

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151309	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/02/2014
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NAME OF PROVIDER OR SUPPLIER ST VINCENT CLAY HOSPITAL INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1206 E NATIONAL AVE BRAZIL, IN 47834
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S000000	This visit was for a standard licensure survey. Facility Number: 005046 Survey Date: 03/31-04/02/14 Surveyors: Jack I. Cohen, MHA Medical Surveyor Jennifer Hembree, RN Public Health Nurse Surveyor Ken Ziegler Medical Surveyor	S000000		
S000270	QA: cloughlin 04/09/14 410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1(a)(6) (a) The governing board is legally responsible for the conduct of the hospital as an institution. The governing board shall do the following: (6) Review, at least quarterly, reports of management operations, medical staff actions, and quality monitoring, including patient services provided, results attained, recommendations made, actions taken and follow-up. Based on document review and interview, the	S000270	Responsible Person: Chief Nursing Officer The following directly-provided services will	05/27/2014

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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S000310	<p>governing board failed to review reports of quality activities for 6 directly-provided services and 10 contracted services for the calendar year 2014.</p> <p>Findings:</p> <ol style="list-style-type: none"> Review of the governing board minutes for calendar year 2013 indicated they did not include review of reports for the directly-provided services of Chemotherapy, Electroencephalography (EEG), Infection Control, Medication Errors, Post-Operative Recovery, and Utilization Review/Social Services/Discharge Planning. In interview, on 4-2-14 at 12:00 noon, employee #A1 confirmed the above and no further documentation was provided prior to exit. Review of the governing board minutes for calendar year 2014 indicated they did not include review of reports for the contracted services of Bioengineering, Biohazardous Waste Hauler, Central Sterile, Dietetic Service, Laundry, Medical Records, Nuclear Medicine, Occupational Therapy, Speech Pathology, and Transcription. In interview, on 4-2-14 at 12:00 noon, employee #A1 confirmed the above for contracted services and no further documentation was provided prior to exit. <p>410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1(c)(6)(C)</p> <p>(c) The governing board is responsible for managing the hospital. The governing board shall do the following:</p>		<p>provide quality activity reports to the governing board at the next scheduled Board Meeting These reports will be presented to the Board at a minimum of annually thereafter NOTE: We do NOT administer any Chemotherapy 1) EEG 2) Infection Control 3) Medication Errors - these were reported to the Board on 3/25/14 4) Postoperative Recovery 5) Case Management (Utilization/Social Service/Discharge Planning) 6) Bioengineering (TriMedx Contract) 7) Biohazardous Waste Disposal (Hauler) (Contracted) 8) Central Sterile Supply 9) Dietetic Service 10) Laundry (Contracted) 11) Medical Records (HIM) 12) Occupational Therapy (Contracted) 13) Speech Pathology (Contracted) 14) Transcription 15) Nuclear Medicine (Contracted)</p>	

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	<p>(6) Require that the chief executive officer develops policies and programs for the following:</p> <p>(C) Ensuring that all health care workers, including contract and agency personnel, for whom a license, registration, or certification is required, maintain current license, registration, or certification and keep documentation of same so that it can be made available within a reasonable period of time.</p> <p>Based on document review and interview, the hospital failed to maintain a current license for 1 health care worker for whom a license is required.</p> <p>Findings:</p> <ol style="list-style-type: none"> Review of credential file AH#2 indicated the individual had requested and been granted privileges by the medical staff and governing board in November, 2012. Review of a document entitled Core Privileges, indicated AH#2 requested Psychology Core Privileges, including, but not limited to, consultation, differential diagnosis, and treatment planning for all [psychological] disorders, and mental status assessment, crisis intervention, short and long term psychotherapy for individuals, families, couples and groups. Review of Indiana Code 25-33, Article 33, Psychologists, section IC 25-33-1-2, Definitions, indicated "Practice of Psychology" includes the following: 	S000310	<p>Responsible Person: Chief Executive Officer Medical Director, Craig Johnson will ensure that Telehealth psychology staff will have a Certification or equivalent document (Allied Health Professional (AHP) form) in their personnel file that verifies he or she has been trained in a Crisis Intervention Program. Prior to our survey, we had treated these staff as a practitioner We will review and modify the Certificate Program process. These staff assist our ED physicians via Telehealth communications in assessing the patient with crisis intervention techniques. They are under the direction of the credentialed Psychiatrist. When: Beginning May 30, 2014</p> <p>How: Any Telehealth Crisis Intervention staff will have a Certificate of AHP form completed and filed in the</p>	05/05/2014			

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S000312	<p>(2) Diagnosis and treatment of mental and behavioral disorder by a health service provider in psychology</p> <p>(7) Techniques used in interviewing, counseling, psychotherapy, and behavioral modification of individuals or groups</p> <p>3. Review of the credential file of AH#2 indicated there was no documentation of a current psychologist's license granted by the State of Indiana.</p> <p>4. In interview, on 4-2-14 at 10:00 am, employee #8 confirmed the credential file contained no current psychologist's license granted by the State of Indiana and no other documentation was provided prior to exit.</p> <p>410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1(c)(6)(D)</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>(D) Annual performance evaluations, based on a job description, for each employee providing direct patient care or support services, including contract and agency personnel, who are not subject to a clinical privileging process.</p> <p>Based on document review and interview, the facility failed to conduct, per hospital policy, a performance evaluation for 5 of 10 employee</p>	S000312	<p>Administration Suite. The "Telemedicine Consult" policy/procedure will be revised to include the changes stated above. Follow-up: This will be reported to the bi-monthly Medical Staff and Board of Directors meetings.</p> <p>Responsible Person: Chief Executive Officer PolicyStat ID 696719 - HR1.07-- "Role Summaries and Competency Evaluations" was Last Revised on</p>		

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S000318	<p>files reviewed.</p> <p>Findings:</p> <p>1. Review of PolicyStat ID: 696719, entitled Role Summaries and Competency Evaluations, HR1.07, last revised 11/2010, indicated Competency Evaluations shall be ... reviewed by the Administrative Representative.</p> <p>2. Review of 10 personnel files indicated files PF#1, PF#4, PF#6, PF#8, and PF#10 did not contain any documentation of performance evaluation reviewed by the Administrative Representative.</p> <p>3. In interview on 4-1-14 at 3:45 pm, employee #A8 confirmed the above and no other documentation was provided prior to exit.</p> <p>410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1(c)(6)(F)</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>(F) Ensuring cardiopulmonary resuscitation (CPR) competence in accordance with current standards of practice and hospital policy for all health care workers, including contract and agency personnel, who provide direct patient care.</p>		<p>11/2010 but Last Approved (without revisions) on 01/2014 This policy has been revised to state "Contracted Services Directors' performance evaluations will be reviewed by the Administrator or appropriate Administrative Representative," ie Pharmacy Director's Evaluation will be reviewed by the CNO, Housekeeping Manager's Evaluation will be reviewed by the CEO, etc. How: Revised HR policy will state the above. When: Beginning FY15 (July 1, 2014)</p>		

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S000322	<p>Based on document review and interview, the hospital failed to ensure cardiopulmonary resuscitation (CPR) competence for 2 of 5 physicians who provide direct patient care.</p> <p>Findings:</p> <ol style="list-style-type: none"> Review of 5 physician credential files who provide direct patient care indicated files MD#2, and MD#3 did not have any documentation of CPR competence. In interview, on 4-2-14 at 9:45 am, employee #A8 confirmed the above and no other documentation was provided prior to exit. Review of file MD#5 contained a document entitled American Academy of CPR & First Aid, Inc. The document indicated [the physician] had demonstrated proficiency in the subject by passing the examination. <p>2. In interview, on 4-2-14 at 11:15 am, employee #A8 indicated the company issuing the documentation of CPR competence for MD#5, did not have hands-on demonstration as part of the proficiency process. No further documentation was provided prior to exit.</p> <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:</p>	S000318	<p>Responsible Person: Chief Executive Officer One of the two physicians MD#2 identified as not having CPR competency documented retired on 04/17/14 The second physician's MD#3 competency to perform CPR will be confirmed and documented MD#5, has provided documentation of completing CPR online, but currently does not have competency skills documented in her credentialing file. Competency skills for this physician will be completed All physicians and licensed independent providers who provide direct patient care will ensure competencies in CPR (Basic Life Support) and such documentation will be maintained in their credential file</p>	05/05/2014	

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	<p>(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, the hospital failed to have policies and procedures reviewed at least annually for 7 of 10 policies.</p> <p>Findings:</p> <p>1. Review of PolicyStat ID: 691506, entitled Annual Policy Review, AD2.13, Last Revised 08/2012, indicated policies will be reviewed annually by each department manager.</p> <p>1. Review of hospital policy documents indicated the following policies had not been reviewed annually:</p> <p>PolicyStat ID: 691506, Last Revised 08/2012 PolicyStat ID: 696719, Last Revised 11/2010 PolicyStat ID: 188515, Last Revised 03/2012 PolicyStat ID: 191029, Last Revised 03/2012 PolicyStat ID: 185770, Last Revised 06/2009 PolicyStat ID: 659675, Last Revised 04/2012 PolicyStat ID: 371465, Last Revised 03/2011</p> <p>2. No further documentation was provided prior to exit.</p>	S000322	<p>Responsible Person: Chief Executive OfficerAll expired policies will be revised as needed and approved prior to their expiration datePolicyStat ID: 691506, "Annual Policy Review," was Last Revised on 08/2012, but was last Approved (no revisions were required) on 01/2014PolicyStat ID: 696719, "Role Summaries and Competency Evaluation," was Last Revised on 11/2010, but was last Approved (no revisions were required) on 01/2014PolicyStat ID: 659675, "Release of Information from Medical Records," was Last Revised on 04/2012, but was last Approved (no revisions were required) on 01/2014PolicyStat ID: 188515, "Pyxis MedStation Medication Administration," was Last Revised on 03/2012, and Expired on 03/2014 the initial day of this survey. This policy has been Approved 04/2014--Responsible Person: Sandy Haggart, CNOPolicyStat ID: 191029, "Organizational Performance Plan," was Last Revised on 03/2012, and Expired on 03/2014 the initial day of this survey. This policy was Approved on 04/2014--Responsible Person: Sandy Haggart, CNOPolicyStat ID: 185770, "Security and</p>	04/30/2014	

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S000416	<p>410 IAC 15-1.4-2 QUALITY ASSESSMENT AND IMPROVEMENT 410 IAC 15-1.4-2(a)(3)</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>(3) All medical and surgical services performed in the hospital with regard to appropriateness of diagnosis and treatments related to a standard of care and anticipated or expected outcomes.</p> <p>Based on document review and interview, the hospital failed to review medical and surgical services performed in the hospital with regard to appropriateness of diagnosis and treatments related to a standard of care and anticipated or expected outcomes for 4 of 5 physician credential files reviewed.</p> <p>Findings:</p> <p>1. Review of 5 credential files of medical staff members indicated files MD#2, MD#3, MD#4, and MD#5 did not contain any documentation of performance review.</p>	S000416	<p>Confidentiality," was Last Revised on 06/2009 and Expired on 01/2013 This policy has been revised on 04/2014--Responsible Person: Wayne Knight, CFO</p> <p>Responsible Person: Chief Executive Officer Medical Director, Craig Johnson, will ensure the Medical staff members have Performance Reviews documented and maintained in their credential file. In compliance with The Joint Commission Standards, the following reviews will be documented and maintained in the credentialing file of each licensed independent practitioner: (1) Focused Professional Practice Evaluations (FPPE) -- time-limited evaluation of the practitioner's</p>	05/16/2014			

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S000554	<p>2. In interview, on 4-2-14 at 9:30 am, employee #A8 confirmed the above and no documentation was provided prior to exit.</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, the hospital created conditions which failed to provide a healthful environment that minimized infection exposure and risk to patients, employees and visitors in 5 instances.</p> <p>Findings:</p> <p>1. On 3-31-14 at 1:00 pm in the presence of employee #A2, it was observed in both the men's and women's locker rooms in the</p>	S000554	<p>competence in performing a specific privilege; this process will be implemented for all initially requested privileges and whenever a question arises regarding a practitioner's ability to provide safe, high-quality patient care. (2) Ongoing Professional Practice Evaluations (OPPE) -- a document summary of ongoing data collected for the purpose of assessing a practitioner's clinical competence and professional behavior; the information gathered during this process is factored into decisions to maintain, revise, or revoke existing privilege(s) prior to or at the end of the two-year license and privilege renewal cycle.</p> <p>Responsible Person: Chief Executive Officer Radiology Department Manager, John Klaibler (Directly Responsible) will ensure the following employee equipment areas will be cleaned thoroughly by the staff operating the equipment according to a daily cleaning schedule maintained by the Radiology/Imaging Department: (1) Computer Tomography (CT) Scanner, (2) Bone Densitometry</p>	05/12/2014	

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S000556	<p>radiology area, there were large clumps of dust on the top of the lockers.</p> <p>2. On 3-31-14 at 1:10 pm in the presence of employee #A2, it was observed in the Computer Tomography (CT) Scanner room, there were large clumps of dust on the top of the CT Scanner machine.</p> <p>3. On 3-31-14 at 1:35 pm in the presence of employee #A2, it was observed in the bone density room, there were large clumps of dust on the top of the bone densitometry machine.</p> <p>4. On 3-31-14 at 3:25 pm in the presence of employee #A2, it was observed in the mammography room, there were large clumps of dust on the top of the mammography machine.</p> <p>410 IAC 15-1.5-2 INFECTION CONTROL 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>	S000556	<p>machine, (3) Mammography machine. All Radiology staff will be educated on their responsibility. How: Staff meeting-individual communication with staff responsible for cleaning equipment When: Effective 05/12/14 Follow-up: Cleaning Maintenance Checklist will be monitored daily by the Radiology Department Manager. The Environmental Services Department Manager, Ted Redenbarger will be responsible for floor maintenance, restroom cleaning and trash disposal including the Radiology men's and women's locker rooms. How: Staff meeting will educate housekeeping staff of their responsibilities as stated above. When: Effective 05/12/14 Follow-up: Cleaning Checklist will be monitored weekly by the Environmental Services Department Manager.</p> <p>Responsible Person: Chief</p>	05/05/2014

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	<p>Based on document review and staff interview, the facility failed to maintain an active and effective infection control program.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Facility policy titled "Plan, IC1.01" last reviewed/revised 3/13 states on page 2: "INFECTION CONTROL COORDINATOR:.....The ICC is responsible or the identification, investigation, reporting, prevention and control of nosocomial infections among patients and personnel." Page 3 states under the same heading of INFECTION CONTROL COORDINATOR: "Investigation of positive cultures, clusters of pathogens, inpatients and personnel involved." 2. Review of facility infection control documents beginning on 3/31/14 and continuing on 4/1/14, indicated the facility had no data to support statements made in the infection control meeting minutes related to hospital acquired infections. The infection control documents lacked evidence of positive culture review, tracking and trending of infections etc. 3. Staff member #A2 indicated the following in interview at 4:00 p.m. on 4/1/14: <ol style="list-style-type: none"> (A) The infection control coordinator works at the facility 1 day a month. (B) He/she (staff member #A2) had requested information from the infection control coordinator related to positive patient cultures, tracking and trending etc. and was unable to receive the information prior to the exit conference. 		<p>Nursing Officer Infection Control Plan, Last Reviewed/Revised on 03/2013 has been Approved (no required revisions) on 04/2014 Infection Control Coordinator is currently shared with another St Vincent Hospital and is only at our hospital one day monthly This has not allowed adequate time for "identification, investigation, reporting, prevention and control of nosocomial infections" to be monitored adequately There is inadequate IC documents to show tracking and trending data such as "Investigation of positive cultures, clusters of pathogens, inpatients and personnel involved" The current IC Preventionist will do the following to meet compliance of the standard: (1) An Infection Control Binder will be created to include (a) a tracking log that identifies isolates cultured and reported by Mid-America College of Laboratories (MACL) for our hospital, (b) culture results will be monitored and logged monthly and presented to the Infection Control Committee, (c) a listing of Communicable Diseases reported to the ISDH, and (d) a listing of data reported to the CDC through the National Healthcare Safety Network, i.e. Surgical Site Infections (SSI) and Multi-drug Resistant Organisms (MDRO). Another associate from our current staff will be identified to assume the Infection Control Coordinator position Tracking</p>	

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S000558	<p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(c)</p> <p>(c) The infection control program shall have a method for identifying and evaluating trends or clusters of nosocomial infections or communicable diseases.</p> <p>Based on document review and staff interview, the facility failed to maintain a method for identifying and evaluating trends or clusters of infections.</p> <p>Findings include:</p> <p>1. 1. Facility policy titled "Plan, IC1.01" last reviewed/revised 3/13 states on page 2: "INFECTION CONTROL COORDINATOR:.....The ICC is responsible or the identification, investigation, reporting, prevention and control of nosocomial infections among patients and personnel." Page 3 states under the same heading of INFECTION CONTROL COORDINATOR: "Investigation of positive cultures, clusters of pathogens, inpatients and personnel involved."</p> <p>2. Review of facility infection control documents beginning on 3/31/14 and</p>	S000558	<p>and trending of surveillance data will begin prior to 05/05/2014NOTE: It is anticipated that any new posting for this position will not be possible until at least 05/12/2014 due to major network changes and installs across the St Vincent Health System</p> <p>Responsible Person: Chief Nursing Officer Our current Infection Control Preventionist will do the following to meet compliance of the standard: (1) An Infection Control Binder will be created to include (a) a tracking log that identifies and evaluates trends or clusters of nosocomial infections or communicable diseases and (b) a listing of Communicable Diseases reported to the ISDH. Note: It is anticipated that any new posting for a person to fill the Infection Control Coordinator's position will not be possible until at least 05/12/2014 due to major network changes and installs across the St. Vincent Health System which involve Human Resources and the hiring process.</p>	

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S000596	<p>continuing on 4/1/14, indicated the facility had no data related to the identification, tracking or trending of infections.</p> <p>3. Staff member #A2 indicated the following in interview at 4:00 p.m. on 4/1/14: (A) The infection control coordinator works at the facility 1 day a month. (B) He/she (staff member #A2) had requested information from the infection control coordinator related to positive patient cultures, tracking and trending etc. and was unable to receive the information prior to the exit conference. 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: (iii) Cleaning, disinfection, and sterilization.</p> <p>Based on document review and staff interview, the infection control committee failed to ensure facility policy related to sterilizer maintenance was followed for 1 sterile processing area toured.</p> <p>Findings include:</p>	S000596	Responsible Person: Chief Nursing Officer Surgery Department Nurse Manager, Jamie Webster, will ensure the maintenance of sterilizer (Autoclave) specifically, the chamber drain strainer must be cleaned at least once a day, preferably in the morning before	04/28/2014

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S000932	<p>1. Preventative maintenance guidelines for the facility autoclave states on page 3-6, "The chamber drain strainer must be cleaned at least once a day, preferably in the morning before running the first cycle."</p> <p>2. Staff member #S1 indicated in interview at 11:30 a.m. on 4/1/14 that he/she does not clean the drain strainer on the autoclave.</p> <p>410 IAC 15-1.5-6 NURSING SERVICE 410 IAC 15-1.5-6 (b)(4)</p> <p>(b) The nursing service shall have the following:</p> <p>(4) The nursing staff shall develop and utilize an ongoing individualized plan of care based on standards of care for each patient.</p> <p>Based on document review, the facility failed to ensure care plans were individualized for 5 of 8 patients (patients #4, 5, 9, 18 and 21).</p> <p>Findings include:</p> <p>1. Facility policy titled "Plan for the Provision Nursing Care" last reviewed/ revised 1/2013 states on page 1 under mission: "Each patient's plan of care is developed on an individual basis involving the family and</p>	S000932	<p>running the first cycle. Surgery Nurse Manager will be responsible for monitoring this cleaning and document such each day that the department uses the AutoclaveHow: This has been added to PolicyStat entitled "Sterilization Process" NS3.80.02 and monitoring will be reported to the monthly Quality Council. The staff will received education on the policy change at their April 24, 2014 Department meeting. When: 04/28/14F/U: Daily Checklist maintained by Surgery Nurse Manager and resported to monthly Quality Council.</p> <p>Responsible Person: Chief Nursing Officer The Inpatient Nurse Manager, Denise Lakin will be responsible for ensuring that all patient's have individualized nursing care plans Pre-printed Nursing Care Plans must identify areas pertinent to the individual patient All nursing associates will be re-educated and policy, "Plan for the Provision of Nursing Care" (Last Reviewed/Revised on 01/2013), discussed at the</p>	05/05/2014			

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S001014	<p>significant other(s)....." Page 5 states under standards of practice: "3. Is based upon data which is collected continuously and systematically, is recorded, retrievable, and communicated appropriately, and is reviewed regularly in order to modify the nursing plan of care;...." and page 6 states under standards of care: "Care plans follow the nursing process and include nursing diagnosis which is individualized to meet the needs of the patient....."</p> <p>2. Review of patients #4, 5, 9, 18, and 21 medical records indicated the care plans were a pre-printed care plan that was not individualized for the patient. The nursing intervention section lacked identification of areas pertinent to the individual patient. Additionally, patient #9 had been a patient since 3/25/14 and there were no modifications made to his/her care plan. Staff initialed the same care plan each shift.</p> <p>410 IAC 15-1.5-7 PHARMACEUTICAL SERVICES 410 IAC 15-1.5-7(c)</p> <p>(c) In order to provide patient safety, the director of pharmacy shall develop and implement written policies and procedures for the appropriate selection, control, labeling, storage, use, monitoring, and quality assurance of all drugs and biologicals.</p> <p>Based on document review, observation, and staff interview, the facility failed to ensure medications were labeled according to facility policy for 1 of 3 departments.</p> <p>Findings include:</p>	S001014	<p>upcoming department staff meetings scheduled for 4/29 and 4/30/2014 This Policy has been reviewed/ revised on 04/2014 Compliance will be monitored and reported to the Quality Council monthly.</p> <p>Responsible Person: Chief Nursing Officer Surgery Director, Jamie Webster will ensure compliance as stated in policy, "Medication Administration" - All medications are to be labeled with Medication Name, Medication Strength, Medication</p>	04/03/2014

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S001020	<p>1. Facility policy titled "Medication Administration" last reviewed/revise 2/14 states on page 3: "K. Any medication(s) removed from the original container that will not be immediately administered will be labeled and used within the recommended timeframe. Pre-administration labeling of any medication(s) will be labeled appropriately as recommended by the United States Pharmacopeia 797. In perioperative and other procedural settings both on and off the sterile field, labeling of the medication(s) or solution(s) will include the following: Medication Name, Medication Strength, Medication Quantity, Diluents and volume (if not apparent from the container), Preparation date and time, and Initials of preparer."</p> <p>2. During tour of the surgery department beginning at 10:35 a.m. on 4/1/14, the following was observed in the anesthesia cart in operating room (OR) #1: (A) Two (2) syringes with a clear solution with a sticker type label indicating the syringes contained Midazolam 2 mg/ml. The label did not include the preparation date, time and initials of the preparer. (B) Three (3) syringes with a clear solution with a sticker type label indicating the syringe contained Demerol. The label did not include the medication strength, preparation date and time or the initials of the preparer.</p> <p>3. RN #1 indicated in interview at the time of the observation that he/she had drew up the medications in preparation for a procedure in the room and did not complete the documentation on the labels. 410 IAC 15-1.5-7 PHARMACEUTICAL SERVICES 410 IAC 15-1.5-7 (d)(2)(A)</p>		Quantity, Diluents, and Volume (if not apparent from the container), Preparation Date and Time, and Initials of the preparer" When: Associate in the OR Room#1 - was Counseled appropriately by the Surgery Nurse Manager on 04/22/14.How: Re-education on policy, "Medication Administration" will occur at the 04/24/2014 Surgery Department Nursing Staff meeting. F/U: Random spot checks by Nurse Manager during daily operations for any unlabeled medications and disciplinary action as appropriate.	

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S001118	<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>(A) Separation of drugs designed for external use from drugs intended for internal use.</p> <p>Based on interview, the hospital failed to ensure the monthly inspection of 1 area where drugs are stored.</p> <p>Findings</p> <p>1. In interview, on 3-31-14 at 2:50 pm, PD1 indicated some medications were stored in the physical therapy department. The Director was requested to provide documentation of monthly inspection reports for that area. PD1 indicated there were no reports and no further documentation was provided prior to exit.</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</p>	S001020	<p>Responsible Person: Chief Nursing Officer Pharmacy Director, Lora Fougrousse will ensure monthly inspection of any medications stored outside of the Pharmacy Department and document such, i.e. Topical medication stored in the Physical Therapy Department adjacent to the hospital in the Medical Office Building Responsible Person under CNO is Lora Fougrousse, Pharmacy Director How: Tracks each medication leaving the Pharmacy on a Unit Inspection Form When: Each time a medication such as Topical ointment to PT Dept leaves Pharmacy. F/U: Maintains Unit Inspection Form in a binder in the Pharmacy Dept</p>	05/05/2014

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	<p>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, the hospital created a condition which resulted in a hazard to patients, public or employees in 6 instances.</p> <p>Findings:</p> <ol style="list-style-type: none"> On 3-31-14 at 1:30 pm in the presence of employee #A2, it was observed in Electroencephalography Room 1, there was a Pulmonary Function Gas cylinder on the floor not secured by chain or holder. On 3-31-14 at 2:15 pm in the presence of employee #A2, it was observed in gas storage area, there were 4 small gas cylinders on the floor not secured by chain or holder. If any of the above extinguishers were knocked over and broke the head off the compressed cylinder, it could result in harm to people and/or property. On 3-31-14 at 3:50 pm in the presence of employee #A2, it was observed in the ED time clock area, there was an alcohol-based hand sanitizer (ABHS) affixed on the wall directly above the time clock (an electrical ignition source). The location of the ABHS directly above an electrical ignition source posed a fire hazard. 	S001118	<p>Responsible Person: Chief Financial Officer Cardiopulmonary Department Manager, Barb Duncan will ensure Hazardous conditions identified in the following areas will be or have already been corrected: 1) In Cardiopulmonary Department -- In Electroencephalography Room -- a Pulmonary Function Gas cylinder on the floor not secured by chain or holder --- has been removed from the department on 04/01/14 2) Gas Storage Area in Materials Management Department -- 4 small gas cylinders on the floor were not secured by chain or holder - - these had just arrived at our facility and were still in their shipping carton. They were removed from the carton and placed in the appropriate cylinder container. This has been discussed with the Managers of the Materials and Cardiopulmonary departments The person that makes the delivery to the storage area will be responsible for ensuring that the cylinders are taken out of the shipping carton and placed in the secure storage rack Responsible Person: Chief</p>	05/05/2014

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S001164	<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 document review and interview, the hospital failed to provide evidence of preventive maintenance (PM) for 4 pieces of equipment.</p> <p>Findings:</p> <ol style="list-style-type: none"> On 3-31-14 at 11:30 am, employee #A2 was requested to provide documentation of PM on a hydrocollator. On 3-31-14 at 1:20 pm, employee #A2 	S001164	<p>Executive Officer Maintenance Department Manager, Randy Collins will ensure Hazardous conditions identified in the following area will be corrected: 3) ED Time Clock Area -- Alcohol-based hand sanitizer (ABHS) was affixed on the wall directly above the time clock (an electrical ignition source) -- the ABHS has been removed and remounted in a location away from the electric time clock.</p> <p>Responsible Person: Chief Executive Officer Maintenance Department Director, Randy Collins will ensure documentation of Preventive Maintenance (PM) is more detailed as recommended during the survey. He will ensure PM is completed and reported to the Quality Council quarterly for the following equipment: (1) Dishwashing machine in Dietary Department Responsible</p>		

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S001166	<p>was requested to provide documentation of PM on an echo machine located in the Echo Room.</p> <p>3. On 3-31-14 at 3:45 pm, employee #A2 was requested to provide documentation of PM on a shoulder pulley in the Physical Therapy area.</p> <p>4. On 3-31-14 at 3:45 pm, employee #A2 was requested to provide documentation of PM on a BATCA Fitness System exerciser in the Physical Therapy area.</p> <p>5. Prior to exit, no documentation of PM was provided on any of the above pieces of equipment.</p> <p>6. On 3-31-14 at 11:30 am, employee #A2 was requested to provide documentation of PM on a dishwashing machine in dietary and a hydrocollator.</p> <p>7. In interview on 4-1-14 at 10:50 am, employee #A2 confirmed there was no PM on these pieces of equipment and no other documentation was provided prior to exit.</p> <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</p>		<p>Person: Chief Financial Officer Materials Management Department Director, Martha Maurer will ensure TriMedx performs Preventive Maintenance (PM) and documents such. This will be reported to the Quality Council quarterly. (1) Hydrocollator in Physical Therapy (PT) Department (2) Shoulder Pulley in PT Department (3) BATCA Fitness System Exerciser in PT Department (4) Echo Machine in Cardiopulmonary Department</p>		

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S001186	<p>leakage checks.</p> <p>Based on document review and interview, the hospital failed to keep current leakage checks on 1 piece of equipment.</p> <p>Findings:</p> <ol style="list-style-type: none"> Review of a preventive maintenance (PM) document for an adult bed indicated it did not document current leakage checks. In interview, on 4-1-14 at 10:50 am, employee #A2 confirmed the above and no further documentation was provided prior to exit. <p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8 (f)(3)(A)(B)(C)(D)(E) (i)(ii)(iii)(iv)(v)</p> <p>(f) The safety management program shall include, but not be limited to, the following: (3) The safety program that includes, but is not limited to, the following:</p> <p>(A) Patient safety. (B) Health care worker safety. (C) Public and visitor safety. (D) Hazardous materials and wastes management in accordance with federal and state rules. (E) A written fire control plan that contains provisions for the following: (i) Prompt reporting of fires. (ii) Extinguishing of fires. (ii) Protection of patients, personnel, and guests. (iv) Evacuation. (v) Cooperation with firefighting</p>	S001166	<p>Responsible Person: Chief Financial OfficerMaterials Management Department Manager, Martha Maurer, will ensure Preventive Maintenance (PM) is documented for one adult bed that indicated it did not have current leakage checks documented.How: TriMedx has re-checked the identified bed and completed documentation for current leakage checks.When: April 15, 2014F/U: TriMedx does PMs on all beds monthly. This is reported to the Quality Council monthly.</p>	04/15/2014			

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	<p>authorities.</p> <p>Based on document review and interview, the facility failed to conduct quarterly fire drills in accordance with facility policy in 1 instance.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. Review of hospital policy PolicyStat ID: 677098, entitled Safety Management Plan, S100, last revised 01/2013, indicated a quarterly review of safety monitoring tools to identify trends or outliers These tools will include ... Fire drills. .2. Review of fire drills conducted at the facility for calendar year 2013, indicated there were no fire drills conducted for any quarter at the physical therapy building. 3. In interview, on 4-1-14 at 11:25 am, employee #A2 confirmed the above and no further documentation was provided prior to exit. 	S001186	Responsible Person: Chief Executive Officer Maintenance Department Manager, Randy Collins will ensure Quarterly Fire Drills are conducted and documented in the Physical Therapy (PT) Department by Maintenance associate PT Fire Drill has been added to the Maintenance Department's list of areas in which they will conduct such drills Quarterly	05/05/2014	