

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  150047	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  03/07/2012
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NAME OF PROVIDER OR SUPPLIER  ST JOSEPH HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 700 BROADWAY FORT WAYNE, IN 46802
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S0000	<p>This visit was for a licensure survey.</p> <p>Facility Number: 005043</p> <p>Survey Date: 03-05-12 to 03-07-12</p> <p>Surveyors: Brian Montgomery, RN Public Health Nurse Surveyor Linda Plummer, RN Public Health Nurse Surveyor Lynnette Smith, BS MLT (ASCP) Medical Surveyor 3</p> <p>QA: claughlin 03/12/12</p>	S0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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S0308	<p>410 IAC 15-1.4-1 GOVERNING BOARD 15-1.4-2 (c)(6)(B)</p> <p>(c) The governing board is responsible for managing the hospital. The governing board shall do the following: (6) Require that the chief executive officer develops policies and programs for the following:</p> <p>(B) Orientation of all new employees, including contract and agency personnel, to applicable hospital, department, service, and personnel policies.</p> <p>Based on document review and interview, the facility failed to ensure that orientation to applicable hospital and department policy/procedures was provided to contracted housekeeping personnel for 2 contractors.</p> <p>Findings:</p> <p>1. On 3-05-12 at 1445 hours, staff A2 was requested to provide a policy/procedure and documentation of orientation to hospital policies regarding infection control, sanitation and safety for housekeeping staff providing services at off-site locations and none was provided prior to exit.</p>	S0308	<p>1. How are you going to correct the deficiency, include steps taken and date of correction? A procedure for providing contracted housekeeping staff orientation to hospital policies and procedures including infection control, sanitation and safety will be completed and implemented on March 26, 2012. All existing contracted housekeeping staff will be required to complete the orientation process. The manager of environmental services will have on file a copy of all completed orientation documentation for all contracted housekeeping employees by April 7, 2012. 2. How are you going to prevent the deficiency from reoccurring in the future? After all contracted housekeeping employees have completed competencies, they will be required to sign a document of</p>	04/05/2012			

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	2. During an interview on 3-07-12 at 1245 hours, staff A2 confirmed that the hospital lacked documentation of orientation to applicable department and hospital policies for contracted housekeeping staff.		completion. Files of contracted housekeeping employees will be audited 2 times per year making sure that each employee is up to date with all required competencies. Finding will be reported to Quality Council. 3. Who is going to be responsible for #1 & 2 above? Environmental Services Manager 4. By what date are you going to have the deficiency corrected? April 5, 2012		

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S0322	<p>410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1(c)(6)(H)</p> <p>(c) The governing board is responsible for managing the hospital. The governing board shall do the following: (6) Require that the chief executive officer develops policies and programs for the following:  (H) Requiring all services to have policies and procedures that are updated as needed and reviewed at least triennially.</p> <p>Based on document review and interview, the facility policy/procedure lacked a process to ensure that all policy/procedures are reviewed annually and failed to ensure that affiliated hospital policies/procedures were authorized for use at the facility and reviewed annually by a responsible person.</p> <p>Findings:</p> <p>1. The administrative Policies And Procedures (revised 2-12) indicated the following: " All policies will be reviewed annually. This review will be documented in the policy manual ... [and] ...On occasion it may be necessary to utilize a Community Health Systems</p>	S0322	<p>1. How are you going to correct the deficiency, include steps taken and date of correction? (If already corrected, include the steps taken and the date of correction) St. Joseph Hospital Policy # Adm 100 was revised on 5/14/2012 to state that all policies will have St Joseph Hospital name on each policy. St Joseph Hospital will not use policies as their own from Community Health Systems or a Lutheran Health Network. Polices Medication Variance Reporting System, Drug Therapy Management, Adverse Drug Reactions will have documented policy review by April 7, 2012. St. Joseph Leadership team was reeducated to have annual review of other policies completed for 2012 by May 1, 2012. Leadership was reeducated on the standard policy format (policy identifier header and page number on</p>	04/06/2012			

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	<p>corporate policy as a hospital policy. "</p> <p>The policy/procedure failed to authorize use of Network Hospital policy/procedures at the hospital and lacked a provision for an annual review by hospital staff if adopted.</p> <p>2. During an interview on 3-05-12 at 1150 hours, staff A1 indicated that the hospital policy/procedures were maintained in an electronic format and that the review process was documented separately.</p> <p>3. Network pharmacy policy/procedures provided for review (Medication Variance Reporting System, Drug Therapy Management, Adverse Drug Reactions) failed to indicate that the policies/procedures were applicable to St Joseph Hospital and failed to indicate a review and approval by St Joseph personnel if adopted for use at the facility.</p> <p>4. The St Joseph policy/procedures provided for review lacked a policy identifier on consecutive pages and failed to indicate a consistent method for indicating annual review by a responsible</p>		<p>every page of policy) on March 23, 2012. All leadership was educated on the revised hospital policy Admin #100 related to only accepting St Joseph Hospital policies with St. Joseph Hospital name as hospital on May 14, 2012. All policies provided to surveyor during survey will be revised by April 6, 2012. All other hospital policies will be revised to standard approved format by May 31, 2012. 2. How are you going to prevent the deficiency from reoccurring in the future? There will be an ongoing annual review of policies. Each year the CQO will ensure that all policies have been reviewed. Results will be reported to quality council. 3. Who is going to be responsible for #1 &amp; 2 above? Chief Quality Officer4. By what date are you going to have the deficiency corrected? Policy was revised on 3/23/2012. Annual review of all policies will be completed by 5/1/2012. Revision to policies submitted during survey, to ensure policies in standard format by May 31, 2012.</p>		

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	<p>person.</p> <p>5. During an interview on 3-07-12 at 0900 hours, staff A1 confirmed that the St Joseph administrative Policies And Procedures failed to authorize use of network policy/procedures and confirmed that the current method for policy review failed to ensure that an available policy/procedure was up-to-date.</p>			
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S0332	<p>410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1(c)(6)(L)</p> <p>(c) The governing board is responsible for managing the hospital. The governing board shall do the following: (6) Require that the chief executive officer develops policies and programs for the following:</p> <p>(L) Demonstrating and documenting personnel competency in fulfilling assigned responsibilities and verifying inservicing in special procedures.</p> <p>Based on document review and interview, the facility failed to document contracted housekeeping personnel competency for cleaning and disinfecting areas at off-site locations for 2 contracted services.</p> <p>Findings:</p> <p>1. The policy/procedure Position Description (revised 7-10) indicated the following: "All staff, contractors ...must demonstrate competency ...all departments must have a process for determining staff competency at the time of hire and for assessing and documenting continued competency."</p> <p>2. On 3-05-12 at 1445 hours, staff A2 was requested to provide documentation of competency for all housekeeping staff</p>	S0332	<p>1. How are you going to correct the deficiency, include steps taken and date of correction? All contracted housekeeping employees working in a St. Joseph Hospital facility will be required to complete competencies of job tasks for housekeeping. The Environment Servicess manager will have on file a copy of all completed competencies of contracted housekeeping employees of by April 3, 2012. 2. How are you going to prevent the deficiency from reoccurring in the future? After all contracted housekeeping employees have completed competencies, they will be required to sign a document of completion. Files of contracted housekeeping employees will be audited 2 times per year making sure that each employee is up to date with all required</p>	04/05/2012			

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	<p>providing services at off-site locations and none was provided prior to exit.</p> <p>3. During an interview on 3-07-12 at 1245 hours, staff A2 confirmed that the hospital lacked documentation of competency for 2 contracted housekeeping staff services.</p>		<p>competencies. 3. Who is going to be responsible for #1 &amp; 2 above? Environmental Services Manager is responsible for correction and ongoing compliance 4. By what date are you going to have the deficiency corrected? April 3, 2012</p>		

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S0394	<p>410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1(f)(3)</p> <p>(f) The governing board is responsible for services delivered in the hospital whether or not they are delivered under contracts. The governing board shall insure the following:</p> <p>(3) That the hospital maintains a list of all contracted services, including the scope and nature of the services provided.</p> <p>Based on document review and interview, the facility failed to maintain a list of all contracted services, including the scope and nature of services provided for 17 contracted services.</p> <p>Findings:</p> <p>1. On 3-05-12 at 1435 hours, a list of all contracted services was received from staff A2. The list of services failed to indicate a service provider for air exchange testing, anesthesia machines, biohazardous waste, elevators, exhaust hoods, 5 fire services, generator, 2 off-site housekeeping providers, pest control, medical physicists, radiology equipment and sterilizers.</p>	S0394	<p>1. How are you going to correct the deficiency, include steps taken and date of correction? (If already corrected, include the steps taken and the date of correction) Annual evaluation, including scope and nature of services of the following: provider for air exchange testing, anesthesia machines, biohazardous waste, elevators, exhaust hoods, 5 fire services, generator, 2 off-site housekeeping providers, pest control, medical physicists, radiology equipment and sterilizers, air exchange testing , anesthesia machine service, biohazardous waste disposal, elevator service, exhaust hoods inspectors, fire service providers included, fire panel monitoring, generator service , housekeeping services at off-sites, pest control, medical physicist calibration and inspection, radiology equipment service, and sterilizer service will be completed will be completed</p>	04/06/2012			

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	<p>2. Review of facility documentation indicated the following: air exchange testing by CS1, anesthesia machine service by CS2, biohazardous waste disposal by CS3, elevator service by CS4, exhaust hoods were inspected by CS5, fire service providers included CS6, CS7, CS8, and CS9 and fire panel monitoring by CS10, generator service by CS11, housekeeping services at off-sites by CS12 and CS13, pest control by CS14, medical physicist calibration and inspection by CS15, radiology equipment service by CS16, and sterilizer service by CS17.</p> <p>3. On 3-07-12 at 1410 hours, staff A1 confirmed the list of contracted services failed to include the indicated service providers.</p>		<p>by 4/7/2012. The contract evaluations, including scope and nature of the provider will be approved at Medical Executive Committee on April 9 and Board of Trustees on May 10, 2012 2. How are you going to prevent the deficiency from reoccurring in the future? Contract evaluations of clinical and non-clinical service providers will be completed annually each March and approved at following Quality Council, Medical Executive Committee and the Board of Trustees. 3. Who is going to be responsible for #1 &amp; 2 above? Chief Quality Officer who will maintain the list of contracted servies, including scope and nature of services. 4. By what date are you going to have the deficiency corrected? May 10 th , 2012</p>		

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S0406	<p>410 IAC 15-1.4-2 QUALITY ASSESSMENT AND IMPROVEMENT 410 IAC 15-1.4-2(a)(1)</p> <p>(a) The hospital shall have an effective, organized, hospital-wide, comprehensive quality assessment and improvement program in which all areas of the hospital participate. The program shall be ongoing and have a written plan of implementation that evaluates, but is not limited to, the following:</p> <p>(1) All services, including services furnished by a contractor.</p> <p>Based on document review and interview, the Quality Improvement Program (QI) failed to ensure that contracted services were included in the QI program for 17 services.</p> <p>Findings:</p> <p>1. The 2011 Quality Improvement Program (approved 3-11) lacked a provision for monitoring, evaluating, and reporting contracted services provided at the facility.</p> <p>2. Review of program documentation failed to indicate monitoring and periodic reporting for 2 contracted housekeeping</p>	S0406	<p>1. How are you going to correct the deficiency, include steps taken and date of correction? (If already corrected, include the steps taken and the date of correction) The QI plan for 2012 includes a provision for monitoring, evaluating, and reporting contracted services provided at the St. Josaph Hospital. The plan was approved at Medical Executive Committee on April 9 and Board of Trustees on May 10, 2012 Evaluation of contract services Monitoring, evaluating and periodic reporting for the following : provider for air exchange testing, anesthesia machines, biohazardous waste, elevators, exhaust hoods, 5 fire services, generator, 2 off-site housekeeping providers, pest control, medical physicists, radiology equipment and sterilizers, air exchange testing ,</p>	04/06/2012	

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	<p>services, 14 repair/maintenance/certification services and 1 professional/technical service.</p> <p>3. During an interview on 3-06-12 at 1500 hours, staff A2 indicated that the facility failed to include the contracted services in its QI program.</p>		<p>anesthesia machine service, biohazardous waste disposal, elevator service, exhaust hoods inspectors, fire service providers included, fire panel monitoring, generator service , housekeeping services at off-sites, pest control, medical physicist calibration and inspection, radiology equipment service, and sterilizer service will be completed by 4/6/2012. The contract evaluations will be approved at Medical Executive Committee on April 9 and Board of Trustees on May 10, 2012 2. How are you going to prevent the deficiency from reoccurring in the future? The QI plan will include a provision for monitoring, evaluating and reporting contract services. Contract evaluation and monitoring of clinical and non-clinical service providers will be completed annually each March and approved at following, Quality Council, Medical Executive Committee and the Board of Trustees. 3. Who is going to be responsible for #1 &amp; 2 above? Chief Quality Officer 4. By what date are you going to have the deficiency corrected? May 10th , 2012</p>		

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S0554	<p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(a)</p> <p>(a) The hospital shall provide a safe and healthful environment that minimizes infection exposure and risk to patients, health care workers, and visitors.</p> <p>Based on review of "High Level Chemical Disinfection" policy and "Cidex OPA" manufacturer's package insert, observation, and staff interview, the hospital failed to provide an environment that minimized the risk of infection to patients who used ventilators from the middle of January to date of survey.</p> <p>Findings included:</p> <p>1. On 3-6-12 between 10:05 AM and 10:45 AM, review of "High Level Chemical Disinfection" policy, policy number "6-255", last revised "7/11" read:</p> <p>a. "Record the date that the Cidex OPA Solution is opened along with the expiration date (75 days after opening) on the container and initial."</p> <p>b. "Opened unused OPA Solution may be stored for up to 75 days in the original container provided the solution is used prior to the preprinted expiration on the container."</p> <p>c. "Prior to submersion of each item and prior to use of a newly opened bottle</p>	S0554	<p>1. How are you going to correct the deficiency, include steps taken and date of correction? (If already corrected, include the steps taken and the date of correction) As of 3/20/12 Cidex container was removed from Respiratory Department As of 3/20/12 the temperature probes will be thoroughly cleaned with SUPER SANI-CLOTH wipes by the Respiratory Therapist. These will then be sent to Surgery to be disinfected using CIDEX OPA per manufacturer's recommendations. 2. How are you going to prevent the deficiency from reoccurring in the future? As of 3/20/12 CIDEX OPA will not be stored or used in the Respiratory Care Department 3. Who is going to be responsible for #1 &amp; 2 above? The manager of Respiratory Care is responsible for the above and will educate the Respiratory staff on the same effective 3/20/12 4. By what date are you going to have the deficiency corrected? The deficiencies will be completely corrected on 3/20/12.</p>	03/20/2012			

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	<p>of Cidex OPA, the Cidex OPA Solution must pass the OPA Solution Test Strip. Record results in appropriate log."</p> <p>2. On 3-6-12 between 10:05 AM and 10:45 AM, review of "Cidex OPA" manufacturer's package insert, copyright "2006", read:</p> <p>a. "High Level Disinfection...immerse device completely...for a minimum of 12 minutes at 20 C (68 F) or higher..."</p> <p>b. "During the usage of CIDEX OPA Solution as a high level disinfectant, it is recommended that a thermometer and timer be utilized to ensure that the optimum conditions are met."</p> <p>c. "Once opened, the unused portion of the solution may be stored in the original container for up to 75 days until used."</p> <p>3. During tour of the respiratory department on 3-6-12 between 9:00 AM and 9:30 AM while accompanied by Staff Members #L9, #L11, and #L12, an opened container of Cidex OPA Solution was observed in the Respiratory Manager's office. The date the container was opened and the new expiration date was not recorded on the container, as required by approved policies and procedures.</p> <p>4. In interview on 3-6-12 between 1:00</p>			

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	<p>PM and 1:30 PM, Staff Member #L11 indicated the following:</p> <ul style="list-style-type: none"> <li>a. The Cidex OPA solution was used to disinfect heater temperature probes from the ventilators.</li> <li>b. The container of Cidex OPA Solution was opened in mid-January, but the date it was opened and the new expiration date was not recorded on the container.</li> <li>b. A timer was not used during the disinfection process to ensure the heater temperature probes were immersed for a minimum of 12 minutes, as required.</li> <li>c. A thermometer was not used to ensure a minimum temperature of 20 degrees Celsius during the disinfection process, as required.</li> <li>d. The Cidex OPA Solution was not tested prior to use when the container was newly opened and the solution was not tested prior to submersion of each item, as required by approved policies and procedures.</li> </ul>			

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S0592	<p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(f)(3)(D)(i)</p> <p>(f) The hospital shall establish an infection control committee to monitor and guide the infection control program in the facility as follows: (3) The infection control committee responsibilities shall include, but not be limited to, the following:</p> <p>(D) Reviewing and recommending changes in procedures, policies, and programs which are pertinent to infection control. These include, but are not limited to, the following:</p> <p>(i) Sanitation.</p> <p>Based on document review and interview, the infection control (IC) program failed to ensure that contracted housekeeping services were provided in a safe and effective manner.</p> <p>Findings:</p> <p>1. On 3-05-12 at 1445 hours, staff A2 was requested to provide a policy/procedure and documentation of orientation to hospital policies regarding infection control, sanitation and safety for housekeeping staff providing services at off-site locations and none was provided prior to exit. Staff A2 was requested to</p>	S0592	<p>1. How are you going to correct the deficiency, include steps taken and date of correction? Off site contracted cleaning companies provided a complete list of cleaning chemicals to the Manager of Environmental Services on 03/22/2012 used for disinfecting surfaces at the off-site locations, to ensure that all high touch surfaces are disinfected. The list will be approved by the Infection Control Committee on April 20, 2012. Policy was revised by 4/6/2012 by Environmental Services manager to state orientation and competency documentation is required for all contracted housekeeping services staff. Orientation and competency of contracted housekeeping services staff was</p>	04/06/2012

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	<p>provide documentation of competency for housekeeping staff providing services at off-site locations and none was provided prior to exit.</p> <p>2. Documentation of agreements between the hospital and 2 contracted housekeeping services indicated that the contractor would provide the cleaning chemicals used for disinfecting surfaces at the off-site locations. The agreements lacked a provision to ensure that all high touch surfaces were disinfected and failed to indicate a list of hospital-approved products for use by the services.</p> <p>3. During an interview on 3-07-12 at 1245 hours, staff A2 confirmed that the infection control committee failed to ensure that the contracted housekeeping products and services were safe and effective.</p>		<p>received by 4/6/2012 and documented. The agreement with the cleaning companies was revised by the admin director of Ancillary Services to include a provision to ensure that all high touch surfaces were disinfected and included a list of hospital-approved products by May 14. 2. How are you going to prevent the deficiency from reoccurring in the future? Bi-annually, the list of cleaning chemicals used by contracted cleaning services will be submitted to the hospital for review and approval. Monthly x 3 months, then quarterly the environmental services manager will review all orientation and competency documentation 3. Who is going to be responsible for #1 &amp; 2 above? Environmental Services Manager is responsible for correction and ongoing compliance 4. By what date are you going to have the deficiency corrected? May 14, 2012</p>		

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S0606	<p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(f)(3)(D)(viii)</p> <p>(f) The hospital shall establish an infection control committee to monitor and guide the infection control program in the facility as follows: (3) The infection control committee responsibilities shall include, but not be limited to, the following: (D) Reviewing and recommending changes in procedures, policies, and programs which are pertinent to infection control. These include, but are not limited to, the following:</p> <p>(viii) An employee health program to determine the communicable disease history of new personnel as required by state and federal agencies.</p> <p>Based on policy and procedure review, personnel file review and staff interview, the infection control practitioner and employee health services failed to implement policies and procedures related to TB (tuberculosis) testing for 2 staff members (P3 and P10); related to immunization status of Rubella, Rubeola and Varicella at the time of hire for 1 staff member (P3); and related to a non immune Rubella titer for one staff member (P2).</p> <p>Findings: 1. at 1:45 PM on 3/7/12, review of the policy and procedure "Pre-Employment Health Screening", policy # HS 120,</p>	S0606	<p>1. How are you going to correct the deficiency, include steps taken and date of correction? (If already corrected, include the steps taken and the date of correction)On 3/07/2012 all of the old TB test forms from the Nursing Administration Office were shredded and new forms were given to the office secretary and Nursing Administration Manager was educated personally by the CNO. An email sent out to all House Managers regarding using the correct forms that were revised 5/09 on 3/21/2012. Begining 3/8/12, a declination form will be completed, by employees who are undecided with regards to receiving a vaccination, no later</p>	04/06/2012			

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	<p>indicated:</p> <p>a. under "Procedure", it reads: "...3. Immunity/Immunization Status...B. Healthcare personnel will be offered vaccination in conjunction with CDC (centers for disease control and prevention) guidelines as indicated in the following table. Varicella, Measles, and Rubella immunity are indicated for new employees..."</p> <p>b. on the attached table, it reads: "...Measles live virus vaccine...Healthcare personnel born in or after 1957 without documentation of (1) receipt of two doses of live vaccine on or after their 1st birthday, (b) physician diagnosed measles or (c) laboratory evidence of immunity...Rubella live virus vaccine...Healthcare personnel both male &amp; female who lack documentation of receipt of live vaccine or after their 1st birthday or of laboratory evidence of immunity...Varicella...Healthcare personnel without reliable history of varicella or laboratory evidence of varicella immunity..."</p> <p>2. at 12:45 PM on 3/7/12, review of personnel health files indicated:</p> <p>a. staff member P3 had a TB test given on 5/10/11 and read on 5/13/11, but was lacking the time given and the time read to indicate that the reading occurred between 48 and 72 hours as per the form</p>		<p>than 30 days of notice. As of 3/19/12, the new form, 'acknowledgement of responsibility' with regards to vaccination/titer status of new employees, will be implemented to ensure the proper documentation of those employees whose immunization status is in question and/or those who are undecided on receiving vaccines (Rubella, Rubeola, and Varicella). This form documents that follow-up of vaccine/titer status will be the responsibility of the employee. In addition, as of 4/1/12, email reminders to managers, of those employees who have outstanding vaccination status, will be sent out no later than 30 days of hire. 2. How are you going to prevent the deficiency from reoccurring in the future?The Employee Health Nurse will check any results received from TB tests given outside of the Employee Health Office on a daily basis. If incorrect, or date/time is omitted, the Employee Health Nurse will contact the employee that same day and tell them the test needs to be re-done. The person who administered the TB test will be contacted by the Employee Health Nurse on that day for counseling on using correct form. This contact with employee and TB test administrator will be documented and kept in the employee file. For vaccinations if the employee is un-decided, a</p>				

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	<p>and per facility procedure</p> <p>b. staff member P10 had a TB test given on 1/6/12 and read on 1/9/12, but was lacking the time given and the time read to indicate that the reading occurred between 48 and 72 hours as per the form and per facility procedure</p> <p>3. interview with staff member NA at 1:00 PM on 3/7/12 indicated:</p> <p>a. the facility was cited at the last ISDH survey for lack of documentation for times given and times read for TB testing</p> <p>b. new forms were created 5/09 and all old TB forms were to have been destroyed</p> <p>c. two staff members were given TB tests, one 5/11 and one 1/12, and the wrong forms were used and the time given and the time read was not documented making it unknown if the TB tests were read within 48 and 72 hours, as per facility procedure</p> <p>4. at 12:45 PM on 3/7/12, review of personnel health files indicated:</p> <p>a. staff member P2 was hired 9/13/10 and had:</p> <p>A. a non immune (&lt;5) Rubella titer dated 9/2/10 in the personnel file (lab form indicates anything below 5 is non immune)</p> <p>B. a memo from employee health on</p>		<p>declination form will be filled out no later than 30 days after employee was notified. Notifications will be kept in the employee file. On 3/19/2012 a new form was added to the employee new hire process explaining the process and delineates the employees responsibility to return to health services for vaccinations/declination. The original, signed by employee and witnessed by Employee Health staff, will be kept in employee file and a copy given to employee. Emails will be sent to the managers regarding employee's failure to return to Employee Health no later than 30 days from hire date.3. Who is going to be responsible for #1 &amp; 2 above?The Employee Health Nurse is responsible for the plan of correction and for ongoing compliance for TB tests and vaccinations (or declinations). 4. By what date are you going to have the deficiency corrected? For TB-The old TB forms were shredded on 3/7/2012. Email notification sent on 3/21/2012. Daily check of TB test results received began on 3/8/2012.For vaccinations- The new form for employees stating acknowledgement of responsibility put into place on 3/19/2012. Monthly emails to manager will begin on 4/1/2012 for notification of outstanding vaccinations.</p>				

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	<p>12/30/10 indicating notice was given to the employee for the need of a MMR (measles, mumps, rubella) booster and to call the employee health nurse</p> <p>C. a notation on the form/memo was dated 1/2/11 when the staff member called to say they were "unsure [they] should take vaccine. Wants to consult [their] MD"</p> <p>D. no further indication of contact with employee P2 since the 1/2/11 phone conversation was noted in the file</p> <p>b. staff member P3 lacked any history of disease, documentation of immunization, or titer information for rubella, rubeola and varicella</p> <p>5. interview with staff member NP at 1:45 PM on 3/7/12 indicated:</p> <p>a. there has been no further follow up with staff member P2 since the 1/2/11 phone call</p> <p>b. staff member P2 is working as a known non immune rubella employee, which is not in compliance with facility/employee health expectations to receive a booster vaccine</p> <p>c. staff member P3:</p> <p>A. was hired 5/17/11</p> <p>B. was requested to bring history of immunization for rubella, rubeola and varicella to the employee health office, but has failed to do so</p>			

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	C. facility policy was not implemented for staff member P3 related to the requirements for immunization status at the time of hire				

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S0608	<p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(f)(3)(D)(ix)</p> <p>(f) The hospital shall establish an infection control committee to monitor and guide the infection control program in the facility as follows: (3) The infection control committee responsibilities shall include, but not be limited to, the following: (D) Reviewing and recommending changes in procedures, policies, and programs which are pertinent to infection control. These include, but are not limited to, the following:</p> <p>(ix) Requirements for personal hygiene and attire appropriate for work settings.</p> <p>Based on policy and procedure review, observation, and staff interview, the infection control practitioner failed to ensure appropriate surgical attire was maintained in the surgery area and the cath lab.</p> <p>Findings: 1. at 9:45 AM on 3/6/12, review of the policy and procedure "Surgical Attire", Policy # 4-220, indicated: a. under "II. Procedure:", it reads: "A...6. Masks should cover both mouth and nose and be secured in a manner that prevents venting. When removing masks, touch only the strings;..." b. under "II. Procedure:", it reads: "C.....All possible head and facial hair</p>	S0608	<p>1. How are you going to correct the deficiency, include steps taken and date of correction? (If already corrected, include the steps taken and the date of correction) Write and implement a dress code policy for cath lab (Policy was written 3/12/2012). Educate cath lab associates and physicians about policy. Reeducate OR Staff on their existing policy with updates emphasized. Will utilize doc tv for policy change and update for physicians. Roll out education to be completed by 4/5/2012</p> <p>2. How are you going to prevent the deficiency from reoccurring in the future? Managers and IC will do surveillance and report to IC committee and other committees as necessary. Annual competency for staff and</p>	03/08/2012

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	<p>including sideburns, beards, and neckline should be covered when in the semi-restricted and restricted area of the surgical suite. The surgical hat or hood should be clean and free of lint and should confine hair."</p> <p>c. under "II. Procedure:", it reads: "D...Jewelry: 1. All personnel entering the semi or restricted areas should confine or remove jewelry..."</p> <p>2. at 12:00 PM on 3/7/12, review of the policy and procedure "Interventional Radiology Preparation and Attire", policy # CL-145, indicated:</p> <p>a. under "II. Procedure:", it reads: "...C. Mask and surgical cap should be worn in the procedural area and during preparation"</p> <p>b. under "II. Procedure:", it reads: "...E. Jewelry should be kept at a minimum..."</p> <p>3. at 1:40 PM on 3/6/12, while on tour of the cath lab in the company of staff members NA and ND, it was observed that staff preparing a patient for a cath procedure in one of the suites had:</p> <p>a. at least one staff member with two or more earrings/ear not confined within the bouffant cap</p> <p>b. two staff members with single earrings not confined within the bouffant cap</p>		<p>education for physicians. 3. Who is going to be responsible for #1 &amp; 2 above? The Infection Control Preventionist will be responsible for the policy and education. 4. By what date are you going to have the deficiency corrected? The policy was written and approved on 3/21/2012 and education will be completed with OR, Cath lab and Physician staff on 4/5/2012</p>				

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	<p>c. one staff member with a bun at the back of the head not confined within the surgical cap</p> <p>4. interview with staff members NA and ND at 1:40 PM on 3/6/12 indicated this was a semi-restricted area, but it was thought that the attire was less restrictive than for surgery cases in the OR (operating room) areas</p> <p>5. at 2:15 PM on 3/6/12, while on tour of the surgery area in the company of staff members NA and NJ, it was observed that:</p> <p>a. one male staff member was present in the OR hallway with a surgical mask dangling about the neck--this staff member left the OR area and appeared to exit to the recovery area</p> <p>b. the male staff member returned and walked to the end of the surgical hallway toward an OR suite in which a case was underway (laparoscopic cholecystectomy) --the surgical mask was still dangling about the neck</p> <p>6. interview with staff members NA and NJ at 2:30 PM on 3/6/12 indicated:</p> <p>a. the staff member with a mask about the neck was identified as an anesthesiologist</p> <p>b. it was unknown why this staff member was in the surgical area as they</p>			

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	<p>were not scheduled to participate in any of the afternoon surgical cases</p> <p>c. surgical masks are to be changed after each case and not left dangling about the neck</p> <p>7. interview with the infection control practitioner, staff member NN, at 10:55 AM on 3/7/12, indicated:</p> <p>a. this staff member was unaware of a separate policy by Interventional Radiology with staff attire that differs from surgery requirements for semi restricted areas</p> <p>b. even in the cath lab area, earrings should be confined within the bouffant head covering</p> <p>c. even though the surgical attire policy does not state that surgical masks must be discarded after each case, and not to be worn dangling about the neck, that is the facility expectation</p>			

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S0718	<p>410 IAC 15-1.5-4 MEDICAL RECORD SERVICES 410 IAC 15-1.5-4 (c)(3)</p> <p>(c) An adequate medical record shall be maintained with documentation of service rendered for each individual who is evaluated or treated as follows:</p> <p>(3) The hospital shall use a system of author identification and record maintenance that ensures the integrity of the authentication and protects the security of all record entries. Each entry shall be authenticated promptly in accordance with the hospital and medical staff policies.</p> <p>Based upon document review, the facility policy/procedure failed to ensure that medical record (MR) entries were dated and timed when authenticated and failed to indicate that electronic authentication was an approved method for authenticating MR entries.</p> <p>Findings:</p> <p>1. The policy/procedure Authentication of Entries into the Medical Record (approved 9-11) indicated the following: " To establish a method in which to identify and authenticate authors of entries into the medical record. " The policy/procedure failed to indicate a requirement to date and time the entry when authenticated and failed to indicate</p>	S0718	<p>1. How are you going to correct the deficiency, include steps taken and date of correction? (If already corrected, include the steps taken and the date of correction)</p> <p>HIM Policy HIM 115 was revised on 3/22/2012 to reflect that all entries are to be dated, timed and authenticated and states that an electronic signature is acceptable.</p> <p>2. How are you going to prevent the deficiency from reoccurring in the future?</p> <p>Policy has been revised on</p>	03/22/2012			

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	that electronic authentication was an approved method. 2. On 3-06-12 at 0845 hours, staff A1 confirmed that the policy/procedure lacked the indicated provisions.		3/22/2012 and will be reviewed annually.  3. Who is going to be responsible for #1 & 2 above? The HIM Director is responsible for the plan of correction  4. By what date are you going to have the deficiency corrected? POLICY HIM 115 revised on 3/22/2012.		

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S0746	<p>410 IAC 15-1.5-4 MEDICAL RECORD SERVICES 410 IAC 15-1.5-4 (e)(2)</p> <p>(e) All entries in the medical record shall be:</p> <p>(2) made only by individuals given this right as specified in hospital and medical staff policies; and</p> <p>Based on document review and interview, the facility policy/procedure failed to ensure that only authorized individuals, staff members and medical professionals were permitted to make entries in the medical record (MR).</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>Personnel documentation indicated that certified surgical techs, physical therapists, occupational therapists, speech therapists, physical therapy assistants, occupational therapy assistants, pathology aides, dental assistants, podiatry assistants, and nursing students might provide services at the facility.</li> <li>The policy/procedure Authentication of Entries into the Medical Record (approved 9-11) failed to indicate that the listed personnel were authorized to make MR entries.</li> <li>During an interview on 3-06-12 at 0845 hours, staff A1 confirmed that the</li> </ol>	S0746	<ol style="list-style-type: none"> <li>How are you going to correct the deficiency, include steps taken and date of correction? (If already corrected, include the steps taken and the date of correction) HIM Policy HIM 115 was revised on 3/22/2012 to reflect all personnel that are authorized to make entries in the medical record including certified surgical techs, physical therapists, occupational therapists, speech therapists, physical and occupational therapy assistants, pathology aides, dental and podiatry assistants and nursing students. 2. How are you going to prevent the deficiency from reoccurring in the future? Policy has been revised on 3/22/2012 and will be reviewed annually. 3. Who is going to be responsible for #1 &amp; 2 above? The HIM Director is responsible for the plan of correction 4. By what date are you going to have the deficiency corrected? POLICY HIM 115 revised on 3/22/2012.</li> </ol>	03/22/2012			

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	policy/procedure lacked the indicated health care providers.			

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S0868	<p>410 IAC 15-1.5-5 MEDICAL STAFF 410 IAC 15-1.5-5(b)(3)(M)(i)(ii)(iii)</p> <p>(b) The medical staff shall adopt and enforce bylaws and rules to carry out its responsibilities. These bylaws and rules shall: (3) include, but not be limited to, the following:</p> <p>(M) A requirement that a complete physical examination and medical history be performed: (i) on each patient admitted by a practitioner who has been granted such privileges by the medical staff; (ii) within seven (7) days prior to date of admissions and documented in the record with a durable, legible copy of the report and changes noted in the record on admission; or (iii) within forty-eight (48) hours after an admission.</p> <p>Based on medical staff rules and regulations, policy and procedure review, patient medical record review, and staff interview, the medical staff failed to implement its rules and regulations related to OB (obstetric) history and physicals for 1 of 1 OB record reviewed (pt. N10).</p> <p>Findings: 1. at 11:30 AM on 3/6/12, review of the medical staff rules and regulations, last amended December 5, 2011, indicated: a. in section "2.2 Admission History", it</p>	S0868	<p>1. How are you going to correct the deficiency, include steps taken and date of correction? (If already corrected, include the steps taken and the date of correction) Education will be done with the Fort Wayne Medical Education Residency Program and credentialed OB physicians as it relates to the requirements for updating H&amp;P's within 24 hours of admission by March 31, 2012</p> <p>2. How are you going to prevent the deficiency from reoccurring in the future? 100% audit of H&amp;P's for timeliness</p>	04/01/2012

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	<p>reads: "Each patient admitted for inpatient care shall have complete admission history and physical examination recorded by a qualified physician...A history and physical performed within thirty (30) days prior to hospital admission may be used, as long as the medical record contains durable, legible practitioner documentation indicating the H &amp; P was reviewed, and noting any changes in the patient's condition not consistent or other wise reflected in the H &amp; P"</p> <p>b. in section "2.7 Obstetrical Patient Histories", it reads: "The history for obstetrical patients, when adequately updated with progress notes setting forth the current history and changes in physical findings, shall be accepted as a valid and actual history and physical..."</p> <p>2. at 1:55 PM on 3/7/12, review of the policy and procedure "Chart Completion Requirements for Inpatients", policy # HIM 121, indicated:</p> <p>a. under "Requirements", it reads: "History and Physical A complete history and physical examination shall be recorded no more than thirty days prior to or within twenty-four hours of admission. If recorded prior to admission, it must be updated on the date of admission or within 24 hours of admission by indicating no changes or listing the</p>		<p>weekly for 3 months April, May, and June 2012</p> <p>Random chart audits for continued compliance monthly July, August, and September 2012</p> <p>If a deficiency is found, immediate physician notification will occur</p> <p>3. Who is going to be responsible for #1 &amp; 2 above? The Admin Director for OB Services is responsible for the plan correction and continued compliance</p> <p>4. By what date are you going to have the deficiency corrected? Education will be completed with all physicians who do H&amp;P updated on OB patients by 4/1/2012</p>				

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	<p>changes..."</p> <p>3. at 11:55 AM on 3/6/12, while touring the OB area and reviewing the medical record for pt. N10, it was noted that:</p> <p>a. the H &amp; P was dated 3/2/12, but the patient's admission date was 3/4/12</p> <p>b. there was no progress note made at the time of admission, or within 24 hours of admission, that indicated what, if any, changes had occurred since the 3/2/12 history and physical was written</p> <p>4. interview with staff member NI at 11:55 AM on 3/6/12 indicated no update to the H &amp; P for pt. N10 since the 3/2/12 history and physical could be found</p>				

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S0952	<p>410 IAC 15-1.5-6 NURSING SERVICE 410 IAC 15-1.5-6(d)</p> <p>(d) Blood transfusions and intravenous medications shall be administered in accordance with state law and approved medical staff policies and procedures. If the blood transfusions and intravenous medications are administered by personnel other than physicians, the personnel shall have special training for these procedures in accordance with subsection (b)(6).</p> <p>Based on review of "Blood Transfusion" policy, patient records, and staff interview, the blood transfusions failed to be administered in accordance with approved medical staff policies and procedures for 2 of 2 transfusion reactions and 1 of 10 routine blood transfusion records reviewed.</p> <p>Findings included:</p> <p>1. On 3-5-12 between 2:20 PM and 4:00 PM, review of "Blood Transfusion" policy, policy number "NUR 280", last revised on "08/11" read:</p> <p>a. "All blood products distributed...require a specific physician order..."</p> <p>b. "...Two licensed nurses...should check the original order for administration of blood..."</p> <p>c. "...One registered nurse and a</p>	S0952	<p>1. How are you going to correct the deficiency, include steps taken and date of correction? (If already corrected, include the steps taken and the date of correction)</p> <p>Re-education of Nursing related to Blood Transfusion and transfusion reaction management will occur by 3/31/12</p> <p>2. How are you going to prevent the deficiency from reoccurring in the future?</p> <p>100% audit of all blood products given for 7 days 20 audits a week for the following 3 weeks will follow . 20 random audits per month for 4 months. 100% audit of transfusion reactions when and if they occur Any deficiency will be addressed with staff member involved and appropriate corrective action will be taken. Audit results will be submitted to Quality Council, to determine if &gt; 5 months is needed.</p>	04/06/2012	

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	<p>second licensed nurse verify the physician order for blood or blood product and verify the patient's name, blood bank armband number, and hospital number against the patient's identification bands at the bedside. They then sign product chart copy as a confirmation that the verifications were completed..."</p> <p>d. "...Blood products must be identified at the bedside, against the blood requisition, and the patient armband and blood bank band, by one registered nurse and a second licensed nurse..."</p> <p>e. "...The transfusion record must be completely filled out..."</p> <p>f. "Document start and stop times. Be sure the start and stop times are listed on the Product Chart Copy."</p> <p>g. "Discontinue the transfusion immediately and notify the Blood Bank and the physician if there are signs of a transfusion reaction."</p> <p>h. "...Transfusion Reactions...Procedure...Discontinue transfusion immediately...Notify physician immediately...Notify lab of suspected blood reaction and complete information on blood requisition..."</p> <p>2. Review of patient records on 3-6-12 between 1:30 PM and 4:00 PM revealed the following:</p> <p>a. Patient #L1 had a blood transfusion on "5-30-11". The transfusion was</p>		<p>3. Who is going to be responsible for #1 &amp; 2 above? CNO</p> <p>4. By what date are you going to have the deficiency corrected? 3/31/12</p>	

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	<p>initiated at "1945" and discontinued at "2046". The record did not indicate two nurses verified the patient's name, hospital number, and the patient and blood bank armbands against the blood requisition, as required by approved policies and procedures.</p> <p>b. Patient #L2 had a blood transfusion on "5-7-11". The transfusion was initiated at "1615" and the patient had a subsequent reaction to the blood transfusion. The time the blood was discontinued and the time the physician and laboratory were notified of the suspected transfusion reaction were not documented on the transfusion record, as required by approved policies and procedures.</p> <p>c. Patient #L7 had a blood transfusion on "1-20-12". The transfusion was initiated at "1316" and discontinued at "1506". The physician's order on the patient's medical record read "T&amp;C for 2 units RBC" and did not indicate to give the blood to the patient, as required by approved policies and procedures.</p> <p>3. In interview on 3-6-12 between 1:30 PM and 4:00 PM, Staff Member #L9 and #L10 acknowledged the above findings.</p>			

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S1118	<p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8 (b)(2)</p> <p>(b) The condition of the physical plant and the overall hospital environment shall be developed and maintained in such a manner that the safety and well-being of patients are assured as follows:</p> <p>(2) No condition shall be created or maintained which may result in a hazard to patients, public, or employees.</p> <p>Based on observation, document review and interview, the facility failed to ensure that no condition would be created that might result in ill effects to patients and employees related to pantry refrigerators, cabinets, and microwaves, staff food in a patient refrigerator, and a floor mat that was deteriorating and filled with dirt/dust in a patient care area and failed to safely store and maintain 5 compressed gas cylinders which resulted in a hazard to patients and employees.</p> <p>Findings:</p> <p>1. on 3/5/12 at 2:05 PM, while on tour of the ED (emergency department), in the company of staff members NA and ND, it was observed that:</p> <p>a. a staff member's plastic container from home, containing milk, was found in the patients' drink refrigerator located in</p>	S1118	<p><u>Section 1,2- ED Patient Refrigerator</u> 1. How are you going to correct the deficiency, include steps taken and date of correction? Staff food removed from ED patient refrigerator immediately 2. How are you going to prevent the deficiency from reoccurring in the future? Education to staff provided 3/7/12. Sign placed on refrigerator 3/9/2012 "patient refrigerator only, no staff food". Will audit each week for 3 months. Will report findings to Quality Council, to determine if monitoring &gt; 3 months necessary. 3. Who is going to be responsible for #1 &amp; 2 above? ER Director 4. By what date are you going to have the deficiency corrected? Was corrected 3/5/2012 <u>Section 3, 10 -Telemetry dirty refrigerator</u> 1. How are you going to correct the deficiency, include steps taken and date of correction? Refrigerator cleaned</p>	04/06/2012

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	<p>the nursing station</p> <p>b. a container of yogurt was in the patient refrigerator without a patient label or date, making it unknown if this was a staff member's or a patient's food item</p> <p>2. interview with staff member ND at 2:05 PM on 3/5/12, indicated staff food was not to be in the patient drink refrigerator--it was unknown where the yogurt came from</p> <p>3. at 2:55 PM on 3/5/12, while on tour of the 4th floor Telemetry nursing unit, in the company of staff members NA and NG, it was observed that the pantry refrigerator had dirty, food stained shelves and was dirty with dried food and pieces of styrofoam cups, under the two lower vegetable drawers</p> <p>4. interview with staff members NA and NG at 2:55 PM on 3/5/12 indicated it was unknown what the schedule for cleaning the refrigerator is, and who is responsible to do the cleaning</p> <p>5. on 3/6/12 at 10:40 AM, while on tour of the 5 East medical/surgical nursing unit in the company of staff members NA and NL, it was observed that:</p> <p>a. the upper wall cabinets were dirty around the tracks that the doors slide open and closed in</p>		<p>by unit aid on 3/5/2012. 2. How are you going to prevent the deficiency from reoccurring in the future? 3/14/2012 Chief Nursing Officer, directors of ED, Med Surg, Psych, OB, Critical Care and Food and Nutrition meet. Food and Nutrition policy revised by 3/28/2012 to specify that F &amp; N is responsible to cleaning patient refrigerators. Policy will be taken for approval to next infection control committee on 4/20/2012. Based on the calendar, every patient refrigerator will be thoroughly cleaned every 2 weeks by the catering assistants. Auditing will be completed by the nurse manager of the unit every week for 3 months. Will report findings to Quality Council, to determine if monitoring &gt; 3 months necessary. 3. Who is going to be responsible for #1 &amp; 2 above? Food and Nutrition Director 4. By what date are you going to have the deficiency corrected? Was corrected 3/5/2012 <u>Section 5, 6, 10 -5 East Cabinets dirty, microwave dirty</u> 1. How are you going to correct the deficiency, include steps taken and date of correction? Cabinets and microwave cleaned by unit aid on 3/5/2012. 2. How are you going to prevent the deficiency from reoccurring in the future? Reeducation to unit manager on 3/5/2012. Policy created on 3/23/2012 that states thorough microwave and panty cleaning to be completed weekly by nursing.</p>		

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	<p>b. the lower wall cabinets were dirty and had spots of dried liquid/substance on the edge of the bottom shelf</p> <p>c. the microwave oven was extremely dirty</p> <p>6. interview with staff members NA and NL at 10:45 AM on 3/6/12 indicated:</p> <p>a. it was thought that nursing staff were responsible for cleanliness of the pantry area</p> <p>b. the cabinets are an old, metal style and have some rust along the track for the sliding doors and hard to keep clean, but they are dirty besides being rusty</p> <p>7. at 1:45 PM on 3/6/12, while on tour of the cath lab in the company of staff members NA and ND, it was observed that the floor mat, in the viewing area/nursing station just outside one cath procedure room, was crumbling and dirty with clumps of dust and dirt in the holes of the mat and beneath the mat</p> <p>8. interview with staff members NA and ND at 1:50 PM on 3/6/12 indicated:</p> <p>a. it was unknown why there is a mat in this location</p> <p>b. it does not appear that the floor mat, or the area beneath the floor mat, has been cleaned for a long time</p> <p>9. interview with staff member NA at</p>		<p>Policy will be taken for approval to next infection control committee on 4/20/2012. Spills to be cleaned up prn. Education to all nursing units on 3/26/2012. Documentation of cleaning will be done. Auditing will be completed by the nurse manager of the unit every week for 3 months. Will report findings to Quality Council, to determine if monitoring &gt; 3 months necessary. 3. Who is going to be responsible for #1 &amp; 2 above? Nurse Manager 4. By what date are you going to have the deficiency corrected? Was corrected 3/5/2012 <u>Section 6b -5 East Cabinets rusty</u> 1. How are you going to correct the deficiency, include steps taken and date of correction? Cabinets cleaned, sanded, primed and painted on 3/22/2012 2. How are you going to prevent the deficiency from reoccurring in the future? The cabinet condition will be monitored during semi-annual Environment of Care audits. 3. Who is going to be responsible for #1 &amp; 2 above? Facilities Manager 4. By what date are you going to have the deficiency corrected? Was corrected 3/22/2012 <u>Section s 7, 8a, &amp; 8b – Cath Lab</u> 1. How are you going to correct the deficiency, include steps taken and date of correction? Corrections were made to fix the deficiency by removing the mat, cleaning and mopping the disinfecting the floor where it was previously located</p>		

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	<p>9:30 AM on 3/7/12 indicated:</p> <p>a. there is confusion as to who is responsible for cleaning pantry refrigerators, cabinets, and microwaves</p> <p>b. it was unclear whether dietary staff or nursing staff were responsible for the cleaning of the pantry and it's appliances</p> <p>c. a review of the patient food services policy #C034, provided by the contracted dietary company, addresses only the temperature checking and maintenance of said temperature in regards to pantry refrigerators</p> <p>d. further review of the patient food services policy #C034 indicated that "Procedures for cleaning and care of pantry area have been developed by Nursing/Food &amp; Nutrition/Housekeeping and are on file with the Infection Control Committee and include: Cleaning of refrigerator/pantry; Defrosting freezer;...", but no policies related to these topics could be found</p> <p>10. no policies related to cleaning and maintenance of the food pantry areas and patient food refrigerators and microwaves could be found/provided prior to exit of the facility</p> <p>11. The policy/procedure Handling and Use of Compressed Gas Cylinders (reviewed 1-11) indicated the following: " Free standing cylinders shall be properly chained or supported in a proper</p>		<p>on March 7, 2012. 2. How are you going to prevent the deficiency from reoccurring in the future? To prevent this occurrence from happening Environmental Services manager will do weekly audits of this area for cleanliness of the mats for 3 months. Will report findings to Quality Council, to determine if monitoring &gt; 3 months necessary.</p> <p>3. Who is going to be responsible for #1 &amp; 2 above? Environmental Services manager</p> <p>4. By what date are you going to have the deficiency corrected? Was corrected 3/7/2012 <u>Section s 11-14 - Cylinders</u></p> <p>1. How are you going to correct the deficiency, include steps taken and date of correction? All four cylinders were removed from the premises by the company that owned the cylinders. 2. How are you going to prevent the deficiency from reoccurring in the future? Audit the boiler room weekly, for the next three months to verify no gas cylinders are left unattended n an unsafe manner. Will report findings to Quality Council, to determine if monitoring &gt; 3 months necessary.</p> <p>3. Who is going to be responsible for #1 &amp; 2 above? Facilities Manager</p> <p>4. By what date are you going to have the deficiency corrected? Was corrected 3/6/2012 <u>Section s 13-15 - Extinguishers</u></p> <p>1. How are you going to correct the deficiency, include steps taken</p>				

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	<p>cylinder stand or cart. They shall not be chained ...or supported by radiators, steam pipes and heat ducts. "</p> <p>12. During a tour on 3-06-12 at 1040 hours, the following hazardous condition was observed in the boiler maintenance room: 2 unsecured acetylene gas cylinders standing upright behind the entry door to the office space.</p> <p>13. During a tour on 3-06-12 at 1050 hours, the following hazardous condition was observed in the chiller room: 1 unsecured carbon dioxide fire extinguisher cylinder standing upright on the floor.</p> <p>14. During a tour on 3-06-12 at 1100 hours, the following hazardous condition was observed in the boiler room: 2 unlabeled gas cylinders standing upright and tied to a 1 " diameter vertical pipe with a piece of 18 gauge electrical wire and a piece of 1/16 " soft steel wire.</p> <p>15. During a tour on 3-06-12 at 1125 hours, the following hazardous condition was observed in the plan room: an unsecured fire extinguisher lying horizontally on a shelf inside a 6 ' tall metal storage cabinet.</p> <p>16. During an interview on 3-06-12 at 1125 hours, staff A5 confirmed that the cylinders were improperly stored and confirmed that the hazardous condition was observed on the previous licensure survey.</p>		<p>and date of correction? The carbon dioxide fire extinguisher was removed from the boiler room. Also the extinguisher in the plan room was removed. 2. How are you going to prevent the deficiency from reoccurring in the future? Audit the boiler and plan room weekly, for the next three months to verify no fire extinguishers are left in an unsafe manner. 3. Who is going to be responsible for #1 &amp; 2 above? Facilities Manager 4. By what date are you going to have the deficiency corrected? The extinguishers was removed the day of inspection 3/6/12.</p>		

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S1124	<p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8 (b)(5)(A)</p> <p>(b) The condition of the physical plant and the overall hospital environment shall be developed and maintained in such a manner that the safety and well-being of patients are assured as follows:</p> <p>(5) Provision shall be made for the periodic inspection, preventive maintenance, and repair of the physical plant and equipment by qualified personnel as follows:</p> <p>(A) Operation, maintenance, and spare parts manuals shall be available, along with training or instruction of the appropriate personnel, in the maintenance and operation of the fixed and movable equipment.</p> <p>Based on policy and procedure review, manufacturer's manual review, observation, and interview, the facility failed to implement manufacturer's recommendations for two blanket warmers.</p> <p>Findings: 1. at 12:00 PM on 3/7/12, review of the policy and procedure "Blanket Warmer Temperatures", (EC.02.01.01.12) indicated: a. under "Policy", it reads: "...The upper limit for temperature settings on</p>	S1124	<p>1. How are you going to correct the deficiency, include steps taken and date of correction? (If already corrected, include the steps taken and the date of correction) Blanket warmers were added to the PM schedule for PM or lint filter cleaning on a quarterly bases on 03/21/2012. By 3/31/2012 PM and lint filter cleaning will be completed on all blanket warmers. The blanket warmer policy was revised on 3/28/2012 to specify temperatures based on ERCI institute, July 2009 standards and manufacturers recommendations. Education to</p>	04/06/2012

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	<p>blanket warming cabinets is limited to 130 degrees F..."</p> <p>2. at 11:55 AM on 3/7/12, review of the Blickman warming cabinet "Operation and Maintenance General Instructions" indicated:</p> <p>a. under "Operating Instructions", it reads: "1...The thermostat is preset on number 2 to provide a temperature of approximately 120 degrees F and automatically cycles the temperature..."</p> <p>b. under "Maintenance and Component Replacement Procedures", it reads: "...2. Periodically, lint or threads may accumulate in the heater compartment. Removing the false bottom permits access to this area and vacuuming or cleaning can help keep the unit operating more efficiently."</p> <p>3. at 11:55 AM on 3/7/12, review of the Olympic Warmette "Instruction Manual", indicated:</p> <p>a. in the "Service--Section 3", it reads under "Quarterly Maintenance Cleaning Lint Filter": "The model 48 Warmette has a lint filter located on the inside left wall of the cabinet...The filter should be cleaned at least once every three months..."</p> <p>4. at 2:35 PM on 3/6/12, it was observed in the post op recovery area that a</p>		<p>nursing staff will be disseminated on 4/1/2012. 2. How are you going to prevent the deficiency from reoccurring in the future? Audit blanket warmer temperature log daily for 7 days, then weekly for 3 months, and monthly for 2 months. Results to Quality Council, to determine if ongoing monitoring needed. 3. Who is going to be responsible for #1 &amp; 2 above? Unit Manager with blanket warmers and Facility Manager 4. By what date are you going to have the deficiency corrected? 4/6/2012</p>				

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	<p>Blickman blanket warmer was in use</p> <p>5. at 2:45 PM on 3/6/12, it was observed in the OB C-Section area (in a storage room) that the Olympic Warmette was dusty with blanket lint along the edges of the lower shelf of the cabinet</p> <p>6. at 10:55 AM on 3/7/12, interview with staff members NA and NN, indicated:</p> <ul style="list-style-type: none"> <li>a. one of the blanket warmer manufacturers recommends 120 degree heat for warming blankets, but the facility policy indicates 130 degrees is OK, creating confusion and lack of following the manufacturer's recommendations</li> <li>b. it was unknown that quarterly cleaning of a lint filter was recommended for one of the blanket warmers</li> <li>c. the blanket warmer policy as listed in 1. above, does not address preventive maintenance, or quarterly lint filter cleaning, of the blanket warmers</li> </ul>						

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S1160	<p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8(d)(1)</p> <p>(d) The equipment requirements are as follows:</p> <p>(1) All equipment shall be in good working order and regularly serviced and maintained.</p> <p>Based on observation and interview, the facility failed to maintain its negative airflow isolation room located in the emergency department (ED) in good working order.</p> <p>Findings:</p> <p>1. During a tour of the ED on 3-06-12 at 1105 hours, in the presence of staff A3 and A5, the following condition was observed: The airflow indicators for airborne isolation room 2 failed to indicate proper system operation (green light and negative air pressure reading [-0.01]) when the door was closed.</p> <p>2. During a follow-up observation on 3-07-12 at 1015 hours, in the presence of A2 and A3, it was observed that the visual indicators for the ED airborne isolation room 2 failed to indicate proper</p>	S1160	<p>1. How are you going to correct the deficiency, include steps taken and date of correction? This isolation room is monitored seven (7) days a week for negative pressure. On Sunday, 3/4/12 the room was checked and a work order (276765) was generated. The work order was to repair the Phoenix digital monitor, it was reading in alarm. The room was working in a negative airflow when the door was closed. On Monday 3/5/12, Artec environmental monitoring was here and certified the room was in negative pressure.</p> <p>2. How are you going to prevent the deficiency from reoccurring in the future? We will follow our present policy of monitoring the room daily.</p> <p>3. Who is going to be responsible for #1 &amp; 2 above? Facilities Manager</p> <p>4. By what date are you going to have the deficiency corrected? On Wednesday, 3/21/12 Quality Air Service, Inc. an authorized service representative for Phoenix controls was here and made repairs to the monitor</p>	03/21/2012

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	<p>system operation.</p> <p>3. During an interview on 3-07-12 at 1020 hours, staff A5 confirmed that the condition had not been corrected.</p>			

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S1162	<p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8(d)(2)(A)</p> <p>(d) The equipment requirements are as follows: (2) There shall be sufficient equipment and space to assure the safe, effective, and timely provision of the available services to patients, as follows:</p> <p>(A) All mechanical equipment (pneumatic, electric, or other) shall be on a documented maintenance schedule of appropriate frequency and with the manufacturer's recommended maintenance schedule.</p> <p>Based on document review, observation, and interview, the facility failed to ensure that all emergency equipment was included on a maintenance schedule and failed to ensure that periodic preventive maintenance (PM) was performed for 1 emergency aspirator (Gomco Suction model 790).</p> <p>Findings:</p> <p>1. The policy/procedure Medical Equipment Inclusion Policy (reviewed 1-11) indicated the following: " The Medical Equipment Maintenance (MEM) inventory will include all equipment covered by Biomedical Engineering. "</p>	S1162	<p>1. How are you going to correct the deficiency, include steps taken and date of correction? (If already corrected, include the steps taken and the date of correction) All the Gomco Emergency Aspirators have been identified and put on a PM schedule. This was completed on 21 March 2012.</p> <p>2. How are you going to prevent the deficiency from reoccurring in the future? The Aspirators have been added to the automated PM generator for annual PMs.</p> <p>3. Who is going to be responsible for #1 &amp; 2 above? The Biomed Lead Tech, will be responsible for the plan of correction and ongoing compliance</p>	03/31/2012			

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	<p>2. During a tour on 3-06-12 at 1305 hours, accompanied by A2 and A5, the following condition was observed: One electrically powered Gomco Suction model 790 (Allied Healthcare Products) serial 4128A with no indication of PM since 2005. The equipment lacked the MEM preventive maintenance label. Staff A2 was requested to provide documentation of recent PM and none was provided prior to exit.</p> <p>3. During a telephone interview on 3-8-12 at 1400 hours, the Allied Healthcare Products technical support staff indicated the Gomco model 790 serial 4128A was obsolete and no longer supported.</p> <p>4. During an interview on 3-07-12 at 1245 hours, staff A2 confirmed that the suction equipment was not included in the MEM inventory and no recent PM was available.</p>		<p>4. By what date are you going to have the deficiency corrected? The PM's and electrical safety checks completed and documented on all aspirators by 31 March 2012.</p>	

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S1164	<p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8(d)(2)(B)</p> <p>(d) The equipment requirements are as follows: (2) There shall be sufficient equipment and space to assure the safe, effective, and timely provision of the available services to patients, as follows:</p> <p>(B) There shall be evidence of preventive maintenance on all equipment.</p> <p>Based on observation and interview, the facility failed to perform equipment maintenance ensuring a safe working environment for employees in one department.</p> <p>Findings:</p> <p>1. On 3-05-12 at 1130 hours, staff A1 was requested to provide documentation of preventive maintenance (PM) for a facility floor scrubber and none was provided prior to exit.</p> <p>2. During a tour of the environmental services department on 3-06-12 at 1106 hours, in the presence of A3 and A5, [3] Charger model 1500 floor buffers were observed without evidence of recent</p>	S1164	<p>1. How are you going to correct the deficiency, include steps taken and date of correction? On 3/22/2012 all environmental services equipment was put into a PM program checking cords, electrical wiring, ground current leakage and overall performance issues of the equipment. 2. How are you going to prevent the deficiency from reoccurring in the future? Prevention of this violation will occur by having each piece of equipment inspected for deficiencies quarterly. 3. Who is going to be responsible for #1 &amp; 2 above? Facilities Manager 4. By what date are you going to have the deficiency corrected? All equipment will be checked by April 3, 2012</p>	04/06/2012

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	<p>inspection or PM.</p> <p>3. During an interview on 3-07-12 at 1100 hours, staff A5 confirmed that the 170 rpm floor scrubbers were not receiving preventive maintenance including periodic ground current leakage testing to ensure safe operation by hospital personnel.</p>			

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S1166	<p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8(d)(2)(C)</p> <p>(d) The equipment requirements are as follows: (2) There shall be sufficient equipment and space to assure the safe, effective, and timely provision of the available services to patients, as follows:</p> <p>(C) Appropriate records shall be kept pertaining to equipment maintenance, repairs, and current leakage checks.</p> <p>Based on document review and interview, the facility failed to maintain appropriate documentation of preventive maintenance (PM), repairs, and ground current leakage testing on all equipment for 34 of 39 items reviewed at the hospital.</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>The policy/procedure Electrical Safety Inspection (no review date) lacked a provision to validate performance of ground current leakage testing and failed to ensure that the observed values did not represent a hazard to patients or personnel.</li> <li>PM documentation provided for</li> </ol>	S1166	<ol style="list-style-type: none"> <li>How are you going to correct the deficiency, include steps taken and date of correction? (If already corrected, include the steps taken and the date of correction)The Electrical Safety Policy was revised on 3/21/2012 to include documentation of electrical safety check data.</li> <li>How are you going to prevent the deficiency from reoccurring in the future?The Electrical Safety Procedure, 010-0105, has been modified to have values documented when electrical safety checks are completed and recorded on the PM report. A weekly audit will be completed weekly for 3 months to ensure values are documented whenever an electrical safety check is conducted. Audit results to Quality Council who will determine if &gt; 3 months audits needed.</li> <li>Who is going to be responsible for #1 &amp; 2 above?The</li> </ol>	03/21/2012

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	<p>review (audiometer, C-arm, CT scanners, defibrillators, clothes dryers, EKG machine, Gamma camera, hydrocollator, OR lights, renal dialysis, sterilizers, and washing machines) failed to validate performance of ground current leakage testing for equipment serviced by hospital personnel. Documentation validating performance of current leakage checks for hospital equipment was observed on 5 equipment records provided by 3 manufacturers support services.</p> <p>3. During an interview on 3-07-12 at 1210 hours, staff A4 confirmed that the policy/procedure lacked a provision for documenting the current leakage testing performed on equipment and confirmed that the PM documentation failed to validate testing and ensure that the equipment was safe for use.</p>		<p>Biomed Lead Tech, will be responsible for the plan of correction and ongoing compliance. By what date are you going to have the deficiency corrected? The policy was updated on 3/21/2012 and all Electrical Safety checks will be documented using a value instead of a pass/fail as of 3/21/2012</p>	

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S1168	<p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 150-1.5-8 (d)(3)</p> <p>(d) The equipment requirements are as follows:</p> <p>(3) Defibrillators shall be discharged at least in accordance with manufacturers recommendations and a discharge log with initialed entries shall be maintained.</p> <p>Based on document review, observation and interview, the facility failed to ensure that defibrillator inspection and testing was performed as recommended by the manufacturer.</p> <p>Findings:</p> <p>1. The policy/procedure Cardiac / Respiratory Arrests (Code Blue) &amp; Code Blue Cart Maintenance (approved 8-11) indicated the following: "Once each shift...a designated person ...will check the Code Blue cart and defibrillator." The policy/procedure lacked a provision to perform the checks and defibrillator discharge according to the manufacturers recommendations.</p> <p>2. During a tour of the facility on 3-06-12 at 1210 hours , in the company of A2 and</p>	S1168	<p>1. How are you going to correct the deficiency, include steps taken and date of correction? (If already corrected, include the steps taken and the date of correction) Corrected on 3/6/2012. The wrong form was in use on a floor that needed the AED check and not the defib discharge. It was immediately exchanged for the correct form and the staff was re-educated as to which form to use. All other areas were audited and were found to be using the appropriate form. 2. How are you going to prevent the deficiency from reoccurring in the future? Audit for correct form usage at the first of each month for 3 months. *If error found, appropriate corrective action will be taken. Audit results will be taken to quality council. This committee will determine if &gt; 3 months audited required. 3. Who is going to be responsible for #1 &amp; 2 above? Unit Managers 4. By what date are you going to have the deficiency corrected?</p>	03/07/2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  150047	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  03/07/2012
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	<p>A7, a Hewlett Packard (HP) Codemaster XL defibrillator was observed on the Code Cart located in the nuclear medicine area. The Defibrillator/Crash Cart Checklist failed to ensure that the defibrillator was checked according to the manufacturers recommendations and a copy of the operators manual indicating how to perform the shift checks was not available.</p> <p>3. During an interview on 3-06-12 at 1410 hours, staff A2 and A3 reviewed the operators manual regarding Shift Checks and Daily Checks for the HP CodeMaster XL defibrillator. Staff A2 and A3 confirmed that the facility failed to ensure that the staff were performing defibrillator checks according to the manufacturers recommendations. Staff A2 and A3 confirmed that the policy/procedure Cardiac / Respiratory Arrests (Code Blue) and the Defibrillator/Crash Cart Checklist lacked a provision for performing the defibrillator checks per the manufacturers recommendations.</p>		Corrected 03/06/2012		

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S1804	<p>410 IAC 15-1.6-5 PSYCHIATRIC SERVICES 410 IAC 15-1.6-5(a)</p> <p>(a) If the hospital provides psychiatric services, the service shall meet the needs of the patients served, within the scope of the service offered, in accordance with acceptable standards of practice.</p> <p>Based on personnel file review and staff interview, the facility failed to ensure special crisis intervention training had occurred for one patient care assistant/behavioral health technician (staff member P3).</p> <p>Findings:</p> <p>1. at 12:45 PM on 3/7/12, review of the personnel file for staff member P3, a patient care assistant on the behavioral health unit hired 5/17/11, indicated the staff member was lacking CPI training (crisis prevention intervention) documentation</p> <p>2. interview with staff members NA and NO at 1:00 PM indicated:</p> <p>a. P3 was required to have CPI training within 60 days of hire for the position and job requirements performed</p> <p>b. the job description for P3 indicates CPI within 60 days is required for emergency department staff, and should also be noted as required for staff working in the behavioral units, as P3 does</p>	S1804	<p>1. How are you going to correct the deficiency, include steps taken and date of correction? (If already corrected, include the steps taken and the date of correction) A list of CPI recertification dates for all Behavioral Health staff (Generations, Adult Behavioral, and IOP) has been compiled and sent to Human Resources (HR) as of 3/23/2012. HR will monitor expirations and staff will not be allowed to work with expired CPI effective 3/23/2012 2. How are you going to prevent the deficiency from reoccurring in the future? HR will send out monthly list (just like they do for other expiring items) and associates who have outstanding CPI training will be removed from the schedule. 3. Who is going to be responsible for #1 &amp; 2 above? The Administrative Director for Psychiatric Services will be responsible for the plan of correction and ongoing compliance. 4. By what date are you going to have the deficiency corrected? The deficiency has been corrective effective</p>	03/23/2012			

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S1906	<p>c. it is unclear why staff member P3 never received CPI training when they were hired in May 2011</p> <p>410 IAC 15-1.6-6 REHABILITATION SERVICES 410 IAC 15-1.6-6(b)</p> <p>(b) The services shall be under the direction of a physician qualified by training or experience and supervised by a qualified person or persons.</p> <p>Based on document review and interview, the facility failed to ensure that the rehabilitation services were provided under the direction of a physician qualified by training and experience.</p> <p>Findings:</p> <p>1. On 3-05-12 at 11 hours, staff A1 was requested to provide documentation that the rehabilitation services were under the direction of a qualified physician approved by the medical staff and none was provided prior to exit.</p> <p>2. During an interview on 3-05-12 at 1630 hours, staff A1 indicated that the inpatient rehabilitation services lacked a medical director.</p>	S1906	<p>3/23/2012</p> <p>1. How are you going to correct the deficiency, include steps taken and date of correction? Administrative Director of Therapy Services will be responsible for initiation of the Medical Director Contract for Rehabilitation Services by March 25, 2012. The contract will be executed by May 4, 2012. A board certified neurologist has agreed to assume the responsibilities of the medical director. 2. How are you going to prevent the deficiency from reoccurring in the future? The Medical Director Contract will be renewed every 2 years 3. Who is going to be responsible for # 1 and 2 above? The Administrative Director of Therapy Services 4. By what date are you going to have the deficiency corrected? The deficiency will be corrected by May 4, 2012.</p>	04/06/2012