

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  150045	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/21/2012
NAME OF PROVIDER OR SUPPLIER  DEKALB HEALTH			STREET ADDRESS, CITY, STATE, ZIP CODE 1316 E SEVENTH ST AUBURN, IN 46706		
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S0000	The visit was for a licensure survey.  Facility Number: 005041  Survey Date: 6-19-12 to 6-21-12  Surveyors: Brian Montgomery, RN Public Health Nurse Surveyor Albert Daeger, SFPIO, CFM Medical Surveyor 3  QA: claughlin 06/28/12	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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S0266	<p>410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1(a)(4)</p> <p>(a) The governing board is legally responsible for the conduct of the hospital as an institution. The governing board shall do the following:</p> <p>(4) Review the bylaws at least triennially.</p> <p>Based on document review and interview, the governing board failed to ensure that the board bylaws were reviewed at least triennially.</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>1. The facility document Bylaws of Dekalb Memorial Hospital indicated that the bylaws were last reviewed and adopted on 1-16-2009.</li> <li>2. On 6-21-12 at 0900 hours, staff A4 was requested to provide documentation indicating that the governing board bylaws had been reviewed within the past 3 years and none was provided prior to exit.</li> <li>3. During an interview on 6-21-12 at 1350 hours, staff A4 confirmed that the bylaws had not been reviewed or revised within the past 3 years.</li> </ol>	S0266	<p>The Board Bylaw Committee reviewed and approved the Board Bylaws on July 6, 2012. The approved bylaws will be presented to the full Board of Directors on July 20, 2012. In order to maintain compliance, future review dates will be monitored through the MCN software. MCN is a repository software program that maintains and monitors documents for review / approvals. The Executive Assistant is the responsible person to assure triennial review of the Board Bylaws is complete.</p>	07/06/2012			

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S0322	<p>410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1(c)(6)(H)</p> <p>(c) The governing board is responsible for managing the hospital. The governing board shall do the following: (6) Require that the chief executive officer develops policies and programs for the following:  (H) Requiring all services to have policies and procedures that are updated as needed and reviewed at least triennially.</p> <p>Based on document review and interview, the facility failed to follow its policy/procedure and ensure that all policy/procedures in use were updated and reviewed at least triennially for 4 of 17 pharmacy policy/procedures reviewed.</p> <p>Findings:</p> <p>1. The policy/procedure titled: Policy &amp; Procedures New/Revised (revised 3-10) indicated the following: " All policies and procedures books shall be reviewed every three (3) years in order to ensure their continued appropriateness. "</p> <p>2. During a review of 17 pharmacy policy/procedures provided as evidence of compliance with State rules, 4 policy/procedures (Unusable and Outdated Drugs (revised 6-1-09),</p>	S0322	<p>New MCN policy and procedure software currently being implemented. Transitioning current policies to MCN that will allow tracking processes electronically. Unusable and Outdated Drug, Medication Loss or Theft was reviewed and updated on 7/6/2012. The Director of Pharmacy is the responsible person to review the Pharmacy policies and procedures utilizng the new MCN Software. (7/6/12)Automatic Stop Orders and Patient Medication orders will be reviewed by the Pharmacy and Therapeutics Committee Members on 7/6/2012. Future policy reviews and policy compliance will be the responsibility of the Director of Pharmacy by utilizing the new MCN software. (7/6/12) Implementation of MCN software will assure policies are reviewed within facility policy. The MCN</p>	07/06/2012	

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	<p>Medication Loss of Theft (reviewed 10-20-08), Automatic Stop Orders (revised 4-16-09) and Patient Medication Orders (revised 7-30-08)) failed to indicate that an update or review had been performed within the past 3 years.</p> <p>3. During an interview on 6-21-12 at 1110 hours, staff A4 confirmed that the indicated policy/procedures had not been reviewed or revised within the past 3 years in accordance with facility policy.</p>		software will be monitored monthly by the Executive Administrative Assistant. (7/9/12)		

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S0394	<p>410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1(f)(3)</p> <p>(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:</p> <p>(3) That the hospital maintains a list of all contracted services, including the scope and nature of the services provided.</p> <p>Based on document review and interview, the facility failed to maintain a list of all contracted services for the hospital for 228 of 825 contracted services.</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>1. Review of a list of 825 contracted service agreements provided by staff A3 on 6-19-12 indicated that 228 service provider agreements were expired.</li> <li>2. During an interview on 6-20-12 at 1415 hours, staff A3 confirmed that the list of contracted services had not been maintained.</li> </ol>	S0394	<p>A list of current contracts has been reviewed and revised as of 7/9/12. This list will be maintained in the MCN repository software system that will alert responsible parties of contract review and renewal dates. The Executive Assistant will be responsible to monitor the MCN process.</p>	07/09/2012			

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S0406	<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.</p> <p>Based on document review and interview, the Quality Management Plan lacked a provision ensuring that contracted services were included in the Quality Assessment and Performance Improvement (QAPI) program for 16 indirect services.</p> <p>Findings:</p> <p>1. The policy/procedure Quality Management Plan (reviewed 6-19-09) lacked a provision for monitoring, evaluating, and reporting contracted services provided at the facility.</p> <p>2. Review of program documentation failed to indicate monitoring and periodic reporting for the following service providers: anesthesia equipment service,</p>	S0406	<p>Anesthesia Equipment Service – has been added to our quality plan and will be monitored on a quarterly basis. The Director of Surgery will be responsible for reporting and assuring monitoring is done. Results will be reported to the hospital quality committee. (7/9/12)</p> <p>Bio hazardous Waste Disposal - has been added to our quality plan and will be monitored on a quarterly basis. The Director of Plants Operations will be responsible for reporting and assuring monitoring is done. Results will be reported to the hospital quality committee (7/9/12)</p> <p>Document Disposal - has been added to our quality plan and will be monitored on a quarterly basis. The Director of Materials Management will be responsible for reporting and assuring monitoring is done. Results will be reported to the hospital</p>	07/09/2012	

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	<p>biohazardous waste disposal, document disposal, endoscope service, elevator service, fire extinguisher service, fire system monitoring, generator service, 2 housekeeping services, pest control, 3 radiology equipment maintenance services, snow removal and a trash disposal service.</p> <p>3. During an interview on 6-21-12 at 945 hours, staff A7 confirmed that the Quality Management Plan failed to include the indicated service providers in the QAPI program.</p>		<p>quality committee (7/10/12) Endoscope Equipment Service - has been added to our quality plan and will be monitored on a quarterly basis. The Director of Surgery will be responsible for reporting and assuring monitoring is done. Results will be reported to the hospital quality committee. (7/9/12) Trash Disposal Service - has been added to our quality plan and will be monitored on a quarterly basis. The Director of Plants Operations will be responsible for reporting and assuring monitoring is done. Results will be reported to the hospital quality committee (7/9/12) Housekeeping Services - has been added to our quality plan and will be monitored on a quarterly basis. The Manager of Environmental Services will be responsible for reporting and assuring monitoring is done. Results will be reported to the hospital quality committee (7/10/12) Pest Control - has been added to our quality plan and will be monitored on a quarterly basis. The Director of Plants Operations will be responsible for reporting and assuring monitoring is done. Results will be reported to the hospital quality committee (7/9/12) Radiology Equipment Maintenance Services has been added to our quality plan and will be monitored on a quarterly basis. The Director of Radiology</p>		

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			<p>will be responsible for reporting and assuring monitoring is done. Results will be reported to the hospital quality committee (7/9/12)</p> <p>Snow removal - has been added to our quality plan and will be monitored on a quarterly basis. The Director of Plants Operations will be responsible for reporting and assuring monitoring is done. Results will be reported to the hospital quality committee (7/9/12)</p> <p>Elevator Service - has been added to our quality plan and will be monitored on a quarterly basis. The Director of Plants Operations will be responsible for reporting and assuring monitoring is done. Results will be reported to the hospital quality committee (7/9/12)</p> <p>Fire Extinguisher Service - has been added to our quality plan and will be monitored on a quarterly basis. The Director of Plants Operations will be responsible for reporting and assuring monitoring is done. Results /will be reported to the hospital quality committee (7/9/12)</p> <p>Fire System Monitoring - has been added to our quality plan and will be monitored on a quarterly basis. The Director of Plants Operations will be responsible for reporting and assuring monitoring is done. Results will be reported to the hospital quality committee</p>		

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			(7/9/12) Generator Service - has been added to our quality plan and will be monitored on a quarterly basis. The Director of Plants Operations will be responsible for reporting and assuring monitoring is done. Results will be reported to the hospital quality committee (7/9/12)		

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S0592	<p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(f)(3)(D)(i)</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:</p> <p>(D) Reviewing and recommending changes in procedures, policies, and programs which are pertinent to infection control. These include, but are not limited to, the following:</p> <p>(i) Sanitation.</p> <p>Based on observation, documentation review and interview, the infection control (IC) committee failed to ensure the sanitizer was diluted as per manufacturer requirements for being used on food contact surfaces within the Dietary Department and failed to ensure that the operating room (OR) cleaning and disinfecting was performed in a safe and effective manner for the surgery department of the facility.</p> <p>Findings included:</p> <p>1. The Portion Pak sanitizer SFS17 manufacturer label notes to add the 4.5 ounce portion pack into 4 gallon water to be 200 ppm. The concentrated portion</p>	S0592	<p>1, 2: The Portion Pak sanitizer SFS17 will be utilized in accordance to the manufacturers mixing and usage instructions. The sanitizer will be changed and tested every two hours to assure the concentration is between 150 to 200 parts per million quaternary ammonia.3: Dietary staff will utilize the process per the manufacturer's dilution recommendations. Staff has been in-serviced regarding proper dilution processes. 4, 5, 6, 7, 8: OR cleaning and disinfecting processes by surgery staff and housekeeping personnel policy and procedure has been reviewed by the Infection Preventionist and added to the approval process of the Infection Control Committee. Environmental Services</p>	07/10/2012			

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	<p>pack packages, when properly diluted, shall range between 150 to 200 parts per million quaternary ammonia concentration when utilized for food contact surfaces.</p> <p>2. At 1:00 PM on 6/20/2012, the main kitchen prep area was toured. Three of three sanitizing buckets did not meet 150 to 200 ppm concentration as required by Portion Pak Chemical Corp. for proper sanitizing food-contact services within the Dietary Department. Two of the three containers did not register anything after being tested QT 40 testing kit. the third container exceeded 500 ppm after being tested with a QT 40 test kit. The product is packaged in concentration 4.5 ounce portion package. However, the hospital was emptying the 4.5 ounce concentrated pack into a 32 ounce pump container with water followed by pumping 4 ounces of this mixed solution into another 64 ounces of water. .</p> <p>3. At 2:30 PM on 6/20/2012, the contracted vendor indicated to empty the 4.5 ounce portion pack into the pump container and add water to fill the container up. The vendor indicated to prepare sanitizing buckets, pump one squirt (2 ounces) into the bucket and fill to the fill line to equal 200 ppm. The vendor confirmed the process that was</p>		<p>Representative has been added to the Infection Control Committee. The revised policy includes between-case and terminal surgical suite cleaning responsibility, a process to prevent contamination of previously disinfected services, and off shift duty terminal cleaning. The Infection Preventionist will monitor for compliance.</p>		

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	<p>instructed to this surveyor was not spelled out in the manufacturer dilution recommendations.</p> <p>4. The policy/procedure Infection Prevention and Control Program (approved 2-12) lacked a provision for IC committee review of OR cleaning and disinfecting processes by surgery staff and housekeeping personnel.</p> <p>5. The Surgical Services policy/procedure Cleaning of OR and Post-op (reviewed 10-09) and Cleaning Schedules - Housekeeping Department (reviewed 2-12) failed to indicate the following: A. IC committee or representative review/approval B. responsibility for between-case and terminal surgical suite cleaning C. a specific process for surgery suite cleaning to prevent contamination of previously disinfected surfaces</p> <p>6. The document Surgery Shift Duty Assignments - Cleaning Procedures for Terminal Cleaning in Operating Rooms (no effective date) failed to indicate the following: A. IC committee or representative review/approval B. Surgery representative review/approval C. Environmental Services representative</p>						

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	<p>review/approval</p> <p>7. During an interview on 6-20-12 at 1300 hours, staff A18 indicated that surgery staff performed the between case OR cleaning and that 2 dedicated housekeeping staff performed the terminal OR cleaning for the department.</p> <p>8. During an interview on 6-20-12 at 1650 hours, staff A2 and A6 confirmed that the policy/procedures lacked the indicated provisions and confirmed that the IC committee failed to ensure that the OR cleaning and disinfecting was performed in a safe and effective manner.</p>				

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S1168	<p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 150-1.5-8 (d)(3)</p> <p>(d) The equipment requirements are as follows:</p> <p>(3) Defibrillators shall be discharged at least in accordance with manufacturers recommendations and a discharge log with initialed entries shall be maintained.</p> <p>Based on document review, observation and interview, the facility failed to maintain its policy/procedure regarding defibrillator inspection and testing as recommended by the manufacturer and ensure that the equipment was ready for use if needed.</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>1. The policy/procedure Defibrillator Maintenance (reviewed 2-05) indicated a daily testing process for a Hewlett Packard Code Master XL defibrillator.</li> <li>2. During a tour on 6-20-12 at 1215 hours, the following emergency equipment was observed in the Pre and Post Surgical Unit: a crash cart with an Agilent/Philips model 4735A Defibrillator on top of the cabinet.</li> <li>3. During an interview on 6-21-12 at 1105 hours, staff A4 confirmed that the</li> </ol>	S1168	The defibrillator policy and procedure has been reviewed and rewritten as of July 9, 2012. New MCN policy and procedure software currently being implemented. MCN will allow tracking processes electronically for review and tracking. Director of Critical care will be responsible for review in MCN.	07/09/2012			

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	policy/procedure had not been maintained and failed to indicate an inspection and testing process for the defibrillator currently in use.				