STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	150058	A. BUILDING 00 B. WING	02/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL HOSPITAL OF SOUTH BEND	615 N MICHIGAN ST SOUTH BEND, IN 46601

(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
S000000	This visit was for a standard licensure survey. Facility Number: 005053 Survey Date: 2/ 10, 11, 12 & 13 /2014 Surveyors: ReBecca Lair, LCSW Medical Surveyor Jacqueline Brown, RN Public Health Nurse Surveyor Lynnette Smith Medical Surveyor Saundra Nolfi, RN Public Health Nurse Surveyor QA: claughlin 02/26/14	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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	150058	A. BUILDING 00 B. WING	02/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL HOSPITAL OF SOUTH BEND	615 N MICHIGAN ST SOUTH BEND, IN 46601

(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
S000330	410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1(c)(6)(K) (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: (K) Maintaining personnel records for each employee of the hospital which include personal data, education and experience, evidence of participation in job related educational activities, and records of employees which relate to post offer and subsequent physical examinations, immunizations, and tuberculin tests or chest x-ray, as applicable. Based on policy and procedure review, personnel record review, and staff interview, the chief executive officer failed to ensure personnel records were maintained for each employee that included immunization status and/or communicable disease history related to hepatitis B for 2 of 11 (P3 and P8) inpatient psychiatric unit personnel files reviewed. Findings: 1. Policy titled, "Immunization Requirements for All Persons working in a Healthcare Setting" revised/reapproved 11/13, was reviewed	S000330	On February 25, 2014 the Associate Health Manager met with the Epworth leadership team and provided the team with a list of Associates who lacked documentation of Heb B immunization status. On March 3, 2014 all identified Associates were required to sign a declination, provide a copy of prior vaccinations, or begin receiving Heb B vaccinations. All Associates, with the exception of one Associate who is on FMLA, completed the Heb B Immunization requirements as outlined in the policy "Immunization Requirements for All Persons working in a Healthcare Setting" by March 14,	03/14/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	150058	A. BUILDING 00 B. WING	02/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL HOSPITAL OF SOUTH BEND	615 N MICHIGAN ST SOUTH BEND, IN 46601

(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 2/12/14 at approximately 1:00 PM, and indicated on pg. 1., under: A. Description section, "Beacon Health Service (BHS) will follow all immunization recommendations set forth by the Centers for Disease Control (CDC) and the Indiana State Department of Health for Rubeola, (Measles), Mumps, Rubella, Varicella, Pertussis, Tetanus, Diptheria, Influenza and Hepatitis B virus." B. Procedure/Instructions section, "As a condition of employment, medical staff credentialing, or other affiliation with BHS, all persons, (Associates, Medical Staff, Ambassadors/Volunteers, Traveling/Agency staff and Students) will be required to provide proof of immunity or be screened for...5. Hepatitis B (those who are expected to have occupational risk for blood/body fluid exposure)." C. Screening section, "Documentation of vaccination or declination will be maintained as follows: Associates - Employee Health Service..." 2. Policy titled, "Post Job Offer Screening Process" revised/reapproved 9/13, was reviewed on 2/12/14 at approximately 1:15 PM, and indicated on pg. 1., under: A. Description section, "All candidates who have been extended an offer of		2014. The Associate who is on FMLA will be held to the same requirements upon return to work. The Associate Health Manager is responsible for corrective actions and for communicating future non-compliance with policy requirements to the appropriate Manager and Executive Director or Vice President. Hospital Executive Leadership is responsible for ensuring ongoing compliance and Associate disciplinary action as appropriate.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	150058	A. BUILDING 00 B. WING	02/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL HOSPITAL OF SOUTH BEND	615 N MICHIGAN ST SOUTH BEND, IN 46601

(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
	employment with Beacon Health System will be screened post offer and will not start working until all health requirements have been satisfactorily met." B. Purpose section, "To ensure a consistent business process, which is also compliant with Indiana State Department of Health and Centers for Disease Control (CDC) health recommendations for all persons working in a healthcare environment." C. Procedure/Instructions section, "Confirm Hepatitis B immunity or need for vaccination for all associates who are at risk for blood and bodily fluid exposure." 3. Review of personnel files on 2/12/14 at 2:00 PM, indicated per document titled, "Memorial Employee New Hire Checklist" personnel: A. P3 "to find and provide" documentation of Hep B immunity. B. P8 "will provide" documentation of Hep B immunity. 4. Personnel P42 was interviewed on 2/13/14 at approximately 10:24 AM and confirmed, the above-mentioned personnel were lacking documentation that included immunization status and/or communicable disease history related to hepatitis B as required per facility policy			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	150058	A. BUILDING 00 B. WING	02/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL HOSPITAL OF SOUTH BEND	615 N MICHIGAN ST SOUTH BEND, IN 46601

(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
	and procedure.			
S000612	410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(f)(3)(D)(xi) (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: (xi) A program of linen management for personnel involved in linen handling. Based on staff interview, the hospital failed to establish a policy of linen management to ensure the proper laundering of the therapy hot pack covers. Findings included: 1. In interview on 2-13-14 between 2:30 PM and 4:30 PM, Staff Member L2 indicated the hospital did not have a policy for laundering the therapy hot pack covers. 2. In interview on 2-11-14 between 2:15	S000612	At the time of survey the hospital did not have a written policy related to the usage and maintenance of the hydrocollator. The Director of Rehabilitation Services developed a policy "Hydrocollator Usage and Cleaning" to ensure the safe and effective use of hydrocollator hot packs for those patients that can benefit from thermotherapy. The policy requires laundering of hot pack covers by HLC at least monthly or when visibly soiled or after contact with patients. A checklist will be used by staff daily to record required actions related to the Hydrocollator including the laundering of the hot	03/27/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	150058	A. BUILDING 00 B. WING	02/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL HOSPITAL OF SOUTH BEND	615 N MICHIGAN ST SOUTH BEND, IN 46601

(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
	PM and 2:40 PM, Staff Member L8 indicated s/he took the therapy hot pack covers home to launder them.		pack covers. The policy was approved by the Infection Control Committee on March 10, 2014 and by Hospital Leadership Committee on March 12, 2014. The Rehabilitation Services associates were educated on the new process via email on March 4, 2014. In addition, Rehabilitation Services associates will receive education as part of the Rehabilitation Services Staff meeting on March 27, 2014. The Director of Rehabilitation Services is responsible for corrective actions and will monitor ongoing compliance by reviewing the daily checklist. The checklist will be faxed to the director on a weekly basis to ensure the policy is being followed. Logs found out of compliance will be immediately addressed by the director with the responsible associate. Failure to comply with the policy will result in disciplinary action.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	150058	A. BUILDING 00 B. WING	02/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL HOSPITAL OF SOUTH BEND	615 N MICHIGAN ST SOUTH BEND, IN 46601

(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
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 medical record review, policy and procedure review, and interview, the nurse executive failed to ensure assessments were done according to policy and protocol for 3 of 3 newborn	S000912	The nursing associates working on the Mother/Baby units were re-educated on post circumcision assessment and pain assessment requirements defined in the “Infant Circumcision”	03/06/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	150058	A. BUILDING 00 B. WING	02/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL HOSPITAL OF SOUTH BEND	615 N MICHIGAN ST SOUTH BEND, IN 46601

(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
	patients (#N4, N11, and N12), who were circumcised. Findings included: 1. The medical record for newborn N4 indicated a circumcision was performed at 0848 on 02/09/14 and circumcision checks were documented at 0930 and 1230 on 02/09/14. The record indicated pain assessments were performed at 0945, 1230, 1341, and 1944 on 02/09/14 and at 0300 and 0901 on 02/10/14. The record lacked any further documentation of circumcision or pain assessments. 2. The medical record for newborn N11 indicated a circumcision was performed at 1637 on 12/04/13 and the only circumcision check was documented at 2130 on 12/04/13. The record indicated a pain assessment was performed at 1647 on 12/04/13, immediately after the procedure, and at 0750 on 12/05/13. The record lacked any further documentation of circumcision or pain assessments. 3. The medical record for newborn N12 indicated a circumcision was performed at 1240 on 12/10/13 and circumcision checks were documented at 1255, 1405, 1535, and 1800 on 12/10/13. The record indicated pain assessments were		policy. The education was provided via a department newsletter and during associate rounds completed by the unit Director on February 12, 2014 and February 28, 2014. The unit nurse educator also provided associates education via a bulletin board display posted on February 14, 2014 and in department meetings for both day and night shifts on March 4, 2014 and March 6, 2014. Charge nurses reminded nurses of the requirements at both change of shift "Jumpstart" meetings for a one week period of February 16, 2014 – February 22, 2014. The Director of Mother/Baby unit is responsible for corrective actions and ongoing compliance. Ongoing compliance with be monitored by a daily chart audit on 100% of circumcisions conducted by the unit nurse educator. If charting is found to be missing during the audit, the associate receives a follow-up page denoting the missing charting and an alert to the particular policy that states the documentation requirement. The associate signs the form and indicates if they need a copy of the policy. The form is returned to the educator who reports non-compliance to the Director. Audit results are posted daily on the unit Key Performance Indicator board. The KPI board is monitored daily by hospital	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	150058	A. BUILDING 00 B. WING	02/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL HOSPITAL OF SOUTH BEND	615 N MICHIGAN ST SOUTH BEND, IN 46601

(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
	performed at 1405, 1535, and 2235 on 12/10/13, then not again until 0815 on 12/11/13. The record lacked any further documentation of circumcision or pain assessments. 4. The facility policy "Infant Circumcision", effective 06/04/2012, indicated, "Follow-Up Care: Assess infant for pain every 4 hours and give oral acetaminophen as ordered for 24 hours. Document pain assessment in cerner. Check circumcision site within one hour and every 4 hours post-circumcision for 24 hours and prn as needed for excessive bleeding (more than a quarter-size of bright red bleeding on the gauze or diaper). Document assessment in cerner." 5. At 3:00 PM on 02/12/14, staff members A14 and A16, who assisted with the electronic medical record review, confirmed the findings and indicated the infants were not assessed according to policy and protocol.		leadership as part of the hospital's lean daily management process.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	150058	A. BUILDING 00 B. WING	02/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL HOSPITAL OF SOUTH BEND	615 N MICHIGAN ST SOUTH BEND, IN 46601

(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
S000930	410 IAC 15-1.5-6 NURSING SERVICE 410 IAC 15-1.5-6 (b)(3) (b) The nursing service shall have the following: (3) A registered nurse shall supervise and evaluate the care planned for and provided to each patient. Based on policy and procedure review, medical record review, and personnel interview, the registered nurse failed to supervise and evaluate the care planned for each patient related to assessing and/or updating allergies according to policy and procedure for 3 of 14 (N1, N3 and N5) open patient medical records reviewed and 2 of 2 (N15 and N16) closed patient medical records reviewed. Findings: 1. Policy titled, "Assessment - Initial, Ongoing, and Reassessment, Nursing", revised/reapproved 11/5/12, was reviewed on 2/12/14 at approximately 2:00 PM, and indicated on pg. 1, under Scope of Initial Nursing Assessment, History, and Screening, "Allergies..." 2. Review of open and closed patient medical records on 2/12/14 at approximately 10:00 AM, indicated Patient:	S000930	On Friday, February 14, 2014 a Safety Alert was emailed to Nursing Leadership to inform them of the deficiencies found during the survey chart review related to assessing and/or updating patient allergies. The safety alert instructed leaders to share the information with their nursing associates and to take action as appropriate to ensure compliance. An instructional sheet was included in the safety alert to assist nurses with the steps required to document allergy assessments/updates in the electronic medical record. On Friday, February 21, 2014 the Director of Clinical Informatics sent an email to all Management which included a document providing guidance to nurses on documenting that a patient's allergies had been reviewed with every new admission. On Monday, March 3, 2014 the Safety Coordinator presented the ISDH survey results to Clinical Leadership which included discussion related to the need to ensure allergy assessments were completed with every new	03/29/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	150058	A. BUILDING 00 B. WING	02/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL HOSPITAL OF SOUTH BEND	615 N MICHIGAN ST SOUTH BEND, IN 46601

(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
	A. N1 was admitted to the facility on 2/10/14 and allergies were last reviewed on a prior admission on 12/31/13 at 6:34 and were not updated on the current admission. B. N3 was admitted to the facility on 1/29/14 and allergies were not reviewed and updated until 2/11/13, which is 13 days after admission. C. N5 was admitted to the facility on 2/10/14 and allergies were last reviewed on a prior admission on 1/8/14 at 9:09 and were not updated on the current admission. D. N15 was admitted to the facility on 12/15/13 and allergies were not reviewed and updated until 12/17/13 at 18:40, which is 2 days after admission. E. N16 was admitted to the facility on 8/9/13 and allergies were last reviewed on a prior admission on 7/1/13 and were not updated on the current admission. 3. Personnel P19 was interviewed on 2/12/14 at approximately 3:00 PM and confirmed, allergies were not reviewed and/or updated according to facility policy and procedure for the above-mentioned open and closed patient medical records.		admission. Additionally, on Tuesday, March 4, 2014 the Safety Coordinator reported the ISDH survey results to the Nursing Professional Development Council (nursing educators from each clinical unit). The unit nursing educators were tasked with educating the bedside nurses on the need to assess every patient for allergies with each new admission. The education will be completed by March 29, 2014. Compliance of the requirements for allergy assessments and/or updates will be monitored as part of the quarterly closed record review process. The Chief Nursing Officer is responsible for corrective actions and will ensure ongoing compliance by reviewing the quarterly closed record review results.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	150058	A. BUILDING 00 B. WING	02/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL HOSPITAL OF SOUTH BEND	615 N MICHIGAN ST SOUTH BEND, IN 46601

(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
S000952	410 IAC 15-1.5-6 NURSING SERVICE 410 IAC 15-1.5-6(d) (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). Based on review of "Blood Transfusion, including Blood Components" policy, patient records, and staff interview, the nursing staff failed to ensure blood transfusions were administered in accordance with approved medical staff policies and procedures for 8 of 12 blood transfusion records reviewed. Findings include: 1. On 2-10-14 between 3:20 PM and 3:32 PM, review of "Blood Transfusion, including Blood Components," policy number "BB-NUR-080," effective date "04/22/2013," read: "Blood and Blood components are administered upon order of the physician..." and "Obtain patient consent to the procedure...." and "...an initial set of Vital Signs (T, P, R, BP) shall be obtained as pre-transfusion, baseline vitals...These vitals shall be obtained within one hour of starting the	S000952	The Nursing Professional Development Council (clinical nurse educators) revised the Blood Transfusion computer based learning education module and quiz to place a greater emphasis on the documentation piece. The Council also developed a quick reference guide on blood transfusion requirements and documentation for nurses to use when administering transfusions. All Associates who participate in the blood administration process are required to complete the CBL between March 10, 2014 and March 29, 2014. The quick reference guide was provided to these associates on March 7, 2014. The Chief Nursing Officer is responsible for corrective actions and will ensure ongoing compliance by utilization of an audit. 100% of all blood transfusion documentation will be	03/29/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	150058	A. BUILDING 00 B. WING	02/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL HOSPITAL OF SOUTH BEND	615 N MICHIGAN ST SOUTH BEND, IN 46601

(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
	first unit of blood..." and "Begin infusion of the blood...immediately, but within 30 minutes of the blood leaving the Blood Bank..." and or Physician just prior to administration..." and "...At the patient's bedside, both parties shall verify the physician's order to administer blood with the blood bag tag and the patient's ID band (name, date of birth, MRN)..." and "The RN (transfusionist) will complete proper identification with another RN, LPN, Perfusionist "...take T, P, R, and BP at the end of the first 15 minutes of administration (documentation within a 10 minute window of this time is acceptable)..." and "...take T, P, R, and BP upon completion of the blood transfusion..." 2. On 2-13-14 between 2:30 PM and 4:30 PM, review of patient records indicated the following: a. Patient L1 received a unit of packed red blood cells on "11-10-13." The unit of blood was released from the blood bank at "13:37" and the transfusion was initiated at "14:25," 48 minutes after the blood was released from the blood bank. Additionally, there was no documentation of patient consent to the transfusion. b. Patient L2 received a unit of packed red blood cells on 12-17-13. The unit was released from the blood		audited by unit leaders the week of March 24, 2014. Unit leaders will provide additional education to any associate whose documentation was not consistent with policy requirements. Another audit of 100% of blood transfusion documentation will occur the week of April 21, 2014. The results of both audits will be evaluated by the Chief Nursing Officer who will then determine future audit activities to ensure ongoing compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	150058	A. BUILDING 00 B. WING	02/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL HOSPITAL OF SOUTH BEND	615 N MICHIGAN ST SOUTH BEND, IN 46601

(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
	bank at "9:39." However, the time the transfusion was initiated was not documented. It could not be determined if the transfusion was initiated within 30 minutes, as required by approved policies / procedures. c. Patient L3 received a unit of packed red blood cells on 11-15-13. The transfusion was initiated at "16:55." Pre transfusion vital signs were taken at "7:55," 9 hours prior to the initiation of the transfusion. Additionally, there was no documentation of a physician order to transfuse the unit of blood. d. Patient L4 received a unit of packed red blood cells on 11-5-13. The transfusion was initiated at "17:40" and the pre transfusion vital signs were taken at "16:18," one hour and 22 minutes prior to initiating the infusion. e. Patient L5 received a unit of packed red blood cells on 11-29-13. The unit of blood was released from the blood bank at "12:16" and the transfusion initiated at "12:05," 11 minutes before the blood was released from the blood bank. Fifteen minute vital signs were not documented. The transfusion was completed at "15:35" and the post transfusion vital signs were taken at "15:50," 15 minutes after the transfusion was completed and not upon completion, as required by approved policies / procedures.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	150058	A. BUILDING 00 B. WING	02/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL HOSPITAL OF SOUTH BEND	615 N MICHIGAN ST SOUTH BEND, IN 46601

(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
	f. Patient L6 received a unit of packed red blood cells on 11-20-13. The transfusion was initiated at "2:53" and was completed at "4:40." Post transfusion vital signs were taken at "6:00," one hour and twenty minutes after the transfusion was completed and not upon completion, as required by approved policy / procedure. Additionally, there was no documentation of a physician order the transfusion this unit of blood. g. Patient L8 received a unit of packed red blood cells on 12-29-13. The transfusion was initiated at "10:20." Pre transfusion vital signs were not documented and the time the transfusion was completed were not documented. It could not be determined if post transfusion vital signs were taken in accordance with approved policies / procedures. h. Patient L10 received a unit of packed red blood cells on 12-12-13. There was no documentation the patient was properly identified by two witnesses, as required by approved policies / procedures. The infusion was initiated at "20:50" and the fifteen minute vital signs were taken at "21:20," thirty minutes after the transfusion was initiated. i. Patient L11 received a unit of packed red blood cells on 1-21-14. The			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	150058	A. BUILDING 00 B. WING	02/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL HOSPITAL OF SOUTH BEND	615 N MICHIGAN ST SOUTH BEND, IN 46601

(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
	transfusion was initiated at "12:15." There was no documentation of fifteen minute vital signs. 3. In interview on 2-13-14 between 2:30 PM and 4:30 PM, Staff Member L1 acknowledged approved policies / procedures were not followed during blood transfusions of the above mentioned patients.			
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 review of "Hydrocollator Master Heating Units Operation Manual", Hydrocollator temperature logs, patient records, observation and staff interview, the hospital failed to 1) ensure hydrocollator temperatures were recorded on dates of patient use to ensure appropriate temperature for 16 of 69 dates reviewed between November, 2013 and date of survey; 2) failed to ensure hydrocollator temperatures were	S001118	At the time of survey the hospital did not have a written policy related to the usage and maintenance of the hydrocollator. The Director of Rehabilitation Services developed a policy “Hydrocollator Usage and Cleaning” to ensure the safe and effective use of hydrocollator hot packs for those patients that can benefit from thermotherapy. The policy defines the appropriate temperature range of 160°F - 165°F following the	03/27/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	150058	A. BUILDING 00 B. WING	02/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL HOSPITAL OF SOUTH BEND	615 N MICHIGAN ST SOUTH BEND, IN 46601

(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
	within the manufacturer's recommended range for 51 of 69 dates reviewed between November, 2013 and date of survey; and 3) failed to ensure a safe environment for patients by following facility policy and manufacturer's recommendations regarding warming intravenous fluids and the use of the hydrocollator in the therapy department. Findings include: 1. On 2-12-14 between 1:30 PM and 2:05 PM, review of "Hydrocollator Master Heating Units Operation Manual," copyright "2000," read: "The recommended operating temperature is 160 (degrees Fahrenheit) to 166 (degrees Fahrenheit)...." and "The temperature of the water should be checked...before using the HotPacs..." 2. On 2-11-14 between 2:15 PM and 2:40 PM, review of hydrocollator temperature logs from November, 2013 to date of survey indicated the following: Date Temp. _____ 11-1-13 NT 11-4-13 NT 11-5-13 154 11-6-13 155		manufacturer's recommendations. A checklist was developed to ensure temperatures are being monitored and recorded daily as required in the new policy. The policy was approved by the Infection Control Committee on March 10, 2014 and by Hospital Leadership Committee on March 12, 2014. The Rehabilitation Services associates were educated on the new process via email on March 4, 2014. In addition, Rehabilitation Services associates will receive education as part of the Rehabilitation Services Staff meeting on March 27, 2014. The Director of Rehabilitation Services is responsible for corrective actions and will monitor ongoing compliance by reviewing the daily checklist. The checklist will be faxed to the director on a weekly basis to ensure the policy is being followed. Logs found out of compliance will be immediately addressed by the director with the responsible associate. Failure to comply with the policy will result in disciplinary action. The warming cabinet in the Child Birth Unit has a top chamber utilized for intravenous fluids and a bottom chamber utilized for blankets. There are two separate polices that guide associates on the use of warming cabinets based on the product being	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	150058	A. BUILDING 00 B. WING	02/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL HOSPITAL OF SOUTH BEND	615 N MICHIGAN ST SOUTH BEND, IN 46601

(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
	11-7-13 155 11-8-13 156 11-11-13 156 11-12-13 157 11-13-13 156 11-14-13 154 11-15-13 NT 11-18-13 154 11-19-13 155 11-20-13 155 11-21-13 156 11-22-13 NT 11-25-13 NT 11-26-13 153 11-27-13 154 11-29-13 156 12-2-13 155 12-3-13 156 12-4-13 154 12-5-13 156 12-6-13 NT 12-9-13 152 12-10-13 155 12-11-13 156 12-12-13 155 12-16-13 155 12-17-13 156 12-18-13 155 12-19-13 155 12-20-13 NT 12-23-13 156 12-14-13 155 12-26-13 NT 12-27-13 NT		warmed. The policy "Warming Fluids" pertains to the warming of intravenous fluids and stipulates a maximum temperature of 104°F for intravenous fluids in plastic bags with the overwrap intact. The policy "Warming Cabinet Maintenance and Temperature Monitoring" pertains to the warming of blankets and personal cleansing products. This policy stipulates not to exceed temperatures of 130°F for blankets and 125° for personal cleansing products. Both policies have temperature monitoring logs to allow for recording of daily temperatures. At the time of survey the Child Birth Unit was utilizing the blanket/personal cleansing product log sheet for both chambers of their warming cabinet. Upon the surveyor's discovery of the inappropriate log on February 11, 2014, an email was sent to all unit Directors who have warming cabinets with separate chambers for fluids and blankets to ensure they were following the appropriate policy and utilizing the appropriate log for products stored in each chamber. The Chief Nursing Officer is responsible for corrective action and ongoing compliance. The Chief Nursing Officer will monitor the weekly report of blanket and personal cleansing product log compliance to monitor ongoing compliance. The Executive	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	150058	A. BUILDING 00 B. WING	02/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL HOSPITAL OF SOUTH BEND	615 N MICHIGAN ST SOUTH BEND, IN 46601

(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
	12-30-13 NT 12-31-13 155 1-2-14 154 1-7-14 154 1-8-14 156 1-9-14 155 1-10-14 NT 1-13-14 155 1-14-14 153 1-15-14 154 1-16-14 154 1-17-14 NT 1-20-14 154 1-21-14 153 1-22-14 153 1-23-14 154 1-24-14 NT 1-27-14 155 1-29-14 154 1-30-14 155 1-31-14 NT 2-3-14 156 2-4-14 155 2-5-14 155 2-7-14 156 2-10-14 152 2-11-14 153 Temp. - Hydrocollator Temperature; NT - Temperature Not Recorded 3. On 2-13-14 between 2:30 PM and 4:30 PM, review of patient records indicated the following patients had		Director of Surgical Services shall monitor the fluid warmer logs and will report any non-compliance to the Chief Nursing Officer.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	150058	A. BUILDING 00 B. WING	02/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL HOSPITAL OF SOUTH BEND	615 N MICHIGAN ST SOUTH BEND, IN 46601

(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

moist heat therapy using hot pack from the hydrocollator on the following dates, when hydrocollator temperatures were not recorded:

Patient	Date
L30	11-1-13
L31	11-4-13
L32	11-15-13
L33	11-25-13
L34	12-6-13
L35	12-13-13
L36	12-20-13
L37	12-26-13
L38	12-27-13
L39	12-30-13
L40	1-3-14
L41	1-10-14
L42	1-17-14
L43	1-24-14
L44	1-31-14

4. In interview on 2-11-14 between 2:15 PM and 2:40 PM, Staff Members L8 and L9 acknowledged hydrocollator temperatures were not taken on the above dates when they were not recorded and acknowledged the hydrocollator temperatures were lower than 160 degrees Fahrenheit from November, 2013 to date of survey.

5. In interview on 2-12-14 between 2:05

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	150058	A. BUILDING 00 B. WING	02/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL HOSPITAL OF SOUTH BEND	615 N MICHIGAN ST SOUTH BEND, IN 46601

(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
	PM and 2:10 PM, Staff Member L2 acknowledged the hydrocollator manufacturer recommended the temperature to be between 160 degrees Fahrenheit and 166 degrees Fahrenheit and indicated the facility did not have a policy for hydrocollator temperatures. 6. During the tour of the obstetrical department at 2:00 PM on 02/11/14, accompanied by staff members A17 and A18, six 1000 milliliter bags of fluids for intravenous use were observed in the top chamber of a warming cabinet in the C/S room. The temperature of the chamber registered 115 degrees Fahrenheit (F). The Warming Cabinet Temperature Log taped to the front of the cabinet indicated the blanket warmer should be set to 125 degrees F. and the cleansing warmer (Sage) should be set at 115 degrees F. The log did not address the intravenous fluids. 7. At 2:00 PM on 02/11/14, staff members A17 and A18 confirmed the fluids were kept in the warmer at 115 degrees F. and the log did not address the fluid temperature, but instead, the Sage warmer, which did not apply. 8. The facility policy "Warming Fluids", effective 02/12/13, indicated, "A. Temperature parameters: 1. Intravenous fluids in plastic bag with			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	150058	A. BUILDING 00 B. WING	02/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL HOSPITAL OF SOUTH BEND	615 N MICHIGAN ST SOUTH BEND, IN 46601

(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
	overwrap intact: a. Warm to a maximum of 104 degrees F. ...F. Temperatures will be monitored on a daily basis and recorded on the Fluid Warmer Cabinet Temperature Monitoring Form. Completed log forms to be reviewed weekly by surgery administration." Attachments to the policy were a Warming Cabinet Temperature Log and a Fluid Warmer Cabinet Temperature Monitoring Form. 9. During the tour of the first floor therapy rooms at 10:15 AM on 02/12/14, accompanied by staff members A2 and A22, a hydrocollator containing hot packs was observed registering 165 degrees F. A clipboard with the unit contained Hydrocollator Temperature Check Records which indicated "*please record after date if this is a temp. check before patient use". The forms indicated documentation of 37 temperature checks for 2012 and 29 checks for 2013, but lacked indication if the checks were before patient use. Cleaning documentation was also recorded on the logs with the last one listed as 01/09/13 and the last temperature documentation was 05/23/13. 10. At 10:25 AM on 02/12/14, staff member A2 indicated the Rehab Aide			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	150058	A. BUILDING 00 B. WING	02/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL HOSPITAL OF SOUTH BEND	615 N MICHIGAN ST SOUTH BEND, IN 46601

(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
	indicated he/she just "eyeballs" the temperature. 11. A facility form "Hydrocollator Cleaning Guidelines and Temp Checks" indicated, "Hydrocollators located on first floor gym should be cleaned and the temperature should be checked on a regular basis. Cleaning: Drain and clean hydrocollator one time per quarter. ...Temperature: 1. Hydrocollator will have routine temperature checks one time per month. 2. Prior to use on a patient." 12. The manufacturer's Operation Manual for the Hydrocollator indicated, "2. The thermostat is extremely sensitive and the slightest adjustment will alter the temperature several degrees. The recommended operating temperature is 160 degrees F. to 166 degrees F....The temperature of the water should be checked with a thermometer after every adjustment, before using the HotPacs. ...5. Check water level daily as it has a natural loss due to evaporation. ...Water is constantly lost during operation due to evaporation. Therefore, it is essential that water be added daily. The tank should also be drained and cleaned systematically, at a minimum every two weeks."			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	150058	A. BUILDING 00 B. WING	02/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL HOSPITAL OF SOUTH BEND	615 N MICHIGAN ST SOUTH BEND, IN 46601

(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
	13. At 3:30 PM on 02/12/14, staff member A2 indicated the hydrocollator was in use for patients since the last documented temperature checks and confirmed the facility form did not match the manufacturer's directions regarding cleaning.			
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 review of "Hydrocollator Master Heating Units Operation Manual," hydrocollator cleaning procedures, hydrocollator cleaning documentation, patient records, and staff interview, the facility failed to ensure one of one hydrocollator at the "Lighthouse Place Physician Therapy" off - site facility had evidence of preventative maintenance (cleaning) performed in accordance with manufacturer's instructions from	S001164	At the time of survey the hospital did not have a written policy related to the usage and maintenance of the hydrocollator. The Director of Rehabilitation Services developed a policy “Hydrocollator Usage and Cleaning” to ensure the safe and effective use of hydrocollator hot packs for those patients that can benefit from thermotherapy. The policy addresses the following in accordance with the manufacturer’s recommendations: ·	03/27/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	150058	A. BUILDING 00 B. WING	02/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL HOSPITAL OF SOUTH BEND	615 N MICHIGAN ST SOUTH BEND, IN 46601

(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
	February, 2013 to date of survey. Findings include: 1. On 2-12-14 between 1:30 PM and 2:05 PM, review of "Hydrocollator Master Heating Units Operation Manual," copyright "2000," read: "Maintenance...Care and Cleaning...The tank should also be drained and cleaned systematically, at a minimum every two (2) weeks..." and "Do regular cleaning and draining of the tank (every two weeks)..." 2. On 2-12-13 between 1:30 PM and 2:05 PM, review of a procedure titled: "Cleaning the Hydrocollator," effective date unknown, read: "The hydrocollator should be cleaned at least monthly and more frequently if needed...." 3. On 2-11-14 between 2:15 PM and 2:40 PM, review of hydrocollator cleaning documentation indicated: a. The hydrocollator was cleaned once a month, on the following dates: 2-20-13; 3-21-13; 4-15-13; 5-1-13; 7-17-13; 9-30-13; 11-25-13; 12-31-13; and 2-7-13 b. There was no documented cleaning on the following months: August, 2013; October, 2013; and January, 2014.		Temperature range between 160°F - 165°F · Water level to be over the top of the hot packs · Inspections of the Hydrocollator periodically for signs of leaking · Inspections of the hot packs and covers prior to and after each use · Appropriate use of hot packs including cautionary language (i.e. wrapping with towel or terry cover, monitoring every 5 minutes, etc.) · Maintenance inspections and cleaning at a minimum of every two weeks · Laundering of hot pack covers by HLC at least monthly or when visibly soiled or after contact with patients. · A checklist to be used by staff daily to record the water temperatures, water added, unit cleaning and the laundering of the hot pack covers. The policy was approved by the Infection Control Committee on March 10, 2014 and by Hospital Leadership Committee on March 12, 2014. The Rehabilitation Services associates were educated on the new process via email on March 4, 2014. In addition, Rehabilitation Services associates will receive education as part of the Rehabilitation Services Staff meeting on March 27, 2014. The Director of Rehabilitation Services is responsible for corrective actions and will monitor ongoing compliance by reviewing the daily checklist. The checklist will be faxed to the director on a weekly basis to ensure the policy is being	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	150058	A. BUILDING 00 B. WING	02/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL HOSPITAL OF SOUTH BEND	615 N MICHIGAN ST SOUTH BEND, IN 46601

(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
	4. On 2-13-14 between 2:30 PM and 4:30 PM, review of patient records indicated the following patients had moist heat therapy using hot pack from the hydrocollator on the following dates, when hydrocollator cleaning was not documented in accordance with manufacturer's instructions: Patient Date _____ L30 11-1-13 L31 11-4-13 L32 11-15-13 L33 11-25-13 L34 12-6-13 L35 12-13-13 L36 12-20-13 L37 12-26-13 L38 12-27-13 L39 12-30-13 L40 1-3-14 L41 1-10-14 L42 1-17-14 L43 1-24-14 L44 1-31-14 5. In interview on 2-11-14 between 2:15 PM and 2:40 PM, Staff Member L9 acknowledged the hydrocollator cleaning was not documented every two weeks, as required by the manufacturer.		followed. Logs found out of compliance will be immediately addressed by the director with the responsible associate. Failure to comply with the policy will result in disciplinary action.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	150058	A. BUILDING 00 B. WING	02/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL HOSPITAL OF SOUTH BEND	615 N MICHIGAN ST SOUTH BEND, IN 46601

(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