

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151323	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/05/2012
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NAME OF PROVIDER OR SUPPLIER PARKVIEW LAGRANGE HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 207 N TOWNLINE RD LAGRANGE, IN 46761
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S0000	<p>The visit was for a licensure survey.</p> <p>Facility Number: 005085</p> <p>Survey Date: 9-04-12 to 9-05-12</p> <p>Surveyors: Brian Montgomery, RN Public Health Nurse Surveyor</p> <p>Linda Plummer, RN Public Health Nurse Surveyor</p> <p>Lynnette Smith, BS MLT (ASCP) Medical Surveyor 3</p> <p>QA: claughlin 09/10/12</p>	S0000		

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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S0606	<p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(f)(3)(D)(viii)</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>(viii) An employee health program to determine the communicable disease history of new personnel as required by state and federal agencies. Based on policy and procedure review, staff health file review, and staff interview, the infection control practitioner failed to ensure the implementation of the policy related to annual mandatory employee TB(tuberculin) skin tests for 1 of 2 ICU (intensive care unit) nurses (staff member P9).</p> <p>Findings: 1. at 4:55 PM on 9/5/12, review of the policy and procedure "Annual Mandatory Employee/Volunteer Tuberculin Skin Test" (no policy number), with a last reviewed date of 10/09, indicated: a. under "Procedure", in section B., it</p>	S0606	<p>A. How are you going to correct the deficiency? If already corrected, include the steps taken and the date of correction. Employee immediately notified of noncompliance and removed from schedule and not allowed to work until current TB documentation confirmed. Also confirmed TB Control Plan policy updated. Completed 9/6/12. B. How are you going to prevent the deficiency from recurring in the future? Implemented new One Step process related to annual mandatory requirements. This process requires all employees to go to Occupational Health during assigned month. Occupational Health will perform</p>	09/06/2012

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	<p>reads: "Each facility will be considered LOW RISK, MEDIUM RISK, or a Setting With Potential Ongoing Transmission. Each facility's classification could change annually, and subsequently, those employees required to comply with the annual mandatory TST (tuberculin skin testing) requirement could change annually as well."</p> <p>b. under "Procedure", in section D., it reads: "MEDIUM RISK will require TST for all HCW's (health care workers). HCW's will include all co-workers who provide direct patient care activities and have the following licensure, certification, job title or equivalent job status:...a. RN's (registered nurses)..."</p> <p>2. review of personnel files, especially health files, on 9/5/12 at 11:10 AM, indicated:</p> <p>a. one ICU RN, labeled as P9, had a last noted TB test on 4/11</p> <p>3. interview with staff member NJ, employee health staff member, at 1:15 PM on 9/5/12, indicated:</p> <p>a. staff member P9 reported they had a TB in the Spring of 2012</p> <p>b. this staff member checked the schedule for last Spring and could not find that staff member P9 had an appointment during that time frame</p> <p>c. the computer was re checked and no</p>		<p>required mandatory testing, including TB skin testing. They will complete the documentation directly into the employee record and the department manager/supervisor will receive notification to better communicate compliance. This process implemented 9/1/12. C. Who is going to be responsible for steps "a" and "b" above? The VP of Patient Care Services and the Operations Manager Employee Health/Occupational Health. D. By what dates are you going to have the deficiency corrected? You must provide a specific date the deficiency will be or has been corrected (month, day, and year). Corrected 9/6/12.</p>		

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	<p>current TB test results could be found</p> <p>4. interview with staff member NA, vice president of patient care services, at 4:45 PM on 9/5/12, indicated:</p> <ul style="list-style-type: none"> a. this facility has been determined to be a medium risk entity b. the facility is moving to annual TB tests in the Fall to correspond to the Fall influenza promotion c. staff member P9 is a prn (as needed) staff member and was not allowed to be scheduled for work until they had a TB test last Spring d. it is unknown what happened to the TB results for staff member P9, nor why employee health staff are unable to retrieve the results 				

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S0754	<p>410 IAC 15-1.5-4 MEDICAL RECORD SERVICES 410 IAC 15-1.5-4(f)(5)</p> <p>(f) All inpatient records, except those in subsections (g), shall document and contain, but not be limited to, the following:</p> <p>(5) Evidence of appropriate informed consent for procedures and treatments for which it is required as specified by the informed consent policy developed by the medical staff and governing board, and consistent with federal and state law.</p> <p>Based on policy and procedure review, newborn medical record review, and staff interview, the facility failed to implement its policy and procedure related to authorization to admit and treat for 1 of 2 newborns (pt. # 8).</p> <p>Findings:</p> <p>1. at 4:55 PM on 9/5/12, review of the policy and procedure "Consents - Adults, Minors, Emancipated Minors, Incompetent Patients, and Emergency Treatment" (with no policy number), last date reviewed 8/16/2010, indicated:</p> <p>a. under section "I. POLICY STATEMENT", it reads: "Under Indiana law, a patient must consent to the Health Care provided to him/her. Parkview LaGrange Hospital complies with the requirement of Indiana law and with the standards of accrediting agencies relating</p>	S0754	<p>A. How are you going to correct the deficiency? If already corrected, include the steps taken and the date of correction. Notification was distributed to all Patient Access staff on 9/6/12. Staff was informed; effective 9/6/12 all newborn consent forms must be scanned into the patient's electronic medical record prior to sending the original to the Family Birthing Center. 9/19/12 Information shared at the Patient Access Staff Meeting and each staff member is being asked to sign a statement that they have read and understand the documentation received on the new process of scanning the new born consents into the patient's electronic medical record. The new hire orientation list will include orientation to the scanning of newborn consent form into the patient's electronic</p>	09/19/2012			

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	<p>to consent for treatment. Consent must be obtained for all hospital admissions."</p> <p>2. review of patient medical records at 1:20 PM on 9/5/12 indicated:</p> <p>a. the newborn male admitted on 6/22/12 (pt. #8) lacked an authorization to admit and treat in the medical record</p> <p>3. interview with staff member NC at 2:30 PM on 9/5/12 indicated:</p> <p>a. the medical record staff searched, but could not find, an authorized consent for admission and treatment form for pt. #8</p> <p>b. registration staff go to the obstetrics area to have parents sign the consent forms, parents do not sign the consents prior to delivery of the infants</p>		<p>medical record. B. How are you going to prevent the deficiency from recurring in the future? Scanning the signed newborn consent into the patient's electronic medical record prior to sending the original to the Family Birthing Center. 9/10/12 A log sheet was created for auditing all new born baby records to ensure that an Authorization to Treat has been obtained and scanned in to the patient's electronic medical record. Auditing will occur at least weekly for the next three consecutive months and the goal is 100% compliance. C. Who is going to be responsible for steps "a" and "b" above? Patient Access Service Manager.</p> <p>D. By what dates are you going to have the deficiency corrected? You must provide a specific date the deficiency will be or has been corrected (month, day, and year). Corrected 9/19/12.</p>	

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S0872	<p>410 IAC 15-1.5-5 MEDICAL STAFF 410 IAC 15-1.5-5(b)(3)(P)</p> <p>(b) The medical staff shall adopt and enforce bylaws and rules to carry out its responsibilities. These bylaws and rules shall: (3) include, but not be limited to, the following:</p> <p>(P) A requirement that the the final diagnosis be documented along with completion of the medical record within thirty (30) days following discharge.</p> <p>Based on review of medical staff rules and regulations, patient medical record review, and staff interview, the medical staff failed to implement its rules and regulations related to discharge summaries for 1 of 2 surgery patients (pt. #6) and 1 of 2 death patients (pt. # 13).</p> <p>Findings: 1. at 9:30 AM on 9/5/12, review of the medical staff rules and regulations, with a last revised date of 12/09/2011, indicated: a. in "Section 5. The Discharge Summary", it reads: A. "A. A discharge Summary must be completed for all patients that are admitted to the hospital as inpatients or for observation..." B. "B. A short stay summary sheet or discharge progress note can be used</p>	S0872	<p>A. How are you going to correct the deficiency? If already corrected, include the steps taken and the date of correction. 1) The Medical Staff Completion Technician failed to flag the chart deficiency error was immediately notified on 9-5-12. Upon immediate notification, a deficiency was assigned to the physician for the missing Discharge Summary. The deficiency was assigned to the physician on 9-5-12. 2) The citation was shared at the Quality Resource Management Committee and a memo was sent to all active Medical Staff on 9/11/12 for educational purposes and as a reminder to complete a Discharge Summary as per Medical Staff Rules & Regulations. The Discharge Criteria was included in the memo. The memo will be shared in the next Clinical Committee</p>	10/02/2012

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	<p>for...stays less than 48 (forty-eight) hours, as long as the documentation reflects the elements of a discharge summary..."</p> <p>C. "E. Documentation of the Discharge Summary will include the following: 1. Patient Identification 2. Dates of admission and discharge 3. Reason for admission 4. Discharge diagnoses...5. Operative or other procedures...6. Significant findings...7. Hospital course and conclusions 8. Condition on discharge."</p> <p>2. review of patient medical records #6 and #13 at 1:20 PM on 9/5/12 indicated:</p> <p>a. pt. #6 was admitted as an observation patient on 6/21/12, had a cholecystectomy on 6/22/12, was discharged on 6/23/12, and lacked a discharge summary in the medical record</p> <p>b. pt. #13 was admitted on 5/10/12 and died that same day, other documentation in the medical record included:</p> <p>A. a history and physical was dictated that indicated impending demise</p> <p>B. a brief progress note was made on admission indicating the history and physical was dictated and death was expected (due to intracranial hemorrhage)</p> <p>C. there was no death/discharge statement or summary in the chart</p> <p>3. interview with staff member NC at 2:45 PM on 9/5/12, indicated:</p>		<p>meeting on 9/27, Medical Staff News on 9/28/12, and at the next Medical Executive Committee meeting scheduled for 10/2/12.</p> <p>B. How are you going to prevent the deficiency from recurring in the future? 1) The HIM Chart Completion Supervisor spoke directly to the Medical Staff Completion Technician that made the error and discussed with them the correct process of assigning a Discharge Summary for this type of chart according to the Medical Staff Rules and Regulations. Additionally, an HIM QA Form (i.e., an internal error documentation form) was filled out and placed in the employee's HIM personnel record as an error to be factored into the employee's upcoming annual performance review. Notification was also distributed to all of the Medical Staff Completion Technicians to remind them of the Medical Staff Rules and Regulations that specifically govern the assignment of a Discharge Summary for this type of chart. All staff confirmed that they have read and understand the documentation received to prevent further errors being made regarding this type of chart. 2) On an ongoing basis, physicians are notified when a discharge summary is greater than 21 days. On a monthly basis the Administrative Committee reviews delinquency rates, issues, and trends. On a</p>		

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	<p>a. medical record staff thought the progress note for pt. #6 was OK for a discharge summary</p> <p>b. the progress note for pt. #6 does not meet criteria for a discharge summary, per the medical staff rules and regulations, in relation to #2 (date of admission is missing), #3, #4, #5, #6, and #7</p> <p>c. pt. #13 died within an hour of the dictation of the history and physical</p> <p>d. there is no discharge summary, or progress note with death information, for pt. #13</p>		<p>quarterly basis a Medical Record Review is shared with the Quality Resource Management Committee and the Medical Executive Committee to identify issues and trends. C. Who is going to be responsible for steps "a" and "b" above? 1) HIM Chart Completion Supervisor. 2) Community Hospital Medical Director. D. By what dates are you going to have the deficiency corrected? You must provide a specific date the deficiency will be or has been corrected (month, day, and year). 1) The deficiency for the missing Discharge Summary was assigned to responsible physician on 9-5-12. A call was placed to the physician's nurse on 9-7-12, asking that he expedite the dictation for the Discharge Summary. The physician's nurse stated that she would relay the message to him that he needed to complete the Discharge Summary. The responsible physician dictated the Discharge Summary on 9/7/12 at 12:48:05. The Discharge Summary was transcribed on 9-9-12 at 16:23:28. 2) Corrected 10/2//12</p>		

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S1118	<p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8 (b)(2)</p> <p>(b) The condition of the physical plant and the overall hospital environment shall be developed and maintained in such a manner that the safety and well-being of patients are assured as follows:</p> <p>(2) No condition shall be created or maintained which may result in a hazard to patients, public, or employees.</p> <p>Based on policy and procedure review, observation, and interview, the facility failed to ensure that no hazard, in relation to the possibility of incorrect lab results, might occur in the OB (obstetric) nursery area.</p> <p>Findings: 1. at 4:45 PM on 9/5/12, review of the policy and procedure "Supply Expiration Outdates" (with no policy number), had a last review date of 1/12, and indicated: a. under section "III. Procedure", it reads: "D. In the event of an impending medical supply, equipment or medical product expiration date. 1 - remove the supplies from general stock 2 - forward the supplies to appropriate holding area, or if perishable item, destroy the stock. 3 - replace the expired stock with new stock..."</p>	S1118	<p>A. How are you going to correct the deficiency? If already corrected, include the steps taken and the date of correction. 9/6/2012 The two expired lavender microtainers and the two Sepp antiseptic packages were immediately removed and discarded. B. How are you going to prevent the deficiency from recurring in the future? The laboratory will do a monthly check removing/rotating laboratory supplies nearing their expiration date for locations outside the laboratory that are stocked by the lab department. 9/10/12 A lab supply rotation-expiration check log was created and will be utilized on a monthly basis. C. Who is going to be responsible for steps "a" and "b" above? Lab Supervisor. D. By what dates are you going to have the deficiency corrected? You must provide a</p>	09/10/2012			

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	<p>2. on 9/4/12 at 2:00 PM while on tour of the New Life Center/Family Birthing Center (Obstetrics and nursery) in the company of staff members NA and NB, it was observed that the following lab supplies located in a lab box in the nursery cupboard had expired:</p> <ul style="list-style-type: none"> a. one lavender top microtainer that expired 1/12 b. one lavender top microtainer that expired 7/12 c. two 10% Povidone antiseptic packets (ampoules) that expired 9/11 <p>3. on 9/4/12 at 2:05 PM, interview with staff members NA and NB indicated lab was responsible for the supplies they keep in the nursery</p> <p>4. interview at 4:35 PM on 9/5/12 with staff member NL, lab supervisor, indicated:</p> <ul style="list-style-type: none"> a. there is no written policy or procedure related to routine checking of lab supplies for out dates b. it is thought that lab staff take a cart with supplies to the nursing units for any blood draws c. the small box with lab supplies in the nursery area was probably not being used and not being monitored for expiration dates on a routine basis 		<p>specific date the deficiency will be or has been corrected (month, day, and year). Corrected 9/10/2012.</p>				