

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150018	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/05/2014
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S000000	<p>This visit was for a State hospital licensure survey.</p> <p>Dates: 6/2/2014 through 6/5/2014</p> <p>Facility Number: 005017</p> <p>Surveyors: Albert Daeger, CFM, SFPIO Medical Surveyor</p> <p>Saundra Nolfi, RN PH Nurse Surveyor</p> <p>QA: claughlin 06/17/14</p>	S000000		
S000308	<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</p>			

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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	<p>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 personnel file review and interview, the facility failed to ensure all staff received initial departmental orientation in 4 of 11 staff files reviewed (P5, P9, P12, and P13).</p> <p>Findings included:</p> <p>1. Review of nursing department personnel files with staff member A55, beginning at 9:15 AM on 06/05/14, indicated the following:</p> <p>A. Staff member P5, an RN (Registered Nurse) hired 01/14/13, lacked documentation of completed departmental orientation.</p> <p>B. Staff member P9, an RN hired 02/11/13, lacked documentation of completed departmental orientation.</p> <p>C. Staff member P12, a CNA (Certified Nursing Assistant) hired 04/08/13, lacked documentation of completed departmental orientation.</p> <p>D. Staff member P13, a CNA hired 09/04/12, lacked documentation of completed departmental orientation.</p> <p>2. At 11:15 AM on 06/05/14, staff</p>	S000308	The Nursing Department has developed a system to ensure each nursing associate completes nursing orientation in a timely manner (See attached Associate Dept Records Policy and Procedure) effective July 1, 2014. The nursing directors were educated on Dept Records P & P on June 20, 2014. The four nursing associates noted to have incomplete orientation will be educated on deficient areas noted on initial orientation paperwork by July 31, 2014. The nursing directors will be monitoring 2 different associate department files a month for completeness. The Nursing Directors will be accountable for complete nursing orientation records for each nursing associate, including the 4 noted to have deficient orientation and completing monthly audits; The Executive Directors of Nursing are responsible for analyzing the monthly audits and ensuring compliance; Vice President of Nursing responsible for completeness of all nursing orientation paperwork and providing report monthly at Strategy Deployment through 2014.	07/01/2014			

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S000554	<p>members A4 and A5 confirmed the staff members did not have completed orientation documentation that should have been completed within 90 days of hire.</p> <p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(a)</p> <p>(a) The hospital shall provide a safe and healthful environment that minimizes infection exposure and risk to patients, health care workers, and visitors.</p> <p>Based on observation and interview, the facility failed to ensure clean supplies and equipment were protected from contamination in the Laboratory Department.</p> <p>Findings included:</p> <p>1. During the tour of the Laboratory main storage room at 9:10 AM on 6/4/2014, accompanied by staff members #43 and #54, several cardboard shipping boxes of supplies were observed stored in the clean supply</p>	S000554	<p>On 6/24/14 shipping boxes were removed from shelves that contained clean stock items, items were placed into clean storage bins and the bins placed on the shelves by the Lab Supervisor. All remaining shipping boxes are now completely separate from clean items by a barrier or a shelf; this was validated by the Lab Director during a walk through of the area on 6/24/14. All lab employees were notified by email of the deficiency and the need to assure segregation of shipping boxes from clean supplies and the planned inspection processes. Inspection of the lab will occur twice weekly and be conducted by the Lab Supervisor to assure ongoing compliance and any breaches corrected and documented for the Lab Director.</p>	06/24/2014

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S000592	<p>room, alongside unprotected clean equipment and supplies on gray storage shelves. The shipping boxes evidenced shipping labels. Three shipping boxes were also utilized as storage containers to store assorted unprotected laboratory supplies: assorted lab tubes, syringes, etc.</p> <p>2. At 9:22 AM on 6/4/2014, staff member #43 confirmed some of the boxes arrived directly to the room from the outside and were not boxes removed from an outer wrap.</p> <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</p>		The Executive Director of Quality/PI will be speaking to all Department Directors 6/30/14 to assure that in areas of responsibility inspection occurs the week of 6/30/14 and any identified breach is immediately corrected, reported to PI and ongoing routine inspection plans be implemented. The Director of Laboratory Services will be responsible for the ongoing compliance with this plan.				

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	<p>limited to, the following:</p> <p>(i) Sanitation.</p> <p>Based on observation and interview, the hospital failed to maintain the handwashing lavatory in a clean and sanitary manner for the in-house Laundry and Environmental Services (EVS) storage room.</p> <p>Findings included:</p> <ol style="list-style-type: none"> During the tour of the in-house Laundry and EVS storage room at 9:10 AM on 6/4/2014, accompanied by staff members #43 and #54, the laundry room's handwashing sink/eye wash station was observed with heavy accumulation of soil residue covering the sink basin, faucet, and eye wash station's plumbing. The handwashing sink was not clean and sanitary for handwashing or the event of emergency eye flushing. The observation was confirmed by staff members #43 and #54 at 	S000592	<p>The eyewash station in the Laundry/EVS Storage room was cleaned and eyewash clean and check log was put in place on 6/9/14. A daily cleaning schedule for eye wash stations and sinks was published to responsible associates on 6/20/14 and education provided 6/23/14. A new sink was ordered for this area on 6/24/14 by the Director of Engineering Services. It is expected to be installed by July 15, 2014. The Emergency Eyewash Station and Shower policy and log was updated by the Director of EVS and will be presented for approval to Hospital Safety Committee on July 11, 2014 and Infection Prevention Committee on July 18, 2014 (attached) Eyewash stations are cleaned and checked by EVS associates weekly. EVS supervisors will verify sustainment by a check of the logs monthly. Engineering will do annual preventive maintenance checks and complete any work order generated from the weekly checks by EVS associates. The Director of Environmental Services will be responsible for assuring the ongoing compliance with this plan.</p>	06/24/2014

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S000596	<p>time of tour.</p> <p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(f)(3)(D)(iii)</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>(iii) Cleaning, disinfection, and sterilization.</p> <p>Based on observation, policy and procedure review, manufacturer's directions, and interview, the infection control committee failed to ensure chemicals were used safely and appropriately in the Emergency Department (ED) and in the Wound Care Center.</p> <p>Findings included:</p> <p>1. During the tour of the ED at 9:30 AM on 06/03/14, accompanied by staff members A4 and A21, a container of Aseptozyme enzymatic cleaner was</p>	S000596	<p>Findings 1-2: On June 2, 2014 the Executive Director of ED developed and implemented a visual management system to assure proper mixing of Aseptizyme solution for instrument cleaning; specifically marked the water fill line on the instrument container at 4 gallons and posted instruction above the container to add 2 ounces of Aseptizyme to the 4 gallon water demarcation. A log to document daily change of solution was created and implemented to be completed by the associate. Manager rounds to assure sustainment of the process began on June 4, 2014 and will occur</p>	06/19/2014
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	<p>observed in the soiled utility room along with a plastic bin for instruments. Manufacturer's label directions indicated 1/2 ounce of the product was to be mixed with each gallon of water for instrument cleaning.</p> <p>2. At 9:40 AM on 06/03/14, the ED tech, staff member A22, indicated he/she put 2 pumps of the chemical into the plastic bin of water, but did not measure and did not know how much water was in the bin.</p> <p>3. During the tour of the Wound Care Center at 9:50 AM on 06/03/14, accompanied by staff members A4, A23, and A24, an open container of Cidex OPA high level disinfectant was observed on a shelf in the soiled utility room. The container was not marked with an open date. The label directions indicated gloves, gown, and goggles were to be worn when using the chemical in a well-ventilated area. First aid for a splash was a 15 minute flush.</p> <p>4. At 10:00 AM on 06/03/14, the clinic nurse manager, staff member A25, indicated used instruments were cleaned and soaked in the chemical before being sent to the main hospital for processing. When questioned regarding the use of the chemical, staff member A25 indicated he/she had too much to remember and</p>		<p>daily until process is sustained at 100% compliance x 30 days then will occur weekly. Staff education in ED Unit meeting occurred June 19, 2014. Roster is attached. The Executive Director of Emergency Services is responsible for the ongoing compliance with this plan. Findings 3-5: On June 3, 2014 the Manager of the Wound Care Center (WCC) removed Cidex OPA from the department. On June 4, 2014 all expired supplies were removed from WCC and properly discarded. A checklist for proper usage and handling of Aseptizyme was developed and implemented and clinical staff reviewed and signed June 5, 2014. On June 6, 2014 Aseptizyme and appropriate PPE was obtained for the WCC. A checklist to assure weekly supply expiration date monitoring was developed and implemented on June 5, 2014 with monitoring begun on June 9, 2014. The Dirty Instrument Handling Procedure, appropriate use of Aseptizyme and appropriate use of PPE ws reviewed again with clinical staff on June 9, 2014. The Manager of the Wound Care Center is responsible for the ongoing monitoring and compliance with this plan.</p>				

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	<p>would just read the label directions. When questioned regarding PPE (personal protective equipment), he/she indicated there were gloves in the room, but indicated there was no eyewash station in the clinic.</p> <p>5. The facility policy "Cidex OPA Solution, Use Of", effective 05/13, indicated, "A. Training: 1. The user will be trained in the disinfection of semi-critical medical devices and the handling of Cidex OPA Solution prior to performing the high level disinfection process. ...C. Pre-Cleaning of Medical Devices: ...2. Prior to disinfection, blood, body fluids and lubricants must be thoroughly cleaned from the surfaces and lumens of all semi-critical, reusable medical devices as the presence of organic material inhibits the effectiveness of disinfection. ...6. An enzyme presoak or detergent to remove dirt or dissolve protein material may be used. ...D. Use of Cidex OPA Solution: 1. Staff using Cidex OPA solution shall wear gloves, mask eye protection, and a fluid resistant gown. 2. Cidex OPA solution must be used in a well-ventilated area. 3. An eyewash station must be within 10 seconds of where Cidex OPA solution is used. 4. Record the date the Cidex OPA solution bottle was opened ...Once opened, the remaining solution may be</p>						

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S000612	<p>stored in its original container for up to 75 days."</p> <p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(f)(3)(D)(xi)</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>(xi) A program of linen management for personnel involved in linen handling. Based on observation and staff interview, the hospital failed to ensure clean rags and mop heads were stored in a clean and sanitary environment in the in-house laundry department.</p> <p>Findings included:</p> <p>1. At 9:30 AM on 6/4/2014, the in-house Laundry Department was toured. The department contained 3 blue and 2 yellow 55-gallon</p>	S000612	<p>On 6/23/14 the following changes were made re: the in house Laundry Department: The ceiling, pipes, sink, shelving and floor were cleaned. A process was developed to assure that all soiled mops and rags are kept covered. The room was also modified by removing the chemical dispensing station and relocating the paper towel and soap dispensers. on 6/24/14 a new sink for the area was ordered (expected to be installed by 7/15/14). Also on 6/23/14 new processes were developed(see attached STANDARD ROOM CLEANING PROCEDURE FOR</p>	06/25/2014			

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	<p>containers filled with uncovered clean rags and clean mop heads. The room also had containers of soiled rags and soiled mop heads. The rooms also were observed storing assorted supplies: boxes of paper towels, chemicals, equipment, etc. The ceiling surface and piping that ran along the ceiling were observed with accumulation of dirt and other debris on them. The uncovered containers of clean rags and mop heads were observed under the dirty ceiling. The shelving units and the floor surface where the clean uncovered rags and mop heads were observed were heavily soiled with accumulation of soil residue.</p> <p>2. At 9:38 AM on 6/4/14, staff member #55 indicated the in-house Laundry Department only washes the rags and mop heads for the hospital. The rags and mop heads are used in the surgery areas and patient rooms. The staff member confirmed the containers of rags in</p>		<p>STORAGE ROOM and STANDARD PROCESS FOR PROCESSING CLEAN AND SOILED LINEN) and posted in the area by the EVS Director. On 6/25/14 the EVS supervisor provided training to all staff on these two procedures. The EVS supervisor will be observing associates adherence to the process and immediate feedback daily for one week, then monthly for three months, then quarterly to assure 100% compliance. Assessment of the area for cleanliness will be completed monthly ongoing by the EVS supervisor. On 7/14/14 the area used for processing the soiled and clean rags and mopheads was observed by two Infection Preventionists and the Executive Director of Quality/PI along with the Director of EVS. The soiled rags and mopheads were located in covered carts approximately 12 feet from the washer/dryer used to process these items. The carts holding these soiled items were covered with a cloth cover. The Director of EVS demonstrated that the process has been improved - covered barrels from the clean area are wheeled to the dryer discharge when completed, a lid placed over the clean barrel, and the barrel wheeled back into the clean room, which is approximately 30 feet away. A staff member was then watched performing the process which</p>				

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S000754	<p>the laundry room were both containers of clean and soiled rags and mop heads.</p> <p>410 IAC 15-1.5-4 MEDICAL RECORD SERVICES 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 policy review, medical record review, and interview, the facility failed to ensure all patient records contained an appropriately executed Consent for Treatment for 6 of 21 records reviewed (N1, N3, N15, N17, N18, and N20).</p> <p>Findings included:</p> <p>1. The facility policy "Consent to Treat", last reviewed 01/14, indicated, "1. Per</p>	S000754	<p>showed need for remedial education, and the Director of Environmental Services will be assuring competency validation of the new process with all staff that work in the area on each employee's next shift to work. The Director of Environmental Services will be responsible for assuring compliance with this plan.</p> <p>Education on Document / Process: 1. 6/18/14 - e-mail sent to all registration staff to re-educate current hospital policy on "Consent to Treat" (see attached policy and e-mail) 2. 6/25/14 – Emergency Room Department Meeting Education (see attached minutes) 3. 6/26/14 – Admitting Department Meeting Education (see attached minutes) 4. Emergency Department Executive Director sent e-mail 6/26/14 to clinical</p>	07/05/2014

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	<p>Indiana Law, all patients must sign a general consent agreeing to receive treatment. This consent is obtained whenever possible during the registration process. ...3. When a patient or responsible party is not present during the registration process, Admitting staff will document 'patient unable to sign' below the patient signature area and will flag the consent form. Nursing staff will then follow-up and obtain the signature either from the patient or a responsible family member. Telephone consent can be obtained. 4. During the admission process, nursing staff are to verify that a consent to treat form has been obtained."</p> <p>2. The facility policy "Consent Forms for Minors", last revised 04/14, indicated, "All effort will be made to locate the closest relative or legal guardian to give consent, if not in person, then over the telephone, with documentation and follow-up. If a health hazard exists and the relative or guardian cannot be located, the family physician in some cases, may choose to use his discretion and sign the consent for the minor."</p> <p>3. The medical record for patient N1, a 13-month old brought to the ED (Emergency Department) by a grandmother on 03/16/14, had a Consent for Treatment form with "Pt. physically</p>		<p>staff related to flags on consents that have not been signed. Implementation Monitoring Indicators: 1. Follow up audit to be done by Admitting Manager and Supervisors on dates of service June 22 & 23, 2014 to monitor compliance. Follow up individualized education to be provided based on audit findings. 2. Follow up audit to be done on week of July 14, 2014 to monitor compliance and follow up education provided to individuals not compliant with policy by Admitting Manager and Supervisors.3. Follow up audit week of August 25, 2014 by Admitting Manager and Supervisors to monitor compliance and follow up education provided to individuals not compliant with policy. 4. Follow up audit to be done Quarterly on-going by Admitting Manager and Supervisors.The Admitting Manager will be responsible for compliance to this plan.</p>	

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	<p>unable to sign" written in the space for the patient signature. However, the block "Patient Rights/Advance Directives copies refused" was initialed. The record lacked any documentation of follow-up regarding the consent form.</p> <p>4. The medical record for patient N3, a 59 year old who was seen in the ED on 01/30/14, had a Consent for Treatment form with "Pt. physically unable to sign" written in the space for the patient signature. The physician indicated the patient was alert and oriented. The record lacked any documentation of follow-up regarding the consent form.</p> <p>5. The medical record for patient N15, an 85 year old who was seen in the ED on 02/05/14, had a Consent for Treatment form with "Pt. physically unable to sign" written in the space for the patient signature. The physician indicated the patient was alert and oriented. The record lacked any documentation of follow-up regarding the consent form.</p> <p>6. The medical record for patient N17, an 87 year old who was admitted from Rehab on 03/15/14, lacked any documentation of a Consent for Treatment for that admission.</p> <p>7. The medical record for patient N18, a</p>						

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S000912	<p>92 year old who was seen in the ED on 02/06/14, had a Consent for Treatment form with "Pt. physically unable to sign" written in the space for the patient signature. The physician indicated the patient was alert and oriented. The record lacked any documentation of follow-up regarding the consent form.</p> <p>8. The medical record for patient N20, a 57 year old who was seen in the ED on 04/24/14, had a Consent for Treatment form with "Pt. physically unable to sign" written in the space for the patient signature. The physician indicated the patient was alert and oriented. The record lacked any documentation of follow-up regarding the consent form.</p> <p>9. At 4:00 PM on 06/04/14, staff members A4, A7, and A27 confirmed the medical record findings and the lack of follow-up with the consent forms.</p> <p>410 IAC 15-1.5-6 NURSING SERVICE 410 IAC 15-15-6 (a)(2)(B)(i)(ii) (iii)(iv)(v)</p> <p>(a) The hospital shall have an organized nursing service that provides twenty-four (24) hour nursing service furnished or supervised by a registered nurse. The service shall have the following:</p>						

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	<p>(2) A nurse executive who is: (B) responsible for the following: (i) The operation of the services, including, but not limited to, determining the types and numbers of nursing personnel and staff necessary to provide care for all patient care areas of the hospital. (ii) Maintaining a current nursing service organization chart. (iii) Maintaining current job descriptions with reporting responsibilities for all nursing staff positions. (iv) Ensuring that all nursing personnel meet annual in-service requirements as established by hospital and medical staff policy and procedure, and federal and state requirements. (v) Establishing the standards of nursing care and practice in all settings in which nursing care is provided in the hospital.</p> <p>Based on policy and procedure review, medical record review, and interview, the nurse executive failed to ensure pain assessments were done according to policy and protocol for 4 of 5 pediatric patients seen in the Emergency Department (ED) (N9, N10, N12, and N13).</p> <p>Findings included:</p> <p>1. The facility policy "Pain Management", last revised 11/11, indicated, "1. Assessment for and</p>	S000912	ED clinical staff were educated on the elements of Pediatric Pain Assessment by the ED Nurse Educator on June 19, 2014 (powerpoint and roster attached). In addition, a "hard stop" was created in the electronic medical record (Cerner) documentation for patient assessment which now must be done during triage assessment and cannot be bypassed. The hard stop was implemented June 17, 2014. The ED Nurse educator will be doing monthly random audits of 20 records of pediatric patients and will provide corrective education	06/19/2014

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	<p>documentation of the presence and rating of pain should occur with all patients at a minimum of: on pre-admission, on admission, at the beginning of each nurse's shift of care, prior to administration of pain medications, and after pain medication is administered or a non-medication intervention is done. ...Pain documentation is done in the patient's electronic medical record. ...2. Measurement of pain will be consistent throughout the institution. ...Faces scale will be utilized for pediatric and non-cognitive patients will have the Non-Cognitive Discomfort Scale used."</p> <p>2. The medical record for patient N9, a 2-year old seen in the ED on 01/01/14 for cough and congestion and admitted to the facility, lacked any documentation of a pain assessment in the ED.</p> <p>3. The medical record for patient N10, a 2-year old seen in the ED on 01/30/14 for cough, fever, and dyspnea and admitted to the facility, lacked any documentation of a pain assessment in the ED.</p> <p>4. The medical record for patient N12, a 19-month old seen in the ED on 02/02/14 for possible ingestion of diabetic medication and admitted to the facility, lacked any documentation of a pain assessment in the ED.</p>		as indicated. The Executive Director of the Emergency Department will have responsibility for the monitoring of compliance with this plan.				

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S000952	<p>5. The medical record for patient N13, an 8-month old seen in the ED on 03/10/14 for cough, fever, and ear pain and admitted to the facility, lacked any documentation of a pain assessment in the ED.</p> <p>6. At 4:00 PM on 06/04/14, staff members A4, A7, and A27 confirmed the medical record findings and indicated the pediatric patients should have documentation of a pain assessment using the Faces Scale.</p> <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). Based on policy review, medical record review, and interview, the facility failed to ensure the facility's policy was followed regarding blood transfusions for</p>	S000952	Effective July 1, 2014, the Blood Administration: Packed Cells P & P will be revised to align with AABB standards (See attached Blood Administration: Packed	07/01/2014

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	<p>5 of 5 patients receiving blood transfusions (N17, N18, N19, N20, and 21).</p> <p>Findings included:</p> <p>1. The facility policy "Blood Administration: Packed Cells", last revised 12/13, indicated, "12. The patient is assessed for vital signs and signs of reaction every 30 minutes during blood product infusion. ...Administration: 1. ...Vital signs should be taken prior to picking up blood from Transfusion Service. If elevated temperature, transfusion may be delayed. ...9. Vital signs are to be taken before transfusion begins, 15 minutes (+/- 5 min.) after starting transfusion, at the completion of transfusion and prn; and documented. ...13. Assess every 30 minutes during infusion for reaction."</p> <p>2. The medical record for patient N17 indicated 2 units of packed cells transfused on 03/20/14. The second unit was started at 2045, but the record lacked documentation of 15 minute vital signs and both units lacked documentation of every 30 minute assessments.</p> <p>3. The medical record for patient N18 indicated 2 units of packed cells transfused on 02/07/14. The first unit</p>		<p>Cells P & P). Initial education will be provided at shift huddles from June 25, 2014-July 1, 2014 related to changes in timing of VS/assessment and concurrent audits. Computer based learning (CBL) module will start July 1 and be completed by all bedside RNs by October 1, 2014. Each unit of blood will be audited concurrently by to assist the RN to achieve complete, timely VS and assessments during blood administration. The audits will be turned into the department director daily. The department director will review 5 patient charts for blood administration compliance per month (See concurrent and prospective monitoring tools). Each department's audit findings with applicable action plans will be submitted to Blood Bank Committee for review every other month. The Bedside RN will be responsible for completing concurrent blood audit with each unit of blood. The Unit Director will be responsible for auditing 5 patients with blood transfusions a month (8 inpatient/ER units =40 patients house wide a month). The Executive Director of Nurses will be responsible for analyzing compliance with audits with actions monthly; Vice President of Nursing or designee responsible for communicating audit results to Blood Bank Committee routinely. the Vice President of Nursing will have responsibility for assuring</p>				

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	<p>was started at 0530 with the 15 minute checks at 0550, but both pre-transfusion and 15 minute vital signs lacked temperature checks. Both units lacked documentation of every 30 minute assessments.</p> <p>4. The medical record for patient N19 indicated 2 units of packed cells transfused on 03/15/14. The second unit was started at 1400 with the pre-transfusion vital signs also documented at 1400 and the 15 minute checks at 1425. Both units lacked documentation of every 30 minute assessments.</p> <p>5. The medical record for patient N20 indicated 2 units of packed cells transfused on 04/26/14. The record indicated the first unit was started at 1455, but other documentation indicated 1505. Both units lacked documentation of every 30 minute assessments.</p> <p>6. The medical record for patient N21 indicated a unit of packed cells was started at 0015 on 04/17/14, but other documentation indicated 0035. A second unit of packed cells was started at 2041 on 04/18/14 with pre-transfusion vital signs taken at 1901, an hour and forty minutes prior. The post-transfusion vital signs for the second unit lacked a</p>		compliance with this plan.				

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S001118	<p>temperature check. Both units lacked documentation of every 30 minute assessments.</p> <p>7. At 4:00 PM on 06/04/14, staff members A4, A7, and A27 confirmed the medical record findings and staff member A4 indicated the policy was going to be changed regarding the 30 minute assessments, but had not been changed yet.</p> <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 documentation review, observation and staff interview, the hospital failed to ensure eye wash station checks were performed, as per policy, that was located in the Laboratory.</p>	S001118	The Director of Environmental Services, Director of Engineering, Director of Lab, Director of Quality/PI and Infection Preventionists collaborated on the development of a procedure, log of inspection, accountability process, and reporting structure and revised the Safety Policy #	07/05/2014			

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	<p>Findings included:</p> <ol style="list-style-type: none"> 1. Eye Wash Station Checks policy #20 (last reviewed 3/2013) stated, "Monthly, Environmental Services will check all eyewash stations to make sure they are functioning properly." 2. At 9:00 AM on 6/4/2014, the Laboratory was toured. The department had two eyewash stations: one was a shower and the other one was mounted over a handwashing sink. Each eyewash station had a different log which was maintained by the contracted Laboratory and Environmental Services. 3. The eye wash shower station log, maintained by Environmental Services, noted a six week period not being checked. The eye wash station check exceeded the month requirement as noted per hospital policy. 		<p>20 EMERGENCY EYEWASH AND SHOWER STATIONS CHECKS to assure that all elements required are incorporated in the implementation and sustainment of this process (see attached policy). The procedure and logs will be implemented the week of June 30, 2014 and the policy taken to Safety Committee for approval July 11, 2014. EVS staff training was conducted on 6/25/14 by the EVS supervisor. Department Directors will be educated on 6/30/14 by the EVS Director. The Director of Environmental Services has responsibility for assuring compliance with this plan.</p>				

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S001162	<p>4. At 9:15 AM on 4/6/2014, staff member #43 indicated the staff member was not at work for a six week period, therefore, a staff member was not assigned to perform the eye wash station checks in his/her absence.</p> <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, the facility failed to comply with manufacturer recommendations for 1 of 2 Hydrocollators in the Rehabilitation Department and failed to ensure 6 pieces of equipment were scheduled for routine preventive maintenance.</p>	S001162	Findings 1-2: The Rehab Services Director revised the temperature range on tracking sheet to reflect correct temperature range of 160 – 165 degrees on June 4, 2014. Education conducted on June 26, 2014 to all Rehab services staff by the Rehab Services Director included detail on 1)on the appropriate temperature range, 2)requirement for documentation	07/05/2014			

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	<p>Findings included:</p> <p>1. The Operation Manual instructions for the use and operation for Rehabilitation Department's 2 Hydrocollator M-2 Master Heating Units noted the thermostats are extremely sensitive and the slightest adjustment will alter the temperature several degrees. The recommended operating temperature was 160 to 166 degrees Fahrenheit. The temperature of the water should be checked before using the Steam Packs.</p> <p>2. The Rehabilitation Department Hydrocollator M-2 Master Heating Unit May 1, 2014 temperature log revealed the water temperature was less than 160 degrees Fahrenheit for 10 of 31 days. The Daily Temperature Log noted at the bottom of the form, the Hydrocollator's temperature should be between 143 and 177 degrees Fahrenheit, which exceeded the</p>		<p>daily and prior to each use, and 3)need to adjust thermostat and recheck in one hour if out of range and do not use until the reading is in the appropriate range. Minutes from this educational session and roster are attached. A copy of the updated log beginning 6/4/14 is also attached. The Rehab Services Director or Manager will review the tracking sheets as well as take any corrective action required on a monthly basis. The Rehab Services Director has the responsibility for compliance with this plan. Findings 3-7: The Capital Purchasing Process has been modified to indicate on capital equipment request form that inspection is required and to deliver to either Clinical Engineering (CE) or destination department. Buyer will then check box in Peoplesoft (purchasing system) indicating "Inspection Required" and specify in Comment section to deliver to either CE or destination department with notification to CE. CE will perform the incoming inspection and risk assessment to determine inclusion in Medical Equipment Management Program. CE will indicate inspection completed in Peoplesoft. CE Manager or Purchasing Manager will run reports weekly to verify that all inspections were completed and verified. CE Manager will be</p>		

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	<p>required temperatures specified by the manufacturer's recommendations.</p> <p>3. The hospital's preventive maintenance schedules were reviewed with staff members #34 and #54. The documentation provided evidenced two separate type of floor scrubbers, the hospital's industrial washer and dryer, Total Joint Unit's Rehabilitation steps and car simulator.</p> <p>4. Clarke Operator's Manual for the Rotary/Cylindrical floor scrubber and the Aquaride floor scrubber maintenance sections required specified preventive maintenance inspections for weekly, monthly, and annually timeframe's.</p> <p>5. Medical Equipment Risk Assessment policy #CE-05 (last approved 10/2012) stated, "To establish criteria used to determine whether a medical device should</p>		<p>notified of any incomplete inspections and take corrective action. This process has been approved by the Director of Purchasing and the Director of Engineering Services and was started on 6/24/14. Purchasing staff, Receiving staff, and Clinical Engineering staff will be educated by July 3, 2014 by the Clinical Engineering Manager. The Director of Engineering Services has the responsibility for compliance with this plan. The Staircase and Car Simulator in the Total Joint Unit were inspected and added to the medical equipment inventory. A book and checklist has been developed and implemented for EVS personnel using the floor care equipment to document checks of equipment before and after each use. Tepe Sanitary Supply is going to perform preventive maintenance checks twice a year to be done in March and September. In addition, a contract has been executed with Spin Tech to conduct preventive maintenance checks on the washer and dryer quarterly, inspections will begin July 15 2014. A contract with Spartan/ HP has been executed and will be performing the pm's on the Laundry chemicals and equipment quarterly. The Director of Environmental Services has the responsibility for assuring compliance with this</p>				

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	<p>be included in the Clinical Engineering Medical Equipment Management Program and, if included, to determine specific periodic inspection intervals."</p> <p>6. At 1:15 PM on 6/4/2014, staff member #54 indicated the two floor scrubbers have never had a documented preventive maintenance performed on them.</p> <p>7. At 1:25 PM on 6/4/2014, staff member #34 indicated all patient care equipment in the facility have a risk assessment performed on them. The risk assessment helps the clinical engineering department determine the frequency of preventive maintenance to be performed. The staff member indicated the Total Joint Unit's rehabilitation steps and car simulator have never had a risk assessment performed, therefore, the two health care pieces of equipment had never under gone a preventive maintenance inspection.</p>		plan.				

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

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