

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152013	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/12/2011
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S0000	<p>This visit was for a State hospital licensure survey.</p> <p>Dates: 10/11/2011 through 10/12/2011</p> <p>Facility Number: 008900</p> <p>Surveyors: Albert Daeger, CFM, SFPIO Medical Surveyor</p> <p>Deborah Franco, RN PH Nurse Surveyor</p> <p>QA: cloughlin 11/01/11</p>	S0000		
S0406	<p>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. Based on document review, the facility</p>	S0406	<b>S 406 410 IAC 15-1.4-2 Quality Assessment and Improvement</b>	10/13/2011

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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S0554	<p>failed to ensure 2 services provided by the contractors as part of it's comprehensive quality assessment and improvement (QA&amp;I) program.</p> <p>Findings included:</p> <ol style="list-style-type: none"> <li>1. Quality Assessment and Performance Improvement Plan states, "Ensure coordination and integration of all performance improvement activities by maintaining an Organization Improvement Committee (OIC)..."</li> <li>2. Review of the facility's QA&amp;I program indicated it did not include contracted service's Cardiac Catheterization and Electroencephalogram (EEG).</li> <li>3. At 10:30 AM on 10/12/2011, staff member #3 indicated Cardiac Catheterization and EEG are not being monitored through the OIC committee.</li> </ol> <p>410 IAC 15-1.5-2(a)</p> <p>(a) The hospital shall provide a safe and healthful environment that minimizes infection exposure and risk to patients, health care workers, and visitors.</p> <p>Based on observation, documentation review, and interview, the facility failed to ensure pharmacy staff with upper</p>	S0554	<p>CEO added Cardiac Catheterization and Electroencephalogram (EEG) to the contracted service matrix form on October 13, 2011. Quality of these services will be monitored by the CEO and reported quarterly in the Organizational Improvement Committee, Medical executive Committee, and the Governing Board. Addendum: <b>Responsible Person: Cheryl Gentry, Chief Executive Officer</b></p> <p><b>S 554 410 IAC 15-1.5-2 Infection Control</b> On October 13, 2011, the Director of Pharmacy in serviced all</p>	11/12/2011	

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	<p>respiratory infections not enter the buffer area/IV Room.</p> <p>Findings included:</p> <ol style="list-style-type: none"> <li>1. The Pharmacy was toured at 9:45 AM on 10/11/11 with Pharmacy staff member #6. The door into the Buffer/IV Room had no note on it indicating of gowning before entering the room. Staff member #6 was observed coughing and eyes were red during the tour.</li> <li>2. At 9:50 AM on 10/11/11, staff member #6 indicated he was sick with a running nose and a cough.</li> <li>3. At 1:30 PM on 10/12/2011, staff member #17 indicated it was a good practice to gown up and put on a mask whenever a person enters the Buffer/IV Room. Staff member #17 indicated staff member #6 had an upper respiratory infection and he/she should of worn a mask and gowned up before entering the Buffer/IV Room.</li> <li>4. At 2:20 PM on 10/12/11, staff member #3 indicated staff member #6 had an upper respiratory infection and should not have entered into the Buffer/IV Room.</li> <li>5. Pharmacy policy and procedure #107-P stated, "Pharmacy staff will scrub and don</li> </ol>		<p>pharmacy employees of the need to don appropriate PPE before entering the buffer area/IV room in the pharmacy department as stated in policy #107-P. To maintain compliance, the Director of Pharmacy has purchased a sign which, upon receipt, will be posted outside of the buffer area/IV room in the Pharmacy Department. As a reminder to staff to don appropriate attire before entering the area, sign will be posted by November 12, 2011. The Director of Pharmacy will monitor for compliance daily and will report quarterly to the Organizational Improvement Committee, Medical Executive Committee, and the Governing Board. Addendum: <b>Responsible Person: Najwa Abubaker, Director of Pharmacy</b></p>		

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S0556	<p>appropriate personnel protective attire (PPA) prior to compounding sterile preparations in accordance with USP Chapter 797 'Pharmaceutical Compounding - Sterile Preparations'. Staff with upper respiratory infections should not enter buffer area or compound sterile preparations."</p> <p>410 IAC 15-1.5-2(b)</p> <p>(b) There shall be an active, effective, and written hospital-wide infection control program. Included in this program shall be system designed for the identification, surveillance, investigation, control, and prevention of infections and communicable diseases in patients and health care workers.</p> <p>Based on document review and interview, the facility failed to provide an effective infection control program to prevent the spread of communicable diseases in patients and health care workers.</p> <p>Findings included:</p> <ol style="list-style-type: none"> <li>Review of personnel files on 10/12/2011 lacked evidence that 9 of 14 staff members (P2, P3, P4, P6, P8, P11, P12, P13, and P14) had documented reliable proof of immunity to Rubella.</li> <li>Review of personnel files on</li> </ol>	S0556	<p><b>S 556 410 IAC 15-1.5-2 Infection Control</b> Effective October 13, 2011; all employees will be required to provide vaccination history or immunity to Rubeola, Rubella, and Varicella. Proof must be submitted on official letterhead. If proof cannot be provided; the employees will be required to undergo titer testing for immunity status. Effective October 12, 2011; newly hired employees will be required to provide proof of immunity status within 30 days of hire date. All documentation will be placed in the employee's health file. The Human Resources Coordinator and the Employee Health Nurse will monitor on an ongoing</p>	11/12/2011	

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S0754	<p>10/12/2011 lacked evidence that 13 of 14 staff members (all but P10) had documented reliable proof of immunity to Rubeola.</p> <p>3. Review of personnel files on 10/12/2011 lacked evidence that 11 of 14 staff members (P2, P3, P4, P6, and P 8-14) had documented reliable proof of immunity to Varicella.</p> <p>4. During interview with S1 on 10/12/2011 at 9:50 AM, S1 verified the above.</p> <p>410 IAC 15-1.5-4(f)(5)</p> <p>(f) All inpatient records, except those in subsections (g), shall document and contain, but not be limited to, the following:</p> <p>(5) Evidence of appropriate informed consent for procedures and treatments for which it is required as specified by the informed consent policy developed by the medical staff and governing board, and consistent with federal and state law.</p> <p>Based on document review, medical record review, and interview, the facility failed to follow its policy regarding</p>	S0754	<p>monthly basis and will be reported on a quarterly basis in the Organizational Improvement Committee, Medical Executive Committee, and the Governing Board. The Plan of Correction will be administered in 30 day increments as follows: ( total of 163 employees)11/13/11: 13 employees will have provided proof of immunization status12/13/11: 50 employees will have provided proof of immunization status1/13/12: 50 employees will have provided proof of immunization status2/13/12: 50 employees will have provided proof of immunization status Addendum:</p> <p><b>Responsible Person: Lisa Ruggles, Director of Quality Management</b></p> <p><b>S 754 410 IAC 15-1.5-4 Medical records</b> Chief Nursing Officer has reviewed the consent policy and procedure with staff at</p>	11/11/2011	

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	<p>informed consent in one (1) of ten (10) medical records reviewed.</p> <p>Findings included:</p> <ol style="list-style-type: none"> <li>1. Facility policy C08-A "Consents for Medical Treatment" last reviewed/revise 01/01/2010 states in pertinent part on page 2, Non Routine Tests, Treatments, and/or Procedures "The patient's consent to medical treatment or surgical procedure and an acknowledgement of receipt of medical information consent form shall be signed at the request of the physician for non-routine test, treatment, and/or procedure that the patient receives".</li> <li>2. On 04/18/2011, N3 consented to a procedure requiring informed consent according to facility policy. The informed consent was obtained verbally and signed by two (2) nurses with the comment "Verbal consent obtained secondary to contact isolation". The patient did not sign the consent.</li> <li>3. The medical record lacked any documentation of incompetency of N3 to sign the consent and N3 had signed other facility documents.</li> <li>4. During interview with S18 on 10/12/2011 at 10:25 AM, S18 verified the above and indicated that N3's written</li> </ol>		<p>mandatory staff meetings. All staff meetings were completed by November 11, 2011. Charge Nurse, Chief Nursing Officer, and the Director of Quality will provide 1:1 education to employee (s) not completing form according to policy. Monthly audits of 10 random charts are being performed by the Director of Quality to monitor for compliance. Audit data will be reviewed in the monthly QAPI committee and reported quarterly in the Organizational Improvement Committee, Medical Executive Committee, and the Governing Board. Addendum: <b>Responsible Person: Mandy Fulford, Chief Nursing Officer</b></p>				

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S0762	<p>consent should have been obtained despite contact isolation.</p> <p>410 IAC 15-1.5-4(f)(13)</p> <p>(f) All inpatient records, except those in subsections (g), shall document and contain, but not be limited to, the following:</p> <p>(13) A discharge summary authenticated by the physician. A final progress note may be substituted for the discharge summary in the case of a normal newborn infant and uncomplicated obstetric delivery. The final progress note should include any instruction given to the patient and family.</p> <p>Based on medical record review and interview, the facility failed to maintain an adequate medical record for one (1) of ten (10) medical records reviewed.</p> <p>Findings included:</p> <ol style="list-style-type: none"> <li>N9 was admitted on 01/31/2011 and discharged on 02/23/2011. The medical record lacked a discharge summary.</li> <li>During interview with S18 on 10/12/2011 at 10:25 AM, S18 verified the above.</li> </ol>	S0762	<p><b>S 762 410 IAC 15-1.5-4 Medical Records</b> Charts of discharge patients are being held on the 2 nd floor nurse's station for 48 hrs to allow for record/documentation completion. Discharge summaries are being printed to the second floor nurse's station to be placed in the chart for provider signature. Health Information Manager will review discharge summaries on a daily basis to monitor for compliance. Data will be reported quarterly in the Organizational Improvement Committee, Medical Executive Committee, and the Governing Board. Addendum: <b>Responsible Person: Robert Leslie, Health</b></p>	11/11/2011	

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S0952	<p>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). Based on document review, medical record review, and interview, the facility failed to follow its policy for the administration of blood in one (1) of four (4) patients receiving a blood transfusion.</p> <p>Findings included:</p> <ol style="list-style-type: none"> <li>1. Facility policy B04-N "Blood/Blood components administration" last reviewed/revised on 07/01/2011, states in pertinent part on page 6, Documentation, 3, "Complete the Blood Administration Record".</li> <li>2. Per physician order, N5 received a blood transfusion on 04/26/2011 at 15:55. The transfusion record form includes yes or no check mark areas for "Blood warmer used?" and "Transfusion reaction suspected?" which were not completed by</li> </ol>	S0952	<p><b>Information Manager</b></p> <p><b>S 952 410 IAC 15-1.5-6 Nursing Service</b> The Chief Nursing Officer has reviewed the Blood Transfusion form with employees at mandatory staff meetings. All staff meetings were completed by November 11, 2011. Monthly audits of 5 random charts are being performed by the Director of Quality to monitor for compliance. Data will be reviewed in the monthly QAPI committee and reported quarterly in the Organizational Improvement Committee, Medical Executive Committee, and the Governing Board. Addendum: <b>Responsible Person: Mandy Fulford, Chief Nursing Officer</b></p>	11/11/2011	

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S1022	<p>the administering nurse.</p> <p>3. During interview on 10/12/2011 with S18 at 10:25 AM, S18 confirmed the above.</p> <p>410 IAC 15-1.5-7 (d)(2)(B)</p> <p>(d) Written policies and procedures shall be developed and implemented that include the following:</p> <p>(2) Ensure the monthly inspection of all areas where drugs and biologicals are stored and which address, but are not limited to, the following:</p> <p>(B) Appropriate storage conditions. Based on observation, document review, and interview, the facility failed to follow procedures on temperature monitoring of the Pharmacy Drug Refrigerator when it dropped below acceptable temperature range.</p> <p>Findings included:</p> <p>1. At 9:45 AM and 11:30 AM on 10/11/11, the thermometer in the Pharmacy Drug Refrigerator registered 32 degrees F. However, the Refrigerator Temperature Log notes the temperature was 38 degrees F on 10/11/2011.</p>	S1022	<p><b>S 1022 410 IAC 15-1.5-7 Pharmaceutical Services</b> .The Director of Pharmacy has purchased digital thermometers to be installed in the medication refrigerators. Digital thermometers will allow continuous monitoring of refrigerator temp. Digital thermometers will be installed by November 12, 2011. All medication refrigerator temps will be recorded daily by the Pharmacy staff. Pharmacy staff will notify the Maintenance Department at St. Francis Hospital-Beech Grove for temps falling outside of the specified range. Pharmacy data will be</p>	11/12/2011	

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	<p>2. The Pharmacy Refrigerator Temperature Log states, "The temperature of the refrigerator compartment of this refrigerator must be between 35 and 45 degrees Fahrenheit to meet U.S.P. standards. Daily documentation of the temperature of the refrigerator compartment of this refrigerator is required. If the temperature falls outside the accepted range, notify Pharmacy and Maintenance immediately and indicate the times of notification in appropriate boxes."</p> <p>3. At 1:30 PM on 10/12/2011, staff member #17 indicated the temperature would be watched for about a couple hours before action would be taken. The staff member indicated maintenance has never been called for a malfunction refrigerator in Pharmacy. Maintenance Department was not notified on the drop in temperature of the refrigerator and the drop was never recorded on the temperature log because after a couple hours the temperature came back into the right parameters.</p>		<p>reported quarterly in the Organizational Improvement Committee, Medical executive Committee, and the Governing Board. Addendum: <b>Responsible Person: Najwa Abubaker, Director of Pharmacy</b></p>		

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S1164	<p>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. Based on observation and document review, the facility failed to ensure preventive maintenance was conducted on the hospital's 3 elevators.</p> <p>Findings included:</p> <p>1. The hospital's Safety Management Plan policy #125 states, "Safety Program activities includes policies and procedures regarding the maintenance of the hospital facilities and it's grounds; the preventive maintenance programs for the equipment..."</p> <p>2. The hospital's contracted service ensures's all building fixed equipment had their routine preventive maintenance conducted. However, the hospital could not provide documentation that the three elevators to the hospital had their annual preventive maintenance.</p>	S1164	<p><b>S 1164 410 IAC 15-1.5-8 Physical Plant Informal Dispute: Tag S 1164.</b> On October 12, 2011, the Safety Officer obtained the preventive maintenance records for the elevators. The PM records have been placed in the EOC manual which is located in the office of the Safety Officer. The host hospital will provide copies of the elevator PM to the Safety Officer on a quarterly basis as well as upon request. Preventive maintenance data will be reviewed monthly in the Safety Committee and reported quarterly to the Organizational Improvement Committee, Medical Executive Committee, and the Governing Board. <b>Responsible Person: Ken Hall, Safety Officer</b></p>	10/12/2011	

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S1172	<p>3. At 3:00 PM on 10/11/2011, staff member #4 indicated he/she contacted the vendor that conducts the preventive maintenance and they could not locate documentation confirming the three elevators of Select Specialty Hospital of Beech Grove were done.</p> <p>410 IAC 15-1.5-8(e)(1)(A)(B)(C)</p> <p>(e) The building or buildings, including fixtures, walls, floors, ceiling, and furnishings throughout, shall be kept clean and orderly in accordance with current standards of practice as follows:</p> <p>(1) Environmental services shall be provided in such a way as to guard against transmission of disease to patients, health care workers, the public, and visitors by using the current principles of the following:</p> <p>(A) Asepsis (B) Cross-infection; and (C) Safe practice.</p> <p>Based on observation, the facility failed to maintain the Renal Dialysis Department's floor clean.</p> <p>Findings included:</p> <p>1. At 11:05 AM on 10/11/2011, an area of floor approximately 3-feet by 4-feet under the dialysis machines was observed with a white powdery substance on the</p>	S1172	<p><b>S 1172 410 IAC 15-1.5-8 Physical Plant</b> Effective immediately, the Dialysis Nurse will ensure that the floor is mopped at the end of each dialysis day. The Dialysis Nurse will perform spot checks of the floor in between patients and will have area cleaned if needed. The Dialysis Nurse will be responsible for notifying the housekeeping staff. Random spot checks will be performed during the monthly</p>	10/13/2011	

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S1184	<p>floor.</p> <p>2. At 11:10 AM on 10/11/2011, staff member #5 confirmed there was a white substance on the floor and the staff from the department was in the room the previous day.</p> <p>410 IAC 15-1.5-8 (f)(2)</p> <p>(f) The safety management program shall include, but not be limited to, the following:</p> <p>(2) A safety committee appointed by the chief executive officer that includes representatives from administration, patient services, and support services.</p> <p>Based on document review and interview, the facility failed to ensure there was a Safety Committee and failed to report monthly safety violations as defined by the facility's policy.</p> <p>Findings included:</p> <p>1. Environmental, of Care Policy and Procedure policy #128 states, "The Safety Officer reports findings, recommendations, actions taken and the results of the monitoring at least every other month to the Environment of Care/Safety Committee. This information</p>	S1184	<p>EOC rounds by the Leadership team according to the rotation schedule. Deficiencies in the cleaning log will be reviewed in the QAPI committee on a monthly basis and final summary will be reported quarterly in the Organizational Improvement Committee, Medical Executive Committee, and the Governing Board. Addendum: <b>Responsible Person: Ken Hall, Safety Officer</b></p> <p><b>S 1184 410 IAC 15-1.5-8 Physical Plant</b> Safety Committee will be established and meet monthly. First meeting was initiated on November 8, 2011 and will continue on a monthly meeting schedule. EOC rounds will be rotated through the Leadership team on a monthly basis. Safety Officer has created a rotation schedule and was provided to the Leadership team. Monthly EOC documentation will be submitted to the Safety Officer at the time of completion and reviewed in the EOC/safety meetings. EOC/ Safety data will be reviewed in the monthly QAPI committee and reported by the</p>	11/08/2011	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  152013	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/12/2011
NAME OF PROVIDER OR SUPPLIER  SELECT SPECIALTY HOSPITAL-BEECH GROVE			STREET ADDRESS, CITY, STATE, ZIP CODE 1600 ALBANY ST STE 200 BEECH GROVE, IN46107		
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	<p>flows quarterly to the Medical Executive Committee and Governing Board for Review and approval on recommendations."</p> <p>2. Environmental of Care Policy and Procedure #139 states, "The Safety officer and members of the EOC/Safety Committee will conduct monthly environmental/safety rounds of the hospital clinical area using the Monthly Environmental/Safety Round's checklist."</p> <p>3. The Monthly Environmental/Safety reports were reviewed for the the previous 12 months. The facility only provided 3 of 12 required reports: 2/15/2011, 5/10/2011, and 6/15/2011.</p> <p>4. At 9:45 AM on 10/12/2011, staff member #3 indicated the hospital does not have a Safety Committee.</p>		<p>Safety Officer quarterly in the Organizational Improvement Committee, Medical Executive Committee, and the Governing Board. Addendum: <b>Responsible Person: Ken Hall, Safety Officer</b></p>		