

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152025	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/20/2012
NAME OF PROVIDER OR SUPPLIER CENTRAL INDIANA AMG SPECIALTY HOSPITAL LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 2401 W UNIVERSITY AVE 8TH FL MUNCIE, IN 47303		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
S0000	<p>The visit was for investigation of a State hospital complaint.</p> <p>Complaint Number: IN 00102695</p> <p>Substantiated: Deficiencies related and unrelated to the allegations cited.</p> <p>Date: 4/20/12</p> <p>Facility Number: 004811</p> <p>Surveyor: Brian Montgomery, RN, BSN Public Health Nurse Surveyor</p> <p>QA: claughlin 05/18/12</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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S0560	<p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(d)</p> <p>(d) A person qualified by training or experience shall be designated as responsible for the ongoing infection control activities and the development and implementation of policies governing control of infections and communicable diseases.</p> <p>Based on document review and interview, the infection control officer failed to ensure that the infection control policy/procedures included a provision for documenting the time that a PPD skin test was administered and the time it was read and failed to ensure that the information was documented in all staff health records for 5 of 6 personnel files reviewed.</p> <p>Findings:</p> <ol style="list-style-type: none"> The Centers for Disease Control and Prevention (CDC) <u>Fact Sheets: Tuberculosis: General Information</u>. July 2007 indicated the following: " The [PPD] skin test reaction should be read between 48 and 72 hours after administration. A patient who does not return within 72 hours will need to be rescheduled for another skin test. " The policy/procedure Employee Health (revised 4-17-12) failed to ensure that Tb skin test documentation included 	S0560	The documentation of PPD Testing and Reading will be updated to include a time, as well as a date, by the Human Resources Coordinator. This documentation will be monitored by the HRC each time it is completed. The Director of Nursing will assist the HRC in this monitoring.	07/25/2012			

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	<p>a time of administration and a time of interpretation or reading.</p> <p>3. Personnel health records for staff 41, 42, 44, 45, and 46 failed to indicate a time for skin test administration or interpretation and indicated that the infection control officer had reviewed the record.</p> <p>4. On 4-20-12 at 1550 hours, staff A1 confirmed that the policy/procedure lacked the indicated requirement and confirmed that the test documentation was incomplete.</p>				

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S0930	<p>410 IAC 15-1.5-6 NURSING SERVICE 410 IAC 15-1.5-6 (b)(3)</p> <p>(b) The nursing service shall have the following:</p> <p>(3) A registered nurse shall supervise and evaluate the care planned for and provided to each patient.</p> <p>Based upon document review and interview, the registered nurse failed to ensure that a bed exit alarm was turned on or in place when fall risk precautions were ordered for 1 of 5 medical records (MR) reviewed.</p> <p>Findings:</p> <p>1. The policy/procedure Fall Reduction (revised 12-11) indicated the following: " [Nursing staff] will keep the bed exit alarm turned on or in place ...if the bed exit alarm is not used, document reason. "</p> <p>2. The MR for patient #25 indicated that on 12-14-11 an order was written for fall precautions when an antipsychotic medication was ordered and the 24 hour nursing flowsheet lacked documentation to indicate that the bed exit alarm was activated under the section for Bed Alarm (every hour entry indication), Safety/Care (up to three entries per day), Risk for Falls (two entries per day) or otherwise indicate why the bed exit alarm</p>	S0930	<p>1. Staff will be educated, by the Director of Nursing, on appropriate Bed Alarm documentation.2. Appropriate Bed Alarm documentation will be assessed by direct Chart Audit by the DON.</p>	07/20/2012	

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	<p>was not required before and after the fall event on 12-30-11.</p> <p>3. During an interview on 4-20-12 at 1515 hours, staff A1 confirmed that the MR for patient #25 lacked documentation of bed exit alarm use.</p>				