

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152014	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 06/20/2016
--------------------------------------------------	-----------------------------------------------------------------	---------------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER SELECT SPECIALTY HOSPITAL-EVANSVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 400 SE 4TH ST EVANSVILLE, IN 47713
--------------------------------------------------------------------------	--------------------------------------------------------------------------------

(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
A 0000 Bldg. 00	<p>This visit was for a Federal investigation of a complaint.</p> <p>Complaint #IN00199509 Unsubstantiated; lack of sufficient evidence. An unrelated deficiency is cited.</p> <p>Date of survey: 6/20/16</p> <p>Facility Number: 009443</p> <p>QA: 7/7/16 jlh</p>	A 0000		
A 0395 Bldg. 00	<p>482.23(b)(3) RN SUPERVISION OF NURSING CARE A registered nurse must supervise and evaluate the nursing care for each patient. Based on document review and interview, the nurse executive failed to ensure nursing personnel followed established Central Venous Access Device policies and procedures (P&P) for 10 of 10 patient medical records (MR) (P1-P10).</p> <p>Findings:</p> <p>1. Review of the policy titled Central Venous Access Devices (CVAD),</p>	A 0395	<p>A0395: WHAT: All nursing staff on the current schedule will be re-educated on Policy C-56-N Central Venous Access Devices (CVAD) (General Policy Information) to include key components of the central line post insertion care and maintenance bundle and Policy C-56-N-2 Central Venous Access Devices (CVAD) (Maintenance, Site Care, Access/De-access, Removal).</p>	07/16/2016

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152014		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/20/2016	
NAME OF PROVIDER OR SUPPLIER SELECT SPECIALTY HOSPITAL-EVANSVILLE				STREET ADDRESS, CITY, STATE, ZIP CODE 400 SE 4TH ST EVANSVILLE, IN 47713			
(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>Number C-56-N, indicated the following:</p> <p>a. CVADs include centrally inserted catheters, peripherally inserted central catheters (PICCs), and implantable ports.</p> <p>b. The key components of the Central Line Post Insertion Care and Maintenance Bundle are:</p> <p style="padding-left: 40px;">* Hand Hygiene * Aseptic technique during dressing changes</p> <p>*Consistent care during dressing changes, tubing changes, cap changes, flushes, line accessing by providing specific procedures *Ensuring patency of the line</p> <p>c. RN (registered nurse) staff will be responsible for care and maintenance of all central lines</p> <p>d. Dressing changes will be done...</p> <p style="padding-left: 40px;">*Whenever the dressing becomes damp, loosened or visible soiled</p> <p>*TSM (transparent dressing) every 7 days</p> <p>*Gauze dressings every 2 days *A gauze dressing underneath a TSM dressing is considered a gauze dressing</p> <p>e. Tubing changes, flushing and locking of devices will be done per policy/procedure</p> <p>f. Caps will be changed once a week during dressing change...</p> <p>g. The policy was approved 3/10/16 and issued 4/1/16</p> <p>2. Review of the policy titled Central</p>		<p>WHO:</p> <p>The Chief Nursing Officer will be responsible for the overall correction and on-going compliance.</p> <p>HOW:</p> <p>The Director of Quality Management will audit a total of 30 cases of patients with central venous access per month to ensure nursing personnel followed established central venous access device policies and procedures. The numerator will be the number of central venous access cases in compliance with Policy C-56-N and C-56-N-2 and the denominator will be the 30 cases of patients with central venous access. This will be audited until a goal of 100% is reached for 3 months.</p> <p>Non-compliance may result in disciplinary action up to termination of employment. Results will be reported in monthly Quality Assessment and Performance meetings and quarterly in Organization Improvement Committee, Medical Executive Committee and Governing Board.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152014	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/20/2016
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER SELECT SPECIALTY HOSPITAL-EVANSVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 400 SE 4TH ST EVANSVILLE, IN 47713
--------------------------------------------------------------------------	--------------------------------------------------------------------------------

(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>Venous Access Devices (CVAD), Number C56-N-2, indicated the following:</p> <ul style="list-style-type: none"> a. Administration sets, including add-on-devices, are changed at established intervals... b. Administration Set Change Frequency by Administration Type: <ul style="list-style-type: none"> i. Continuous - every 72-96 hours ii. Intermittent - every 24 hours iii. Intravenous fat emulsion - every 12 hours/with each container change iv. Parenteral Nutrition - every 24 hours c. Assessment, Site Care/Dressing Changes: <ul style="list-style-type: none"> i. CVAD catheter site care and dressing changes are performed at established intervals and...as follows: *Whenever the dressing becomes damp, loosened or visible soiled *TSM (transparent dressing) every 7 days *Gauze dressings every 2 days *A gauze dressing underneath a TSM dressing is considered a gauze dressing d. Documentation: *Performance of procedure, including type of antiseptic solution/type of dressing *Patient's response to the procedure *Instructions given to patient e. Accessing and Deaccessing 			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152014	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/20/2016
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER SELECT SPECIALTY HOSPITAL-EVANSVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 400 SE 4TH ST EVANSVILLE, IN 47713
--------------------------------------------------------------------------	--------------------------------------------------------------------------------

(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>Implanted Vascular Access Ports:</p> <p>i. When administering an infusion via an implanted port, the noncoring needle is replaced at least every 7 days.</p> <p>ii. A sterile dressing is maintained over the access site if the implanted vascular access port remains accessed.</p> <p>f. Documentation: *Appearance of port site *Performance of procedure *Noncoring needle gauge/length *Medication/solution administration *Pain management interventions *Flush/lock solution and volume * Patient education * Patient's response to the procedure</p> <p>g. The policy was approved 3/10/16 and issued 4/1/16</p> <p>3. Review of patient MRs indicated the following:</p> <p>a. P1 was admitted to the hospital on 1/21/16 with a PAC (implanted port) in place, was administered continuous, intermittent, fat emulsion and parenteral nutrition infusion solutions throughout the course of stay and discharged 2/4/16. The MR lacked documentation of PAC dressing change procedures, at least every 7 days per P&P, that included type of antiseptic solution/type of dressing, patient's response to the procedure and instructions given to patient, lacked</p>			
--	---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152014	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/20/2016
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER SELECT SPECIALTY HOSPITAL-EVANSVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 400 SE 4TH ST EVANSVILLE, IN 47713
--------------------------------------------------------------------------	--------------------------------------------------------------------------------

(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>documentation of any tubing changes and lacked documentation of cap changes every 7 days.</p> <p>b. P2 was admitted to the hospital on 11/25/15 with a PAC in place, was administered intermittent infusions and discharged on 12/9/15. The MR lacked documentation of the PAC needle being changed after 11/25/15, dressing changes per P&P with documentation of procedure including type of antiseptic solution/type of dressing, patient's response to the procedure and instructions given to patient for any dressing change or cap change every 7 days.</p> <p>c. Review of P3's MR indicated P3 was admitted to the hospital on 1/27/16 with a HD (hemodialysis) catheter in place, was administered intermittent infusions and discharged on 2/29/16. The MR indicated a "permacath" was placed in the right chest on 2/4/16 at 19:40 hrs. Nursing IV Documentation dated 2/16/16 at 9:11 hrs indicated the patient had a PICC (peripherally inserted central catheter). Dialysis Treatment Records indicated CVAD dressing changes were done on 2/8/16, 2/10/16, 2/15/16 and 2/19/16 but lacked documentation of which dressing, type of solution/type of dressing, patient's response and instructions given to patient for the 2/8/16, 2/10/16 and 2/15/16</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152014	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/20/2016
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER SELECT SPECIALTY HOSPITAL-EVANSVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 400 SE 4TH ST EVANSVILLE, IN 47713
--------------------------------------------------------------------------	--------------------------------------------------------------------------------

(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>dressing changes. The Dialysis Treatment Record also indicated a dressing change was performed on 2/23/16, but lacked documentation of which dressing, type of solution/type of dressing and instructions given to patient. The MR lacked other documentation of CVAD dressing changes every 7 days per P&P with documentation of procedure including type of antiseptic solution/type of dressing, patient's response to the procedure and instructions given to patient for any dressing changes.</p> <p>d. P4 was admitted to the hospital on 1/19/16 was administered intermittent and continuous infusion solutions and discharged 3/1/16. The MR indicated an existing IJ device was removed and replaced with another triple lumen IJ catheter on 1/26/16. The MR lacked documentation of CVAD dressing changes every 7 days per P&P with performance of procedures that included type of antiseptic solution/type of dressing, patient's response to the procedure and instructions given to patient for any dressing change and lacked, lacked documentation of any tubing changes and lacked documentation of cap changes every 7 days.</p> <p>e. P5 was admitted to the hospital on 9/9/15 was administered intermittent and continuous infusions throughout the stay and discharged on 2/4/16. MR IV</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152014	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/20/2016
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER SELECT SPECIALTY HOSPITAL-EVANSVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 400 SE 4TH ST EVANSVILLE, IN 47713
--------------------------------------------------------------------------	--------------------------------------------------------------------------------

(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>documentation indicated on 10/7/15 the patient had a Trialysis infusion catheter and on 12/7/15 a ML (midline) infusion catheter. The MR lacked documentation of Trialysis or ML dressing change procedures, at least every 7 days per P&P, that included type of antiseptic solution/type of dressing, patient's response to the procedure and instructions given to patient lacked documentation of any tubing changes and lacked documentation of cap changes every 7 days.</p> <p>f. P6 was admitted to the hospital on 10/12/15 with a PICC (peripherally inserted central catheter) in place, was administered intermittent IV medications and discharged on 11/11/15. The MR lacked documentation of PICC dressing change procedures that included type of antiseptic solution/type of dressing, patient's response to the procedure and instructions given to patient. Nursing IV Documentation for 11/13/15 at 21:50 hrs, 11/14/15 at 20:32 hrs and 11/24/15 at 7:15 hrs was void of catheter type/site code, PICC Line Bundle, Justification for patient having a central line, Location, Insertion date, Phlebitis scale, Last Date Dressing Changed and Injection cap changed documentation.</p> <p>g. P7 was admitted to the hospital on 6/15/16 with a PICC in place, had been administered intermittent and</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152014	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/20/2016
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER SELECT SPECIALTY HOSPITAL-EVANSVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 400 SE 4TH ST EVANSVILLE, IN 47713
--------------------------------------------------------------------------	--------------------------------------------------------------------------------

(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>continuous infusions and was an in-patient at time of survey. The MR lacked documentation of PICC dressing change procedures that included type of antiseptic solution, patient's response to the procedure and instructions given to patient for any dressing change and lacked documentation of any tubing changes.</p> <p>h. P8 was admitted to the hospital on 6/9/16 and was an in-patient at time of survey. The MR indicated the patient had IV push medications, fat emulsion and parenteral nutrition infusions. Nursing IV Documentation on 6/13/16 indicated the patient had a PICC in place. The MR lacked documentation of PICC dressing change procedures that included type of antiseptic solution, patient's response to the procedure and instructions given to patient for any dressing change and lacked documentation of any tubing changes.</p> <p>i. P9 was admitted to the hospital on 6/15/16 and was an in-patient at time of survey. The MR indicated the patient had IV push medications and intermittent infusions. Nursing IV Documentation on 6/15/16 indicated the patient had a PICC in place. The MR lacked documentation of PICC dressing change procedures that included type of antiseptic solution, patient's response to the procedure and instructions given to</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152014	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/20/2016
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER SELECT SPECIALTY HOSPITAL-EVANSVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 400 SE 4TH ST EVANSVILLE, IN 47713
--------------------------------------------------------------------------	--------------------------------------------------------------------------------

(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>patient for any dressing change and lacked documentation of any tubing changes.</p> <p>j. P10 was admitted to the hospital on 1/11/16 with a PAC in place, was administered continuous, intermittent, fat emulsion and parenteral nutrition infusion solutions throughout the course of stay and discharged 1/25/16. Nursing IV Documentation dated 1/11/16 at 19:18 hrs indicated the Last Date Dressing Changed as "01/12/2016". The MR lacked documentation of PAC dressing change procedures that included type of antiseptic solution/type of dressing, patient's response to the procedure and instructions given to patient for any dressing change and lacked documentation of any tubing changes.</p> <p>4. On 6/20/16 at 12:30 pm, A3, Infection Control Nurse, indicated the facility had identified inconsistencies in CVAD dressing changes and implemented a plan of action for one specified nurse to perform all scheduled dressing changes. This was implemented at the end of February 2016. At 5:30 pm, A3 indicated review of MRs since the new process did not show documentation of dressing changes per policy/procedure and that tubing change documentation was not included in the MR.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152014	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 06/20/2016
--------------------------------------------------	-----------------------------------------------------------------	---------------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER SELECT SPECIALTY HOSPITAL-EVANSVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 400 SE 4TH ST EVANSVILLE, IN 47713
--------------------------------------------------------------------------	--------------------------------------------------------------------------------

(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
S 0000 Bldg. 00	<p>This visit was for a State investigation of a complaint.</p> <p>Complaint #IN00199509 Unsubstantiated; lack of sufficient evidence. A State deficiency unrelated to the allegations is cited.</p> <p>Date of survey: 6/20/16</p> <p>Facility Number: 009443</p> <p>QA: 7/7/16 jlh</p>	S 0000		
S 0912 Bldg. 00	<p>410 IAC 15-1.5-6 NURSING SERVICE 410 IAC 15-15-6 (a)(2)(B)(i)(ii) (iii)(iv)(v)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152014	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 06/20/2016
--------------------------------------------------	-----------------------------------------------------------------	---------------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER SELECT SPECIALTY HOSPITAL-EVANSVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 400 SE 4TH ST EVANSVILLE, IN 47713
--------------------------------------------------------------------------	--------------------------------------------------------------------------------

(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>(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 document review and interview, the nurse executive failed to ensure nursing personnel followed established Central Venous Access Device policies and procedures (P&P) for 10 of 10 patient medical records (MR) (P1-P10).</p>	S 0912	<p>S0912: WHAT: All nursing staff on the current schedule will be re-educated on Policy C-56-N Central Venous Access Devices (CVAD) (General Policy Information) to include key components of the central line post insertion care and maintenance bundle and Policy C-56-N-2 Central</p>	07/16/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152014	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/20/2016
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER SELECT SPECIALTY HOSPITAL-EVANSVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 400 SE 4TH ST EVANSVILLE, IN 47713
--------------------------------------------------------------------------	--------------------------------------------------------------------------------

(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>Findings:</p> <p>1. Review of the policy titled Central Venous Access Devices (CVAD), Number C-56-N, indicated the following:</p> <p>a. CVADs include centrally inserted catheters, peripherally inserted central catheters (PICCs), and implantable ports.</p> <p>b. The key components of the Central Line Post Insertion Care and Maintenance Bundle are:</p> <p style="padding-left: 40px;">* Hand Hygiene * Aseptic technique during dressing changes</p> <p>*Consistent care during dressing changes, tubing changes, cap changes, flushes, line accessing by providing specific procedures</p> <p>*Ensuring patency of the line</p> <p>c. RN (registered nurse) staff will be responsible for care and maintenance of all central lines</p> <p>d. Dressing changes will be done...</p> <p style="padding-left: 40px;">*Whenever the dressing becomes damp, loosened or visible soiled</p> <p>*TSM (transparent dressing) every 7 days</p> <p>*Gauze dressings every 2 days *A gauze dressing underneath a TSM dressing is considered a gauze dressing</p> <p>e. Tubing changes, flushing and locking of devices will be done per policy/procedure</p> <p>f. Caps will be changed once a week during dressing change...</p>		<p>Venous Access Devices (CVAD) (Maintenance, Site Care, Access/De-access,Removal).</p> <p>WHO: The Chief Nursing Officer will be responsible for the overall correction and on-going compliance.</p> <p>HOW: The Director of Quality Management will audit a total of 30 cases of patients with central venous access per month to ensure nursing personnel followed established central venous access device policies and procedures. The numerator will be the number of central venous access cases in compliance with Policy C-56-N and C-56-N-2 and the denominator will be the 30 cases of patients with central venous access. This will be audited until a goal of 100% is reached for 3 months. Non-compliance may result in disciplinary action up to termination of employment. Results will be reported in monthly Quality Assessment and Performance meetings and quarterly in Organization Improvement Committee, Medical Executive Committee and Governing Board.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152014	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 06/20/2016
--------------------------------------------------	-----------------------------------------------------------------	---------------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER SELECT SPECIALTY HOSPITAL-EVANSVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 400 SE 4TH ST EVANSVILLE, IN 47713
--------------------------------------------------------------------------	--------------------------------------------------------------------------------

(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>g. The policy was approved 3/10/16 and issued 4/1/16</p> <p>2. Review of the policy titled Central Venous Access Devices (CVAD), Number C56-N-2, indicated the following:</p> <p>a. Administration sets, including add-on-devices, are changed at established intervals...</p> <p>b. Administration Set Change Frequency by Administration Type:</p> <p>i. Continuous - every 72-96 hours</p> <p>ii. Intermittent - every 24 hours</p> <p>iii. Intravenous fat emulsion - every 12 hours/with each container change</p> <p>iv. Parenteral Nutrition - every 24 hours</p> <p>c. Assessment, Site Care/Dressing Changes:</p> <p>i. CVAD catheter site care and dressing changes are performed at established intervals and...as follows: *Whenever the dressing becomes damp, loosened or visible soiled *TSM (transparent dressing) every 7 days *Gauze dressings every 2 days *A gauze dressing underneath a TSM dressing is considered a gauze dressing</p> <p>d. Documentation: *Performance of procedure, including type of antiseptic</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152014	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/20/2016
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER SELECT SPECIALTY HOSPITAL-EVANSVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 400 SE 4TH ST EVANSVILLE, IN 47713
--------------------------------------------------------------------------	--------------------------------------------------------------------------------

(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>solution/type of dressing *Patient's response to the procedure *Instructions given to patient</p> <p>e. Accessing and Deaccessing Implanted Vascular Access Ports:</p> <p>i. When administering an infusion via an implanted port, the noncoring needle is replaced at least every 7 days.</p> <p>ii. A sterile dressing is maintained over the access site if the implanted vascular access port remains accessed.</p> <p>f. Documentation: *Appearance of port site *Performance of procedure *Noncoring needle gauge/length *Medication/solution administration *Pain management interventions *Flush/lock solution and volume * Patient education * Patient's response to the procedure</p> <p>g. The policy was approved 3/10/16 and issued 4/1/16</p> <p>3. Review of patient MRs indicated the following:</p> <p>a. P1 was admitted to the hospital on 1/21/16 with a PAC (implanted port) in place, was administered continuous, intermittent, fat emulsion and parenteral nutrition infusion solutions throughout the course of stay and discharged 2/4/16. The MR lacked documentation of PAC dressing change procedures, at least every</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152014	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 06/20/2016
--------------------------------------------------	-----------------------------------------------------------------	---------------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER SELECT SPECIALTY HOSPITAL-EVANSVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 400 SE 4TH ST EVANSVILLE, IN 47713
--------------------------------------------------------------------------	--------------------------------------------------------------------------------

(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>7 days per P&P, that included type of antiseptic solution/type of dressing, patient's response to the procedure and instructions given to patient, lacked documentation of any tubing changes and lacked documentation of cap changes every 7 days.</p> <p>b. P2 was admitted to the hospital on 11/25/15 with a PAC in place, was administered intermittent infusions and discharged on 12/9/15. The MR lacked documentation of the PAC needle being changed after 11/25/15, dressing changes per P&P with documentation of procedure including type of antiseptic solution/type of dressing, patient's response to the procedure and instructions given to patient for any dressing change or cap change every 7 days.</p> <p>c. Review of P3's MR indicated P3 was admitted to the hospital on 1/27/16 with a HD (hemodialysis) catheter in place, was administered intermittent infusions and discharged on 2/29/16. The MR indicated a "permacath" was placed in the right chest on 2/4/16 at 19:40 hrs. Nursing IV Documentation dated 2/16/16 at 9:11 hrs indicated the patient had a PICC (peripherally inserted central catheter). Dialysis Treatment Records indicated CVAD dressing changes were done on 2/8/16, 2/10/16, 2/15/16 and 2/19/16 but</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152014	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/20/2016
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER SELECT SPECIALTY HOSPITAL-EVANSVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 400 SE 4TH ST EVANSVILLE, IN 47713
--------------------------------------------------------------------------	--------------------------------------------------------------------------------

(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>lacked documentation of which dressing, type of solution/type of dressing, patient's response and instructions given to patient for the 2/8/16, 2/10/16 and 2/15/16 dressing changes. The Dialysis Treatment Record also indicated a dressing change was performed on 2/23/16, but lacked documentation of which dressing, type of solution/type of dressing and instructions given to patient. The MR lacked other documentation of CVAD dressing changes every 7 days per P&P with documentation of procedure including type of antiseptic solution/type of dressing, patient's response to the procedure and instructions given to patient for any dressing changes.</p> <p>d. P4 was admitted to the hospital on 1/19/16 was administered intermittent and continuous infusion solutions and discharged 3/1/16. The MR indicated an existing IJ device was removed and replaced with another triple lumen IJ catheter on 1/26/16. The MR lacked documentation of CVAD dressing changes every 7 days per P&P with performance of procedures that included type of antiseptic solution/type of dressing, patient's response to the procedure and instructions given to patient for any dressing change and lacked, lacked documentation of any tubing changes and lacked documentation of cap changes every 7 days.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152014	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/20/2016
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER SELECT SPECIALTY HOSPITAL-EVANSVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 400 SE 4TH ST EVANSVILLE, IN 47713
--------------------------------------------------------------------------	--------------------------------------------------------------------------------

(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>e. P5 was admitted to the hospital on 9/9/15 was administered intermittent and continuous infusions throughout the stay and discharged on 2/4/16. MR IV documentation indicated on 10/7/15 the patient had a Trialysis infusion catheter and on 12/7/15 a ML (midline) infusion catheter. The MR lacked documentation of Trialysis or ML dressing change procedures, at least every 7 days per P&P, that included type of antiseptic solution/type of dressing, patient's response to the procedure and instructions given to patient lacked documentation of any tubing changes and lacked documentation of cap changes every 7 days.</p> <p>f. P6 was admitted to the hospital on 10/12/15 with a PICC (peripherally inserted central catheter) in place, was administered intermittent IV medications and discharged on 11/11/15. The MR lacked documentation of PICC dressing change procedures that included type of antiseptic solution/type of dressing, patient's response to the procedure and instructions given to patient. Nursing IV Documentation for 11/13/15 at 21:50 hrs, 11/14/15 at 20:32 hrs and 11/24/15 at 7:15 hrs was void of catheter type/site code, PICC Line Bundle, Justification for patient having a central line, Location, Insertion date, Phlebitis scale, Last Date Dressing Changed and Injection cap</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152014	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/20/2016
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER SELECT SPECIALTY HOSPITAL-EVANSVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 400 SE 4TH ST EVANSVILLE, IN 47713
--------------------------------------------------------------------------	--------------------------------------------------------------------------------

(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>changed documentation.</p> <p>g. P7 was admitted to the hospital on 6/15/16 with a PICC in place, had been administered intermittent and continuous infusions and was an in-patient at time of survey. The MR lacked documentation of PICC dressing change procedures that included type of antiseptic solution, patient's response to the procedure and instructions given to patient for any dressing change and lacked documentation of any tubing changes.</p> <p>h. P8 was admitted to the hospital on 6/9/16 and was an in-patient at time of survey. The MR indicated the patient had IV push medications, fat emulsion and parenteral nutrition infusions. Nursing IV Documentation on 6/13/16 indicated the patient had a PICC in place. The MR lacked documentation of PICC dressing change procedures that included type of antiseptic solution, patient's response to the procedure and instructions given to patient for any dressing change and lacked documentation of any tubing changes.</p> <p>i. P9 was admitted to the hospital on 6/15/16 and was an in-patient at time of survey. The MR indicated the patient had IV push medications and intermittent infusions. Nursing IV Documentation on 6/15/16 indicated the patient had a PICC in place. The MR lacked</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152014	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 06/20/2016
--------------------------------------------------	-----------------------------------------------------------------	---------------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER SELECT SPECIALTY HOSPITAL-EVANSVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 400 SE 4TH ST EVANSVILLE, IN 47713
--------------------------------------------------------------------------	--------------------------------------------------------------------------------

(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>documentation of PICC dressing change procedures that included type of antiseptic solution, patient's response to the procedure and instructions given to patient for any dressing change and lacked documentation of any tubing changes.</p> <p>j. P10 was admitted to the hospital on 1/11/16 with a PAC in place, was administered continuous, intermittent, fat emulsion and parenteral nutrition infusion solutions throughout the course of stay and discharged 1/25/16. Nursing IV Documentation dated 1/11/16 at 19:18 hrs indicated the Last Date Dressing Changed as "01/12/2016". The MR lacked documentation of PAC dressing change procedures that included type of antiseptic solution/type of dressing, patient's response to the procedure and instructions given to patient for any dressing change and lacked documentation of any tubing changes.</p> <p>4. On 6/20/16 at 12:30 pm, A3, Infection Control Nurse, indicated the facility had identified inconsistencies in CVAD dressing changes and implemented a plan of action for one specified nurse to perform all scheduled dressing changes. This was implemented at the end of February 2016. At 5:30 pm, A3 indicated review of MRs since the new process did</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152014	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/20/2016
NAME OF PROVIDER OR SUPPLIER SELECT SPECIALTY HOSPITAL-EVANSVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 400 SE 4TH ST EVANSVILLE, IN 47713		
(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	
	not show documentation of dressing changes per policy/procedure and that tubing change documentation was not included in the MR.				