

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150097	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/20/2015
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NAME OF PROVIDER OR SUPPLIER MAJOR HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 150 W WASHINGTON ST SHELBYVILLE, IN 46176
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S 0000 Bldg. 00	This visit was for a standard licensure survey. Facility Number: 005086 Survey Date: 5-18/20-2015 QA: cjl 06/04/15 IDR Committe held on 06-17-15; Tag 1168 deleted. JL	S 0000		
S 0270 Bldg. 00	410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1(a)(6) (a) The governing board is legally responsible for the conduct of the hospital as an institution. The governing board shall do the following: (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. Based on document review and interview, the governing board failed to review of a report of quality activities for 1 contracted service (autopsy) and 2 offsites (Rampart Lab, Major Hospital Radiology offsite) for calendar year 2014.	S 0270	1 The autopsy contracted service will be included in the quarterly mortality report which will be reported to Hospital Quality Council on June 18, 2015 and to the Board of Directors on July 27, 2015. 3 The Rampart Lab Site	10/26/2015

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

TITLE

(X6) DATE

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

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	<p>Findings:</p> <ol style="list-style-type: none"> 1. Review of the governing board minutes for calendar year 2014 indicated they did not include review of a report for the contracted service of autopsy. 2. In interview on 5-20-2015 at 2:05 pm, employee #A4, Director of Quality, confirmed this and no further documentation was provided prior to exit. 3. Review of the governing board minutes for calendar year 2014 indicated they did not include review of a report for the Rampart Lab offsite. 4. In interview on 5-20-2015 at 2:20 pm, employee #A8, Director of Lab, confirmed this and no further documentation was provided prior to exit. 5. Review of the governing board minutes for calendar year 2014 indicated they did not include review of a report for the Major Hospital Radiology offsite. 6. In interview on 5-20-2015 at 2:25 pm, employee #A9, Director of Radiology, confirmed this and no further documentation was provided prior to 		<p>has been added to the Lab Quarterly report which is reported at Hospital Quality Council. The 2nd qtr report will be reported to Hospital Quality Council on September 17, 2015 and reported to the Board of Directors on October 26, 2015 5 The Rampart Radiology Offsite will be added to the Radiology Quarterly report which is reported at Hospital Quality Council. The 2nd qtr report will be reported to Hospital Quality Council on September 17, 2015 and reported to the Board of Directors on October 26, 2015. Person Responsible: Quality Director</p>	

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S 0330 Bldg. 00	<p>exit.</p> <p>410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1(c)(6)(K)</p> <p>(c) The governing board is responsible for managing the hospital. The governing board shall do the following: (6) Require that the chief executive officer develops policies and programs for the following:</p> <p>(K) Maintaining personnel records for each employee of the hospital which include personal data, education and experience, evidence of participation in job related educational activities, and records of employees which relate to post offer and subsequent physical examinations, immunizations, and tuberculin tests or chest x-ray, as applicable.</p> <p>Based on document review and interview, the facility failed to document it followed its policy to establish a baseline health screening for 1 (#P1) of 10 employee files reviewed.</p> <p>Findings:</p> <p>1. Review of hospital policy SPP NO: EH-4, entitled New Staff Member Health Screening, last revised 4-25-2015, indicated [a] hearing screening will be performed for employees that work in</p>	S 0330	<p>Upon further review it was found that no employees at Major Hospital meet the noise level which indicates a need for hearing screening pre-employment. SPP NO: EH 4 New Staff Member Health Screening will be revised with deletion of "Hearing screening will be performed for employees that work in areas where hearing protection is provided." The policy revision will be taken to the Infection Control Committee by the Infection Preventionist on August 12, 2015</p>	08/12/2015

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S 0406 Bldg. 00	<p>areas where hearing protection is provided.</p> <p>2. Review of 10 employee personnel files indicated file #P1 was an Engineering worker and the personnel file of employee #P1 lacked documentation of a hearing screening for the employee.</p> <p>3. In interview, on 5-19-2015 at 1:30 pm, employee #A6, Director of Engineering, indicated employee #P1 worked in areas where no hearing protection was provided.</p> <p>4. In interview on 5-20-2015 at 2:50 pm, employee #A7, Infection Control Preventionist, confirmed there was no documentation of a hearing screening for employee #P1 and no other documentation was provided prior to exit.</p> <p>410 IAC 15-1.4-2 QUALITY ASSESSMENT AND IMPROVEMENT</p>		Person Responsible: Infection Preventionist		

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	<p>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.</p> <p>Based on document review and interview, the hospital failed to include monitors and standards for 1 (autopsy) service provided by a contractor as part of its comprehensive quality assessment and performance improvement (QAPI) program for calendar year 2014.</p> <p>Findings:</p> <p>1. Review of the facility's QAPI program for calendar year 2014 indicated it did not include monitors and standards for the contracted service of autopsy.</p> <p>2. In interview on 5-20-2015 at 2:05 pm, employee #A4, Director of Quality confirmed the above and no further documentation was provided prior to exit.</p>	S 0406	<p>In 2014 there was one autopsy ordered at Major Hospital. It was performed by the contracted service. The physician who ordered and received the results of the autopsy completed a satisfaction survey indicating ratings for Communication, Service, Quality/Usability and Cost/Value. This will be reported to Hospital Quality Council on June 18, 2015 and to the Board of Directors on July 27, 2015 Person Responsible: Quality Director</p>	07/27/2015

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S 0554 Bldg. 00	<p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(a)</p> <p>(a) The hospital shall provide a safe and healthful environment that minimizes infection exposure and risk to patients, health care workers, and visitors.</p> <p>Based on document review and observation, the facility created 1 condition which failed to provide a healthful environment that minimized infection exposure and risk to patients and failed to ensure that Accucheck Control Solution was dated when opened on 3 of 6 units.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. On 5-18-2015 at 12:00 noon, it was observed in an ultrasound room there was an open CIDEX Solution Test Strip bottle. 2. Review of the manufacturer's recommendation for the bottle of Cidex Test Strips, indicated testing of positive and negative controls be performed on each newly opened test strip bottle of CIDEX Solution Test Strips. 3. On the above date and time, an ultrasound staff member (#R1) was requested to provide documentation of performing a positive and negative 	S 0554	<p>3 The open bottle of Cidex test strips was discarded on May 19, 2015. The Ultrasound Department has recently replaced Cidex with Trophon. If the use of Cidex is resintated the Ultrasound Department will utilize the the Central Sterile Cidex OPA Solution Log Sheet which includes the positive and negative test at the time of opening test strips. Person Responsible: Radiology Director</p> <p>6 The unlabeled Accucheck Control Solution bottles were replaced with newly opened bottles with the appropriate labeling of open date on May 21, 2015. The Nursing P&P "Accu-Chek Inform II" was updated on June 11, 2015 with the following information "Point of Care controls and test strips will be obtained from Lab. When opening vials of controls, the word "open" and the actual date will be placed on each control bottle by Clinical Staff. The controls are good for 3 months from open date." Appropriate staff were updated on the policy change. Person Responsible: Inpatient Clinical Practice Coordinator</p>	06/11/2015

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S 0592 Bldg. 00	<p>control test when the test strip bottle was opened. No documentation was provided by exit.</p> <p>4. Review of policy and procedure "Accu-chek Inform II Glucose Testing" issued on 10/24/13 indicated: Accu-Chek Inform II Controls: package contains 2 controls,Controls are stable for 3 months once opened or until the date printed on the control vials, whichever comes first.</p> <p>5. During the tour on 05/18/15 beginning at 1012 hours in the Emergency Department, accompanied by staff member #1, 2 open bottles of Accucheck Control Solution were observed to not have a date when opened.</p> <p>6. During tour on 05/19/15 beginning at 1345 hours on the Post Surgery Care Unit and the Adult Medical Unit, accompanied by staff member #2, 4 of 4 open bottles of Accucheck Control Solution were observed to not have date when opened.</p> <p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(f)(3)(D)(i)</p>			

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	<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 policy/procedure review, observation and interview, the facility failed to ensure that patient nourishment refrigerators were cleaned on 2 of 5 units.</p> <p>Findings:</p> <p>1. Review of policy and procedure, "Supplying Nourishment Pantries for Nursing Units" last reviewed 9/14 indicated under "Procedure": a. "2. Nursing will be responsible for the maintenance of all nourishment pantry equipment, and cleaning of refrigerators."</p> <p>2. On 5/18/15 at 1040 hours, the Adult Medical Unit was toured. The nourishment refrigerator was observed to have dried food on the shelves storing patient nourishments.</p>	S 0592	<p>All patient nourishment refrigerators were cleaned on the 5 units on June 11, 2015. All food that is stored in the patient nourishment refrigerators is packaged - Food Service recommended that patient nourishment refrigerators be cleaned once a month and as needed by nursing personnel. A cleaning log will be utilized to ensure that this cleaning is being done. Nursing Policy and Procedure: "Nursing Responsibility for the Nourishment Room" is being developed and will include this information to ensure that this cleaning is maintained. The policy and log will be completed by July 1, 2015 to ensure that refrigerators are cleaned on a monthly basis. Person Responsible: Inpatient Clinical Practice Coordinator</p>	06/11/2015

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S 0732 Bldg. 00	<p>3. On 5//18/15 at 1320 hours, the Obstetrics Unit was toured. The nourishment refrigerator was observed to have dried food on the shelves storing patient nourishments.</p> <p>4. On 5/19/15 at 1400 hours, staff #2 verified that the nursing units do not records of when the nourishment refrigerators were cleaned. He/she also indicated that the nursing units do not have a schedule for routine cleaning of the nourishment refrigerators.</p> <p>410 IAC 15-1.5-4 MEDICAL RECORD SERVICES 410 IAC 15-1.5-4(d)(1)(2)(3)(4)</p> <p>(d) The medical record shall contain sufficient information to:</p> <p>(1) identify the patient; (2) support the diagnosis; (3) justify the treatment; and (4) document accurately the course of treatment and results.</p> <p>Based on policy and procedure and medical record review, the facility failed to ensure that transfer documentation was completed on 1 (#11) or 4 medical records. The facility failed to ensure that restraint documentation was complete on 1 (#24) of 1 medical records.</p> <p>Findings:</p>	S 0732	4 The nurse who discharged the patient without the "Pt Request to Transfer" completed was informed of the missing documentation on 5/29/15. As of June 1st, 2015 all transfers from ICU will be monitored for the "Pt Request to Transfer" and this will be documented on the ICU quarterly quality report which is submitted to Hospital Quality Council.	06/12/2015

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	<p>1. Review of policy and procedure SPP NS: 21, " Transfer of Patients to Other Facilities/EMTALA Compliance", last revised 12/10/13 indicated under "Procedure":</p> <p>1. All patient transfers.</p> <p>1.122 The District 5 Authorization For Transfer form section "Patient Request for Transfer must be signed and witnessed."</p> <p>2. Review of policy and procedure, "Nursing Unit Guidelines for Arranging Transfers", last revised 1/14 indicated under "Procedure":</p> <p>"Please refer to SPP NS: 21 Transfer of Patients to Other Facilities EMTALA Compliance."</p> <p>3. Review of policy and procedure, SPP NS: 14, "Use of Restraints and Seclusion", last revised 2/26/15 indicated:</p> <p>2.7 Patient monitoring and reassessment will be documented by a RN trained in</p> <p>restraint/seclusion practices at least every hour and will include safety, comfort, mental status, skin integrity/circulation checks, fluids and nourishment, toileting, range of motion and</p> <p>systematic release, readiness for</p>		<p>Person Responsible: Director of Inpatient Nursing</p> <p>5. When restraints are applied for violent reasons, a staff member at the ED desk will use a timer to ensure that observation of the patient is completed every 15 minutes by the appropriate staff member. The Quality department will review the next 10 violent restraints in the ED to ensure that the documentation for observation every 15 minutes is completed.</p> <p>Person Responsible: ER Director</p>	

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S 0952 Bldg. 00	<p>release from restraint/seclusion and the charge nurse's knowledge of restraint/seclusion use. VS will be monitored per individualized plan of care and PRN. Patients will be observed by clinical staff every 15 minutes.</p> <p>4. Review of medical record (MR) #11 indicated that patient was transferred to another acute care facility, the MR did not have evidence that a "Patient Request for Transfer" was completed.</p> <p>5. Review of medical record #24 indicated that the patient had restraints ordered on 6/8/14 in the Emergency Department. The MR did not have evidence that the patient was observed every 15 minutes after the restraints were applied.</p> <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</p>			

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S 1118 Bldg. 00	<p>administered by personnel other than physicians, the personnel shall have special training for these procedures in accordance with subsection (b)(6). Based on policy/procedure review, and transfusion record review, the facility failed to follow an approved medical staff policy/procedure for the administration of blood and blood products for one (T#6) of six transfusion records reviewed.</p> <p>Findings included:</p> <ol style="list-style-type: none"> On 5/19/15 review of a policy/procedure titled: "ADMINISTRATION OF BLOOD AND BLOOD PRODUCTS, NPP: BT-1, Latest revision or review: FEB 2015" on page 6 stated: "12.6 Obtain another set of vital signs one hour after completion of unit of blood and record in transfusion record, with 5 minute deviation." On 5/20/15 during review of transfusion records T#1 through T#6, documentation indicated T#6 was stopped at 12:49 but the one hour post transfusion set of vitals were not taken until 15:30 which exceeds policy/procedure by almost 3 hours. <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</p>			S 0952	<p>Upon further review of the medical record of T#6 the documentation of the stop time for the transfusion was documented incorrectly at 12:49 The Oncology Nurse's Notes state: "second unit of PRBC finished infusion at 14:30" The 1 hour post transfusion vital signs were taken at 15:30. The Oncology Nursing Staff was educated on the importance of the documenting in the Transfusion Administration Record (TAR) on June 10, 2015. Since the number of transfusions in Oncology is not that great, all transfusions will be monitored for accurate documentation and this will be reported on the Medical Oncology quarterly quality report. Person Responsible: Medical Oncology Manager</p>		06/10/2015

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	<p>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, interview and document review, the hospital created 2 conditions which resulted in a hazard to patients, public or employees.</p> <p>Findings:</p> <p>1. On 5-18-2015 at 11:50 am, in the presence of employee #A1, Vice President Facility Operations, and employee #A6, Director of Engineering, it was observed in the gas storage area there were 8 large cylinders tanks of nitrous oxide standing upright and not secured by chain or holder. If any of the above cylinder tanks were knocked over and broke the head off the compressed gas cylinder, it could result in harm to people and/or property.</p> <p>2. On 5-18-2015 at 3:00 pm, in the presence of employees #A1 and #A6, it was observed at the offsite Benessee Oncology building, Computerized Tomography (CT) Simulator room, there was a hot water bath used to soften an</p>	S 1118	<p>1 The 8 large cylinder tanks of nitrous oxide were secured by a chain to the wall on May 18, 2015. The Engineering Staff were informed of this requirement on May 18, 2015.</p> <p>Personal Responsible: Engineering Manager</p> <p>2-3 A temperature log was created for the hot water bath used to soften an aqua plastic face mask in the CT Simulator room. Whenever this hot water bath is used the Date Used, Temperature and Initials will be logged. This hot water bath is preheated before each use so a daily log would not be beneficial. Staff who use the hot water bath were informed of the new requirement</p> <p>Person Responsible: Radiation Oncology Manager</p>	05/27/2015

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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>aqua plastic face mask. The temperature reading of the hot water bath was 155 degrees Fahrenheit.</p> <p>3. On 5-15-2015 at 3:00 PM, an employee (#E1) who used the hot water bath was requested to provide documentation of the water temperature whenever the hot water bath was used, and the employee indicated there was no such documentation. No other documentation was provided by exit.</p>			