and impact on patient care.</p> <p>Based on document review and interview, the facility lacked documentation of a committee response to opportunities for improvement identified through its Quality Assessment and Performance Improvement (PI) program.</p> <p>Findings:</p> <p>1. The Performance Improvement Plan 2013 (approved 4-13) indicated that the Patient Care Committee was responsible for direct oversight of the PI program.</p> <p>2. The Patient Care Committee minutes dated 5-08-13 and the Performance Improvement Meeting for the Medical Staff dated 2-21-13 and 5-16-13 failed to indicate documentation of attendee participation, discussion,</p>	S000418	<p>1. We will develop a policy and procedure for all hospital committee meeting minutes to include: members present, members absent, topics, discussion, action/follow-up, assignment of responsibility in the form of a template.2. This template will demonstrate the discussions and participating membership of the committee meetings. 3. The CNO will provide the template and distribute the information to the staff in the managers meeting.4. All meeting minutes will be using the new template by 07/01/2013.</p>	07/01/2013			

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	<p>recommendations or an action in response to the information provided for review by the members attending each meeting.</p> <p>3. During an interview on 6-06-13 at 1420 hours, staff A5 confirmed that the documentation lacked evidence of a committee review and an action or response to the quality indicators and identified concerns.</p>			

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S000570	<p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2 (f)(1)(A)(b)(C)(D)(E) (f) The hospital shall establish an infection control committee to monitor and guide the infection control program in the facility as follows: (1) The infection control committee shall be a hospital or medical staff committee that meets at least quarterly, with membership that includes, but is not limited to, the following: (A) The person directly responsible for management of the infection surveillance, prevention and control program. (B) A representative from the medical staff. (C) A representative from nursing service. (D) A representative from administration. (E) Consultants from other appropriate services within the hospital, as needed.</p> <p>Based on policy and procedure review, document review, and interview, the infection control committee failed to ensure that a medical staff representative and administration staff representative attended the quarterly infection control committee meetings for two of four meetings in 2012 and 2013.</p> <p>Findings: 1. at 1:15 PM on 6/6/13, review of the policy and procedure "Infection Control Committee" (no policy number), last</p>	S000570	<p>1. Infection Control Committee make-up will be reformatted to include mandatory members and attendees ad hoc who have input into current items presented. The mandatory members will include the Infection Control Preventionist, the CNO, the pathologist acting as the medical staff representative, Medical/Surgical Nurse Manager. The mandatory members may appoint a representative of equal management level or licensure. The meeting is open to all other managers of other departments but</p>	07/01/2013			

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	<p>approved by the chief nursing officer on 7/2012, indicated:</p> <p>a. under 4. "Membership", it reads: "a) The Committee will consist of the following members: 1) Chairman, Medical Staff Representative 2) Nurse Managers 3) Infection Preventionist 4) Risk Manager 5) Pharmacy Director 6) Respiratory Care Manager 7) Safety Director 8) Lab Manager..."</p> <p>2. at 1:50 PM and 4:15 PM on 6/5/13, review of the Infection Control binder with committee meeting minutes indicated:</p> <p>a. infection control committee meetings were held: March 15, 2012; August 16, 2012; October 24, 2012 and February 26, 2013</p> <p>b. there was no representative of the medical staff at the October 24, 2012 meeting</p> <p>c. there was no administrative representative at the February 26, 2013 meeting</p> <p>3. interview with staff member #52, the chief nursing officer, at 1:15 PM on 6/6/13 indicated:</p> <p>a. the staff listed in the policy and procedure as "members" of the infection control committee are not attending the meetings as intended by the policy</p> <p>b. the October 2012 meeting was</p>		<p>their attendance is not required.</p> <p>2. We will only hold meetings when the required membership is in attendance. Meetings will be rescheduled when attendance requirement is not met.</p> <p>3. The Infection Control Preventionist will monitor and enforce this policy.</p>				

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	<p>lacking documentation of a medical staff member in attendance</p> <p>c. the February 2013 meeting lacked the attendance of an administrative staff member</p> <p>d. 2 of 4 of the last infection control meetings lacked the attendance of required staff, per facility policy and per licensure rules</p>				

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S000592	<p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(f)(3)(D)(i)</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:</p> <p>(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>(i) Sanitation. Based on document review and interview, the infection control (IC) committee failed to ensure that the operating room (OR) cleaning and disinfecting was performed in a safe and effective manner for the surgery department of the facility.</p> <p>Findings:</p> <p>1. The policy/procedure Cleaning the Surgical Suite and Recovery Room (reviewed 11-11) failed to indicate it had been reviewed within the past year in accordance with the Infection Control Committee policy and failed to indicate an organized and systematic procedure for terminal operating room (OR) cleaning to minimize contamination of previously disinfected surfaces by housekeeping</p>	S000592	<p>1. In the July meeting, the cleaning policies will be presented and approved and will be reapproved on an annual basis. 2. The cleaning solutions and uses will be presented in the July meeting and approved by the Infection Control Committee. This will be reviewed on an annual basis and as new products are added to the list. 3. Infection Control Preventionist working in conjunction with the housekeeping manager.</p>	07/01/2013			

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	<p>personnel.</p> <p>2. During an interview on 6-05-12 at 1645 hours, staff A9 confirmed that the policy/procedure failed to indicate a systematic process for OR cleaning from high to low and least contaminated to most contaminated areas to reduce the potential for contamination of previously-cleaned surfaces.</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 observation and interview, the infection control committee failed to ensure appropriate storage of endoscopes, to allow for drainage after the cleaning process, in the off site surgery center.</p> <p>Findings: 1. at 12:10 PM on 6/6/13, while touring the off site surgery center in the company of staff member #55, the surgery manager, it was observed that 3 of 5 endoscopes were too long for the storage cabinet and curved at the bottom of the cabinet failing to let them drain after cleaning 2. interview with staff member #55, the surgery manager, at 12:20 PM on 6/6/13 indicated:</p>	S000596	<p>1. Currently, we have had the maintenance department raise the rack where the scopes are hung to ensure adequate drainage. The OR manager has contacted Olympus and one other company for quotes on a cabinet specifically for scopes. We are currently waiting on the quotes. When we receive the quotes, we will then order the appropriate cabinets for housing the scopes. 2. The cabinets will hold six scopes and we will order two cabinets. This will more than meet the need of the hospital ,now and in the future. The Infection Control Preventionist is monitoring that the scopes are hung at the proper height for adequate drainage 3. Infection Control Preventionist will work with Surgical Manager to</p>	07/31/2013			

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	<p>a. the scopes would not be able to drain any fluids that might be left in them after cleaning with the way they are placed in the cabinet (unable to hang straight down)</p> <p>b. this could cause a build up of bacteria or infectious organisms, making this a possible pt. safety and infection control problem</p>		<p>ensure compliance.</p> <p>4. Month date year Scope Rack height changed 06/14/2013. New cabinets will be installed by 07/31/2013.</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 the fall policy for 1 of</p>	S000912	1. We have changed our Falls Prevention Policy to reflect the expected action of placing a red clip on the patient's arm band. We currently monitor this in our safety rounds. We have attained	06/24/2013

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	<p>2 patients (pt. # 5), and failed to ensure the implementation of the pediatric admission assessment policy for 2 of 2 pediatric patients (pts. #7 and #8).</p> <p>Findings:</p> <p>1. at 12:20 PM on 6/5/13, review of the policy "Falls Prevention Protocol" (no policy number), with a last revised date of 1/12, indicated:</p> <p>a. under "Procedure", it reads in item 7.: "...If the patient is a level 3, a red dot will be hung on the bulletin board..."</p> <p>2. interview with staff members #52, the chief nursing officer, and #53, the house supervisor, at 2:40 PM on 6/5/13 indicated fall patients are to have a red clip placed on their hospital arm bands to indicate that they are at risk for falls</p> <p>3. while on tour of the medical/surgical nursing unit at 2:35 PM on 6/5/13, it was observed that pt. #5 was lacking a red clip on their arm band</p> <p>4. interview with staff members #52, the chief nursing officer, and #53, the house supervisor, at 10:55 AM on 6/6/13 indicated:</p> <p>a. the Falls Prevention Protocol does not address the requirement that a red clip be placed on a patient's arm/wrist band if they are at a risk for falls, but that is the</p>		<p>100% compliance in the past. We will add this to the nurse's responsibility in hourly rounding. Nurse Manager will continue to monitor on safety rounds and maintain as a PI improvement measure. For pediatric patients the height and weight are set as a required field in the electronic medical assessment and for pediatric patients under 2 the height, weight, and head circumference is a required field in the electronic medical assessment as per policy.2. Nurse Manager will continue to monitor on safety rounds and maintain as a PI improvement measure. Quality Manager will be monitoring all pediatric charts for compliance and will notify manager of any noncompliance.3. Nurse Manger of Medical/Surgical Floor and Quality Manager</p>		

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	<p>expectation of the facility</p> <p>5. at 10:05 AM on 6/6/13, review of the policy and procedure "Pediatric Assessment", policy number "NURS #654.000", last signed off by the chief nursing officer on 11/11, indicated:</p> <p>a. under "Procedure", it reads: "...4. Areas of the pediatric assessment in bold print on our Pediatric Assessment form refer to growth and development in the Lippincott Manual of Nursing Practices."</p> <p>6. at 10:55 AM on 6/6/13, review of Chapter 50 titled "Pediatric Metabolic and endocrine Disorders" from the Lippincott Manual, indicated:</p> <p>a. under "Assessment...Evaluation of Growth Patterns", it reads: "1. Perform frequent and accurate measurements of height and weight..."</p> <p>7. at 3:00 PM on 6/5/13, review of two pediatric medical records indicated:</p> <p>a. pt. #7 was a 5 month old admitted on 2/19/13 who lacked documentation of a height/length at the time of admission</p> <p>b. pt. #8 was a 7 month old admitted on 4/5/13 who lacked documentation of a height/length at the time of admission</p> <p>8. interview with staff members #52, the chief nursing officer, #53, the house supervisor, and #57, the director of risk</p>						

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	<p>management, at 10:55 AM on 6/6/13 indicated:</p> <ul style="list-style-type: none"> a. both pediatric medical records are lacking a height measurement with the admission assessments performed b. the policy refers to a form no longer used as the admission assessment is now electronic c. only the pediatric head circumference is a required field of the electronic assessment, weight and height are not required fields d. nursing staff failed to enter heights on patients #7 and #8, as required by the Lippincott Manual referred to by facility policy 				

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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 and interview, the facility failed to ensure that no condition would be created that might create a hazard to patients in one area toured.</p> <p>Findings:</p> <p>1. at 2:40 PM on 6/5/13, while on tour of the medical/surgical nursing unit in the company of staff members #52, the chief nursing officer, and #53, the house supervisor, it was observed that:</p> <p>a. the pantry refrigerator had food crumbs and debris on the shelves and the freezer door shelves, along with two hairs on the lower freezer door shelf</p> <p>b. the microwave was dirty with dried splattered food/liquids</p> <p>2. interview with staff member #52, the chief nursing officer, at 3:20 PM on 6/6/13, indicated:</p> <p>a. it is unknown whose responsibility</p>	S001118	<p>1. Will create a policy stating how often, by whom, and how equipment in the patient pantry is to be cleaned. Will create a check sheet for the areas to be cleaned and a temp sheet to monitor the refrigerator temp each night.</p> <p>2. Managers responsible for an area where a patient pantry exist will be responsible for checking the sign-off sheet and for ensuring that all appliances are clean and acceptable.</p> <p>3. Chief Nursing Officer will monitor the areas on daily rounds.</p>	07/01/2013			

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	<p>(housekeeping, dietary, or nursing) it is to clean the medical/surgical nursing unit refrigerator</p> <p>3. interview with staff members #52, the chief nursing officer, #53, the house supervisor, and # 57, the director of risk management, at 3:35 PM on 6/6/13 indicated:</p> <p>a. there is no policy and procedure related to refrigerator temperature checks and the responsibility of cleaning the nursing unit refrigerators</p>			

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S001162	<p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8(d)(2)(A)</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>(A) All mechanical equipment (pneumatic, electric, or other) shall be on a documented maintenance schedule of appropriate frequency and with the manufacturer's recommended maintenance schedule.</p> <p>Based on observation and interview, the facility lacked evidence of preventive maintenance (PM) on equipment in use in all areas for the nurse emergency call system.</p> <p>Findings:</p> <p>1. On 6-05-13 at 1100 hours, staff A1 was requested to provide documentation of PM for the nurse emergency call system equipment and none was provided prior to exit.</p> <p>2. During an interview on 6-06-13 at 1410 hours, staff A3 confirmed that no documentation of recent PM for the nurse emergency call system was available.</p>	S001162	<p>1. We will do a quarterly check of the nurse call system including the pull stations in patient rooms, bathrooms, and exam rooms. This will also verify the audio and visual parts of the system. During the check the paging system check will be performed to make sure the software is functioning properly. 2. A policy will be created by July 26, 2013 stating that we will pm the nurse call system by performing actual nurse tests on each nurse call device by setting off the nurse call and waiting for the response from the nurses' station. The maintenance person will also verify that the hallway light connected to the nurse call activates. During the pm process they will also make one call to verify that the software is working by testing the paging system.</p>	07/26/2013			

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			The information will be documented in a spread sheet that shows the room tested, date/time, who performed the test and that the system worked properly. If the test fails in any form, maintenance will notify nursing of the problem with the nurse call so they can take appropriate measures to insure patient safety. Once nursing has been notified, the maintenance person will create a work order to have the item in question repaired or replaced. Once the equipment has been repaired and tested, they will notify nursing that the nurse call is fully functional.3. Wendell Robbins, the maintenance supervisor will be responsible for meeting the tag by creating a PM testing process for the nurse call system 4. We will start the process of pm testing the nurse call as part of the quarterly pm's performed by maintenance		

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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	
S001168	<p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 150-1.5-8 (d)(3)</p> <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 lacked documentation of defibrillator inspection and testing as recommended by the manufacturer for 1 of 3 areas (emergency department, main surgery and ambulatory surgery) at the facility.</p> <p>Findings:</p> <p>1. The Phillips M4735A HeartStart XL Defibrillator/Monitor (2007) Instructions for Use indicated the following: " perform a Shift/System Check ...along with visual inspection of the device and all cables, controls, accessories and supplies. Also regularly check expiration dates of all supplies, such as multifunction defib electrode pads ... "</p> <p>2. Documentation of the outpatient ambulatory surgery defibrillator checks provided for review lacked evidence that the additional checks indicated on the</p>	S001168	<p>1. The checklist in Outpatient Surgery was changed to mirror the manufacturer's recommendations. All checklists for all crash carts and defibulators were set up to match the manufacturer's recommendations. 2. The Emergency Manager will monitor the checklists monthly for a period of six months for compliance and quarterly thereafter.3. The Emergency Manager will monitor the checklists monthly for a period of six months for compliance and quarterly thereafter.</p>	06/30/2013	

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	<p>monitor report printout Shift/System Checks were performed in accordance with the manufacturer ' s recommendations.</p> <p>3. During an interview on 6-06-13 at 1400 hours, staff A17 confirmed the documentation failed to indicate that the additional checks were performed.</p>				