

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150047	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/25/2014
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NAME OF PROVIDER OR SUPPLIER ST JOSEPH HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 700 BROADWAY FORT WAYNE, IN 46802
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S000000	<p>This visit was for a State hospital licensure survey.</p> <p>Dates: 6/23/2014 through 6/25/2014</p> <p>Facility Number: 005043</p> <p>Surveyors: Albert Daeger, CFM, SFPIO Medical Surveyor</p> <p>Saundra Nolfi, RN PH Nurse Surveyor</p> <p>QA: claughlin 07/01/14</p>	S000000		
S000308	<p>410 IAC 15-1.4-1 GOVERNING BOARD 15-1.4-2 (c)(6)(B)</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:</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>(B) Orientation of all new employees, including contract and agency personnel, to applicable hospital, department, service, and personnel policies.</p> <p>Based on documentation review and staff interview, the hospital failed to ensure 2 (#19 and #45) of 4 contracted foodservice employees completed St. Joseph Hospital's Department Orientation and Initial Competency Assessment (DOICA) forms.</p> <p>Findings included:</p> <ol style="list-style-type: none"> The agreement between St. Joseph Hospital of Fort Wayne and the contracted foodservice was signed on February 1st, 2014. The DOICA form stated, "The DOICA assesses the initial competency of the above employee and is to be completed within 90 days of hire. The observer is to document the method of assessment and sign his/her name after each observation. Please turn the DOICA into HR promptly upon 	S000308	<ol style="list-style-type: none"> How are you going to correct the deficiency? If already corrected, include the steps taken and the date of correction. <ul style="list-style-type: none"> To correct the deficiency, all Metz employee files were reviewed to ensure all DOICA competencies criteria were met and documented appropriately. How are you going to prevent the deficiency from recurring in the future? <ul style="list-style-type: none"> To prevent future deficiencies, the Department General Manager or designee completes the DOICA with all employees within 90 days of hire, documents on the DOICA appropriately, and places a copy of the form in the employee's individual file prior to returning the form into Human Resources, who will complete a second verification that the DOICA is done. The Department General Manager will use email/calendar alerts for all new employees to ensure the DOICA is completed timely. Who is going to be responsible for numbers 1 and 2 above; i.e., director, 	07/16/2014

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	<p>completion."</p> <p>3. Contracted staff member #19's (Foodservice General Manager) DOICA form was not completed, which included the Hire Date section of the form. However, Competency Met column noted dates of 1/30/2014 and 2/1/2014. The Competency Met column was not dated for completion of 11 Department Orientation/Performance Criteria. The criteria that was not completed included: Verbalizes role in fire drill; Locate fire extinguishers; Identifies routes of evacuation; Locates safety manual and verbalizes content; Locates personnel protective equipment; etc.</p> <p>4. Contracted staff member #45's (Foodservice Hostess), hired on 2/1/2014, DOICA form was not completed. Competency Met column, dated 2/1/2014, Competency Met column was not dated for completion of 6</p>		<p>supervisor, etc.?</p> <ul style="list-style-type: none"> The Metz Department General Manager will be responsible for the plan of correction. <p>4. By what date are you going to have the deficiency corrected?</p> <ul style="list-style-type: none"> By 7/16/2014, all Metz employee files were reviewed to ensure all DOICA competencies criteria were met and documented appropriately and Human Resources completed a second verification. 	

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S000322	<p>Department Orientation/Performance Criteria. The criteria that was not completed included: Locates safety manual and verbalizes content; Locates personnel protective equipment; Verbalizes emergency response procedures; etc.</p> <p>5. At 1:30 PM on 6/25/2014, staff member #2 (Chief Nursing Officer) confirmed 2 of 4 contracted foodservice staff members did not complete their mandatory competency within the first 90 days after they started to work for St. Joseph Hospital of Fort Wayne.</p> <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:</p>				

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	<p>(H) Requiring all services to have policies and procedures that are updated as needed and reviewed at least triennially.</p> <p>Based on documentation review and staff interview, the hospital failed to ensure there were foodservice policies and procedures that were reviewed and approved by the Governing Board.</p> <p>Findings included:</p> <ol style="list-style-type: none"> The agreement between St. Joseph Hospital of Fort Wayne and the contracted foodservice company was signed on February 1st, 2014. At 10:00 AM on 6/24/2014, the contracted foodservice General Manager indicated the kitchen follows the Pennsylvania foodservice guidelines. The staff member indicated he/she does not have a copy of Indiana Retail Food Establishment Sanitation Guidelines; 410 IAC 7-24. The staff member confirmed the kitchen does not have any hospital 	S000322	<p>1.How are you going to correct the deficiency? If already corrected, include the steps taken and the date of correction.</p> <ul style="list-style-type: none"> ·410 IAC 7-24 is now available in the department and has been reviewed by all members of the management team. ·Metz Policy and Procedures will be created, reviewed, and sent for approval through Quality, Medical Executive Committee, and the Board of Trustees. <p>1.How are you going to prevent the deficiency from recurring in the future?</p> <ul style="list-style-type: none"> ·Metz Policy & Procedures will be created, reviewed and approved by Quality, Medical Executive Committee, and the Board of Trustees. ·The Policy & Procedure manual will be located in a place that all staff are able to access and staff will be educated to the location of the manual per staff meeting. <p>1.Who is going to be responsible for number 1 and 2 above?</p> <ul style="list-style-type: none"> · The Department General Manager and the COO are responsible for the above plan of correction. 	09/19/2014			

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	<p>policies to assist in managing the kitchen.</p> <p>3. At 11:30 AM on 6/25/2014, staff member #12 (Chief Quality Officer) indicated the contracted food service company started providing dietary services to the hospital in February of 2014. The kitchen hospital policies went with the previous contracted foodservice company the hospital had before February of 2014 because they were the contracted company's policies and procedures. The new contracted foodservice company has not provided the hospital with policies and procedures to be reviewed and approved. The staff member confirmed St. Joseph Hospital does not have policies for the hospital dietary foodservice operations.</p> <p>4. At 12:00 PM on 6/25/2014, staff member #2 (Chief Nursing Officer) confirmed St. Joseph Hospital does not have policies and procedures for Dietary Services.</p>		<p>1. By what date are you going to have the deficiency corrected?</p> <ul style="list-style-type: none"> · On 6/26/2014, 410 IAC 7-24, Retail Food Establishment Sanitation Requirements were available in the department and reviewed by all members of the management team. · By September 18, 2014, Metz Policy & Procedures will be created, reviewed, and taken to Quality, Medical Executive Committee and the Board of Trustees for approval. · By September 19, 2014, the Policy & Procedure manual will be located in a place that all staff are able to access and staff will be educated to the location of the manual per staff meeting. 	

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S000610	<p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(f)(3)(D)(x)</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>(x) A program of food preparation and storage for all personnel involved in food handling which includes, but is not limited to, the following:</p> <p>(AA) Storage of employee food in patient refrigerators.</p> <p>(BB) Medications in nutrition refrigerators.</p> <p>(CC) Refrigerator and freezer temperature monitoring.</p> <p>Based on documentation review, observation, and staff interview, the hospital failed to ensure proper food temperature control practice</p>	S000610	<p>1.How are you going to correct the deficiency? If already corrected, include the steps taken and the date of correction.</p> <p>At the time of survey, the pork roast that was not cooled to</p>	07/25/2014

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	<p>were followed for the kitchen as required by 41 IAC 7-24.</p> <p>Findings included:</p> <ol style="list-style-type: none"> The agreement between St. Joseph Hospital and the contracted foodservice company was signed on February 1st, 2014. Article 5 of the agreement stated, "... agrees to comply with all Applicable Laws, and will operate the Program and provide the Services in accordance with good sanitation practices as mandates by federal and state ordinances and local laws applicable to the Program." Retail Food Establishment Sanitation Requirements 410 IAC 7-24-189 stated, "Cooked potentially hazardous food shall be cooled as follows: Within two (2) hours, from one hundred thirty-five (135) degrees Fahrenheit to seventy (70) degrees Fahrenheit; Within four (4) hours, from seventy (70) degrees Fahrenheit to forty-one (41) degrees Fahrenheit; 		<p>proper temperature within 2 hours was discarded.</p> <ul style="list-style-type: none"> Through department in-service, employees will be trained on proper cooling methods. Cooling methods to be utilized include ice baths or cutting the roasts into smaller pieces to be cooled properly in the walk-in. <p>1.How are you going to prevent the deficiency from recurring in the future?</p> <ul style="list-style-type: none"> To prevent future deficiencies, the Department General Manager will review the 'cooling log' weekly to ensure the proper cooling process is being followed. The cooling process education will be added to new employee orientation. A random weekly audit of the cooling process will be conducted by the Department General Manager. Review will continue until 4 consecutive months at 90% compliance is achieved. Audit results will be reported at the Patient Safety Committee. <p>1.Who is going to be responsible for number 1 and 2 above?</p> <ul style="list-style-type: none"> The Department General Manager will be responsible for the above stated plan. <p>1.By what date are you going to have the deficiency corrected?</p>	

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	<p>The entire cooling process must be completed within six (6) continuous hours."</p> <p>3. At 11:25 AM on 6/24/2014, a kitchen staff member removed a pan of three cooked 10-pound pork loins from the industrial oven. The pork loins registered 153 Fahrenheit at 11:25 AM. At 12:10 PM on 6/24/2014, the cooked pork loins were registered at 136 Fahrenheit on the prep table in the kitchen. At 12:30 PM on 6/24/2014, the three cooked pork loins were observed partially covered with plastic wrap on a shelf in the walk-in cooler and they registered between 129 and 132 Fahrenheit. At 2:55 PM on 6/24/2014, the sheet pan of the three pork loins cooling in the walk-in cooler registred at 79 to 83 Fahrenheit. The pork loins were observed cooling from 136 degrees Fahrenheit to 79 degrees Fahrenheit in 2 hours and 25 minutes. Therefore, the cooked pork loins were observed not</p>		<ul style="list-style-type: none"> · At the time of survey, the pork roast that was not cooled to proper temperature within 2 hours was discarded. · By 7/25/2014, staff will be trained on the use of proper cooling methods. Cooling methods to be utilized include ice baths or cutting the roasts into smaller pieces to be cooled properly in the walk-in. · On 7/25/2014, the observational audits will begin and continue until 4 consecutive months at 90% compliance is achieved and audit results will be reported at the Patient Safety Committee meeting. · By 7/25/2014, , the Department General Manager will review the 'cooling log' weekly to ensure the proper cooling process is being followed. 	

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	<p>cooled within 2 hours from 135 to 70 degrees Fahrenheit. This cooling process of the three 10-pound cooked pork loins were observed with staff #19 (Foodservice Director).</p> <p>4. At 11:30 AM on 6/24/2014, kitchen staff member #18 indicated the cooked pork loins will be stored on a prep counter uncovered until the temperature reaches 130 degrees Fahrenheit then will be partially covered and further cooled in the walk-in cooler. The staff member indicated the pork loins will be served on 6/25/2014.</p> <p>5. At 2:57 PM on 6/24/2014, staff member #19 (Foodservice Director) confirmed the three cooked pork loins did not cool-down to 70 degrees Fahrenheit within two hours as required by state law and contracted foodservice corporate requirements. Staff member #19 indicated the kitchen staff that were responsible for the pork loins</p>			
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S000726	<p>left for the day before the pork loins were properly cooled down.</p> <p>410 IAC 15-1.5-4 MEDICAL RECORD SERVICES 410 IAC 15-1.5-4 (c)(7)(A)(B)</p> <p>(c) An adequate medical record shall be maintained with documentation of service rendered for each individual who is evaluated or treated as follows:</p> <p>(7) The hospital shall ensure the confidentiality of patient records which includes, but is not limited to, the following:</p> <p>(A) A procedure for releasing information from or copies of records only to authorized individuals in accordance with federal and state laws.</p> <p>(B) A procedure that ensures that unauthorized individuals cannot gain access to patient records.</p> <p>Based on observation and staff interview, the facility failed to secure medical information access from unauthorized users for Outpatient Radiology Department offsite.</p>	S000726	<p>1. How are you going to correct the deficiency? If already corrected, include the steps taken and the date of correction.</p> <p><i>To correct the deficiency, a lock was placed on the film room door allowing access to the room by radiology staff only.</i></p>	07/10/2014
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	<p>Findings included:</p> <p>1. At 9:45 AM on 6/25/2014, the offsite Outpatient Radiology was observed storing imaging patient film packets in a room with a door to the room that did not lock. The room was observed with file shelving units surrounding the exterior walls of the room the shelves were filled with patient confidential information (imaging films).</p> <p>2. At 9:55 AM on 6/25/2014, staff member #10 (Director of Radiology) indicated the door to the film room does not lock. The department has no hospital staff present during all times when the contracted housekeeping crew would be cleaning the department.</p>		<p>2. How are you going to prevent the deficiency from recurring in the future?</p> <ul style="list-style-type: none"> · <i>Future deficiencies will be prevented as access to the film room will be limited to radiology staff only.</i> · <i>The film room will be cleaned per Radiology staff only, negating the need for housekeeping services to have access to the room. Staff will be educated/trained via department in-service on the need for a secure film room, who may have access to the room, and the process for cleaning the room.</i> · <i>Environment of Care rounds will include checking to ensure the film room is secure.</i> <p>3. Who is going to be responsible for numbers 1 and 2 above; i.e., director, supervisor, etc.?</p> <ul style="list-style-type: none"> · <i>The Director of Radiology is responsible for this plan of correction.</i> <p>4. By what date are you going to have the deficiency corrected?</p> <ul style="list-style-type: none"> · <i>On 6/24/2014, the lock was placed on the film room door limiting access of the room to radiology staff only.</i> · <i>On 7/10/2014, the outpatient radiology staff were educated and trained via</i> 		

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S000912	<p>410 IAC 15-1.5-6 NURSING SERVICE 410 IAC 15-15-6 (a)(2)(B)(i)(ii) (iii)(iv)(v)</p> <p>(a) The hospital shall have an organized nursing service that provides twenty-four (24) hour nursing service furnished or supervised by a registered nurse. The service shall have the following:</p> <p>(2) A nurse executive who is: (B) responsible for the following: (i) The operation of the services, including, but not limited to, determining the types and numbers of nursing personnel and staff necessary to provide care for all patient care areas of the hospital. (ii) Maintaining a current nursing service organization chart. (iii) Maintaining current job descriptions with reporting responsibilities for all nursing staff positions. (iv) Ensuring that all nursing personnel meet annual in-service requirements as established by hospital and medical staff policy and procedure, and federal and state requirements. (v) Establishing the standards of nursing care and practice in all settings in which nursing care is provided in the hospital.</p>		department in-service on the security of the film room, who may have access to the room and the process of cleaning the room.	

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	<p>Based on policy and procedure review, medical record review, and interview, the nurse executive failed to ensure pain assessments were done according to policy and protocol for 1 of 1 newborns who were circumcised (N9) and for 3 of 3 pediatric patients hospitalized on the burn unit (N10, N12, and N12).</p> <p>Findings included:</p> <p>1. The facility policy "Circumcision Care", effective 11/2012, indicated, "A. Immediate Post-Op Care: 1. Observe for bleeding every fifteen (15) minutes times two, then every thirty (30) minutes times one, the every eight (8) hours or with diaper changes prn and document. 2. Assess and document infant's pain using NIPS pain scale (a score of ZERO must be documented), following comfort measures and assessment frequency."</p> <p>2. The facility policy "Pain Assessment", last revised 07/2012, indicated, "A. Patients have the right to, and will receive, prompt assessment and management of pain. Pain is assessed on admission and reassessed with each shift assessment and following any invasive procedures. Response to pain intervention is assessed within 1 hour after pain intervention to determine effectiveness and to determine whether</p>	S000912	<p>1. How are you going to correct the deficiency? If already corrected, include the steps taken and the date of correction.</p> <ul style="list-style-type: none"> · To correct the deficiency, Burn Unit staff will be reeducated to Policy 630B (Pain Assessment), assessment of pain on admission and reassessed with each shift assessment, following any invasive procedures, and response to pain intervention within 1 hour after pain intervention. Additionally, staff will be reeducated on the requirements of documenting pain given for procedural (hydro) tolerance versus pain in general. · Policy OB 438 (Post Circumcision Care) will be reviewed and modified per the Birthplace Director to define the timeframe for the assessment and reassessment of infant pain post procedure (circumcision) to match best practice procedures. <p>2. How are you going to prevent the deficiency from recurring in the future?</p> <ul style="list-style-type: none"> · To prevent future deficiencies, the Burn Department manager will conduct a pain assessment/reassessment audit of 100% of all admitted pediatric patient charts. Review will continue until 4 consecutive months at 90% compliance is achieved. Results of the audit will be reported at the Patient Safety Committee. 	07/31/2014			

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	<p>further intervention is needed."</p> <p>3. The medical record for newborn N9 indicated a circumcision was performed on 03/15/14, starting at 1202 and ending at 1223. Documentation indicated checks of the circumcision were performed at 1330 and 1730, but there was no pain assessment until 1730.</p> <p>4. The medical record for pediatric patient N10 indicated an admission to the burn unit at 2257 on 02/12/14, but the record lacked documentation of a pain assessment. The record indicated the patient received medication for pain at 0845 on 02/13/14, but was not reassessed until 1030 and received pain medication at 2351, but pain assessments at 2300 on 02/13/14 and at 0000, 0100, and 0200 on 02/14/14 indicated the pain score was zero.</p> <p>5. The medical record for pediatric patient N11 indicated an admission to the burn unit at 1150 on 03/25/14 and the first pain assessment was at 1303. Another assessment was done at 1649 with medication given and the next assessment was documented at 2025. The patient was assessed and medicated at 0900 on 03/26/14 and not reassessed until 1215.</p>		<p><i>All Birthplace nurses caring for newborns will be educated to the revised policy OB 438 (Post Circumcision Care) per unit email, 1:1 communication, and unit informational flyer. Education of the policy will be reviewed during new employee orientation.</i></p> <p><i>An audit of pain assessments post circumcision will be completed on all applicable male infants based on revised policy OB 438 (Post Circumcision Care). Review will continue until 4 consecutive months at 90% compliance is achieved. Results of the audit will be reported at the Patient Safety Committee.</i></p> <p>3. Who is going to be responsible for numbers 1 and 2 above; i.e., director, supervisor, etc.? <i>The Director of Critical Care Services/Birthplace is responsible for the above plan of correction.</i></p> <p>4. By what date are you going to have the deficiency corrected? <i>By 7/19/2014, Burn Unit staff will be reeducated via unit email notification, verbal 1:1 communication, and posted in-service/flyer to Policy 630B (Pain Assessment), assessment of pain on admission and reassessed with each shift assessment, following any invasive procedures, and response to pain intervention within 1 hour after pain</i></p>		

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S000952	<p>6. The medical record for pediatric patient N12 indicated an admission to the burn unit at 1700 on 01/28/14 and the first pain assessment was at 1746, but there was no pain score even though notation indicated the patient was uncomfortable and crying. Medication was given at 1825 with the next pain assessment at 2005.</p> <p>7. At 1:30 PM on 06/25/14, staff member A3, (Quality Manager) who navigated the EMR (electronic medical record), confirmed the findings regarding the newborn and pediatric records.</p> <p>410 IAC 15-1.5-6 NURSING SERVICE 410 IAC 15-1.5-6(d)</p> <p>(d) Blood transfusions and intravenous medications shall be administered in</p>		<p><i>intervention. Additionally, staff will be reeducated on the requirements of documenting pain given for procedural (hydro) tolerance versus pain in general.</i></p> <ul style="list-style-type: none"> · <i>By 7/19/2014, the department manager will begin a pain assessment/reassessment audit of 100% of all admitted pediatric patient charts. Review will continue until 4 consecutive months at 90% compliance is achieved and results will be reported at the Patient Safety Committee.</i> · <i>By 7/30/2014, all Birthplace nurses caring for newborns will be educated to the revised policy OB 438 (Post Circumcision Care) per unit email, 1:1 communication, and unit informational flyer. Education of the policy will be reviewed during new employee orientation.</i> · <i>By 7/31/2014, an audit of pain assessments post circumcision will be started on all applicable male infants based on revised policy OB 438 (Post Circumcision Care) . Review will continue until 4 consecutive months at 90% compliance is achieved. Results of the audit will be reported at the Patient Safety Committee.</i> 		

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	<p>accordance with state law and approved medical staff policies and procedures. If the blood transfusions and intravenous medications are administered by personnel other than physicians, the personnel shall have special training for these procedures in accordance with subsection (b)(6). Based on policy review, medical record review, and interview, the facility failed to ensure the their policy and physician orders were followed regarding blood transfusions for 4 of 5 patients receiving blood transfusions (N1, N2, N4, and N5).</p> <p>Findings included:</p> <p>1. The facility policy "Blood Transfusion", last revised 08/12, indicated, "1. Policy: A. All blood products distributed by the blood bank require a specific physician order. ...Procedure: ...5. Obtain the blood product from the Laboratory just prior to use. Transfusion of the blood and/or product should begin within thirty (30) minutes from the time of issue from the blood bank or it should be returned for proper refrigeration. ...8. Infuse the blood product slowly for the first 15 minutes and record vitals. ...9. Adjust the rate in order to complete the infusion within one & one half to not more than four (1 1/2- 4) hours after the time the blood is picked up from the blood bank.</p>	S000952	<p>1. How are you going to correct the deficiency? If already corrected, include the steps taken and the date of correction.</p> <ul style="list-style-type: none"> The Blood Transfusion Policy (NUR 280) will be reviewed and revised by leadership regarding the 30 minute blood product start time limit from lab release time. According to the 2014 AABB (American Association of Blood Banks) Standards, blood products must be transfused within 4 hours of lab release time (which is stated in NUR 280 policy). There is no standard indicating the need to start a transfusion within 30 minutes of lab release time and therefore this practice noted in the NUR 280 policy will be removed. The policy will continue to state that in the case of a delay in starting the transfusion the product must be returned within 30 minutes and meet the temp requirement of < 10 degrees, and that the transfusion must be complete within 4 hours from the time of issue. Updated blood product transfusion education will be presented to nursing staff who 	09/30/2014

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	<p>...10. Observe the patient at least hourly throughout the transfusion and record hourly vital signs."</p> <p>2. The medical record for patient N1 indicated three units of PRBC (packed red blood cells) were transfused on 01/22/14. Documentation for the units indicated the following: A. First unit: Started at 0531 and completed at 0931, but no time for laboratory release to ensure it was started within 30 minutes and completed within 4 hours from release. B. Second unit: Released from the lab at 1250, but not started until 1349, almost an hour later. C. Third unit: Released from the lab at 1712, notation on the form "Found in tube system" at 1738, and not started until 1810, almost an hour from release.</p> <p>3. The medical record for patient N2 indicated an order for Type and Screen and Crossmatch 2 units of PRBCs from 1311 on 04/11/14. Documentation indicated the first unit of blood was started at 1405, but the record lacked an actual physician order to transfuse.</p> <p>4. The medical record for patient N4 indicated a unit of PRBCs was started at 0030 on 02/22/14 and completed at 0333. Vital signs, but no temperature reading,</p>		<p><i>are responsible for transfusing blood products. The education will emphasize the importance of proper transfusion practices according to the revised NUR 280 policy as well as appropriately following physician orders. Additionally, education will include directions on documentation accuracy related to the blood transfusion process.</i></p> <p>2. How are you going to prevent the deficiency from recurring in the future?</p> <ul style="list-style-type: none"> <i>To prevent the deficiency from recurring, Quality Services will conduct a monthly random audit of 50 charts to monitor compliance of the blood product transfusion process and documentation. Review will continue until 4 consecutive months at 90% compliance is achieved. Audit results will be reported at the Patient Safety Committee meeting.</i> <p>3. Who is going to be responsible for numbers 1 and 2 above; i.e., director, supervisor, etc.?</p> <ul style="list-style-type: none"> <i>The CNO will be responsible for the above stated plan.</i> <p>4. By what date are you going to have the deficiency corrected?</p> <ul style="list-style-type: none"> <i>By 7/ 31 /2014, the Blood Transfusion Policy (NUR 280) will</i> 				

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S001028	<p>were documented at 0103 and full vital signs at 0130 and 0333. The record lacked documentation of 15 minute and every hour vital signs.</p> <p>5. The medical record for patient N5 indicated a physician order from 0957 on 03/02/14 to administer 2 units of PRBCs and to infuse each unit over 1 hour. Documentation indicated the first unit was started at 1140 and completed at 1325 and the second unit was started at 1349 and completed at 1549. The record lacked any documentation to indicated why the units did not infuse in one hour as ordered.</p> <p>6. At 8:45 AM on 06/25/14, staff member A3, (Quality Manager) who navigated the EMR (electronic medical record), confirmed the findings regarding the blood transfusion documentation.</p> <p>410 IAC 15-1.5-7 PHARMACEUTICAL SERVICES 410 IAC 15-1.5-7 (d)(2)(E)</p> <p>(d) Written policies and procedures shall be developed and implemented that include the following:</p> <p>(2) Ensure the monthly inspection of all areas where drugs and biologicals are stored and which address, but are not limited to, the following:</p>		<p><i>be reviewed and revised by leadership regarding the 30 minute blood product start time limit from lab release time.</i></p> <ul style="list-style-type: none"> · <i>By 8/31/2014, Updated blood product transfusion education will be presented to nursing staff who are responsible for transfusing blood products.</i> · <i>By 9/30/2014, the chart audits will begin with results reported at the Patient Safety Committee meeting.</i> 				

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	<p>(E) Security of and authorized access to all drug storage areas within the hospital, as approved by the medical staff, when the pharmacist is absent.</p> <p>Based on observation, interview, and policy and procedure review, the facility failed to ensure medications were secured to prevent unauthorized access in the surgical department.</p> <p>Findings included:</p> <p>1. During the tour of the C/S Room, which was unoccupied and unattended, at 10:20 AM on 06/24/14, accompanied by staff members A1 (Risk Manager), A2 (CNO), A13 (Director, ED and OR) and A15 (OR Manager) three plastic kits containing anesthesia medications were observed unsecured in a cabinet in the room.</p> <p>2. At 10:25 AM on 06/24/14, staff member A13 indicated the the lock seemed broken, but indicated the cabinet was locked on Friday when he/she was present for a C/S delivery. He/she confirmed environmental services and other staff could access the room.</p> <p>3. The facility policy "Medication Storage in patient care areas", last revised 06/10/2013, indicated, "Storage Requirements: Until the time the</p>	S001028	<p>1. How are you going to correct the deficiency? If already corrected, include the steps taken and the date of correction.</p> <ul style="list-style-type: none"> · At the time of the finding, the cabinet containing three plastic kitshousing anesthesia medications was reported to Hospital Facilities for repair of the lock. The medications in the three plastic kits were secured in the AcuDose. <p>2. How are you going to prevent the deficiency from recurring in the future?</p> <ul style="list-style-type: none"> · In order to prevent the deficiency from recurring, the cabinet lock was evaluated by Hospital Facilities and taken out of service entirely. Medications stored in the Cesarean Section room cabinet were relocated to the AcuDose. · Staff were educated via unit email and the monthly education flyer of the permanent relocation of medications from the Cesarean Section room cabinet to the AcuDose. · Anesthetists were directly notified via personal text of the permanent relocation of the Cesarean Section room medications to the AcuDose. 	06/27/2014	

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S001118	<p>medications are administered in the patient care area, medications will be locked or stored in an area that is under constant surveillance of the patient care staff."</p> <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</p>		<p>3. Who is going to be responsible for numbers 1 and 2 above; i.e., director, supervisor, etc.?</p> <ul style="list-style-type: none"> The Director of Surgery is responsible for the plan of correction. <p>4. By what date are you going to have the deficiency corrected?</p> <ul style="list-style-type: none"> The cabinet lock was evaluated on 6/27/2014 and taken from service entirely. Staff were educated via unit email and the monthly education flyer of the permanent relocation of medications from the Cesarean Section room cabinet to the AcuDose on 6/27/2014. Anesthetists were directly notified via personal text of the permanent relocation of Cesarean Section room medications to the AcuDose on 6/27/2014. 		

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	<p>employees. Based on observation, document review, policy and procedure review, and staff interview, the facility failed to ensure patient clothing was stored in a clean and sanitary manner for 1 of 2 behavioral health units: Generations and failed to ensure a safe environment for patients and staff by following their policy regarding warming fluids and by ensuring unobstructed access to eyewash stations.</p> <p>Findings included:</p> <ol style="list-style-type: none"> At 1:30 PM on 6/24/2014, seven containers of patient personnel clothing were observed stored in a shower located in Generations patient storage room. At 1:35 PM on 6/24/2014, staff member #11 (Administrative Director Support Services) indicated the water to the Generation's patient shower stall has not been disconnected. The 	S001118	<ol style="list-style-type: none"> How are you going to correct the deficiency? If already corrected, include the steps taken and the date of correction. <ul style="list-style-type: none"> Patient belongings were removed from the shower room and placed on shelves in a locked closet on the Generations Unit. The locked closet room was appropriated for patient belongings only and staff were educated to the use of the room. At the time of survey, in ICU, the keyboard on top of the eyewash station was removed to the proper place of storage. At the time of survey, the outdated IV fluids and Sterile Water for irrigation found in the sub sterile room were removed and discarded. At the time of survey, the warmer in the Cesarean Section room was taken out of service and Biomed was notified of the need to check the warmer to ensure it was functioning properly. How are you going to prevent the deficiency from recurring in the future? <ul style="list-style-type: none"> Daily environmental rounds will be made on the shower room on the Generations Unit to ensure the room is not used as a storage room. Generations Staff were educated via the daily safety huddle regarding the incorrect 	07/09/2014	

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	<p>staff member indicated the patient personnel items should not be stored in the shower stall.</p> <p>3. During the tour of the surgical department at 9:30 AM on 06/24/14, accompanied by staff members A1 (Risk Manager), A2 (CNO), A13 (Director, ED and OR) and A15 (OR Manager), the following items were observed in the warmer in the substerile room:</p> <p>A. Two of two 250 ml. (milliliter) bottles of sterile water for irrigation with a written removal date of June 20, 2014.</p> <p>B. Three of three 1000 ml. bags of Lactated Ringers IV (intravenous) fluid, two with a written removal date of June 21, 2014 and one with a date of June 19, 2014.</p> <p>C. One of one 1000 ml. bag of PlasmaLyte A IV fluid with a written removal date of June 15, 2014.</p> <p>4. During the tour of the C/S Room at 10:20 AM on 06/24/14, accompanied by staff members A1, A2, A13, and A15, the warmer in</p>		<p><i>use of the shower room as storage and the new area that will be used to store patient belongings, a locked closet with shelving for storage of patient belongings.</i></p> <ul style="list-style-type: none"> · <i>To prevent future deficiencies, all ICU staff were educated per intradepartmental flyer as well as unit email notification that eyewash station access must not be obstructed.</i> · <i>The ICU charge nurse responsibility task list now includes daily monitoring of the eyewash station to ensure access is not obstructed. ICU Charge nurses were educated per one-to-one communication, revision of their daily checklist, and email notification of the new responsibility.</i> · <i>Surgery staff were reeducated of the policy regarding dating of warmer fluids per unit email and the monthly education flyer.</i> · <i>Daily audits of the warmer in the sub sterile room will be conducted to ensure there are no outdated items found in the warmer. Audits will continue until 4 consecutive months at 100% compliance is achieved. Results will be reported at the Patient Safety Committee meeting.</i> · <i>Staff responsible for the Cesarean Section room blanket/fluid warmer were counseled and reeducated per unit email and the monthly education flyer on the proper</i> 		

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	<p>the workroom was observed containing blankets and fluids. The temperature monitoring log on the warmer indicated the acceptable range was 97- 104 F. (Fahrenheit). Instructions on the form indicated, "In the event that the temperature falls outside the acceptable range of 99- 104, please record your corrective actions in the space below. Provide the date of the occurrence, your initials, the actions taken to correct the out of range temperature, and the results of a repeat temperature taken after the problem was corrected." The June 2014 log indicated the temperature was 106 F. on 06/08/14 and a notation that the temperature was decreased was documented, but with no initials of the staff member and no repeat temperature. The temperatures were out of range every day between 06/14/14 through 06/24/14, ranging from 106 to 114 F. Notations in the Corrective Actions Taken space on the form indicated the temperature was</p>		<p><i>process for checking and documentation of the warmer temperatures.</i></p> <ul style="list-style-type: none"> · <i>Daily environmental rounds will be made on the Cesarean Section warmer to ensure the temperature range is maintained and documentation is accurate and complete.</i> <p>3. Who is going to be responsible for numbers 1 and 2 above; i.e., director, supervisor, etc.?</p> <ul style="list-style-type: none"> · <i>The Director of Behavioral Health will be responsible for the plan of correction on the Generations Unit.</i> · <i>The Director of Critical Care Services/ICU will be responsible for theyewash station plan of correction.</i> · <i>The Director of Surgery will be responsible for the plan of correction regarding the warmer in the sub sterile room and the Cesarean Section room blanket/fluid warmer.</i> <p>4. By what date are you going to have the deficiency corrected?</p> <ul style="list-style-type: none"> · <i>On 6/26/2014, all patient belongings were removed from the shower room and placed into the new designated area for storage.</i> · <i>By 7/1/2014, all Generation staff were educated via the daily safety huddle regarding the incorrect use of the shower room as storage and the new area that would be used to store patient</i> 				

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	<p>decreased on 06/16/14 and 06/19/14, but no initials of the staff, no repeat temperatures, or any additional actions taken when the temperature continued to stay out of range were documented.</p> <p>5. During the tour of the ICU (Intensive Care Unit) at 11:20 AM on 06/24/14, accompanied by staff members A1 (Risk Manager), A2 (CNO), A17 (Manager ICU and IMC) and A18 (will be Manager ICU and IMC), the access to the emergency eyewash station in the supply room was observed obstructed by an IV pole and a metal, wheeled oxygen tank holder and a keyboard was observed lying in the eyewash bowl.</p> <p>6. The facility policy "Perioperative Normothermia", effective 04/2013, indicated, "3. The upper compartment of this warmer will be used for solutions used for irrigation and IV purposes and shall not exceed 40 degrees C. [Celsius] (104 F). 4. Irrigation</p>		<p><i>belongings, a locked closet with shelving for storage of patient belongings.</i></p> <ul style="list-style-type: none"> · <i>At time of survey, in ICU, the keyboard on top of the eyewash station was removed to the proper place of storage.</i> · <i>By 7/2/2014, all ICU staff were educated per intradepartmental flyer as well as unit email notification that eyewash station access must not be obstructed.</i> · <i>By 7/2/2014, ICU charge nurse responsibility task list included daily monitoring of the eyewash station to ensure access is not obstructed and charge nurses were educated per one-to-one communication, revision of their daily checklist, and email notification of the new responsibility.</i> · <i>By 7/7/2014, Surgery staff were reeducated of the policy regarding dating of warmer fluids per unit email and the monthly education flyer.</i> · <i>By 7/7/2014, daily audits of the warmer in the sub sterile room were started to ensure there are no outdated items found in the warmer. Audits will continue until 4 consecutive months at 100% compliance is achieved. Results will be reported at the Patient Safety Committee meeting.</i> · <i>On 7/8/2014, Biomed repaired the Cesarean Section room warmer to ensure it was functioning properly and cleared it</i> 		

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	<p>solutions in plastic bottles can remain in the warming chamber for a period not exceeding 14 days. These irrigation solutions will be marked (using a permanent marker or the date stamper) with the date the solution will reach the maximum time allowance before being placed in the warmer. 5. Bagged irrigation solutions can remain in the warming chamber for a period not exceeding 14 days. These irrigation solutions will be marked (using a permanent marker or the date stamper) with the date the solution will reach the maximum time allowance before being placed in the warmer. 6. At the end of the maximum warming period, irrigation solutions will be removed from the warmer."</p> <p>7. During the tour of the surgical department at 9:30 AM on 06/24/14, staff members A13 and A15 indicated the fluids should be removed from the warmer when the 2 week expiration date was reached.</p>		<p><i>to be put back into use.</i></p> <p><i>Daily environmental rounds began 7/9/2014 on the Cesarean Section warmer to ensure the temperature range is maintained and documentation is accurate and complete.</i></p>	

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S001162	<p>8. During the tour of the C/S Room at 10:20 AM on 06/24/14, staff member A13 confirmed the warmer temperature monitoring log was not completed properly and the fluids were kept at a higher temperature for 10 straight days.</p> <p>9. At 9:00 AM on 06/25/14, staff member A2 indicated the only policy regarding the warming units was the one provided, "Perioperative Normothermia".</p> <p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8(d)(2)(A)</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>(A) All mechanical equipment (pneumatic, electric, or other) shall be on a documented maintenance schedule of appropriate frequency and with the manufacturer's recommended maintenance schedule.</p>			
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	<p>Based on document review and staff interview, the facility failed to comply with manufacture recommendations for 1 of 3 Hydrocollators in the Rehabilitation Department.</p> <p>Findings included:</p> <ol style="list-style-type: none"> The Operation Manual instructions for the use and operation for Rehabilitation Department's Hydrocollator M-4 Master Heating Units notes the thermostats are extremely sensitive and the slightest adjustment will alter the temperature several degrees. The recommended operating temperature was 160 to 165 degrees Fahrenheit. The temperature of the water should be checked before using the Steam Packs. The hospital's Outpatient Rehabilitation Department Hydrocollator M-4 Master Heating Unit June 2014 temperature log revealed the water exceeded 165 	S001162	<ol style="list-style-type: none"> How are you going to correct the deficiency? If already corrected, include the steps taken and the date of correction. <ul style="list-style-type: none"> Biomed evaluated the unit to ensure the temperature of the hydrocollator is adjusted to the manufacturer's guidelines of 160-165 degrees F. Findings indicated the hydrocollator was functioning within manufacturer's guidelines and the thermometer measuring the temperature was failing. The temperature log was revised to state what the acceptable temperature range is and actions to take should the temperature be out of the acceptable range. Staff were educated to the modified process and requirements. How are you going to prevent the deficiency from recurring in the future? <ul style="list-style-type: none"> The Temperature of the hydrocollator is checked and documented per the updated temperature log daily, when in use. Anytime the temperature falls outside of the manufacturer's guidelines, hot packs will not be used until proper temperature can be confirmed. Staff were educated regarding the acceptable temperature guidelines and the process to follow should the 	07/10/2014			

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	<p>degrees Fahrenheit for 17 of 17 days. The Daily Temperature Log noted at the top of the form the Hydrocollator's temperature should be between 160 and 170 degrees Fahrenheit which exceeded the manufacturers' recommendations. The M-4 Hydrocollator temperature for 12 days were 170 degrees Fahrenheit.</p> <p>3. At 10:00 AM on 6/25/2014, staff member #9 (Administrative Director Therapy Services) confirmed the June log 2014 for the hospital's outpatient Rehabilitation Department exceeded 165 degrees Fahrenheit. The log was stating the same 160 to 170 degree Fahrenheit range in all three rehabilitation locations; however, the two offsite rehabilitation locations were recording the temperature within the manufacturer's range of 160 to 165 degrees Fahrenheit.</p>		<p><i>temperature be discovered out to the manufacturer's range.</i></p> <ul style="list-style-type: none"> · <i>New employee orientation will include education regarding monitoring hydrocollator temperatures.</i> · <i>Environment of Care rounds will include monitoring of the hydrocollator.</i> <p>3. Who is going to be responsible for numbers 1 and 2 above; i.e., director, supervisor, etc.?</p> <ul style="list-style-type: none"> · <i>The Director of Rehabilitation Services will be responsible for the above plan</i> <p>4. By what date are you going to have the deficiency corrected?</p> <ul style="list-style-type: none"> · <i>On 7/10/2014 Biomed Services evaluated the hydrocollator to ensure it was in good working order and the temperature was within the manufacturer's guidelines. Findings indicated the hydrocollator was functioning within manufacturer's guidelines and the thermometer measuring the temperature was failing. A new thermometer was secured on the hydrocollator.</i> · <i>On 7/9/2014, the temperature log was revised to state what the acceptable temperature range is and actions to take should the temperature be out of the acceptable range.</i> · <i>On 7/10/2014, staff were educated per department issued email regarding the acceptable</i> 		

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S001164	<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 document review and staff interview, the facility failed to assure preventive maintenance was conducted on 3 outpatient Rehabilitation locations.</p> <p>Findings included:</p> <p>1. At 2:20 PM on 6/24/2014, the hospital Outpatient Rehabilitation Department was toured. The department had a wooden Rehab Exercise Stairs for patient's rehabilitation. The stairs was observed without a preventive</p>	S001164	<p><i>temperature guidelines, the new temperature log, and the process to follow should the temperature be discovered out to the manufacturer's range.</i></p> <p>1. How are you going to correct the deficiency? If already corrected, include the steps taken and the date of correction.</p> <ul style="list-style-type: none"> All wooden rehab exercise stairs will be evaluated, tagged with preventive maintenance (PM) stickers, and then placed on the PM rotation list. <p>2. How are you going to prevent the deficiency from recurring in the future?</p> <ul style="list-style-type: none"> To prevent future deficiencies, all wooded rehab exercise stairs will be on the PM rotation list to ensure they are in safe working order and enable staff to notify Biomed with a specific PM number should an 	07/25/2014

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S001168	410 IAC 15-1.5-8 maintenance tag on them. 2. At 9:00 AM on 6/25/2014, the Dupont Rehabilitation offsite location was observed with wooden Rehab Exercise Stairs that had no evidence of a preventive maintenance sticker on it. 3. At 9:43 AM on 6/25/2014, the Anthony Rehabilitation offsite location was observed with wooden Rehab Exercise Stairs that had no evidence of a preventive maintenance sticker on it. 4. At 3:30 PM on 6/24/2014, staff member #32 (biomedical) indicated the three rehab wooden steps have never had preventive maintenance performed on them. The staff member indicated stickers are placed on all health care equipment when preventive maintenance has been performed on them.		<i>issue be observed.</i> 3. Who is going to be responsible for numbers 1 and 2 above; i.e., director, supervisor, etc.? · <i>The Supervisor of Biomedical Engineering is responsible for the plan of correction.</i> 4. By what date are you going to have the deficiency corrected? · <i>By 7/25/2014, all wooden rehab exercise stairs will be evaluated, tagged with preventive maintenance (PM) stickers, and then placed on the PM rotation list.</i>		

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	<p>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, interview, manufacturer's directions, and policy and procedure review, the facility failed to ensure the defibrillator checks were performed according to policy and manufacturer's instructions.</p> <p>Findings included:</p> <p>1. Review of the defibrillator/crash cart check log sheets for June 2014 from the ED (Emergency Department) indicated no checks for 6 of the 24 days and only once daily checks for 14 of the 24 days for one crash cart and no checks for 5 days and once daily checks for 18 days for a second cart. Review of the June 2014 log sheets from the ICU (Intensive Care Unit) indicated 18 out of 24 for one cart and 19 out of 24 for a second cart where only once daily checks were performed.</p> <p>2. During the tour of the ICU at 11:20 AM on 06/24/14, staff member A17</p>	S001168	<p>1. How are you going to correct the deficiency? If already corrected, include the steps taken and the date of correction.</p> <ul style="list-style-type: none"> · Charge nurses who did not follow policy and document the defibrillator checks on the cited days were counseled on the requirements for defibrillator checks and will be monitored for trends in the future. · Education and Instruction via one-to-one communication and written job checklist was provided to all charge nurses that it is their responsibility to check the defibrillators each shift. <p>2. How are you going to prevent the deficiency from recurring in the future?</p> <ul style="list-style-type: none"> · To prevent future deficiencies, routine weekly monitoring of crash cart logs will be initiated until 4 consecutive months at 100% compliance is achieved. Audit results will be reported at the Patient Safety Committee meeting. · The Charge nurse daily checklist was reviewed and found 	07/21/2014	

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	<p>(Manager ICU and IMC) indicated the crash cart and defibrillator should be checked each shift, which was twice a day.</p> <p>3. The manufacturer's instructions for use for the Philips HeartStart XL defibrillator indicated, "Every Shift: Perform a 'Shift/System Check' every shift to verify that the HeartStart XL is functioning properly and to ensure that necessary supplies and accessories are present and ready for use."</p> <p>4. The facility policy "Cardiac/Respiratory Arrests (Code Blue) & Code Blue Cart Maintenance", last reviewed 04/2013, indicated, "1. Each unit housing a Code Blue cart and/or a defibrillator must do equipment checks to verify the equipment and supplies are available and usable. ...4. Once each shift, a unit with a defibrillator is open, a designated person, usually a lead or charge nurse, will check the Code Blue cart and defibrillator, to verify that the lock on the Code Blue cart is intact and all equipment is available and functional. The check includes discharging the defibrillator on battery power. 5. The person doing the check completes documentation on the equipment check record, showing the check was done."</p>		<p><i>to support the policy to check the defibrillators each shift. No changes to policy (NUR 320A, Cardiac/Respiratory Arrests & Code Blue Cart Maintenance) were needed.</i></p> <p>3. Who is going to be responsible for numbers 1 and 2 above; i.e., director, supervisor, etc.?</p> <ul style="list-style-type: none"> · <i>The Director of Critical Care Services and the Director of Emergency Services will be responsible for their respective units.</i> <p>4. By what date are you going to have the deficiency corrected?</p> <ul style="list-style-type: none"> · <i>Education and Instruction via one-to-one communication and written job checklist was provided to all charge nurses that it is their responsibility to check the defibrillators each shift by 7/21/2014.</i> · <i>By 7/21/2014, Charge nurses who did not follow policy and document the defibrillator checks on the cited days were counseled on the requirements for defibrillator checks and will be monitored for trends in the future.</i> · <i>By 7/21/2014, weekly monitoring of crash cart logs will be initiated until 4 consecutive months at 100% compliance is achieved. Audit results will be reported at the Patient Safety Committee meeting.</i> 				

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S001172	<p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8(e)(1)(A)(B)(C)</p> <p>(e) The building or buildings, including fixtures, walls, floors, ceiling, and furnishings throughout, shall be kept clean and orderly in accordance with current standards of practice as follows:</p> <p>(1) Environmental services shall be provided in such a way as to guard against transmission of disease to patients, health care workers, the public, and visitors by using the current principles of the following:</p> <p>(A) Asepsis (B) Cross-infection; and (C) Safe practice.</p> <p>Based on documentation review, observation, and staff interview, the facility failed to follow CDC guidelines and hospital policy on proper washing patient clothing in 2 Behavioral Health Units: SJBH and Generations.</p> <p>Findings included:</p> <p>1. Washer/Dryer Cleaning policy # BH 12.022 (last revised and approved 4/2013) notes the washer/dryer procedures for the two Behavioral Health Units (SJBH & Generations) are to follow CDC guidelines for</p>	S001172	<p>1. How are you going to correct the deficiency? If already corrected, include the steps taken and the date of correction. To correct the deficiency, Behavioral Health Policy 12-022a (Washer/Dryer Cleaning) was revised to include the following: Adult Behavioral and Generation Staff will run 1 cup of bleach through the washer cycle between every patient load. Additionally, a detergent with Bleach Alternative (Oxiclean) will be used to launder all patient clothing. 2. How are you going to prevent the</p>	08/22/2014

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	<p>Environmental Infection Control in Healthcare facilities. The procedure for washing patient clothing indicates use proper amounts of detergent and bleach. The washing machine will be run through cycle with 1 cup of chlorine bleach weekly.</p> <p>2. CDC guidelines for Environmental Infection Control in Healthcare facilities indicates disinfection of washer/dryer tubs between patients is unnecessary when proper laundry procedures are followed: the physical removal of bulk solids before wash/dry cycle; and proper use of temperature, detergent, and laundry additives. CDC guidelines for laundry services in health care facilities states, "Soaps or detergents loosen soil and also have some microbial properties. Hot water provides an effective means of destroying microorganisms, and a temperature of at least 71 C (160 F) for a minimum of 25 minutes is commonly recommended for hot-water washing. A satisfactory reduction of microbial contamination can be achieved at lower water temperatures of 22-50 C (71.6 to 122 F) when the cycling of the washer, the wash formula, and the amount of chlorine bleach are carefully monitored and controlled at a residual of 50-150 ppm during the chlorine bleach cycle."</p>		<p>deficiency from recurring in the future? · To prevent future deficiencies, staff education regarding the revised policy/procedure for disinfecting the washer between patient loads will be provided to all Generations and Adult Behavioral staff per email notification, poster flyer, and Unit meeting. · New employee orientation will include education on the policy/procedure for disinfection of the washer tub between patient loads as well as the need to use the provided detergent with Bleach Alternative. · Daily environmental rounding will be conducted to ensure the new process is being followed. 3. Who is going to be responsible for numbers 1 and 2 above; i.e., director, supervisor, etc.? · The Director of Behavioral Services will be responsible for the plan of correction. 4. By what date are you going to have the deficiency corrected? · By 8/22/2014, staff education regarding the revised policy/procedure for disinfecting the washer between patient loads and the new detergent to be used with each patient load will be provided to all Generations and Adult Behavioral staff per email notification, poster flyer and Unit meeting. · Daily</p>				

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	<p>3. At 1:30 PM on 6/24/2014, the two Behavioral Health Units in the hospital, SJBH and Generations, were observed utilizing non-commercial washers and dryers. The detergent used in the two washers was Tough Guy but bleach was not being used as part of the washing of patient clothes. The manufacture specs note the detergent does not have a disinfectant in it and does not note it is suitable for health care facilities. Generations behavioral health unit did not have bleach present with the washer.</p> <p>4. At 1:45 PM on 6/24/2014, staff member #30 (tech) indicated the hospital policy was to run a cup of bleach through the washer once a week; however, staff actually only could do this process once every two weeks. The staff member indicated bleach is not dispensed in every load of patient clothing.</p> <p>5. At 3:00 PM on 6/24/2014, staff member #11 (Administrative Director Support Services) indicated does the preventive maintenance on the two sets of behavioral health washers/dryers; however, the temperatures are not monitored. The staff member does not know what temperature the washer and dryer maintains. However, the water that enters the washer is 120 degrees Fahrenheit.</p>		<p>environmental rounding to observe compliancy with the new washer disinfection process and use of the detergent with Bleach Alternative will begin on 8/25/2014. · On 8/8/2014, Behavioral Health Policy 12-022a (Washer/Dryer Cleaning) was revised to include the following: Adult Behavioral and Generation Staff will run 1 cup of bleach through the washer cycle between every patient load. Additionally, a detergent with Bleach Alternative (Oxiclean) will be used to launder all patient clothing.</p>				

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	6. At 1:15 PM on 6/25/2014, staff member #3 (Quality Manager) confirmed proper amounts of detergent and bleach was not in each patient's load of clothes as indicated per hospital policy #BH 12.022.			