DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152016	A. BUILDING 00 B. WING	03/20/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SELECT SPECIALTY HOSPITAL-FORT WAYNE	700 BROADWAY 7TH FL E FORT WAYNE, IN 46802

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S000000	This visit was for a State hospital licensure survey. Dates: 03/19-20/13 Facility Number: 009856 Surveyors: Brian Montgomery, RN Public Health Nurse Surveyor Linda Plummer, RN Public Health Nurse Surveyor QA: claughlin 04/09/13 5/2/13 revised due to IDR	S000000		

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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S000278	410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1(b)(2)(A)(B)(C)(D) (b) The governing board is responsible for the conduct of the medical staff. The governing board shall do the following: (2) Ensure that: (A) the requests of practitioners, for appointment or reappointment to practice in the hospital, are acted upon, with the advice and recommendation of the medical staff; (B) reappointments are acted upon at least biennially; (C) practitioners are granted privileges consistent with their individual training, experience, and other qualifications; and (D) this process occurs within a reasonable period of time, as specified by the medical staff bylaws.			
	Based on document review and interview, the governing board failed to ensure that medical staff reappointments were acted upon at least biennially for 2 of 4 medical staff files reviewed. Findings: 1. The credential files for physicians A22 and A23 indicated the following: " Hospital privileges are not to exceed two years and will expire on January 20, 2013. " 2. During an interview on 3-20-13 at	S000278	Review of documentation on March 20, 2013, found credentialing files with incorrect dates. A typographical error was noted; corrected credentialing letters dated July 20, 2011 to July 20, 2013 were mailed to physicians on April 16, 2013, by the Health Information Manager (HIM). Initial appointments and reappointments were approved through a Medical Executive Committee (MEC) meeting and Governing Board (GB) meeting held on July 11, 2011. The Health Information Manager (HIM) will continue to monitor initial appointments and reappointments and track via	05/10/2013

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	1530 hours, staff A9 confirmed that the 2 credential files lacked documentation of current privileges.		spreadsheet on a monthly basis. The Health Information Manager (HIM) will also monitor appointments and reappointments from credentialing committee and report through the Medical Executive Committee (MEC) and Governing Board (GB) meetings at least quarterly.	

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S000312	410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1(c)(6)(D) (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: (D) Annual performance evaluations, based on a job description, for each employee providing direct patient care or support services, including contract and agency personnel, who are not subject to a clinical privileging process.			
	Based on policy and procedure review, employee and agency nursing file review, and staff interview, the governing board failed to ensure the implementation of facility policy related to performance reviews for 1 agency RN (registered nurse) staff member N4, and 2 staff RNs, staff members N8 and N9. Findings: 1. at 4:05 PM on 3/20/13, review of the policy and procedure "Performance Reviews" (no policy number), last reviewed/approved 2/13, indicated: a. under "Policy", it reads: "...Performance reviews will be completed by the supervisor at the completion of the introductory period and annually within 30 days of the employee's	S000312	During the survey it was discovered that employee evaluations were not completed for all employees.Ninety (90) day evaluations that are overdue will be completed by April 24, 2013.The Human Resources Coordinator (HRC) in conjunction with the Chief Nursing Officer (CNO) will: 1. Utilize the Human Resources Information System (HRIS) to be notified of approaching evaluation dates. 2. Thirty days prior to evaluation due date, the Human Resources Information System (HRIS) will email a reminder to the Human Resources Coordinator; the HRC will notify the Chief Nursing Officer of the upcoming evaluation. The HRC will coordinate appropriate paperwork for evaluations and provide to the	05/10/2013

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	anniversary date, or a designated date set by the Company..." b. under "Procedure", it reads: "Time Frames: Performance evaluations are completed, reviewed with the employee and signed by both supervisor and employee at the end of the introductory period and annually within 30 days of the employee's anniversary date..." 2. review of agency RN and RN employee files indicated: a. agency RN N4 first worked at the facility on 2/8/11 and last worked in October 2012 and lacked any evaluation documentation in the personnel file b. RN N8 was hired 5/11/10 and lacked a 2011 or 2012 performance evaluation c. RN N9 was hired 8/7/12 and lacked a 90 day evaluation (end of introductory period) 3. interview with staff member # 56, the human resources manager/director, at 3:40 PM on 3/20/13 indicated: a. other agency files (N1, N2 and N3) had a one page evaluation completed after the first shift worked (and aren't yet due for an annual eval), but RN N4 has no documentation of having had an evaluation since the first day worked in 2011 b. in discussion with the CNO (chief nursing officer), it was thought that		CNO. Two weeks prior to the evaluation date, the HRC will contact the CNO regarding the status of received paperwork. 3. The completed evaluation, signed and reviewed by the CNO and the employee, will be placed in the employee's personnel file.One hundred percent (100%) of employee personnel files will be audited for completeness by April 24, 2013.All new hires 90 day evaluations will be audited for 3 months or until sufficient compliance (90%) is sustained.Results of new hire evaluation audits will be reported quarterly through Organizational Improvement Committee (OIC) and Governing Board (GB) meetings.During the survey it was discovered that active agency files were not completed.One hundred percent (100%) of active agency files were audited for completeness on April 18, 2013. Evaluation process will include: 1. Agency files will be reviewed for completeness by the Human Resources Coordinator prior to working their first scheduled shift 2. During a 2 hour orientation period, the "First Shift Evaluation" form will be completed by the Chief Nursing Officer or designee and placed in the Human Resources Coordinator's mailbox. 3. Active agency list reviewed April 15, 2013. The Human Resources Coordinator will provide to each nursing station by 4/24/13; this list will be	

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	evaluations for RN N8 were completed in 2011 and 2012, but cannot be located at this time c. there is no 90 day evaluation for RN N9 in the personnel file		kept current to reflect changes in active agency staff. Compliance (90%) will be reported at least quarterly through Organizational Improvement Committee and Governing Board meetings.	

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S000320	410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1(c)(6)(G) (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: (G) Providing employee health services and a post offer physical examination, in consultation with the infection control committee.			
	Based on policy and procedure review, employee health file review, and staff interview, the governing board failed to ensure the implementation of facility policy related to post offer physical examinations for 3 CNAs (certified nursing assistants) and 2 RNs (registered nurses) (staff members N5 through N9). Findings: 1. review of the policy and procedure "IC X-1" "Overview of OSHA (Occupational Safety and Health Administration) Guidelines Related to Occupational Health: Healthcare Workers", with an approved date of 2/4/13, indicated: a. under the section "Occupational Health Services", it reads at the bottom of the page, in item 2. "Medical evaluations will be done on initial employment..." and in the same section, but on the next page,	S000320	1. Revision of Policy IC X-1 (General Guidelines Related to the OSHA Guidelines for Occupational Health: Healthcare Workers) on April 17, 2013. A copy of this policy is submitted as Attachment A.2. Human Resources Coordinator will continue to provide Health Screening form at initial employment. The Health Screening form is submitted as Attachment B.3. Policy IC X-1 (General Guidelines Related to the OSHA Guidelines for Occupational Health: Healthcare Workers) will be submitted for approval through Medical Executive Committee (MEC) on April 24, 2013.4. Compliance status (90%) will be reported through Organizational Improvement Committee (OIC) and Governing Board (GB).	05/10/2013

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	it reads in item 8. "Employee health file will be maintained for each employee. The file will include but not be limited to: medical evaluation, health screening,..." 2. review of employee health files indicated the health files for: a. 3 CNAs (N5 hired 11/28/11, N6 hired 7/10/12, and N7 hired 9/11/12) lacked documentation of a medical evaluation in their personnel files b. 2 RNs (N8 hired 5/11/10 and N9 hired 8/7/12) lacked documentation of a medical evaluation in their personnel files 3. interview with staff members #50, the CEO (chief executive officer), and #56, human resources manager/director, at 3:40 PM on 3/20/13 indicated: a. the facility does not require a "post offer physical exam" b. the facility policy IC X-1 requires a "medical evaluation" as well as a health screening for new employees c. staff members N5 through N9 only have the self completed health screening forms in their health records d. staff members N5 throught N9 lacked medical examinations/evaluations completed by a medical professional, as required by policy, in their health files			

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S000322	410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1(c)(6)(H) (c) The governing board is responsible for managing the hospital. The governing board shall do the following: (6) Require that the chief executive officer develops policies and programs for the following: (H) Requiring all services to have policies and procedures that are updated as needed and reviewed at least triennially.			
	Based on document review and interview, the chief executive officer (CEO) failed to ensure that all facility policies/procedures were maintained and designate in writing who would be in charge when the CEO was not present. Findings: 1. The policy/procedure Chain of Command (approved (2-13) indicated the following: " The Director of Clinical Services will assume the rights, privileges, duties, responsibilities and powers of the Administrator in the absence of the CEO. The Director of Provider Relations assumes these responsibilities in the absence of the above two. " 2. The Select Specialty Hospital of Fort	S000322	According to Administration Policy and Procedure C03-A (Chain of Command), there is a specific chain of command in the absence of the CEO. This policy was revised April 16, 2013, to reflect the most recent title changes. A copy of this policy is submitted as Attachment C. This policy will be presented for review and approval at the next Medical Executive Committee (MEC) meeing on April 24, 2013, and Governing Board meeting on June 14, 2013.Staff will be educated by the CNO or designee through Mandatory Day training on May 15 and May 16, 2013 on the chain of command.	05/10/2013

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	Wayne Organizational Chart failed to indicate the positions of Director of Clinical Services and Director of Provider Relations. 3. During an interview on 3-20-13 at 1340 hours, staff A2 and A4 confirmed that the position titles had been changed several years ago and confirmed that the policy/procedure had not been maintained.			

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S000394	410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1(f)(3) (f) The governing board is responsible for services delivered in the hospital whether or not they are delivered under contracts. The governing board shall insure the following: (3) That the hospital maintains a list of all contracted services, including the scope and nature of the services provided.			
	Based on document review and interview, the facility failed to maintain a list of all contracted services, including the scope and nature of services provided, for 5 services. Findings: 1. Review of the Contract and Agreement Log failed to indicate a service provider for the ventilators, wheelchairs, radiology services, dietary services and environmental services providers. 2. During an interview on 3-19-13 at 1100 hours, staff A1 indicated that radiology, dietary, environmental and building services were included in the contracted services agreement with the host facility. 3. During an interview on 3-20-13 at 1630 hours, staff A1 confirmed that the	S000394	Contracted Services Standards Monitors has been reviewed and updated to reflect 2013 contracted services. These services include: 1. Hemodialysis (Fresenius) 2. Linen (Hospital Laundry Services) 3. Saint Joseph Hospital (Host) a. Housekeeping b. Maintenance c. Dietary services d. Laboratory services e. Radiology services 4. Microbiological Testing (Parkview Laboratory) 5. PICC Fusion (PICC placements) 6.Biomedical Services (SPBS) 7.Transcription services 8. IOPO/OLETTBUpon completion of Annual Contract Services Review, Quality monitor indicators will be reviewed quarterly and presented to Organizational Improvement Committee, Medical Executive Committee, and Governing Board by the Director of Quality Management.	05/10/2013

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	list of contracted services lacked the indicated providers.			

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S000406	410 IAC 15-1.4-2 QUALITY ASSESSMENT AND IMPROVEMENT 410 IAC 15-1.4-2(a)(1) (a) The hospital shall have an effective, organized, hospital-wide, comprehensive quality assessment and improvement program in which all areas of the hospital participate. The program shall be ongoing and have a written plan of implementation that evaluates, but is not limited to, the following: (1) All services, including services furnished by a contractor.			
	Based on document review and interview, the facility lacked documentation that contracted services were included in the Quality Assessment and Performance Improvement (QAPI) program for 10 services. Findings: 1. On 3-19-13 at 1100 hours, staff A1 was requested to provide documentation indicating that its contracted services were evaluated and reported through the QAPI program and none was provided prior to exit. 2. Review of QAPI committee minutes for 2012 and 2013 failed to indicate that the contracted services for dialysis, dietary, environmental services, 2	S000406	Contracted Services Standards monitor has been reviewed and updated to reflect 2013 contracted services. These services include:1.) Hemodialysis (Fresenius)2.) Linen (Hospital Laundry Services)3.) Saint Joseph Hospital (Host) a. Housekeeping b. Maintenance c. Dietary services d. Laboratory services e. Radiology services4.) Microbiological Testing (Parkview Laboratory)5.) PICC Fusion (PICC placements)6.) Biomedical Services (SPBS)7.) Transcription Services8.) IOPO/ILETTBUpon completion of Annual Contract Services Review, Quality monitor indicators will be reviewed quarterly and presented to Organizational Improvement Committee, Medical Executive Committee, and Governing Board	05/10/2013

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	equipment maintenance services, 2 biomedical engineering services, laboratory services, laundry services and radiology services were reviewed. 3. Review of the Organization Improvement Committee (OIC) minutes dated 2-15-12, 5-10-12, 8-15-12 and 11-21-12 indicated the following: " Policy, Plan and Contract Review and Approval ...Contract Quality Indicators ...Link to Contract Matrix. " The minutes failed to indicate participation of committee members including acknowledgement of review and approval of the contracted services in 2012 and failed to attach or exhibit the Contract Evaluation tool including quality indicators and findings. Staff A1 was requested to provide the Contract Matrix documentation associated with the OIC committee meetings for 2012 and none was provided prior to exit. 4. During an interview on 3-20-13 at 1630 hours, staff A1 confirmed that the facility lacked documentation for evaluating and reporting its contracted services through the QAPI program.		by the Director of Quality Management.	

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S000422	410 IAC 15-1.4-2.2 QUALITY ASSESSMENT AND IMPROVEMENT 410 IAC 15-1.4-2.2(a)(2) (2) A process for reporting to the department each reportable event listed in subdivision (1) that is determined by the hospital's quality assessment and improvement program to have occurred within the hospital. (b) Subject to subsection (e), the process for determining the occurrence of the reportable events listed in subsection (a)(1) improvement program shall be designed by the hospital to accurately determine the occurrence of any of the reportable events listed in subsection (a)(1) within the hospital in a timely manner. (c) Subject to subsection (e), the process for reporting the occurrence of a reportable event listed in subsection (a)(1) shall comply with the following: (1) The report shall: (A) be made to the department; (B) be submitted not later than fifteen (15) working days after the serious adverse event is determined to have occurred by the hospital's quality assessment and improvement program; (C) be submitted not later than four (4) months after the potential reportable event is brought to the program's attention; and (D) identify the reportable event, the quarter of occurrence, and the hospital, but shall not include any identifying information for any: (i) patient; (ii) individual licensed under IC 25; or (iii) hospital employee involved; or any other information. (2) A potential reportable event may be			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	identified by a hospital that: (A) receives a patient as a transfer; or (B) admits a patient subsequent to discharge; from another health care facility subject to a reportable event requirement. In the event that a hospital identifies a potential reportable event originating from another health care facility subject to a reportable event requirement, the identifying hospital shall notify the originating health care facility as soon as they determine an event has potentially occurred for consideration by the originating health care facility's quality assessment and improvement program. (3) The report, and any documents permitted under this section to accompany the report, shall be submitted in an electronic format, including a format for electronically affixed signatures. (4) A quality assessment and improvement program may refrain from making a determination about the occurrence of a reportable event that involves a possible criminal act until criminal charges are filed in the applicable court of law. (d) The hospital's report of a reportable event listed in subsection (a)(1) shall be used by the department for purposes of publicly reporting the type and number of reportable events occurring within each hospital. The department's public report will be issued annually. (e) Any reportable event listed in subsection (a)(1) that: (1) is determined to have occurred within the hospital between: (A) January 1, 2009; and (B) the effective date of this rule; and			

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	152016	A. BUILDING 00 B. WING	03/20/2013

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	(2) has not been previously reported; must be reported within five (5) days of the effective date of this rule. (Indiana State Department of Health; 410 IAC 15-1.4-2.2) Based on document review and interview, the facility failed to have a policy/procedure for reporting to the Indiana State Department of Health (ISDH) each reportable event determined by the quality assessment and improvement program to have occurred within the hospital. Findings: 1. The facility Quality Assessment and Performance Improvement Plan (approved 2-13), Medical Error Reporting (approved 2-13) and policy/procedure Significant Patient Injury/Unanticipated Outcomes (approved 2-13) failed to indicate a process for reporting each reportable event per 410 IAC 15-1.4-2.2(a)(2). 2. During an interview on 3-20-13 at 1400 hours, staff A1 confirmed that the plan and policy/procedures lacked a provision for reporting an event to ISDH.	S000422	The Director of Quality Management (DQM) will convene an emergency session of the Quality Assessment and Performance Improvement (QAPI) committee if a reportable event, such as those listed in the Policy and Procedure R03-A2 (Risk Management: Significant Patient Injury/ Unanticipated Outcomes), Appendix A, should occur. This process will also be followed if a reportable event, as recognized by the Indiana State Department of Health Medical Error Reporting System should occur. The Director of Quality Management (DQM) will contact the Indiana State Department of Health at the following address: Indiana State Department of Health Medical Errors Reporting System 2 North Meridian Street, 5A Indianapolis, Indiana 46204 Telephone: (317) 233-1325 Fax: (317) 233-7053The report shall: (A) be made to the department; (B) be submitted not later than fifteen (15) working days after the serious adverse event is determined to have occurred by the hospital's quality assessment and improvement	10/18/2013

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			program; (C) be submitted not later than four (4) months after the potential reportable event is brought to the program's attention; and (D) identify the reportable event, the quarter of occurrence, and the hospital, but shall not include any identifying information for any: (i) patient; (ii) individual license under IC 25; or (iii) hospital employee involved; or any other information.An addendum to policy R03-A (2) (Risk Management: Significant Patient Injury / UnanticipatedOutcomes) was created July 16, 2013, for Select Specialty Hospital - Fort Wayne, noting the process for reporting events to the Indiana State Department of Health. This addendum will be submitted for approval at the Medical Executive Committee (MEC) meeting and the Organizational Improvement Committee (OIC) meeting on July 24, 2013.The addendum to R03A (2) (Risk Management: Significant Patient Injury / Unanticipated Outcomes), as supporting documentation, will be submitted as Attachment A.Policy R03A (2) (Risk Management: Significant Patient Injury / Unanticipated Outcomes), as supporting documentation, will be submitted as Attachment B.28 Reportable Events, as supporting documentation, will be submitted	

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			as Attachment C.	

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S000596	410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(f)(3)(D)(iii) (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: (iii) Cleaning, disinfection, and sterilization.			
	Based on observation and interview, the infection control committee (as part of the facility's quality assurance and performance improvement committee) failed to ensure cleanliness in two areas toured: the 7th floor pantry and the 8th floor hallway crash/code cart. Findings: 1. at 10:25 AM on 3/20/13 while on tour of the 7th floor pantry in the company of staff member # 51, the chief nursing officer, it was observed that the microwave was extremely dirty with dried, crusty food particles/debris 2. interview with staff member #51 at 10:26 AM on 3/20/13 indicated they were in agreement that the microwave needed	S000596	Microwave in 7th floor pantry cleaned on 3/20/13 and replaced on 4/18/2013. Post replacement: 1. CNO or designe will delegate daily microwave checks and logging to Unit clerk for each floor. 2. Unit clerk will monitor microwave daily for cleanliness. 3. Unit clerk will document microwave check in daily log. 4. Unit clerk will clean microwave weekly and as needed. 5. Results will be monitored and reported through Organizational Improvement Committee and Governing Board.CNO or designee and Housekeeping Supervisor will: 1. Conduct monthly environment of care rounds. 2. Check the environment daily for infection control issues. 3. Notify housekeeping of need for "high	05/10/2013

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	cleaning 3. at 11:00 AM on 3/20/13, while on tour of the 8th floor in the company of staff member #51, the chief nursing officer, it was observed that the code/crash cart stored in the hallway near the nurses' station had a great amount of accumulation of dust on the top of the cart (especially at the back) and on the bottom of the cart where it sits on a roller base 4. interview at 11:05 AM on 3/20/13 with staff member #51 indicated an accumulation of dust was present on and around the crash cart as stated in 3. above		dusting" and routine dusting needs. 4. Staff will be responsible for dusting on and around the crash cart daily and as needed. 5. Audits will be conducted for 3 months or until sufficient compliance (90%) is sustained. Finding will be monitored and reported through Organizational Improvement Committee (OIC) and Governing Board (GB) meetings.	

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S000606	410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(f)(3)(D)(viii) (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: (viii) An employee health program to determine the communicable disease history of new personnel as required by state and federal agencies.			
	Based on policy and procedure review, agency and employee health file review, and staff interview, the infection control committee (as part of the facility's quality assurance and performance improvement committee) failed to ensure that TB (tuberculin) tests were given appropriately for 3 staff (N1, N3 and N9); and that immunization/communicable disease history for Rubella, Rubeola, and/or Varicella was documented for 3 employees (N1, N5, and N7). Findings: 1. at 1:35 PM on 3/20/13, review of the infection control policy and procedure "Employee Screening: New Hire and	S000606	Human Resources Coordinator or designee will audit 100% of employee and agency health files starting 4/16/2013. Audit will be completed by 4/24/13. These files will be audited for: 1. Proof of 2-step of TST 2. Immunization history for MMR and VaricellaIf 1 or 2 is not present: 1. 2-step TST will be initiated or completed by Director of Quality Management (DQM) or designee 2. Proof of immunization will be established through laboratory blood draws (titers) 3. Completion of employee health files for new employees prior to scheduling any shifts 4. completion of yearly TB assessment-questionnaire 5. All new hires employee health files will be audited for 3 months or	05/10/2013

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	Ongoing", policy number IC X-2, last reviewed/approved on 2/4/13, indicated: a. under "Procedure", in section 4., it reads: "Two step tuberculin skin tests unless applicant can provide documentation of previously negative TST'S (tuberculin skin tests) within the last 12 months. If this is the case, the prior previously negative TST's will act as Step One of the Two step TST'S skin testing..." b. under "Procedure", in section 4., it continues: "...b. The first skin test shall be read in 48 - 72 hours. A second skin test shall be given...and read in 48 - 72 hours..." 2. staff member N1 had documentation of a TB test given 2/16/13 and read 2/18/13 that lacked the time given and the time read so that it cannot be determined that the test results were read within the 48 to 72 hour time frame 3. staff member N3 had documentation of a TB test that lacked the time it was read making it unclear if the test results were read within the 48 to 72 hour time frame 4. staff member N9 was hired 8/7/12 and had a TB test given that was noted as being a "2nd Step" of the two step process. The previous TB test was		until sufficient compliance (90%) is sustained. 6. Findings of non-compliance will be reported through Organizational Improvement Committee (OIC) and Governing Board (GB) 7. Continued employee non-compliance will be grounds for disciplinary action, up to and including termination, as per the progressive disciplinary policy	

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outside the 12 month requirement per policy and there was no indication of when the 1st step TB test was given

5. interview with staff member #56, the human resources manager/director, at 3:40 PM on 3/20/13 indicated:
 a. the TB tests for staff members N1 and N3 should have had times documented to be able to determine that the reading was 48 to 72 hours after they were given
 b. the first step TB test cannot be found for staff member N9, indicating that a two step for this newly hired staff member was not completed as per policy

6. at 1:35 PM on 3/20/13, review of the infection control policy and procedure "Employee Screening: New Hire and Ongoing", policy number IC X-2, last reviewed/approved on 2/4/13, indicated:
 a. under "Procedure", it reads in item 5.: "Measles and mumps and rubella titers will not be done unless this is a specific state requirement. The completed Health screening questionnaire will provide history of vaccination and prior MMR (measles, mumps, rubella) disease. 6. Varicella titer if uncertain or negative history..."
 b. the last page listing of "References" included "Guideline for Infection Control in Healthcare Personnel, 1998" and the

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	"CDC (centers for disease control) Healthcare Worker Immunizations MMWR (morbidity/mortality weekly report)" publication c. the publication (listed in b. above) indicated: "Measles (Rubeola)...One dose...2nd dose at least 1 month later--Healthcare personnel born in or after 1957 without documentation of (a) receipt of two doses of live vaccine on or after their 1st birthday, (b) physician-diagnosed measles, or (c) laboratory evidence of immunity..." d. the publication (listed in b. above) indicated: "Rubella...One dose...no booster--Healthcare personnel , both male and female, who lack documentation of receipt of live vaccine on or after their 1st birthday, or laboratory evidence of immunity..." e. the publication (listed in b. above) indicated: "Varicella-Zoster...Two...doses...Healthcare personnel without reliable history of Varicella or laboratory evidence of Varicella immunity..." 7. review of employee health files indicated: a. staff member N1 had documentation from a physician of having had a "MMR" on 4/28/03, but lacked documentation of a second dose of Rubeola (or a titer that			

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	shows immunity) b. staff member N5 had documentation of having had one "MMR", but lacked documentation of a second dose of Rubeola (or a titer that shows immunity) c. staff member N7 lacked any documentation for Rubella, Rubeola and Varicella 8. interview with staff member #56, the human resources manager/director, at 3:40 PM on 3/20/13 indicated: a. no further documentation of immunization or titer results can be found for staff members N1, N5 and N7 b. the CDC recommendations attached to policy IC X-2 and related to Rubella, Rubeola and Varicella were not followed for staff members N1, N5 and N7			

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S000812	410 IAC 15-1.5-5 MEDICAL STAFF 410 IAC 15-1.5-5 (a)(4)(A)(B)(C)(D)(E)(F)(G)(H)(I)(J)(K) (a) The hospital shall have an organized medical staff that operates under bylaws approved by the governing board and is responsible to the governing board for the quality of medical care provided to patients. The medical staff shall be composed of two (2) or more physicians and other practitioners as appointed by the governing board and do the following: (4) Maintain a file for each member of the medical staff that includes, but is not limited to, the following: (A) A completed, signed application. (B) The date and year of completion all Accreditation Council for Graduate Medical Education (ACGME) accredited residency training programs, if applicable. (C) A copy of the member's current Indiana license showing the date of licensure and current number or an available certified list provided by the health professions bureau. A copy of practice restrictions, if any, shall be attached to the license issued by the health professions bureau through the medical licensing board. (D) A copy of the member's current Indiana controlled substance registration showing the number, as applicable. (E) A copy of the member's current Drug Enforcement Agency registration showing the number,as applicable (F) Documentation of experience in the practice of medicine.			

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	(G) Documentation of specialty board certification, as applicable. (H) Category of medical staff appointment and delineation of privileges approved. (I) A signed statement to abide by the rules of the hospital. (J) Documentation of current health status as established by hospital and medical staff policy and procedure and federal and state requirements. (K) Other items specified by the hospital and medical staff.			
	Based on document review and interview, the facility lacked signed documentation ensuring that its medical staff agreed to abide by the rules of the hospital for 4 of 4 medical staff files reviewed. Findings: 1. The credential files for physicians A20, A21, A22 and A23 lacked a signed statement indicating that each medical staff agreed to abide by the medical staff bylaws, rules and regulations of the hospital. The credential files each contained a signed agreement with Select Medical Corporation ' s Code of Conduct/Compliance Certification Program not observed in the Select Specialty Hospital of Fort Wayne ' s Medical Staff Bylaws. 2. During an interview on 03-20-13 at 1530 hours, staff A9 confirmed that the 4	S000812	The application for Medical and Allied Health Staff has been revised as of July 17, 2013/ The "INFORMATION RELEASE/ACKNOWLEDGEMENTS" page, as part of the initial credentialing application states in paragraph two (2), lines one and two, that medical staff agrees to "be bound by the terms of the medical staff bylaws, policies, rules and regulations of Select Specialty Hospital Fort Wayne"...The supporting documentation will be submitted as Attachment D.The temporary credentialing application has also be revised as of July 17, 2013, noting on the "RELEASE OF INFORMATION CONSENT", number four (4), that physicians will be "bound by the terms of the medical staff bylaws, policies, rules and regulations of Select Specialty Hospital Fort Wayne"...The supporting documentation will be submitted as Attachment E.The revisions to the "INFORMATION RELEASE /	08/01/2013

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	credential files lacked a signed statement to abide by the medical staff rules of Select Specialty Hospital of Fort Wayne. 3. During an interview on 03-20-13 at 1630 hours, staff A1 confirmed that the 4 credential files lacked a signed statement to abide by the medical staff rules of Select Specialty Hospital of Fort Wayne.		ACKNOWLEDGEMENTS" and "RELEASE OF INFORMATION CONSENT" forms will be presented for approval in the Medical Executive Committee (MEC) meeting and Organizational Improvement Committee (OIC) meetingss on July 24, 2013.	

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S000870	410 IAC 15-1.5-5 MEDICAL STAFF 410 IAC 15-1.5-5(b)(3)(N) (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: (N) A requirement that all physician orders shall be: (i) in writing or acceptable computerized form; and (ii) shall be authenticated by the responsible individual in accordance with hospital and medical staff policies.			
	Based on review of medical staff by-laws, patient medical record review, and staff interview, the medical staff failed to ensure the implementation of its by-laws related to dating and timing the authentication of written orders for 4 of 8 patient records (pts. #1, #2, #6, and #7). Findings: 1. at 12:35 PM on 3/20/13, review the medical staff by-laws, last approved 2/4/13, indicated: a. under "D. General Conduct of Care", on page 117, it reads: "1...The responsible practitioner...shall authenticate orders within the time frame specified by state law or no later than 30 days after discharge..." b. under "D. General Conduct of Care",	S000870	Chief Nursing Officer (CNO) and Health Information Manager (HIM) or designee will:1. Place signage stating that physicians are to time, date, and sign each order that is written in the medical record in each physician lounge (completed prior to 3/19/13)2. Place reminders to time, date, and sign orders in each patient chart (completed prior to 3/19/13)3. Conduct 100% physician re-education to policy4. A memo will be sent to each member of the medical staff on 4/23/13, reminding them to sign, date, and time all orders5. Health Information Manager (HIM) will audit 30 charts per month for 3 months or until sufficient compliance (90%) is sustained.6. Authentication of orders will be discussed at the April 24, 2013, Medical Executive Committee	05/10/2013

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SELECT SPECIALTY HOSPITAL-FORT WAYNE	700 BROADWAY 7TH FL E FORT WAYNE, IN 46802

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	on page 118, it reads: "...3. All orders, including verbal orders, must be dated, timed and authenticated by the prescribing practitioner..." 2. review of patient medical records indicated: a. pt. # 1 had: A. restraint orders signed and dated by the practitioner on 1/13/13; 1/14/13; 1/19/13; and 1/20/13 that lacked a time of authentication by the physician B. a restraint order for 1/22/13 that lacked a date, time or authentication of the order by the physician (>30 days after discharge as the patient was discharged 1/22/13) b. pt. #2 had: A. "Acute Hemodialysis Orders" for 12/26/12 that lacked a date, time or authentication of the order by the physician (>30 days after discharge as the patient was discharged 1/4/13) B. "Acute Hemodialysis Orders" for 12/29/13; 12/31/12; 1/2/13; and 1/4/13 that lack a date and time of authentication c. pt. #6 had "Acute Hemodialysis Orders" for 2/13/13 that were authenticated, but lacked a date and time of the authentication		(MEC) meeting.	

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	d. pt. #7 had admission orders signed by the physician without a date and time of the authentication (date of the order unknown as the date and time for the admission orders was also missing) 3. interview with staff member #51, the chief nursing officer, at 4:20 PM on 3/19/13 and 4:40 PM on 3/20/13, indicated physicians have failed to date and time their authentication of orders as noted in 2. above			

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S000872	410 IAC 15-1.5-5 MEDICAL STAFF 410 IAC 15-1.5-5(b)(3)(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) A requirement that the the final diagnosis be documented along with completion of the medical record within thirty (30) days following discharge.			
	Based on review of medical staff bylaws, patient medical record review, and staff interview, the medical staff failed to implement its bylaws related to the timeline for completion of the medical record (discharge summary) being completed within 30 days of discharge for 2 of 4 closed records of one physician (staff member # 57). Findings: 1. at 12:35 PM on 3/20/13, review of the medical staff bylaws, last approved 2/4/13, indicated: a. on page 18, it reads in section (5): "Report any record which is not complete by the dictation or notation of a discharge summary within the 30 day time limit established per policy and procedure to the Medical Executive Committee for action;"	S000872	The Health Information Manager (HIM) will: 1. Provide physician re-education regarding timely completion of discharge summaries (completed) 2. Review of Policy D-04 (Medical Records Suspension) with physicians (completed) 3. Audit 30 charts a month for 3 months or until sufficient compliance (90%) sustained 4. Policy D-04 (Medical Records Suspension) will be reviewed during the Medical Executive Committee meeting on April 24, 2013 5. Delinquent discharge summaries will be reported through Organizational Improvement Committee, Medical Executive Committee, and Governing Board 6. Non-compliance will be subject to physician disciplinary action, up, and including, suspension of privileges until records are compliant as per the Medical Staff bylaws.	05/10/2013

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	2. review of patient (closed) medical records indicated: a. pt. #5 was discharged on 2/1/13 and had a discharge summary completed by physician #57 that: A. inaccurately listed a discharge date of 12/14/12 when the actual date was 2/1/13 B. was dictated on 3/5/13 (3 days after the 30 day requirement per medical staff bylaws) b. pt. # 6 was discharged 2/14/13 and had no discharge summary dictated (by physician #57) as of 3/20/13 (so far, 4 days after the 30 day requirement) 3. interview with staff member # 55, the HIM (health information manager), at 4:45 PM on 3/20/13 indicated: a. pt. #5 was discharged 2/1/13, not 12/14/12 as dictated by physician #57 on the discharge summary b. the dictated date of 3/5/13, on the discharge summary for pt. #5 was beyond the required 30 day requirement of 30 days by the medical staff c. as of today (3/20/13), the physician (#57) has not dictated the discharge summary for patient #6 d. this physician (#57) is frequently late in completing documentation			

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S000912	410 IAC 15-1.5-6 NURSING SERVICE 410 IAC 15-15-6 (a)(2)(B)(i)(ii)(iii)(iv)(v) (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: (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.			
	Based on policy and procedure review, patient medical record review, and staff interview, the nursing manager failed to ensure the implementation of facility policies related to physician orders for 7	S000912	1. Chief Nursing Officer (CNO) provided education to nursing staff regarding Policies O02-G (Orders, Physician) and R02-N (Restraints and Seclusion) on 3/28/13, 4/8/13, and	05/10/2013

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	of 8 records reviewed (pts. #1, 2, 4, 5, 6, 7, and 8). Findings: 1. at 1:25 PM on 3/19/13, review of the policy and procedure "Orders, Physician", with a policy number of O02-G, and an approved date of 2/4/13, indicated: a. under "Procedure", in item 5. "Mechanism", it reads: "...C. Written Orders - All written orders are to be dated and timed;..." 2. at 9:15 AM on 3/20/13, review of the policy and procedure "Restraints and Seclusion", policy number R02-N, with a most recent approved date of 2/4/13, indicated: a. beginning at the bottom of page 2 under "Procedure", it reads: "...If a physician or LIP (licensed independent practitioner) is not available to issue such an order, a registered nurse initiates restraint use based on an appropriate assessment of the patient. In that case, the MD/DO or LIP is notified immediately as clinically possible, of the initiation of the restraint, and a telephone order is obtained from that practitioner and entered into the patient's medical record...A written order, based on an examination of the patient by the MD/DO or LIP is entered into the patient's medical record on a daily basis when restraint use		4/11/13.2. Continued education for all staff will occur on May 15 and 16, 2013 in conjunction with Mandatory Day by Chief Nursing Officer or designee3. Director of Quality Management will audit 100% of restrained patient charts monthly for 3 months or until compliance (90%) is sustained. Results will be reported quarterly through Organizational Improvement Committee (OIC), Medical Executive Committee (MEC), and Governing Board (GB) meetings.4. Non-compliant staff may be subject to the progressive disciplinary process as per the progressive disciplinary policy.	

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	is clinically appropriate..." b. on page 7 under "Medical Record Documentation and Plan of Care:", indicated: "...A time-limited order by a physician, or licensed independent practitioner..." 3. review of patient medical records indicated: a. pt. #1 had: A. restraint orders dated 1/13/13; 1/14/13; and 1/19/13 that lacked: I. a time of the order II. a documentation by nursing of telephone or verbal order with the RN (registered nurse) signature (at the bottom of each page) B. restraint orders dated 1/20/13; 1/21/13; and 1/22/13 all with a time of order noted as 0001 hours, but lacked documentation by nursing of telephone or verbal order with the RN signature (at the bottom of each page) C. lacked time limitations for the restraint orders for 1/13/13; 1/14/13; 1/19/13; 1/20/13; 1/21/13; and 1/22/13, as per facility restraint policy requirements D (related to non-restraint orders) one order written 1/13/13; two orders written 1/14/13; and 3 different orders written on 1/19/13 that lacked documentation of the time the order was written for each of these orders			

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b. pt. #2 had one order written 12/26/12 that lacked documentation of the time the order

c. pt. #4 had one order written by the speech therapist on 3/12/13 that lacked documentation of the time the order

d. pt. #5 had:
A. one order written on 1/5/13; one on 1/10/13; one without date or time (on a page with 1/10/13 and 1/11/13 orders); one dated 1/13/13; one 1/15/13; one 1/17/13; and two on 1/31/13 that lacked documentation of the times of these orders

e. pt. #6 had one order written 2/13/13 that lacked documentation of the time the order

f. pt. #7 had:
A. admission orders (page one) that lacked a date and time of the orders; a page with orders written 2/27/13 with an order at the top of the page which lacked a date and time; and an order written 2/28/13 that lacked documentation of the time the order

g. pt. #8 had:
A. one order written 3/1/13; one order written 3/5/13; one order written 3/7/13; one order written 3/8/13; and one order

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	written 3/9/13 which lacked a time for the order B. one order written 3/1/13 that lacked the author's signature (written by one of the facility pharmacists but left blank) 4. at 4:20 PM on 3/19/13 and 4:40 PM on 3/20/13, interview with staff member # 51, the chief nursing officer, indicated the orders listed in 2. above were lacking dates and/or times of the orders as required by facility policy 5. interview with staff member # 60, a speech therapist, at 11:50 AM on 3/20/13 indicated the order written by this staff member for pt. #5 lacked a time of the order 6. interview with staff member #61, the director of pharmacy, at 4:40 PM on 3/20/13 indicated one of the staff pharmacists wrote the order for pt. #8 and failed to authenticate the order			

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S001118	410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8 (b)(2) (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: (2) No condition shall be created or maintained which may result in a hazard to patients, public, or employees.			
	Based on observation and interview, the hospital failed to maintain its stock supplies to minimize risk and assure the safety and well-being of patients at the facility. Findings: 1. During an observation on 3-20-13 at 1130 hours, the following expired supplies and equipment were observed in the 8th floor clean supply room: (10) 18 gauge BD InSyte IV Catheters exp. 11-2012 (15) 22 gauge BD InSyte IV Catheters exp. 01-2013 (4) 24 gauge BD InSyte IV Catheters exp. 01-2012 (1) Bard 18 French 5ml balloon Catheter exp. 10-2011 (3) Bard 16 French 5ml balloon Catheter exp. 02-2013	S001118	Prior to March 19, 2013, expiration checks of supplies were conducted every 6 months while conductinng 100% inventory audit. On 3/26/13 to 3/28/13, Materials Manager (MM) conducted 100% audit and inventory of all supplies, with zero expired supplies noted in 7th floor supply room and 7th floor overflow supply room. On 3/29/13 to 3/30/13, MM conducted 100% audit of 8th floor supply rooms, ensuring zero expired supplies. Ongoing process will be as follows: 1. Monthly audit of all supply rooms to ensure zero expired supplies 2. Maintenance of par levels	05/10/2013

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	(1) Arrow-Clark Thorocentesis Kit expiration 03-2012 2. During an interview on 3-20-13 at 1150 hours, staff A1 confirmed that the supplies and equipment were expired and removed from use with patients.			

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S001160	410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8(d)(1) (d) The equipment requirements are as follows: (1) All equipment shall be in good working order and regularly serviced and maintained.			
	Based on observation and interview, the facility failed to maintain all equipment in good working order and guard against transmission of disease for one ice machine. Findings: 1. During an observation on 3-20-13 at 1105 hours, the following condition was observed in the 8th floor pantry area: a Scotsman tabletop ice machine with suspected black mold growth in the bottom of the drip pan under the dispensing outlets and suspected black mold on the lower surfaces adjacent to the dispensing outlets in an area with rusty metal surfaces. It was observed that a water leak approximately one drop per 2 seconds was present in the area as well. A6 was requested to provide documentation of the most recent preventive maintenance for the ice machine. 2. A Preventive Maintenance Work	S001160	Host hospital Maintenance informed on 3/20/13 of ice machine issues. maintenance personnel cleaned out the dispenser outlets and inspected the machine to resolve the leak. Ice machine is to be replaced. Expected completion of replacement ice machine installation is 4/30/13.The ice machine will be inspected by the Director of Quality Management (DQM) during monthly environment of care rounds.	05/10/2013

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	Order dated 10-23-12 indicated the following: "Ice dispenser chute leaking. Cannot fix unless replace, ice tank, rotor, and shaft must be replaced to fix." 3. During an interview on 3-20-13 at 1400 hours, staff A6 confirmed that the ice machine had not been maintained.			

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S001164	410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8(d)(2)(B) (d) The equipment requirements are as follows: (2) There shall be sufficient equipment and space to assure the safe, effective, and timely provision of the available services to patients, as follows: (B) There shall be evidence of preventive maintenance on all equipment.			
	Based on observation and interview, the facility failed to ensure that all equipment had evidence of preventive maintenance for 15 equipment items of one department. Findings: 1. During a tour of the physical therapy department on 3-20-13 at 1045 hours, the following condition was observed: a wooden stair steps and adjustable parallel bars without evidence of periodic inspection and maintenance. 2. During a tour of the physical therapy department on 3-20-13 at 1050 hours, the following condition was observed: 13 wheelchairs without evidence of periodic inspection and maintenance. Staff A1 was requested to provide documentation of recent preventive maintenance for the	S001164	Prior to March 19, 2013, the Materials Manager (MM) had established Preventive Maintenance (PM) with James Medical. Preventive Maintenance for wheelchairs was initiated 3/25/13 and completed on 4/10/13. Preventive Maintenance for the wooden steps and parallel bars is scheduled for completion on 4/24/13.Materials Manager (MM) or designee will be responsible to verify that:Preventive Maintenance will be performed every 6 months and as necessary for all wheelchairs, wooden therapy stairs, and the therapy parallel bars.	05/10/2013

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	wheelchairs and none was provided prior to exit. 3. During an interview on 3-20-13 at 1630 hours, staff A1 confirmed that the wheelchairs and indicated therapy equipment was not receiving preventive maintenance to ensure safe use by patients and hospital personnel.			

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S001168	410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 150-1.5-8 (d)(3) (d) The equipment requirements are as follows: (3) Defibrillators shall be discharged at least in accordance with manufacturers recommendations and a discharge log with initialed entries shall be maintained.			
	Based on document review, observation and interview, the hospital failed to ensure that defibrillator inspection and testing was performed according to the manufacturer's recommendations. Findings: 1. The facility Physio-Control LifePak 12 Operating Instructions (2008 edition) Appendix C indicated the Operators Checklist of manufacturer's recommendations for daily inspection and testing of the defibrillator. 2. The policy/procedure Emergency Equipment (Code Cart and Defibrillator) Checking Procedure (approved 2-13) failed to indicate or exhibit the Physio-Control LifePak 12 manufacturer's recommendations and indicated the following: "Testing of defibrillator per manufacturers recommendations (details on Emergency Equipment/Code Cart	S001168	Manufacturer recommendations for the Physio-Control LifePak 12 were placed on the crach cart, with the Crash Cart Checklist Manual on 3/20/13.The Chief Nursing Officer (CNO) and the Director of Quality Management (DQM) or designee will: 1. Monitor monthly crash cart logs for daily checks/defib discharge per manufacturer recommendations 2 . Charge Nurse of designee will document check daily by initialing logbook 3. Compliance will be monitored and reported through Organizational Improvement Committee (OIC) and Governing Board (GB)	05/10/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152016	A. BUILDING 00 B. WING	03/20/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SELECT SPECIALTY HOSPITAL-FORT WAYNE	700 BROADWAY 7TH FL E FORT WAYNE, IN 46802

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Check List)." 3. During a tour of the 7th floor nursing unit on 3-20-13 at 1030 hours, a Lifepak 12 monitor/defibrillator were observed in the hallway opposite the nursing station. The document Emergency Equipment/Code Cart Check List located on top of the Code Cart indicated the following: "Defib Checked (per manufacturer recommendations)" and failed to attach the Operators Checklist or indicate that the additional checks listed on the checklist were completed with acceptable results according to the manufacturer ' s recommendations. 4. During an interview on 3-20-13 at 1310 hours, staff A2 confirmed that the policy/procedure had not been maintained and confirmed that the Emergency Equipment/Code Cart Check List failed to ensure that the equipment was checked in accordance with the manufacturer's recommendations.			

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S001172	410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8(e)(1)(A)(B)(C) (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: (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: (A) Asepsis (B) Cross-infection; and (C) Safe practice.			
	Based on observation and interview, the environmental services failed to ensure that all areas were kept clean and ventilation grilles and diffusers were free of dust at the facility. Findings: 1. During an observation on 3-20-13 at 1055 hours, the following condition was observed in hallway in front of the 8th floor nursing station area: a 24 " square ventilation return grille was observed with a significant accumulation of dust and particulate material in the area of the crash cart, and the crash cart was observed to have accumulated dust on the	S001172	Host housekeeping supervisor contacted 3/20/13. The housekeeper for the unit will: vacuum and/or dust the ventilation supply diffuser weekly and as needed.The Director of Quality Management, along with Saint Joseph Hospital Housekeeping Supervisor will: 1. Monitor for evidence of compliance during monthly Environment of Care rounds 2. The Chief Nursing Officer or designee will report non compliant findings to host hospital 3. Share findings of Environment of Care rounds through Quality Assurance Performance Improvement (QAPI) meetings and quarterly through Organizational	05/10/2013

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	152016	A. BUILDING 00 B. WING	03/20/2013

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	horizontal surfaces. 2. During an observation on 3-20-13 at 1100 hours, the following condition was observed in hallway in front of the 8th floor pantry area: a 24 " ventilation supply diffuser with a significant accumulation of dust and particulate material on the upper horizontal surfaces. 3. During an interview on 3-20-13 at 1100 hours, staff A1 and A6 confirmed that the accumulated dust and ceiling grilles were unsanitary.		Improvement Committee and Governing Board meetings.	