STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	150164	A. BUILDING 00 B. WING	04/25/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONROE HOSPITAL	4011 S MONROE MEDICAL PARK BLVD BLOOMINGTON, IN 47403

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S0000	This visit was for a State licensure survey. Facility #: 004287 Survey Dates: 04-23/25-12 Surveyors: Billie Jo Fritch RN, BSN, MBA Public Health Nurse Surveyor Jennifer Hembree RN Public Health Nurse Surveyor Albert Daeger Laboratory/Kitchen Surveyor QA: claughlin 05/03/12	S0000	no response	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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S0270	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 did not receive/review, at least quarterly, information related to quality monitoring of the care provided to patients to ensure it is provided safely and efficiently. Findings included: 1. Review of governing board meeting minutes on 4-23-12 and 4-24-12 for 2011 and 2012 lacked evidence that the governing board was provided information related to quality monitoring of the care provided to patients to ensure it is provided safely and efficiently. 2. Interview with B#2 and B#3 on 4-24-12 at 1515 hours confirmed the governing board was not provided information related to quality monitoring	S0270	**Quarterly quality reports have been presented to the Board although not reflected in the minutes. Monthly quality reports will be presented at Medical Staff Meetings. These reports will be routed up to Medical Executive Committee and at least quarterly to the Governing Board. Patient Satisfaction for 2011 and first quarter 2012 presented at May 15, 2012 Medical Staff Meeting. Data reviewed and discussion followed with opportunity for questions and suggestions for improvementsThese activities are and will be recorded in the minutes of the meetings.ADDENDUM: The person responsible is the Assistant the CEO.**	05/15/2012

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	during 2011 and 2012 to ensure care provided to patients is provided safely and efficiently.			

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S0286	410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1 (b)(4) (b) The governing board is responsible for the conduct of the medical staff. The governing board shall do the following: (4) Ensure that the medical staff is accountable and responsible to the governing board for the quality of care provided to patients. Based on document review and interview, the governing board failed to conduct performance reviews for 10 of 10 physicians (MD#1 - MD#10) and 4 of 4 allied health professionals (AH#1 - AH#4) to review the quality of care provided to patients as a part of the credentialing/re-credentialing process. Findings included: 1. Review of physician and allied health credential files on 4-24-12 indicated the governing board failed to conduct performance reviews for 10 of 10 physicians (MD#1 - MD#10) and 4 of 4 allied health professionals (AH#1 - AH#4) to review the quality of care provided to patients as a part of the credentialing/re-credentialing process. 2. Interview with B#2 on 4-24-12 at 0913 hours confirmed 10 of 10 physicians (MD#1 - MD#10) and 4 of 4 allied health	S0286	Board of Directors review all credentialing matters. Future reappointments will have detailed information concerning providers performance even if routine care is within acceptable best practice standards. Providers will have a report in file regarding their performance during the previous period and whether or not the expected standard of care has been met. ADDENDUM: The responsible party is the Medical Staff Office Manager.	05/31/2012

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	professionals' (AH#1 - AH#4) credential files did not contain any type of performance reviews to review the quality of care provided to patients as part of the credentialing/re-credentialing process; B#2 confirmed performance reviews are only done if there is a problem with care and not routinely done as part of the credentialing/re-credentialing process to ensure quality of patient care.			

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S0294	410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1 (c) (c) The governing board is responsible for managing the hospital. Based on observation and document review, the governing board failed to maintain patient privacy for 1 of 4 departments toured. Findings include: 1. During during of the intensive care unit beginning at 11:25 a.m. on 4/24/12 and accompanied by staff member #4, the following was observed (A) The nurse station has video monitoring of patient rooms mounted on the wall. The monitors can be viewed by a visitor approaching the side of the nurse station. (B) While standing outside the nurse station area where a visitor could approach, a patient was observed on one of the monitors sitting on a bedside commode. 2. Facility policy titled "Patients' Rights and Responsibilities" last reviewed/revised 3/6/12 states on page 3: "21. You have the right to personal privacy. You have the right to have privacy during personal hygiene activities (toileting, bathing, dressing,	S0294	**In order to provide patient privacy, the video monitors of ICU will be moved so that persons approaching the side of the nurse station will not be able to see the patient.**	06/01/2012

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	etc),....."			

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S0362	410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1(d)(6)(A)(B)(C)(D)(E)(F) (d) The governing board is responsible for assuring that quality patient care is provided. In accordance with hospital policy, the governing board shall do the following: 6) Ensure that the hospital does the following: (A) Establish written protocols to identify potential organ and tissue donors. (B) Has written policies and procedures for the facilitation of organ and tissue donations, including procurement. (C) Inform families or authorized persons of potential organ and tissue donors of the option of donation on admission or at the time of death of a potential donor. (D) Use discretion and sensitivity in contacts with potential organ donor families. (E) Notify the appropriate procurement organization of potential organ donors. (F) Establish membership in the organ procurement and transplantation network if the hospital performs transplants.			
	Based on document review and interview, the facility failed to report 1 of 4 deaths to the Indiana Donation Alliance (IDA) during October 2011 as required by policy and contract.	S0362	**In order to cooperate with IOPO and to insure that all deaths and/or imminent deaths are reported to the Indiana Donation Alliance in a timely manner, an algorithm that**	06/01/2012

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	Findings included: 1. Review of facility documents on 4-24-12 indicated that 1 of 4 patient deaths was not reported to the IDA during October 2011. 2. Review of policy ORGAN DONATION - IOPO, #9.0 on 4-24-12 indicated the following: Monroe Hospital will notify the Indiana Donation Alliance (IDA) in a timely manner of all individuals who have died or whose death is imminent. 3. Review of the contract between Monroe Hospital and the Indiana Organ Procurement Organization (IOPO) on 4-24-12 indicated the following: Hospital agrees to cooperate with IOPO in identifying Potential Donors in order to maximize the number of usable Organs donated, providing Timely Referral to IOPO of Imminent Deaths and deaths which occur in the Hospital. 4. Interview with B#4 on 4-25-12 at 1050 confirmed 1 of 4 deaths in October of 2011 were not referred to the IDA as required by facility policy and the contract with IOPO and steps have not been taken to prevent recurrence.		**reflects the actions of the Organ Donation – IOPO Policy will be established and staff education to the required sequence of events. Monthly reports from IOPO will be monitored for compliance with follow-up and mentoring provided to staff to facilitate adherence to IOPO process.ADDENDUM: Director of Clinical Services is notified when a a death or imminnent death and monitors to ensure compliance. If the Director of Clinical Services is not available the Quality Nurse is notified.**	

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S0390	410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1(f)(1) (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: (1) That a contractor of any service furnishes those services in such a manner as to permit the hospital to comply with all applicable statutes and rules. Based on document review and staff interview, the facility failed to ensure 1 service provided to the hospital has a contract or written agreement for the pathology services provided to Monroe Hospital. Findings included: 1. The Cyto/Pathology Procedure Manual approved on 3/22/2011 index had two sections. The two sections are labeled; Section I On Site Policies/Procedures; and Section 2 Pathology/cytology Referral Site. Section II was broken down by Histology and Cytology. Histology referenced 9 policies that included: Quality Plan, Surgical Pathology, Frozen Section, Use of Tissue Teak Cryo 2000, Placental Examination, Chemical Analysis, Cytogenetic Studies on Placentas (POC and Fetus and Amniotic	S0390	A contract with Fayette Regional Health Hospital for processing Histology and Cytology will be in place no later than June 1, 2012ADDENDUM: The responsible party is the Director of Laboratory Services and/or Pathology Director.	06/01/2012

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	Fluid), and Cytopathology. Cytology referenced 5 policies that included: Quality Plan, Fine Needle Aspiration Biopsy Cytology Procedure, and Routine Cyto Collection. The heading on the 14 policies in Section II states, "Fayette Regional Health System Connersville, Indiana." 2. After reviewing the list of Monroe Hospital's contractual agreements, a written agreement with Fayette Regional Health System could not be located. 3. Medical Director Agreement Pathology Program Article V section 5.4 states, "Referral to Clinical Labratory Services - Clinical Labratory Services should be performed within and by Labratory as agreed to by the parties. 4. At 2:05 PM on 4/23/2012, staff member L2 indicated the hospital does not have a written agreement for the services that Fayette Regional Health System provide to them. Staff member L2 indicated Section II are policies from Fayette Regional Health System.			

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S0406	410 IAC 15-1.4-2 QUALITY ASSESSMENT AND IMPROVEMENT 410 IAC 15-1.4-2(a)(1) (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: (1) All services, including services furnished by a contractor. Based on document review and interview, the facility failed to include all services, including those provided by contract, in the facility Quality Assurance and Performance Improvement (QAPI) program and follow the requirements set forth in the facility QAPI plan. Findings included: 1. Review of facility documents on 4-23-12, 4-24-12, and 4-25-12 lacked evidence that the direct services of ambulance, pediatrics, and tissue transplant and the contracted services of transcription and hazardous waste were included in the facility's QAPI program during 2011 and 2012. 2. Review of facility documents on 4-23-12, 4-24-12, and 4-25-12 lacked	S0406	**A Hospital wide Quality Council is established to collect, monitor and evaluate data for each department of the facility. The "Plan, Do, Study, Act" philosophy will be the basis of the Quality Improvement Process at Monroe Hospital. Department Dashboards will be reviewed and revised to evaluate but is not limited to the following: 1. Services furnished by a contractor including ambulance services, pediatric services, tissue transplant, transcription services and hazardous waste management. 2. Monitoring of Core Measures for CMS. 3. Monitoring of JCAHO required measures. 4. Monitoring of the State of Indiana required measures. 5. Monitoring of Patient Satisfaction. Quality**	05/29/2012

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	evidence that the membership of the QAPI committee, as required by the QAPI plan, was being followed. 3. Review of facility documents on 4-23-12, 4-24-12, and 4-25-12 lacked evidence that QAPI meetings were conducted in 2011 and 2012; limited QAPI information was discussed in the Nursing Leadership meetings to include hand hygiene, IV site infections, ISDH readiness, and development of a job description for a CNS; no discussion of QAPI information at the governing board level during 2011 or 2012. 4. Interview with B#3 and B#4 on 4-24-12 at 1515 hours confirmed there were no QAPI meetings held during 2011 or 2012 by a QAPI committee; QAPI information is not documented as provided to the governing body during 2011 or 2012; limited QAPI was discussed at the Nursing Leadership meetings during 2011 and 2012 related to hand hygiene, IV site infections, ISDH readiness, and development of a job description for a CNS; confirmed that the required membership of the committee, per the QAPI plan, is not followed; confirmed the direct services of ambulance, pediatrics, and tissue transplant and the contracted services of transcription and hazardous waste were not included in the facility's QAPI program during 2011 and 2012.		**Council monthly meeting minutes and monitoring results will be forwarded to the Leadership Team on Monroe Hospital and the Governing Board at least quarterly.410 IAC 15-1.4-2 Quality Assessment and Improvement Contracted Services: HIM will be responsible for submitting quarterly quality audits to the Board for review. A minimum of 30 accounts will be reviewed. The accounts will be randomly selected based on the volume of the transcription for each category that quarter. Example if 60% of contracted transcription consisted of radiology reports, 60% of the audited charts will be radiology reports.** ADDENDUM: The Quality Council will meet monthly and report quarterly.	

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S0418	410 IAC 15-1.4-2 QUALITY ASSESSMENT AND IMPROVEMENT 410 IAC 15-1.4-2(b)(1)(2) (b) The hospital shall take appropriate action to address the opportunities for improvement found through the quality assessment and improvement program as follows: (1) The action shall be documented. (2) The outcome of the action shall be documented as to its effectiveness, continued follow-up and impact on patient care. Based on document review and interview, the hospital failed to address opportunities for improvement through the Quality Assessment and Performance Improvement (QAPI) committee. Findings included: 1. Review of facility documents on 4-23-12, 4-24-12, and 4-25-12 lacked evidence that opportunities for improvement were based on data collected by the departments and action taken; documents provided lacked data collection, trending, or opportunities for improvement. 2. Interview with B#2 on 4-24-12 confirmed the data forms were returned to QA without completion of data, trending, or addressing opportunities for	S0418	**The Quality Council will study the results of the departmental monitoring/dashboards utilizing the "Plan, Do, Study, Act" philosophy to facilitate improvement of patient care. Evaluation of data will guide actions including but not limited to: Staff education, Product evaluation, Process/Procedure evaluation, Innovative Thinking.ADDENDUM: The forms are being analyzed and updated for ease of completion. The forms are reviewed upon submission and if missing information, form is returned for completion. Quality Council is responsible for monitoring.**	06/01/2012

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	improvement.			

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S0554	410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(a) (a) The hospital shall provide a safe and healthful environment that minimizes infection exposure and risk to patients, health care workers, and visitors. Based on observation and staff interview, the facility failed to ensure laboratory services are provided in a clean and sanitary environment and failed to minimize risk to patients by not removing expired items from stock for 2 of 4 unit departments toured. Findings included: 1. At 10:40 AM on 4/23/2012, the Laboratory Department was toured. The department was observed with one large room with a smaller room for the blood bank connected to it. The department performs many essential services for the hospital. The department had 1 designated hand washing sink with 2 utility sinks. The designated hand washing was also used for multi-purposes such as cleaning lab equipment. The counter for the designated hand washing sink was observed with paper towels spread out on the counter with lab equipment drying after being washed in the sink. The designated hand washing sink was observed with plastic quart	S0554	(1) One sink designated for Handwashing only. Staff reminded that this sink is for Handwashing only. Supplies were removed from under sinks.(2) Shower Head, toilet paper holder, toilet seat, soap dispenser removed. Access to area limited to authorized personnel. Supplies moved from under sink to nearby cabinet.(3)One sink designated for Handwashing only. Staff reminded that this sink is for Handwashing only. Restroom where Cryostat machine located is operational and used for flushable waste. (4) A process for staff monitoring of expired equipment will be implemented. Monthly equipment checks will be done by staff as evidenced by signature. Compliance will be monitored through individual department dashboards.(5) Expired supplies were removed and replaced with new product in anesthesia cart. Supplies were replenished to meet with par levels.ADDENDUM: Responsible person is Director of Laboratory Services. Weekly inspections will be completed to ensure compliance.	06/01/2012

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	squirt bottles obstructing the use of the hand soap dispenser that was on the rear of the counter itself. The counter surrounding the hand washing sink was observed with assorted lab supplies and equipment. All three sinks were observed storing supplies under the sink basins and sewage drains. 2. At 10:55 AM on 4/23/2012, the pathology room for the Laboratory Department was toured. The room had a bathroom connected to the room. In the bathroom, the cryostat machine was observed stored adjacent to an operational toilet. On the wall next to the toilet was a dual toilet tissue holder with 1 full roll and 1 partial roll under the full roll, A waste paper basket was located in front of the toilet and next to the cryostat machine. The wastebasket was observed with disposable gloves, paper towels, and other trash. The hand washing lavatory designated for washing hands after using the toilet was observed with hand cleanser and a paper towel dispenser. The counter for the hand washing sink was also observed storing pathology supplies and a cutting board was observed in direct contact with the hand washing sink basin. On the cutting board was a knife for cutting specimens and a microscope was also located next to the cutting board. Therefore, the sink was used for dirty			

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	when using for pathology and clean when using for washing hands after using the operational toilet. Pathology Lab supplies were observed stored under the sink basin and sewage drains. The shower stall was observed storing assorted supplies for the cryostat machine and for the Pathologist. The shower stall contained a gray triple shelf storage cart filled with assorted pathology supplies. The cart was directly under a shower wand. 3. At 11:00 AM on 4/23/2012, staff member L2 indicated which 1 of the 3 sinks were designated as the Laboratory hand washing lavatory. The staff member indicated the designated hand washing lavatory was also used for washing label utensils. The staff member indicated the restroom where the cryostat machine was located was operational. 4. During tour of the intensive care unit beginning at 11:25 a.m. on 4/24/12 and accompanied by staff member #4, the following was observed in ICU room #4: (A) One (1) 500 ml container of sterile water with an expiration date of 3/12. This was the only container of sterile water in the cabinet and could be used in an emergency situation. (B) One (1) Co2 detector with an expiration date 10/11. This was the only Co2 detector in the cabinet and could be used in an emergency situation.			

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	5. During tour of the surgery department beginning at 12:30 p.m. on 4/24/12 and accompanied by staff member #4, the following expired items were found in the anesthesia cart: (A) One (1) 14 GA IV catheter with an expiration date of 12/11/11. This was the only 14 gauge IV catheter in the cart. (B) One (1) 16 GA IV catheter with an expiration date of 1/7/12.			

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S0556	410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(b) (b) There shall be an active, effective, and written hospital-wide infection control program. Included in this program shall be system designed for the identification, surveillance, investigation, control, and prevention of infections and communicable diseases in patients and health care workers. Based on observation, document review, and interview, the facility failed to maintain effective infection control prevention in 1 of 1 CT procedure room. Findings included: 1. While touring the Radiology Department on 4-24-12 at 1001 hours with B#7, B#8 and B#12, it was observed that A-456-II was used to clean the CT table after patient use; the product was in a spray bottle labeled with the name of the product, but no directions for use. 2. Review of the Product Specification Document A-456 II indicated the following: Treated surfaces must remain wet for 10 minutes. 3. Interview with B#12 on 4-24-12 at 1001 hours indicated the product A-456-II is used to clean the CT table between patients, confirmed the spray bottle did not have directions for use, and indicated	S0556	A review of proper use cleaning products reviewed with Radiology Staff at departmental meeting of May 2, 2012.Training will be ongoing to ensure employees use products in the proper manner. Employees will be required to sign the meeting logs and acknowledge training as recorded in the minutes. ADDENDUM: Responsible party is Infection Control. They will ensure products are used correctly.	05/02/2012

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	the product is sprayed onto the table and immediately wiped off. 4. Interview with B#10 on 4-24-12 at 1245 hours confirmed the product is not not a germicidal product and it is not being used correctly as a disinfectant per the manufacturers instructions.			

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S0608	410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(f)(3)(D)(ix) (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: (ix) Requirements for personal hygiene and attire appropriate for work settings. Based on observation, document review, and staff interview the facility failed to ensure the dress code policy was followed for 2 of 4 departments toured. Findings include: 1. During tour of the medical/surgical unit beginning at 10:20 a.m. on 4/24/12 and accompanied by staff member #4 the following observations were made: (A) RN #1 was observed at the nurse station. He/she had a tattoo visible on the inner right wrist. (B) RN #2 was observed at the nurse station. He/she had hair to his/her mid back area which was unsecured.	S0608	**(1) Summary of ISBH concerns posted on units. Dress Code violations "highlighted" in posting. (May 2, 2012) (2) Dress code policy has been reviewed with CRNA and CRNA is now compliant with hospital policy. (3) Individual counciling. (May 20, 2012) (4) Mandatory Staff Meetings with staff signature acknowledgement of Dress Code Policy. (June 1, 2012)** Staff will receive reminders and education regarding the Hospital's Dress and Appearance policy. This information will be presented by Human Resources as well as in unit staff meetings. Employees will receive another copy of the policy, relevant education and an explanation of the corrective	06/01/2012

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	2. During tour of the Intensive care unit beginning at 11:25 a.m. on 4/24/12 and accompanied by staff member #4, the following observation was made: (A) CRNA #1 was observed reviewing a medical record. He/she was on duty as evidenced by a surgical cap on and scrubs. He/she had three (3) hoop earrings observed in the left ear and a nasal piercing in the left nostril. 3. Facility dress code policy which is part of the employee handbook states under personal hygiene: "Long hair should be pulled back and restrained for all patient care positions." and "Jewelry should be conservative. Nose, tongue, eyebrow, lip, cheek or any other body piercing jewelry are not in accord with (facility #1) image. Hoop or dangling earrings and necklaces present a safety concern to direct caregivers and should not be worn. Tattooing of any nature will be covered." 4. Staff member #HR1 indicated in interview at 11:30 a.m. on 4/25/12: (A) 100% of employees receive a handbook and all individuals are required to comply with the dress code within the handbook. He/she cannot think of anyone that would not be required to comply. (B) The handbook is also available on the intranet for staff to view.		measures that will be taken for non-compliance. Education will be focused on infection control and safety as they relate to the policy. Education will include but not be limited to support of the following principles: · Comply with infection control policies and practice · Comply with health and safety policies. · Present a favorable impression topatients, visitors and the general public. · Support a secure and safe environment. · Maintain the dignity of staff. Respect the religious, ethnic and cultural diversities of staff. It is the responsibility of managerial and supervisory staff at all levels to ensure that their staff are following this policy. This includes Senior Leadership, Directors, Managers, Supervisors and Clinical Leads. Leadership will be reminded of their responsibility for ensuring the staff's compliance with the policy and the proper methods of corrective action for non-compliance. Additionally, members of Leadership will be asked to report to Human Resources those with repeated disregard for the policy and any unusual circumstances which may make compliance difficult;	

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			such as religious, ethnic and cultural diversities of staff. A sensitive approach should enable these to be met in a way that does not compromise the practice of safety and infection control. This education will be provided to all Leadership and employees within 21 days. Ongoing monitoring will be the responsibility of Leadership however this information will be included in the annual education requirements for all staff.	

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S0808	410 IAC 15-1.5-5 MEDICAL STAFF 410 IAC 15-1.5-5 (a)(2) (a) The hospital shall have an organized medical staff that operates under bylaws approved by the governing board and is responsible to the governing board for the quality of medical care provided to patients. The medical staff shall be composed of two (2) or more physicians and other practitioners as appointed by the governing board and do the following: (2) Examine credentials of candidates for appointment and reappointment to the medical staff by using sources in accordance with hospital policy and applicable state and federal law. Based on document review and interview, the governing board failed to ensure 1 of 1 allied health professionals (AH#1) had a sponsoring physician according to Indiana Law IC 25-27.5-6-1. Findings included: 1. Review of allied health credential files on 4-24-12 lacked evidence that 1 of 1 allied health professionals (AH#1) had a signed agreement with a sponsoring physician as required by Indiana Law IC 25-27.5-6-1; page 2 of Delineation of Privileges was blank in the area to be signed by the sponsoring physician. 2. Interview with B#2 on 4-24-12 at 0913 hours confirmed page 2 of the Delineation	S0808	Sponsoring physician will sign new Delineation of Privileges form for Allied Health provider. Allied Health provider is not practicing at facility and will not be allowed to practice until new form is signed and verified. Privileges are temporarily suspended until proper signature is obtained. ADDENDUM: The responsible party will be the Medical Staff Office manager.	05/10/2012

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	of Privileges for AH#1 was not signed by the sponsoring physician.			

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S0812	410 IAC 15-1.5-5 MEDICAL STAFF 410 IAC 15-1.5-5 (a)(4)(A)(B)(C)(D)(E) (F)(G)(H)(I)(J)(K) (a) The hospital shall have an organized medical staff that operates under bylaws approved by the governing board and is responsible to the governing board for the quality of medical care provided to patients. The medical staff shall be composed of two (2) or more physicians and other practitioners as appointed by the governing board and do the following: (4) Maintain a file for each member of the medical staff that includes, but is not limited to, the following: (A) A completed, signed application. (B) The date and year of completion all Accreditation Council for Graduate Medical Education (ACGME) accredited residency training programs, if applicable. (C) A copy of the member's current Indiana license showing the date of licensure and current number or an available certified list provided by the health professions bureau. A copy of practice restrictions, if any, shall be attached to the license issued by the health professions bureau through the medical licensing board. (D) A copy of the member's current Indiana controlled substance registration showing the number, as applicable. (E) A copy of the member's current Drug Enforcement Agency registration showing the number,as applicable (F) Documentation of experience in the practice of medicine.			

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	(G) Documentation of specialty board certification, as applicable. (H) Category of medical staff appointment and delineation of privileges approved. (I) A signed statement to abide by the rules of the hospital. (J) Documentation of current health status as established by hospital and medical staff policy and procedure and federal and state requirements. (K) Other items specified by the hospital and medical staff. Based on document review and interview, 2 of 10 physician (MD#1, MD#2) credential files and 1 of 4 allied health (AH#1) credential files lacked documentation of current health status. Findings included: 1. Review of credential files on 4-24-12 lacked evidence that 2 of 10 physician credential files (MD#1 and MD#2) and 1 of 4 allied health professionals' credential files (AH#1) did not contain current health status; MD#1 was left blank and MD#2 and AH#1 did not contain the page titled Health Status. 2. Review of the Medical Staff ByLaws on 4-24-12 indicated the following: 2.2, #3, good reputation and character, including the Applicant's mental and emotional stability and physical health status. 3. Interview with B#2 on 4-24-12 at 0913	S0812	As discussed with the surveyor, current health status was implemented begining January 2011for all reappointments based on requirements noted by The Joint Commission. Files reviewed were reappointed prior to this date. All reappointments and appointments after this date are and will be required to complete the health status form. Files will be periodically reviewed to ensure compliance with this requirement. ADDENDUM: Responsible party is the Medical Staff Office manager. All reappointments require a physical health status statement.	05/10/2012

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	confirmed 2 of 10 physician credential files (MD#1 and MD#2) and 1 of 4 allied health professionals' credential files (AH#1) did not contain current health status; MD#1 was left blank and MD#2 and AH#1 did not contain the page titled Health Status.			

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S0930	410 IAC 15-1.5-6 NURSING SERVICE 410 IAC 15-1.5-6 (b)(3) (b) The nursing service shall have the following: (3) A registered nurse shall supervise and evaluate the care planned for and provided to each patient. Based on document review and staff interview, the facility failed to ensure a registered nurse evaluated the care provided and followed physician orders for 2 of 2 open medical/surgical patients with specific assessment orders (patients #7 and N8). Findings include: 1. Review of patient #N7 medical record indicated the following: (A) He/she was admitted on 4/17/12 with a right lower extremity DVT. (B) An order was written on 4/18/12 at 12:06 a.m. for vital signs every 4 hours. (C) The medical record lacked documentation that the vital signs were taken on nine (9) different occasions including, but not limited to, 8:00 p.m. on 4/18/12, 12:00 p.m., 4:00 p.m. and 8:00 p.m. on 4/19/12. 2. Review of patient #N8 medical record indicated the following: (A) He/she was admitted on 4/18/12 with	S0930	**The "Initial Patient Assessment and Reassessment" policy will be reviewed and revised to clarify the role of the LPN and responsibilities of the RN. This policy will be in support of the Indiana Nurse Practice Act. The Assessment Policy and process will be presented to staff at the "mandatory" staff meeting. Monthly monitoring of adherence to the policy will be conducted with subsequent action plans addressed at required. Adherence to physician orders regarding vital signs and other patient monitoring parameters will be evaluated through the monthly unit dashboard data. A "Vital Sign" board will be established to guide the CNA in the collection of vital sign data. Mandatory staff education will take place to promote follow through.Identification of responsible providers who failed to follow MD orders shall receive additonal remediation on quality of care standards.ADDENDUM:**	06/01/2012

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	a right hip fracture. (B) An order was written at 12:00 on 4/19/12 for vital signs per post op vital sign policy and to include neurovascular checks with the vitals. (C) The medical record lacked documentation of that the vital signs were taken on six (6) different occasions including, but not limited to, 12:00 p.m., 4:00 p.m. and 8:00 p.m. on 4/19/12. (D) The medical record lacked documentation of neuro checks on five (5) different occasions including, but not limited to, 8:00 p.m. on 4/18/12 and 12:00 p.m. on 4/20/12. 3. Facility policy titled "Care of the Post-Operative/Post-Anesthesia Patient on the Medical/Surgical Unit" last reviewed/revised 4/19/11 states on page 2: "3..... Upon completion of the four hour recovery period, vital signs should be recorded no less often than every 4 hours for the first 24 hours post-operatively....." 4. Staff member #4 verified the medical record information at 11:00 a.m. on 4/25/12.		**Responsible person will the Director of Clinical Services.**	

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	150164	A. BUILDING 00 B. WING	04/25/2012

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S1104	410 IAC 15-1.5-8 PHYSCIAL PLANT 410 IAC 15-1.5-8(a)(1)(A)(B) (a) The hospital shall be constructed, arranged, and maintained to ensure the safety of the patient and to provide facilities for services authorized under the hospital license as follows: (1) The plant operations and maintenance service, equipment maintenance, and the environmental service shall be: (A) staffed to meet the scope of the services provided; and (B) under the direction of a person or persons qualified by education, training, or experience. Based on observation, document review, and staff interview, the facility failed to provide adequate diagnostic services for the Laboratory Department. Findings included: 1. At 10:40 AM on 4/23/2012, the Laboratory Department was toured. The department was observed with one large room with a smaller room for the blood bank connected to it. The department performs many essential services for the hospital. The department had 1 designated hand washing sink with 2 utility sinks. The designated hand washing was also used for multi-purposes	S1104	1) One sink designated for Handwashing only. Staff reminded that this sink is for Handwashing only. Sign has been posted labeling the sink for handwashing only. New laboratory area is under construction to meet current storage and productivity demands. Exta supplies were removed from under sink basins and from top of cabinets. Boxes and racks were removed from the top of tall refrigerator. 2) The room that houses the cryostat was designated as a hazardous area. The toilet bowl seat was removed and the toilet paper dispenser removed. Staining supplies were removed from beneath processing sink. The	06/01/2012

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	such as cleaning lab equipment. All three sinks were observed storing supplies under the sink basins and sewage drains. Stand up refrigerators and freezers were observed storing assorted supplies. Lab supplies were also observed stored in direct contact with the ceiling. 2. At 10:55 AM on 4/23/2012, the pathology room for the Laboratory Department was toured. The room had a connected bathroom. In the bathroom, the cryostat machine was observed stored adjacent to an operational toilet. The hand washing lavatory designated for washing hands after using the toilet was observed with hand cleanser and a paper towel dispenser. The counter for the hand washing sink was also observed storing pathology supplies and a cutting board was observed in direct contact with the hand washing sink basin. Pathology Lab supplies were observed stored under the sink basin and sewage drains. The shower stall was observed storing assorted supplies for the cryostat machine and for the Pathologist. 3. The Board of Director 3/22/2012 minutes states, "JCAHO and CAP has put us on notice to a) decrease the procedures and studies or b)increase space." 4. At 11:00 AM on 4/23/2012, staff		sink is being used in the processing of fresh frozen specimens.3) New laboratory space is under construction to meet increasing demands. Currently relocated some testing equipment to another room to meet minimum space requirements for current level of testing. Facility is not increasing the amount of testing until new laboratory space is finished (approximately 90 days). 4) Room with Cryostat is located in the peripheral area of the surgery suite. In the original hospital plans this area was designated as a Nurse's lounge. Because of the location of this room (near the operating rooms), another area of the hospital has been utilized as the Nurse's lounge. This location has allowed easy access to the surgeon and the pathologist for consultation purposes. ADDENDUM: Responsible party is Director of Laboratory Services. New Labotory is under construction and should be operational in 90 days.	

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	member L2 indicated the hospital has run out of room for the Laboratory Department and that was why the cryostat machine was located where it was. The room the cryostat machine was located in used to be a patient room.			

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S1164	410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8(d)(2)(B) (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: (B) There shall be evidence of preventive maintenance on all equipment. Based on document review, the facility failed to ensure periodical inspections of the Cryostat machine as required by the manufacturer. Findings included: 1. The cryostat CRY03 Model 5800 operating manual periodic maintenance frequency requires the machine to have it's vacuum system filter assembly replaced every 2 months or when it's full; perform weekly exterior cleaning. Exterior Maintenance cleaning includes vacuuming the ventilation panels and vacuuming of condenser coils. 2. The 2012 Laboratory Director On-site Activities reports were reviewed. The activity reports did not identify the required preventive maintenance for the filter assembly being replaced and	S1164	PM sheet updated to meet manufacturer's requirements. Exterior Maintenance assigned to phlebotomy staff to be done according to schedule.The Tissue-Tek Cryo3 Model 5800 does not have a vacuum system filter assembly. The Model 5800 has the basic configuration of the company and does not have the Ozone Disinfection system or the Vacuum Debris Removal System as is found in the D and DM models.ADDENDUM: Responsible party is the Director of Laboratory Services.	06/01/2012

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	Exterior Maintenance cleaning was ever done for 2012. 3. The daily Cryostat Maintenance Logs between 2/1/12 and 4/23/12 were reviewed. The logs noted the Exterior Maintenance Cleaning should be done monthly instead of the weekly frequency noted in the operator's manual. However, The Exterior Maintenance Cleaning was only done on 2/15/2012. The documentation revealed that the vacuum system filter was not replaced between 2/1/2012 to 4/23/2012.			

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S2004	410 IAC 15-1.6-7 RESPIRATORY CARE SERVICES 410 IAC 15-1.6-7(a) (a) If the hospital provides respiratory care services, the service shall meet the needs of the patients served, within the scope of the service offered, and in accordance with acceptable standards of practice. Based on document review and interview, it could not be determined that the policies/procedures for the Respiratory Care Department had ever been reviewed and approved to meet the needs of the patients cared for at the facility. Findings included: 1. Review of the Respiratory Care Department polices and procedures on 4-23-12 and 4-24-12 lacked evidence that the policies/procedures had ever been reviewed or approved to meet the needs of the patients cared for at the facility. 2. Interview with B#9 on 4-25-12 at 0920 hours confirmed there is no documentation to indicate the policies/procedures for the Respiratory Care Department have been reviewed or approved to meet the needs of the patients cared for at the facility. 3. Interview with B#1 on 4-25-12 at 1100 hours indicated there were no minutes to indicate the policies/procedures for the	S2004	Respiratory policies will be presented to the Medical Executive Committee members for review and recommendations. They will be submitted to the Medical Staff at the next monthly meeting for review and approval and forwarded to the Board of Directors for approval. Future revisions will be overseen by a qualified physician and forwarded to the Medical Staff for approval. ADDENDUM: Responsible party is the Cardiopulmonary Manager.	06/01/2012

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	Respiratory Care Department had ever been reviewed or approved.			
S2006	410 IAC 15-1.6-7 RESPIRATORY CARE SERVICES 410 IAC 15-1.6-7(b) (b) The service shall be under the direction of a physician who is a pulmonologist or a physician qualified by training or experience, and supervised by a qualified person. Based on document review and interview, the facility failed to ensure a physician who is a pulmonologist or qualified by experience, supervised the Respiratory Care Department. Findings included: 1. Review of facility documents on 4-23-12 indicated MD#7 supervised all clinical departments as Chief of Staff. 2. Review of the physician credential file for MD#7 on 4-23-12 lacked evidence that the physician was a pulmonologist or had the required experience in pulmonology medicine to direct the Respiratory Care Department. 3. Interview with B#9 on 4-25-12 at 0920 hours confirmed MD#7 supervises the Respiratory Care Department and lacks experience in pulmonary medicine.	S2006	A qualified physician will be appointed to oversee the Respiratory Department and consult on policies and procedures. All revisions or requests will be first reviewed by qualified physician and submitted to the Medical Executive Committee and/or Medical Staff for approval and implementation. ADDENDUM: Responsible party is the Cardiopulmonary Manager.	06/01/2012