

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150048	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 02/18/2015
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NAME OF PROVIDER OR SUPPLIER REID HOSPITAL & HEALTH CARE SERVICES	STREET ADDRESS, CITY, STATE, ZIP CODE 1100 REID PKWY RICHMOND, IN 47374
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S 000 Bldg. 00	<p>This visit was for a standard licensure survey.</p> <p>Facility Number: 005044</p> <p>Survey Date: 2-16/18-15</p> <p>Surveyors: Jack I. Cohen, MHA Medical Surveyor</p> <p>Albert Daeger Medical Surveyor</p> <p>Marcia Anness, RN Public Health Nurse Surveyor</p> <p>Cleone Peterson Medical Surveyor</p> <p>QA: cloughlin 03/13/15</p>	S 000		
S 270 Bldg. 00	<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</p>			

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>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 failed to review reports of quality activities for 1 directly-provided service, 1 contracted service, and 1 other activity for the calendar year 2014.</p> <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 reports for the directly-provided service of massage therapy. 2. Review of the governing board minutes for calendar year 2014 indicated they did not include review of reports for the contracted service tissue transplant. 3. Review of the governing board minutes for calendar year 2014 indicated they did not include review of reports for the other activity of response to patient emergency. 4. In interview, on 2-18-15 at 11:30 am, 	S 270	<ol style="list-style-type: none"> 1. Massage therapy selected quality indicators and began collecting data for these indicators March 10, 2015. This data will be submitted to the Quality Department by May 15, 2015 and reviewed at the June 10, 2015 Quality Committee and the June 22, 2015 Governing Board. Data will continue to be collected and submitted quarterly and included in the Quality Department report which goes to the Governing Board quarterly. Responsible parties: Casey McPherson, Massage Therapy supervisor, and Sally Stohler, Director of Quality 2. Vendor for tissues has been contacted for quality data on their products. This data will be added to the annual review of clinical contracts, with the first review at the May 13, 2015 Quality Committee and May 18, 2015 Governing Board meeting. Responsible parties: Christy Brewer, Clinical Director, Surgery, and Sally Stohler, Director of Quality 3. A Code Blue review committee has been formed with the intent to review Code Blue and Rapid Response 	03/10/2015	

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S 406 Bldg. 00	<p>employee #A8, Director of Quality, confirmed all the above and no further documentation was provided prior to exit.</p> <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 hospital failed to include monitors and standards for 1 service directly-provided by the hospital, and 1 service provided by a contractor as part of its comprehensive quality assessment and performance improvement (QAPI) program for calendar year 2014.</p>	S 406	<p>events. Reports will be made to the Medical Care Evaluation Committee, then Quality Committee, and then the Governing Board. The first report will be available at the May 13, 2015 Quality Committee and May 18, 2015 Governing Board meetings. Ongoing, quarterly reports will be presented. Responsible parties: Amy Engle, Critical Care Instructor, and Sally Stohler, Director of Quality</p> <p>1. Massage therapy selected quality indicators and began collecting data for these indicators March 10, 2015. This data will be submitted to the Quality Department by May 15, 2015 and reviewed at the June 10, 2015 Quality Committee and the June 22, 2015 Governing Board. Data will continue to be collected and</p>	03/10/2015

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S 554 Bldg. 00	<p>Findings:</p> <ol style="list-style-type: none"> Review of the facility's QAPI program for calendar year 2014 indicated it did not include monitors and standards for the directly-provided service of massage therapy. Review of the facility's QAPI program for calendar year 2014 indicated it did not include monitors and standards for the contracted service of tissue transplant. In interview, on 2-18-2015 at 11:30 am, employee #A8, Director of Quality, confirmed all the above and no further documentation was provided prior to exit. <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 observation , the facility failed to ensure that the covering of reusable patient equipment was intact.</p> <p>Findings include:</p>			S 554	<p>submitted quarterly and included in the Quality Department report which goes to the Governing Board monthly. Responsible parties: Casey McPherson, Massage Therapy supervisor, and Sally Stohler, Director of Quality2. Vendor for tissues has been contacted for quality data on their products. This data will be added to the annual review of clinical contracts, with the first review at the May 13, 2015 Quality Committee and May 18, 2015 Governing Board meeting. Responsible parties: Christy Brewer, Clinical Director, Surgery, and Sally Stohler, Director of Quality</p> <p>All positioning pads were removed from service on February 17, 2015. Replacement pads were purchased and installed on March 25, 2015. Responsible party: Christy Brewer, Clinical Director, Surgery.</p>		03/25/2015

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S 594 Bldg. 00	<p>1. During observation beginning at 9:30 AM on 2/17/15, the following was observed in the Surgery Department:</p> <p>(A) Outside OR #4, there was a plastic covered positioning pad with breaks in the covering.</p> <p>(B) In the sub-sterile equipment alcove, there was positioning pads with breaks in the covering and split seams.</p> <p>2. During observation beginning at 11:15 AM on 2/17/15, the following was observed in the Ambulatory Surgery Center in the Professional Building:</p> <p>(A) On a cart in the sub-sterile hall, there was one positioning pad with breaks in the covering.</p> <p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(f)(3)(D)(ii)</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>(ii) Universal precautions, including</p>			

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S 160	<p>infectious waste management.</p> <p>Based on observation and staff interview, the hospital failed to ensure the Sleep Center's clean equipment processing of sleep study's face masks was done in a safe and clean environment.</p> <p>Findings included:</p> <ol style="list-style-type: none"> At 9:25 AM on 2/17/2015, the Sleep Center Soiled Utility room was observed with a cart of soiled linen and on the counter was a Hurricane dryer. The dryer was to air dry sleep study face masks. Therefore, the soiled utility room was storing soiled linen and processing clean sleep study face masks in the same room. At 9:30 AM on 2/17/2015, staff member A6 (Engineering Director) confirmed that processing the clean face masks should not be done in the Soiled Utility Room. 	S 594	<ol style="list-style-type: none"> Soiled linen is now stored in an approved cart located in the room next to the Coordinator's office. This room will be locked at all times. The former Soiled Linen room will now be designated as the Equipment Cleaning Room. It will be used only for the cleaning and drying of equipment used in recording polysomnograms – CPAP masks, tubing, headgear, humidifiers, electrodes, belts, etc. Equipment will be cleaned per Sleep Disorders Center policy EQ-002 (attached.) All equipment will be cleaned in the Equipment Cleaning Room. Responsible parties: Kevin Hurlburt, Sleep Lab Coordinator and Greg Carter, Infection Control Practitioner 	03/31/2015	
	410 IAC 15-1.5-8				

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Bldg. 00	<p>PHYSICAL PLANT 410 IAC 15-1.5-8(d)(1)</p> <p>(d) The equipment requirements are as follows:</p> <p>(1) All equipment shall be in good working order and regularly serviced and maintained.</p> <p>Based on observation, documentation review, and staff interview, the facility failed to assure two blanket warming cabinets were maintained in good working order.</p> <p>Findings included:</p> <p>1. Reid Hospital & Health Care Services Nursing Warming Cabinets policy (last reviewed June 2014) indicated blanket warmers shall maintain a temperature between 128 degrees and 142 degrees Fahrenheit. The blanket warmer procedure notes that hospital staff are required to check the warmers daily. If the warmer temperature(s) are inaccurate, a work order needs to be submitted to the Engineering Department. A Blanket/Fluid Warmer</p>	S 160	<p>1. and 2. The two (2) blanket warmers have been removed from service. They are no longer in the Radiology Department. The policy on checking the temperature of blanket warmers and entering work orders, if necessary, was discussed and distributed to all supervisors and all Radiology staff. Supervisors are responsible for insuring that the blanket warmers in their areas are checked and documented per the policy, and work orders entered if necessary. Date that deficiency was corrected: February 17th, 2015</p> <p>3. The patient weight scale in Mammography has been removed from service on March 27th, 2015 . A new scale will be purchased. Once the new scale is put into service, it will have preventive maintenance as scheduled by Biomed.</p> <p>Responsible Party: Gene DiTullio, Director, Radiology</p>	03/27/2015			

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	<p>Temperature Log was attached to the Warming Cabinet hospital policy.</p> <p>2. At 11:18 on 2/16/2015, the Radiology Department was toured. One blanket warmer was observed with the temperature dial set on 90 degrees Fahrenheit; however, the actual temperature read 125 degrees Fahrenheit. The second blanket warmer was observed with the temperature dial set at 180 degrees Fahrenheit; however, the actual temperature read 212 degrees Fahrenheit. The Blanket/Fluid Warmer Temperature Log were unavailable to be reviewed.</p> <p>3. At 1:05 PM on 2/16/2015, staff member A7 (Maintenance Manager) indicated the Radiology Department staff members never contacted the Engineering Department of the two warming units accuracy of the temperature dials. Staff member A7 confirmed that temperature logs were not kept</p>			
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S 164 Bldg. 00	<p>for the two blanket warmers.</p> <p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8(d)(2)(B)</p> <p>(d) The equipment requirements are as follows: (2) There shall be sufficient equipment and space to assure the safe, effective, and timely provision of the available services to patients, as follows:</p> <p>(B) There shall be evidence of preventive maintenance on all equipment.</p> <p>Based on observation, documentation review, and staff interview, the facility failed to assure preventive maintenance was conducted on three automatic external defibrillators (AED), two portable sleep recorders, and a patient weight scale.</p> <p>Findings included:</p> <p>1. At 1:45 PM on 2/16/2015, the Radiology Department was observed with a patient weight scale. The scale was observed without an asset tag on it.</p>	S 164	<p>1. The scale in Radiology has been removed from service. 2. Clinical Engineering will inventory all mechanical scales with an asset tag. All scales will be brought to biomed for initial inspection and inventoried before they are taken to the patient care area. 3. All AED's in the Wound Center will have the routine visual checks performed and documented monthly per the operator's manual. 4. All AED's in the Sleep Center will have the routine visual checks performed and documented monthly per the operator's manual. 5. The two (2) home testing portable sleep recorders were inventoried and preventative maintenance was completed. 6. All AED's in Outpatient Rehabilitation's offsite location will have the routine</p>	03/31/2015

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	<p>2. At 2:00 PM on 2/16/2015, staff member A6 (Engineering Director) indicated the patient weight scale was brought into the facility by a staff member. The piece of equipment was never added to the list of patient care equipment. Therefore, the scale never had a risk assessment value assigned to it.</p> <p>3. At 8:50 AM on 2/17/2015, the Wound Center offsite was inspected. The AED located mounted on the wall had no documented visual routine checks.</p> <p>4. At 9:15 AM on 2/17/2015, the Sleep Center offsite was inspected. The AED located mounted on the wall had no documented visual routine checks.</p> <p>5. At 9:25 AM on 2/17/2015, two home testing portable sleep recorders were observe with an asset tag on them dated 8/12/2013.</p>		<p>visual checks performed and documented monthly per the operator's manual. 7. The instructions outlined on page 5-2 of the LifePak 500 operator's manual (attached) reads "If the AED is used very infrequently, such as once a year, monthly inspection may be appropriate." Our AED's are rarely if ever used so the frequency for the routine visual inspection will be once a month. 8. The Portable Sleep Recorder home testing units have been checked and the PM frequency set to once a year. 9. All AED's will have the routine visual checks performed and documented monthly per the operator's manual. 10. It was not the AED's that had not been inspected for preventative maintenance since the initial inspection on 8/12/2013; it was the two Portable Sleep Recorder home testing units in the sleep lab. These have been inventoried and PM'd. Responsible Party: Matt Tallman, Biomedical Engineering Manager, TriMedx</p>				

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	<p>6. At 9:45 AM on 2/17/2015, the Outpatient Rehabilitation offsite was inspected. The AED located mounted on the wall had no documented visual routine checks.</p> <p>7. The Lifepak 500 Automatic External Defibrillator operating instructions manual indicated the operator maintenance schedule recommended daily inspections. The operator should examine the AED case, connector, battery well, battery pins, and accessories.</p> <p>8. The Portable Sleep Recorder home testing unit Asset Detail Report identified the initial asset inspection was documented on 8/12/2013. The Asset Detail Report identified the preventive maintenance inspection should be conducted on an annual basis.</p> <p>9. At 2:15 PM on 2/17/2015, staff member A6 (Engineer Director) indicated the AEDs were never inspected routinely by the staff of the areas where the AEDs were</p>			

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	<p>located.</p> <p>10. At 2:30 PM on 2/17/2015, contracted staff member A14 (Clinical Engineer) confirmed the two AEDs were not inspected for preventive maintenance since the initial inspection of 8/12/2013. The contracted staff member indicated his/her contracted company started to operate the Clinical Engineering Department since March 2014. The two home testing units located in the Sleep Center were never identified as part of the hospital's clinical equipment.</p>			