

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/21/2012
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NAME OF PROVIDER OR SUPPLIER SAINT CATHERINE REGIONAL HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 2200 MARKET ST CHARLESTOWN, IN 47111
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S0000	<p>This visit was for a State licensure survey.</p> <p>Facility #: 004975</p> <p>Survey Dates: 2-20/21-12</p> <p>Surveyors:</p> <p>Billie Jo Fritch, RN, BSN, MBA Public Health Nurse Surveyor</p> <p>Jennifer Hembree, RN Public Health Nurse Surveyor</p> <p>Ken Zeigler Laboratorian</p> <p>QA: claughlin 02/27/12</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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S0178	<p>410 IAC 15-1.3-2 POSTING OF LICENSE 410 IAC 15-1.3-2(a)</p> <p>(a)The license shall be conspicuously posted on the hospital premises in an area open to patients and public. A copy shall be conspicuously posted in an area open to patients and public on the premises of each separate hospital building of a multiple hospital building system.</p> <p>Based on observation and interview, the facility failed to post the Hospital Licensure in the main entrance/lobby area of the hospital, a conspicuous area open to patients and the public.</p> <p>Findings included:</p> <ol style="list-style-type: none"> 1. While touring the hospital on 2-21-12 at 1015 hours with B#6, it was observed that the Hospital Licensure was not posted in the main entrance/lobby area of the hospital, a conspicuous area open to patients and the public. 2. Interview with B#6 on 2-21-12 at 1015 hours confirmed the Hospital License was not posted in the main entrance/lobby area of the hospital which is the main entrance into the facility. 	S0178	The hospital's license was posted in the main entrance area on 2/29/2012.	02/29/2012			

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S0286	<p>410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1 (b)(4)</p> <p>(b) The governing board is responsible for the conduct of the medical staff. The governing board shall do the following:</p> <p>(4) Ensure that the medical staff is accountable and responsible to the governing board for the quality of care provided to patients.</p> <p>Based on document review, the governing board failed to ensure quality patient care was provided to 1 of 7 medical/surgical patients and 1 of 5 behavioral health patients.</p> <p>Findings include:</p> <p>1. Review of patient #N21 inpatient medical record on 2/21/12 indicated the following: (A) He/she tested positive for Clostridium difficile (C-diff) on 2/17/12. (B) The medical record lacked documentation there was treatment prescribed for the C-diff.</p> <p>2. Review of patient #5 medical record indicated the following: (A) He/she tested positive for a urinary tract infection with greater than 100,000 colony forming units per ml. The organism was Klebsiella pneumoniae</p>	S0286	<p>Staff members on both the medical/surgical unit and the behavioral health unit will undergo mandatory inservicing regarding both the process of order verification ("chart checks") and communication of both critical and non-critical lab results to medical staff members. The managers of these two units will be accountable for monitoring these processes through concurrent chart audits until a compliance rate of 100% is maintained for a minimum of 60 days.</p>	03/21/2012			

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	<p>sensitive to numerous (>10) antibiotics.</p> <p>(B) The patient was not prescribed an antibiotic that was sensitive to the organism for the urinary tract infection.</p> <p>3. Staff member #12 verified the above information beginning at 12:10 p.m. on 2/21/12.</p> <p>4. M.D. #2 indicated the following in interview at 12:20 p.m. on 2/21/12: (A) He/she did not order treatment for patient #21's C-diff. It would be up to the family practice M.D. or internal medicine M.D. to order treatment.</p>				

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S0314	<p>410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1(c)(6)(E)(i)(ii)(iii)</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: (E) Establishing criteria for each service manager, department director or supervisor that includes, but is not limited to, the following: (i) Definition of educational requirements. (ii) Experience requirements. (iii) Professional certification, licensing, or registration, where appropriate.</p> <p>Based on document review, the governing board failed to establish education requirements for the psychiatric nursing manager.</p> <p>Findings include:</p> <p>1. Review of the clinical manger of the behavioral health unit personnel file indicated the following: (A) He/she does not have a master's degree in psychiatric nursing or equivalent required by PPS excluded unit criteria.</p>	S0314	<p>Finding 1 - The BHS manager will establish an ongoing, consulting relationship with a Registered Nurse with an appropriate master's degree in psychiatric nursing. This relationship will provide for ongoing additional training for the BHS manager. The BHS manager will be accountable for the documentation of these consultative discussions and will report monthly to the Chief Nursing Officer regarding this relationship. Finding 2 - The educational requirments for the BHS manager position were added to the job description on 3/13/2012.</p>	03/21/2012			

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	2. The job description for the clinical manager of the behavioral health unit lacked educational requirements required for the position.		<p>Addendum: 3/15/11: The following language was added to the BHS manager's job description regarding educational requirements for the position.</p> <p>The director of psychiatric nursing services must be a Registered Nurse who has a master's degree in psychiatric or mental health nursing, or its equivalent, from a school of nursing accredited by the National League for Nursing, or be qualified by education and experience in the care of the mentally ill.</p> <p>Additional information regarding current incumbent in the BHS manager position: The incumbent is a Registered Nurse currently licensed in the state of Indiana and holds a BSN. Her additional experience in caring for behavioral health patients includes teaching mental health nursing (didactic - 2 years, clinicals - 3 years in LPN program and clinicals - 1 year in RN program).</p>		

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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, medical record review and interview, the laboratory failed to document QA assessment of corrective action(s) taken for three of eight patients in blood bank and failed to include rehabilitation services and discharge planning in the hospital's Quality Assessment and Performance Improvement (QAPI) program.</p> <p>Findings included:</p> <p>1. The policy, "Blood and Blood Product Administration, reviewed 2/20/12, reviewed 12/09, read: "Lab personnel ...will review the transfusion record and sign post transfusion data under section 3 of the transfusion record."</p>	S0406	<p>#2. The lab manager will conduct reeducation of the laboratory staff regarding this procedure no later than the completion date above. The blood transfusion record is being monitored daily for completeness and accuracy by the lab manager or designee. The results of this monitoring will be reported monthly to the Quality Council. 100% compliance was achieved in January 2012 and February data is currently being compiled.#3. Rehabilitation services has identified quality indicators for both physical therapy and speech therapy (turnaround time on evaluation requests), however the data has been reported only inconsistently to the Quality Council. The director with administrative oversight for rehabilitation services represents this service on the Quality Council and has</p>	03/21/2012			

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	<p>2. In review of three patients receiving blood units, three of these received-units did not have complete documentation, per policy, on the Section 1.</p> <p>Transfusion Record form including laboratory review documentation in the post transfusion data section.</p> <p>Patient #5 --Unit administered on 12/28/11 at 1130: The unit was released at 1115 from the blood bank and ended at 1605; however, there was no laboratory review documentation in the post transfusion data section. The laboratory failed to document that the unit was released at 1115 from the blood bank and ended at 1605 which was a transfusion time of 5 hours and 35 minutes in lieu of 4 hours.</p> <p>Patient #7 --Unit administered on 12/09/11 at 1218: The unit was released at 1200 from the blood bank; however, there was no documentation of the units end time. The laboratory failed to document that it could not be determined whether the post vital time of 1415 was accurate. --Unit administered on 12/09/11 at 1435: The unit was released on 12/09/11 at 1414 from the blood bank; however, there was no documentation of the units end time and, as a result, the laboratory failed</p>		<p>been charged with ensuring consistent documentation of these data. The physical therapist and speech pathologist will work with the department director to evaluate the need for additional monitors. There is a daily (Monday - Friday) utilization review meeting attended by the Medical-Surgical/ICU manager, BHS manager, CNO, CFO and Case Manager. In this meeting lengths of stay and discharge planning needs are discussed. The case manager will be added to the membership of the Quality Council and quality indicators will be established and reported to the Quality Council monthly.</p>	

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	<p>to document whether the post vital time of 1625 was accurate. Additionally, the pretime of the unit was documented at 0945 which was 4 hours and 50 minutes prior to the 1435 start time in lieu of within 30 minutes prior to starting the transfusion; however, this was also not documented by the laboratory.</p> <p>2. On 2/21/12 at 10:45 a.m., staff member #8 acknowledged that there was no documentation of QA assessment for the above-listed blood bank blood unit administration dates.</p> <p>3. Review of facility documents on 2-20-12 and 2-21-12 lacked evidence that rehabilitation services and discharge planning were included in the hospital's QAPI program.</p> <p>4. Interview with B#1 on 2-21-12 at 0930 hours confirmed rehabilitation services and discharge planning are not included in the hospital's QAPI program.</p>				

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S0554	<p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(a)</p> <p>(a) The hospital shall provide a safe and healthful environment that minimizes infection exposure and risk to patients, health care workers, and visitors.</p> <p>Based on observation, document review and staff interview, the facility failed to maintain supplies that minimized risk to patients for 4 of 5 units toured and failed to minimize exposure risk to patients on the behavioral health unit.</p> <p>Findings include:</p> <p>1. During tour of the intensive care unit beginning at 1:35 p.m. on 2/22/12 and accompanied by staff member #1, numerous expired items were found in the crash cart including, but not limited to the following: (A) One (1) arterial blood sampler with an expiration date of 6/11. (B) Two (2) I.V. start kits with an expiration date of 6/11. (C) One (1) arterial line kit with an expiration date of 7/11.</p> <p>2. During tour of the medical/surgical unit beginning at 1:45 p.m. on 2/22/12 and accompanied by staff member #1, the following expired items were found in the</p>	S0554	<p>Finding 1, 2, 3, 4 - A comprehensive inspection of all clinical areas was completed on 3/12/2012 to ensure that all expired supplies were removed from service. A more detailed checklist has been developed for the emergency carts that includes expiration dates for all supplies. The night shift nursing supervisors have been assigned accountability for checking these carts for proper function as well as the presence of the appropriate supplies. The managers for the clinical areas have been assigned accountability for ensuring that supplies nearing their expiration date are either utilized or removed from service. This role will be facilitated by the addition of supply checks to the managers' monthly unit preparedness checklist. Finding 3 - The out-of-date pressure infuser in the surgical department has been removed from service pending appropriate servicing. Finding 5 - The patient was instructed on 2/21/12 to return to her room and to remain in the room. The staff were</p>	03/16/2012			

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	<p>crash cart:</p> <p>(A) Two (2) 18 GA 1.16 in. angioguard cath with expiration dates of 2/11 and 11/10.</p> <p>(B) One (1) 24 GA .75 angioguard cath with an expiration date of 2/11.</p> <p>(C) Two (2) 16 GA 1.16 angioguard cath with an expiration date of 2/11.</p> <p>3. During tour of the surgery department beginning at 2:30 p.m. on 2/22/12 and accompanied by staff member #1, the following expired items were found in the crash cart, malignant hyperthermia cart and PACU emergency box:</p> <p>(A) One (1) central venous catheter kit with an expiration date of 10/11.</p> <p>(B) One (1) pressure infuser with an expiration date of 6/11.</p> <p>(C) All of the blood tubes (>25) blood tubes were expired with expiration dates of 6/11-12/11.</p> <p>(D) One (1) chest tube kit with an expiration date of 10/11.</p> <p>(E) One (1) pneumothorax set with an expiration date of 10/11.</p> <p>4. During tour of the emergency department (ED) beginning at 3:10 p.m. on 2/22/12 and accompanied by staff member #1, the following expired items were found in a chest tube box in the trauma room:</p> <p>(A) One (1) pneumothorax set with an</p>		<p>inserviced on proper contact isolation procedures by the BHS manager. The patient's medical physician was contacted and appropriate treatment ordered. Addendum 3/15/12: Findings 1, 2, 3, 4 - In order to ensure ongoing compliance with this corrective action, crash cart and unit preparedness checklists will be submitted to and reviewed by the Chief Nursing Officer. Compliance results will be reported to the Quality Council.</p>				

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	<p>expiration date of 10/11.</p> <p>5. During tour of the behavioral health unit beginning at 11:50 a.m. on 2/21/22 signage was observed on the doorfacing of patient #N21 room indicating he/she was in contact precautions requiring glove use, gown when entering room if patient was incontinent, and stated "limit the movement/transport of patients from room to essential purposes only." The patient was not in the room and he/she was observed in the lounge/tv area with other patients. Additionally, he/she was later in the dining room at the table with numerous other patients.</p> <p>5. Review of patient #N21 medical record indicated the following: (A) He/she tested positive for Clostridium difficile (C-diff) on 2/17/12. (B) The medical record lacked documentation there was treatment prescribed for the C-diff. (C) The medical record indicated the patient was incontinent of stool.</p> <p>6. M.D. #2 indicated the following in interview at 12:20 p.m. on 2/21/12: (A) He/she did not order treatment for patient #21's C-diff. It would be up to the family practice M.D. or internal medicine M.D. to order treatment.</p>						

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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 staff interview and observation, the facility failed to maintain a sanitary environment that minimized risk to patients for 1 behavioral health unit toured.</p> <p>Findings include:</p> <p>1. Housekeeper #1 indicated the following in interview beginning at 12:40 p.m. on 2/21/12: (A) There is no special cleaner that he/she uses on isolation room for patient #N21 (patient #21 tested positive for Clostridium difficile). (B) He/she uses the cleaner that is premixed and on the wall of the janitor's closet.</p>	S0592	<p>The director of facilities has identified an appropriate cleanser with established efficacy against C-Difficile. Once the product has been procured we will provide necessary training to the staff regarding the use of this product. The director of facilities has been assigned accountability to ensure the proper use of this product. Addendum 3/15/12: The facilities and nursing staff have devised a color coding system for isolation signs that will instruct the housekeeper which products should be used to clean a particular room. The director of facilities has been assigned accountability to monitor this system to ensure the proper products are used.</p>	03/21/2012			

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	(C) He/she would use the same cleaner after the patient was discharged. 2. The premixed disinfectant in the janitor's closet used by housekeeping is Expose 256. The disinfectant does not kill Clostridium difficile.				

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S0704	<p>410 IAC 15-1.5-4 MEDICAL RECORD SERVICES 410 IAC 15-1.5-4(a)</p> <p>(a) The medical record service has administrative responsibility for the medical records that shall be maintained for every individual evaluated or treated within those services that come under the hospital's license.</p> <p>Based on observation and interview, the medical records administrator failed to ensure the integrity of all patient medical records.</p> <p>Findings included:</p> <ol style="list-style-type: none"> While touring the medical records department on 2-21-12 at 1210 hours with B#6, 4 water stained ceiling tiles and water stains down the wall were observed above/beside the area where patient medical records are stored thus compromising the integrity of the patient medical records if they were to become wet. Interview with B#6 on 2-21-12 at 1210 hours confirmed there were 4 water stained ceiling tiles and water stains down the wall above/beside the area where patient medical records are stored which could compromise the integrity of the patient medical records if they were to become wet. 	S0704	<p>The water-stained ceiling tiles were replaced on 03/08/2012. An inspection of the area above the damaged tiles revealed no active leaks. The Medical Records staff and Facilities staff will monitor the area for a reoccurrence of the problem and Facilities will resolve the issue if it reoccurs. Addendum 3/15/12: Facilities will include monitoring of this location on its safety rounds.</p>	03/08/2012			

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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 document review and staff interview, the facility failed to ensure the medical staff completed medical records within 30 days of discharge for 8 of 17 medical records (patients #N3, N4, N5, N9, N10, N12, N13, N19).</p> <p>Findings include:</p> <p>1. Review of patient #N3 medical record indicated the following: (A) He/she was discharged 12/15/11. (B) His/her discharge summary was dictated 2/13/12.</p> <p>2. Review of patient #N4 medical record indicated the following: (A) He/she was discharged 1/8/12. (B) His/her medical record lacked a history and physical exam.</p>	S0872	<p>Since the hiring of a new supervisor of health information management, the backlog of work in chart assembly has been eliminated allowing for the more timely availability of medical records for the medical staff to complete. The HIM supervisor has implemented more efficient processes for follow up with the medical staff members and leadership to allow for appropriately timed intervention to prevent the occurrence of incomplete records. The HIM supervisor has been assigned accountability to monitor the medical record delinquency rate and this data will be reported monthly to both the quality council and the medical executive committee.</p>	03/21/2012			

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	<p>3. Review of patient #N5 medical record indicated the following: (A) He/she was discharged 8/16/11. (B) His/her discharge summary was not signed by the physician until 9/19/11.</p> <p>4. Review of patient #N9 medical record indicated the following: (A) He/she was discharged 11/29/11. (B) His/her discharge summary was dictated 1/15/12.</p> <p>5. Review of patient #N10 medical record indicated the following: (A) He/she was discharged 11/23/11. (B) His/her discharge summary was dictated 1/19/12.</p> <p>6. Review of patient #N12 medical record indicated the following: (A) He/she was discharged 10/29/11. (B) His/her discharge summary was not signed until 11/30/11.</p> <p>7. Review of patient #N13 medical record indicated the following: (A) He/she was discharged 10/23/11. (B) His/her discharge summary was dictated 1/19/12.</p> <p>8. Review of patient #N19 medical record indicated the following: (A) He/she was discharged 8/27/11. (B) His/her discharge summary was</p>						

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	dictated 10/6/11. 9. Staff member #N12 verified the above beginning at 3:50 p.m. on 2/22/12.				

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S0946	<p>410 IAC 15-1.5-6 NURSING SERVICE 410 IAC 15-1.5-7 (c)(4)</p> <p>(c) Drugs and biologicals shall be prepared for administration and administered as follows:</p> <p>(4) In accordance with the signed written orders of the practitioner or practitioners responsible for the patient's care. When verbal or telephone orders are used they shall be accepted only by personnel that are authorized to do so by the medical staff rules.</p> <p>Based on document review and staff interview, the facility failed to ensure medications were administered as ordered for 1 of 4 death records reviewed (patient #N1).</p> <p>Findings include;</p> <p>1. Review of patient #N1 medical record indicated the following: (A) An order was written at 4:30 p.m. on 9/12/11 for Vancomycin 1 gm IVPB every 24 hours to be started "tonight". (B) Per review of the medication administration record, the Vancomycin was not started on the patient.</p> <p>2. Staff member #N12 verified the above beginning at 3:50 p.m. on 2/22/12.</p>	S0946	Staff members on both the medical/surgical unit and the behavioral health unit will undergo mandatory inservicing regarding the process of order verification ("chart checks"). The managers of these two units will be accountable for monitoring this processes through concurrent chart audits until a compliance rate of 100% is maintained for a minimum of 60 days.	03/21/2012	

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S0952	<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 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).</p> <p>Based on blood transfusion policy review, transfusion document chart reviews and staff interview, the hospital failed to administer blood transfusions in accordance with approved medical staff policies and procedure for three of eight patients.</p> <p>Findings include:</p> <p>1. The policy, "Blood and Blood Product Administration, reviewed 2/20/12, read: "After verifying that all information is correct the Medical Technologist and the nurse must sign the Blood Bank Logbook, along with</p>	S0952	<p>Mandatory inservice education will be conducted for all nursing staff potentially involved in the blood transfusion process. Revisions will be made to the Blood Transfusion Record, adding a space for documentation of the transfusion end time. The addition of this charting element will serve as a cue for nursing staff to document this information. The nursing unit manager and/or nursing supervisors will be responsible for monitoring all transfusions in real time to ensure transfusions are completed within the required time frame. All future cases of non-compliance will be referred to the Chief Nursing Officer for evaluation and appropriate disciplinary action. Addendum 3/15/12: The content of the education for the nursing staff was developed on 3/14/12. Inservice education will begin 3/16/12. Due to the size of the nursing staff inservicing will be</p>	03/21/2012			

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	<p>the date and time. Whole blood and packed cells must be initiated within 30 minutes and ...must infuse within 4 hours of leaving the blood bank refrigerator. Blood should be infused in 2-4 hours or according to physician order. Vital signs including temperature, pulse, respiratory and blood pressure, and visual checks of the patient will be as follows: a) Pre- prior to initiating transfusion (within 30 minutes of initiating infusion) b) Post-Upon transfusion completion of the unit within 30 minutes after infusion is complete"</p> <p>2. In review of three patients receiving blood units, four of these received-units did not have complete documentation, per policy, on the Section 1.</p>		<p>completed no later than 3/30/12. A stamp indicating the need to record the transfusion end time has been ordered to temporarily revise the current stock of blood transfusion records. The stamp will cue the nursing staff to record the transfusion end time. The form will be permanently revised when the current stock of forms is depleted.</p>		

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	<p>Transfusion Record form including:</p> <p>Patient #5 --Unit administered on 12/28/11 at 1130: The unit was released at 1115 from the blood bank and ended at 1605 which was a transfusion time of 5 hours and 35 minutes in lieu of 4 hours</p> <p>Patient #7 --Unit administered on 12/09/11 at 1218: The unit was released at 1200 from the blood bank and signed by the nurse; however, there was no documentation of the units end time. As a result it could not be determined whether the post vital time of 1415 was accurate.</p> <p>--Unit administered on 12/09/11 at 1435: The unit was released at 1414 from the blood bank and signed by the nurse; however, there was no documentation of the units end time. As a result it could not be determined whether the post</p>				

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	<p>vital time of 1625 was accurate; the pretime of the unit was documented at 0945 which was 4 hours and 50 minutes prior to the 1435 start time in lieu of within 30 minutes prior to starting the transfusion.</p> <p>Patient #8 --Unit administered on 12/21/11 at 2410: The unit was released at 0005 from the blood bank and ended at 0420 which was a transfusion time of 4 hours and 25 minutes in lieu of within 4 hours.</p> <p>3. On 2/20/12 at 2:00 p.m., staff member #7 acknowledged that the above-listed patients had received blood without benefit of complete documentation, per policy, as required.</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 observation and interview, the facility created a condition that could result in a hazard/harm to the public or staff.</p> <p>Findings included:</p> <ol style="list-style-type: none"> 1. While touring the facility on 2-21-12 at 1110 hours with B#6, one unsecured fire extinguisher was observed on the floor of the maintenance shop in front of a work bench creating a hazard for the public or staff. 2. Interview with B#6 on 2-21-12 at 1110 hours confirmed one fire extinguisher was unsecured on the floor of the maintenance shop in front of a work bench creating a hazard for the public or staff. 	S1118	The unsecured fire extinguisher was placed in appropriate storage. On the afternoon of 2/21/2012 the Director of Facilities held a staff meeting and re-educated the facilities staff on the proper storage of fire extinguishers.	02/21/2012			

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S1124	<p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8 (b)(5)(A)</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>(5) Provision shall be made for the periodic inspection, preventive maintenance, and repair of the physical plant and equipment by qualified personnel as follows:</p> <p>(A) Operation, maintenance, and spare parts manuals shall be available, along with training or instruction of the appropriate personnel, in the maintenance and operation of the fixed and movable equipment.</p> <p>Based on document review and interview, the facility failed to provide periodic inspection and preventative maintenance as required by the facility periodic inspection schedule for the air handlers, air pumps, and boilers.</p> <p>Findings included:</p> <p>1. Review of facility documents on 2-21-12 indicated the following:</p> <p>a. The air handlers last received preventative maintenance (PM) by #JC on 3-3-10.</p>	S1124	<p>A quote and contract for ongoing preventive maintenance of the affected systems has been received. This contract will be executed and preventive maintenance performed as soon as the service can be scheduled with the vendor but no later than 4/15/12. The director of facilities has been assigned accountability to monitor the performance of this contract and ensure that the facility remains in compliance with all required preventive maintenance.</p>	03/21/2012			

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	<p>b. The air pumps last received PM by #JC on 3-3-10.</p> <p>c. The boilers last received PM by #JC on 3-3-10.</p> <p>2. Interview with B#6 on 2-21-12 at 1120 hours confirmed the following:</p> <p>a. The air handlers last received preventative maintenance (PM) by #JC on 3-3-10.</p> <p>b. The air pumps last received PM by #JC on 3-3-10.</p> <p>c. The boilers last received PM by #JC on 3-3-10.</p> <p>3. Interview with B#6 on 2-21-12 at 1120 hours indicated the air handlers are to have PM quarterly; the air pumps are to have PM quarterly; the boilers are to have PM quarterly; PM was not provided as required by facility PM schedule.</p>				

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S1162	<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> <p>Based upon manufacturer's recommendations and staff interview, the laboratory failed to document initial rotations per minute (rpm) testing for two of two centrifuges used for patient testing by the staff.</p> <p>Finding(s) included:</p> <p>1. On 2/21/12 at 11:30 a.m., review of the policy, "Laboratory Centrifugation", effective 10/22/08, read:</p> <p style="padding-left: 40px;">RPM "Urinalysis 1500 Coagulation 3000"</p>	S1162	To ensure correct documentation, all centrifuges were retested on 3/9/2012. Results were recorded by the serial number of the machine, clearly tying a specific result to a specific machine. Three of four machines performed correctly. One machine did not operate at the indicated RPM rate and this machine was removed from service. The laboratory director, on 3/12/2012 implemented a new documentation tool that will provide for more consistent and clear documentation. Addendum 3/15/12: Data on the testing of the centrifuges will be included in the report made by the Laboratory Manager to the Quality Council.	03/12/2012			

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	<p>Legend: RPM: rotations per minute</p> <p>2. On 2/21/12 at 11:30 a.m., staff member #7 conferred the laboratory had two centrifuges it used for urinalysis and coagulation (referred to as the 'urinalysis centrifuge' and 'protime centrifuge').</p> <p>Review of the log, "Laboratory Centrifugation", dated 10/22/08, noted that the review date for centrifugation was 12/07/11; however, there was no indication of which two centrifuges were in use for this data or whether this signoff was for the check of each centrifuge's rpm reading.</p> <p>3. On 5/14/02 at 1:20 p.m., staff member #8 conferred that rpm values for the above-mentioned centrifuges had not been documented as required.</p>			
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S1164	<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 interview, the facility failed to provide preventative maintenance (PM) for seven (7) pieces of patient care equipment.</p> <p>Findings included:</p> <p>1. Review of facility documents on 2-21-12 indicated the following:</p> <p>a. The last PM provided for the Nuclear Medicine camera was 4-22-10.</p> <p>b. The last PM provided for the CT scanner was 7-28-10.</p> <p>c. The last PM provided for the MRI was 12-22-10.</p> <p>d. There were no records of PM's for the anesthesia machines, nurse call system, C-arm, or the ultrasonography machine.</p> <p>2. Interview with B#6 on 2-21-12 at 1300 hours confirmed the following:</p> <p>a. The last PM provided for the</p>	S1164	<p>The preventive maintenance on the nurse call system was completed on 3/13/2012. One anesthesia machine has not been used in several years and was taken out of service on 3/12/2012. Vendors have been contracted to complete the preventive maintenance on the remaining anesthesia machine, the C-arm, the CT Scanner, MRI, Nuclear Medicine camera and ultrasonography machine. Dates for these services are still being scheduled but will not extend beyond 4/15/12. The following managers/directors have been assigned accountability for ensuring that future PM services are completed in a timely manner:Radiology managerC-armNuclear Medicine cameraultrasonography machineMRI scannerCT ScannerFacilities directorNurse call systemSurgical Services directorAnesthesia machines</p>	03/21/2012			

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	<p>Nuclear Medicine camera was 4-22-10.</p> <p>b. The last PM provided for the CT scanner was 7-28-10.</p> <p>c. The last PM provided for the MRI was 12-22-10.</p> <p>d. There were no records of PM's for the anesthesia machines, nurse call system, C-arm, or the ultrasonography machine.</p> <p>e. B#6 confirmed the equipment is required to receive at least annual PM.</p>				

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S1166	<p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8(d)(2)(C)</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>(C) Appropriate records shall be kept pertaining to equipment maintenance, repairs, and current leakage checks.</p> <p>Based upon document review and staff interview, the laboratory failed to assure that quarterly blood bank alarm temperature wheels were properly maintained and in working order for two (6/2011 and 12/2011) of three quarters during 2011.</p> <p>Finding(s) included:</p> <ol style="list-style-type: none"> On 2/21/12 at 10:00 a.m. a tour of the laboratory revealed the lab used a Hema Pro 2000 refrigerator for blood bank storage. On 2/21/12 at 1:15 p.m., review of the policy, "Equipment Maintenance", effective 3/15/08, 	S1166	The procedure for the Blood Bank Refirgerator Alarm Check has been revised to more clearly indicate that the checks must be performed quarterly. The results of these checks will be reviewed by both the Laboratory Manager and Laboratory Medical Director. Corrective actions will be included in the log if needed. In case of an alarm condition, temperatures will be monitored and recorded every 4 hours until the situation is corrected, the alarm conditions met and results reviewed. Prior to the completion date above, all laboratory personned will receive training on the correct procedure.	03/21/2012	

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	<p>read: "Refrigerator/freezer alarm ssystems shall be checked quarterly or per manufacturer's instructions."</p> <p>3. On 2/21/12 at 1:15 p.m., review of the policy, "Blood Bank Temperature Alarm Activation Check Log", no approval date noted, read, "Follow the procedure in the blood bank manual for the temp (sic) check. The procedure can be found in the Equipment Maintenance procedure.</p> <p>4. On 2/21/12 at 2:00 p.m., review of the blood bank temperature alarm activation check log for one date (9/14/11) was available. Documentation could not be located for the two remaining date(s) including neither 6/11 or 12/11.</p> <p>5. On 2/21/12 at 2:00 p.m., staff member #7 conferred that</p>			
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	documentation for the above-listed alarm checks were not available for review.				

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S1216	<p>410 IAC 15-1.5-9 RADIOLOGIC SERVICES 410 IAC 15-1.5-9(b)(1)(A)(B)(i)(ii)(iii)(iv)(v)(C)</p> <p>(b) The services that use ionizing radiation shall not compromise the health, safety, and welfare of patients or personnel in accordance with federal and state rules, as follows:</p> <p>(1) Proper safety precautions shall be maintained against radiation hazards in accordance with the hospital's radiation and safety program as developed by the radiation safety officer. This includes, but is not limited to, the following:</p> <p>(A) Adequate shielding for patients, personnel, and facilities. (B) Procedures for monitoring: (i) skin dosage; (ii) radionuclide contamination; (iii) quality control; (iv) technique charts, where applicable; and (v) handling of hazardous materials. (C) Appropriate storage, use, and disposal of radioactive materials.</p> <p>Based on observation and interview, the Radiology Service failed to ensure the health, safety, and welfare of patients, personnel, and the community by not securing the Nuclear Medicine/Hot Lab area where radioactive materials are stored.</p> <p>Findings included:</p>	S1216	The Nuclear Medicine area/Hot Lab was locked effective 3/7/2012. The Radiology manager will conduct random checks of the area to be sure it remains secure. The manager will conduct a staff meeting no later than 3/15/2012 to re-educate all radiology staff of the need to maintain the security of this area. Addendum 3/15/12: The facilities director will include the	03/15/2012

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	<p>1. While touring the Nuclear Medicine Department on 2-21-12 at 1025 hours with B#6, it was observed that the area where Nuclear Medicine testing is done was unlocked and unattended; the door to the Hot Lab was unlocked and unattended; the area was out of the line-of-site for the staff members in the radiology department thus compromising the health, safety, and welfare of patients, personnel, and the community when radioactive materials are not secured.</p> <p>2. Interview with B#6 on 2-21-12 at 1025 hours confirmed the area where Nuclear Medicine testing is done was unlocked and unattended; the door to the Hot Lab was unlocked and unattended, and the area was out of the line-of-site for the staff members in the radiology department thus compromising the health, safety, and welfare of patients, personnel, and the community when radioactive materials are not secured.</p> <p>3. Interview with B#9 on 2-21-12 at 1030 hours confirmed the door to the Nuclear Medicine area was unlocked, the Hot Lab was unlocked where radioactive materials are stored, the area was not within the line-of-site of the radiology department personnel; B#9 indicated the Nuclear Medicine area and the Hot Lab are locked "some of the time"; B#9 confirmed there are radioactive materials currently present in the Hot Lab that are used to calibrate</p>		<p>security the hot lab in monthly safety rounds. The Chief Nursing Officer will make random checks of this room. Results of checks by all three management staff (Radiology Manager, Facilities Director and Chief Nursing Officer) will be reported to the Quality Council until 100% percent compliance is achieved for a minimum of one quarter.</p>		

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	the instruments and that they are not secured thus compromising the health, safety, and welfare of patients, personnel, and the community.				

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S1230	<p>410 IAC 15-1.5-9 RADIOLOGIC SERVICES 410 IAC 15-1.5-9 (b)(4)</p> <p>(b) The services that use ionizing radiation shall not compromise the health, safety, and welfare of patients or personnel in accordance with federal and state rules, as follows:</p> <p>(4) Written preventive maintenance policies and procedures, in accordance with manufacturer's recommendations and hospital policy, shall be maintained and compliance shall be documented.</p> <p>Based on document review and interview, the facility failed to provide preventative maintenance (PM) for the Nuclear Medicine equipment as required by facility schedule.</p> <p>Findings included:</p> <ol style="list-style-type: none"> 1. Review of facility documents on 2-21-12 indicated the following: <ol style="list-style-type: none"> a. The last PM provided for the Nuclear Medicine camera was 4-22-10. 2. Interview with B#6 on 2-21-12 at 1300 hours confirmed the following: <ol style="list-style-type: none"> a. The last PM provided for the Nuclear Medicine camera was 4-22-10. b. B#6 confirmed the equipment is required to receive at least annual PM. 	S1230	The company with which the facility has a contract for preventive maintenance services has been contacted to complete the PM for the nuclear medicine camera. Final scheduling is still in progress but will not extent past 4/15/12. The radiology manager will be accountable to ensure that this device has PM as required by the manufacturer in the future.	03/21/2012			

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