

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 154052	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/06/2013
NAME OF PROVIDER OR SUPPLIER PORTER-STARKE SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 701 WALL ST VALPARAISO, IN 46383		
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A000000	<p>This visit was for a Federal recertification survey.</p> <p>Facility Number: 005585</p> <p>Survey Date: 2/4-6/2013</p> <p>Surveyors: ReBecca Lair, LCSW Medical Surveyor</p> <p>Jacqueline Brown, RN Public Health Nurse Surveyor</p> <p>QA: cloughlin 02/20/13</p>	A000000			

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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A000395	<p>482.23(b)(3) RN SUPERVISION OF NURSING CARE A registered nurse must supervise and evaluate the nursing care for each patient. Based on policy and procedure review, medical record review, and personnel interview, the registered nurse failed to supervise and evaluate the nursing care related to medications ordered that the patient was allergic to for 1 of 9 (N8) closed patient medical records reviewed, failed to assure the following of physician orders for 1 of 9 (N8) closed patient medical records reviewed and failed to assure accurate documentation of allergies for 1 of 9 (N7) closed patient medical records reviewed.</p> <p><u>Findings:</u></p> <p><u>Medications ordered that the patient was allergic to:</u></p> <p>1. Policy No.: 6.08 titled, "Medication Administration" that was reapproved on 12/20/10, was reviewed at approximately 9:40 AM on 2/6/13 and indicated, on pg. 2, under Action - General Guidelines section, "Every client is asked about drug allergies at the time of admission. Any allergies are noted on the medical record and medication sheet."</p> <p>2. Policy No.: 6.08.01 titled, "Verifying That No Contraindication Exists Before</p>	A000395	To comply with this standard, Porter-Starke Services, Inc. provided education regarding medication administration; noting and red-lining of physician's orders; documentation of patient allergies. This education was provided by the nursing supervisor to all registered nurses on February 22, 2013. Charts are now being audited on a daily basis for allergy discrepancies by a Health Information Management representative. The urine drug screen sheet has since been moved to the medication administration book to ensure easier tracking of urine collection and urine drug screens will be audited by the charge nurse on a nightly basis. Responsible for this correction is: Andrea Farmer, RN, Nursing Supervisor	02/22/2013			

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	<p>Administering Medication" that was reapproved on 12/20/10, was reviewed at approximately 9:40 AM on 2/6/13 and indicated, on pg. 1, under Purpose section, "To promote safe medication use by ensuring that staff have checked for contraindications prior to administering medication."</p> <p>3. Review of closed patient medical records on 2/5/13 at 9:00 AM confirmed patient N8:</p> <p>A. per Physician's Orders dated 12/6/12 at 18:50 PM, Tylenol is listed as an allergy and PRN (as needed) medications states to "please address with physician" for Tylenol 325 mg two tablets by mouth every 4 hours prn pain.</p> <p>B. per History and Physical dated 12/7/12 at 8:41 AM, had an allergy to Tylenol.</p> <p>C. per Medication Profile form, start date for order for Tylenol 325 mg two tablets by mouth every 4 hours prn pain was 12/6/12.</p> <p>D. per PRN Medication Flow Sheet, Tylenol is listed as an allergy.</p> <p>E. per Non-Scheduled Medication Sheet, Tylenol is listed as an allergy but start date for order for Tylenol 325 mg two tablets by mouth every 4 hours prn pain was 12/6/12.</p> <p>F. no doses of Tylenol were documented as being administered to</p>			

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	<p>patient.</p> <p>4. Personnel P1 was interviewed on 2/6/13 at approximately 2:40 PM, and confirmed patient N8 had a documented allergy to Tylenol. The Tylenol order was not addressed with the physician and was started as an order. And although the patient did not receive any doses of Tylenol, facility policy and procedure was not followed.</p> <p><u>Not following physician orders:</u></p> <p>5. Policy No.: 6.05 titled, "Physician's Orders" that was reapproved on 12/20/10, was reviewed at approximately 11:40 AM on 2/5/13 and indicated, on pg. 1, under Action - General Rules for Physician's Orders section, "3. Must be completely understood before being carried out. If order cannot be carried out, physician must be contacted and alternate orders given."</p> <p>6. Policy No.: 2.10 titled, "Urine Drug Screen Collection" that was reapproved on 12/20/10, was reviewed at approximately 12:37 PM on 2/5/13 and indicated, on pg. 1, under:</p> <p>A. Purpose section, "Clients upon admission may be asked for a urine drug screen which will be tested for medication, and/or other drugs. The urine</p>						

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	<p>drug screen will be used to detect the presence of prescribed or otherwise obtained drugs which can, in some cases, endanger the client's life."</p> <p>B. Action section, "1. Upon admission a urine drug screen may be ordered by the physician."</p> <p>7. Policy No.: 7.00 titled, "Client Charts" and 7.01 titled, "General Inpatient Charting Rules" that was reapproved on 12/20/10, was reviewed at approximately 9:53 AM on 2/6/13 and indicated, on pg. 2, under Action - General Guidelines section, "20. All documentation will be fact, not conjecture...When physicians orders were carried out and the results."</p> <p>8. Review of closed patient medical records on 2/5/13 at 9:00 AM confirmed patient N8: A. per Physician's Orders dated 12/6/12 at 18:50 PM, a UDS (urine drug screen) was ordered (unless done in ER [Emergency Room]). B. lacked documentation UDS was done in ER.</p> <p>9. Review of Chart Audit dated 12/11/12 on 2/6/12 at 9:11 AM for patient N1 indicated no lab reports done during this admission.</p> <p>10. Personnel P1 was interviewed on</p>			

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	<p>2/6/13 at approximately 2:40 PM, and confirmed patient N8 had an order on admission for a UDS and lacked documentation that it was completed. Facility policy and procedure was not followed.</p> <p><u>Inaccurate documentation of allergies:</u></p> <p>11. Review of closed patient medical records on 2/5/13 at 9:00 AM confirmed patient N7: A. per History and Physical dated 11/6/12 at 10:02 AM, had an allergy to Omnicef. B. per Pharmacy Enrollment Form dated 11/6/12, allergies listed as NKDA (No Known Drug Allergies). C. per Physician's Orders dated: a. 11/6/12 at 01:00 AM, Omnicef listed as an allergy. b. 11/8/12 at 19:20 PM, allergies listed as NKDA.</p> <p>12. Personnel P1 was interviewed on 2/6/13 at approximately 2:40 PM, and confirmed patient N7 had an allergy documented as Omnicef on some forms and then as NKDA on others. Facility policy and procedure was not followed.</p>						

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A000450	<p>482.24(c)(1) MEDICAL RECORD SERVICES All patient medical record entries must be legible, complete, dated, timed, and authenticated in written or electronic form by the person responsible for providing or evaluating the service provided, consistent with hospital policies and procedures. Based on policy and procedure review, medical record review, and personnel interview, the facility failed to ensure patient medical records were complete and consistent with hospital policies and procedures related to documentation of medications given for 1 of 9 (N5) and completion of transfer forms for 2 of 9 (N3 and N4) closed patient medical records reviewed.</p> <p><u>Findings:</u></p> <p><u>Inaccurate documentation of medications given:</u></p> <p>1. Policy No.: 5.04 titled, "Use of Restraint/Seclusion Patient Monitoring Flow Sheet" that was reapproved on 12/20/10, was reviewed at approximately 10:06 AM on 2/6/13 and indicated, on pg. 2, under Action - Sheet section, "F. Document...medication given..."</p> <p>2. Policy No.: 7.00 titled, "Client Charts" and 7.01 titled, "General Inpatient Charting Rules" that was reapproved on</p>	A000450	To comply with this standard, Porter-Starke Services, Inc. provided education to all registered nurses regarding utilization of the transfer form and transfer log, medication administration and documentation. This education was provided by the nursing supervisor on February 22, 2013. Emphasis was placed on the seclusion and restraint packet where this error occurred. The transfer form was moved to the transfer log to make it more user-friendly. Every three months, management will audit the transfer log and the medical record to ensure consistency and completion of the transfer form. Responsible for this correction is Andrea Farmer, RN, Nursing Supervisor	02/22/2013			

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	<p>12/20/10, was reviewed at approximately 9:53 AM on 2/6/13 and indicated, on pg. 2, under Action - General Guidelines section, "5. Chart all medications and treatments on medication and treatment sheets...20. All documentation will be fact, not conjecture...When physicians orders were carried out and the results."</p> <p>3. Review of closed patient medical records on 2/5/13 at 9:00 AM confirmed patient N5:</p> <p>A. per Medication Orders dated 12/18/12, "Haldol 5 mg p.o./IM (by mouth or intramuscularly) every 8 hours prn (as needed) for agitation, Cogentin 1 mg IM/p.o. every 8 hours, Ativan 2 mg IM/p.o. every 8 hours for anxiety."</p> <p>B. per Restraint/Seclusion Physician Order dated 12/19/12 at 16:20 PM, "Given PRN medication that was already in place. Given Haldol 5 mg IM, Cogentin 1 mg IM, Ativan 2 mg IM due to attacking staff after given long acting shot...Please refer this order to the Seclusion/Restraint Justification."</p> <p>C. per Restraint/Seclusion Justification dated 12/19/12 at 16:20 PM, "PRN/STAT medication given - Haldol 5 mg IM and Ativan 2 mg IM."</p> <p>D. per Restraint/Seclusion Physician One Hour Assessment dated 12/19/12 at 17:10 PM, "PRN/STAT medication given at 16:20 PM - Haldol 5 mg IM and Ativan</p>			

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	<p>1 mg IM." E. per Non-Scheduled Medication Sheet, medications given on 12/19/12 at 16:20 PM were: Haldol 5 mg IM, Cogentin 1 mg IM, and Ativan 2 mg IM. F. lacked documentation that Cogentin 1 mg IM was given on the Restraint/Seclusion Justification form and the Restraint/Seclusion Physician One Hour Assessment form.</p> <p>4. Personnel P1 was interviewed on 2/5/13 at approximately 2:40 PM, and confirmed documentation in the medical record for patient N5 was not complete and there were inconsistencies on different forms related to what medications the patient was given. Facility policy and procedure was not followed.</p> <p><u>Lack of completion of transfer forms:</u></p> <p>5. Policy No.: 3.07 titled, "Client Transfer - Emergency Medical Situations" that was reapproved on 12/20/10, was reviewed at approximately 10:25 AM on 2/5/13 and indicated, on pg. 2, under Action section, "6. The Certification and Authorization Transfer Form will be completed by the nurse, and will accompany the client, along with any relevant medical records."</p>				

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	<p>6. Policy No.: 6.07 titled, "Medication Orders" that was reapproved on 12/20/10, was reviewed at approximately 10:40 AM on 2/6/13 and indicated, on pg. 1, under C. Transfer Orders section, "2. Transfer Orders are transcribed to The Certification and Authorization Transfer Form."</p> <p>7. Review of closed patient medical records on 2/5/13 at 9:00 AM confirmed patient:</p> <p>A. N3:</p> <p>a. per Physician's Orders dated 8/8/12 at 19:00 PM, "Send client to ER (Emergency Room) for medical clearance."</p> <p>b. per Nursing Assessment dated 8/8/12 at 8:59 PM, "[Ambulance] arrived to take patient back to the ER for medical clearance."</p> <p>c. lacked documentation of a Certification and Authorization Transfer Form.</p> <p>B. N4:</p> <p>a. per Physician's Orders dated 9/6/12 at 00:10 AM, "Please send client to ER for evaluation."</p> <p>b. per Nursing Assessment dated 9/6/12 at 7:55 AM, "Client did finally get into ambulance."</p> <p>c. lacked documentation of a Certification and Authorization Transfer</p>			
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	<p>Form.</p> <p>8. Personnel P1 was interviewed on 2/5/13 at approximately 2:40 PM, and confirmed patients N3 and N4 were transferred to an acute care facility for medical emergency situations and lacked documentation of a Certification and Authorization Transfer Form. Facility policy and procedure was not followed.</p>			

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A000505	<p>482.25(b)(3) UNUSABLE DRUGS NOT USED Outdated, mislabeled, or otherwise unusable drugs and biologicals must not be available for patient use.</p> <p>Based on policy and procedure review, observation, and personnel interview, the pharmaceutical service failed to ensure outdated, mislabeled, or otherwise unusable drugs and biologicals were not available for patient use in 1 of 1 (Inpatient Care Center) area toured.</p> <p>Findings: 1. Policy No.: 6.13 titled, "Consultant Pharmacist Responsibilities" that was reapproved on 12/20/10, was reviewed at approximately 9:40 AM on 2/6/13 and indicated, on pg. 1, under Action section, "The Consultant Pharmacist shall be responsible for the general supervision of the facilities Pharmaceutical services. These responsibilities shall include: 1. General supervision of the facilities procedure for the control, storage and accountability for all drugs and biologicals throughout the facility and that such drugs and biologicals shall be approved and dispensed in compliance with state and federal laws and the facilities own policy and procedures...4. Supervision or the labeling of all drugs and biologicals to ensure that such labeling is based on currently accepted professional principles and includes the</p>	A000505	<p>To comply with this standard, Porter-Starke Services, Inc. provided education to the registered nurses and reviewed policies regarding checking for expired medications and ensuring open dates were on all opened medications. This training was provided by the nursing supervisor on February 22, 2013. At this time, policies were reviewed with all registered nurses regarding checking expiration dates on all medications as well as destruction of medications. Additionally, our pharmacy provider is now labeling stock drugs with expiration dates sooner than the actual expiration dates. The Pharmacist will continue weekly checks of medication room to check for expired and opened medications. Responsible for this correction is: Andrea Farmer, RN, Nursing Supervisor</p>	02/22/2013	

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	<p>appropriate accessory and cautionary instructions."</p> <p>2. Policy No.: 6.14 titled, "Expiration Dates" that was reapproved on 12/20/10, was reviewed at approximately 9:40 AM on 2/6/13 and indicated, on pg. 1, under:</p> <p>A. Purpose section, "To assure adequate potency and effectiveness of medication."</p> <p>B. Action section, "2. When repackaged into vials, bottles, or blister pack the expiration date will be the manufacturer's expiration date or one year. 3. On vials of medication the "Date Opened" sticker should be applied. Expiration date is 30 days from date opened. 4. Nurses will monitor expiration date, out dated medication should be destroyed per policy."</p> <p>3. While on tour of the Inpatient Care Center on 2/6/13 at approximately 11:15 AM, in the company of personnel P1, the following was observed in the medication room:</p> <p>A. one open vial of Novolin R, lot #AZF0141, expiration date 8/13, opened date 9/17/12, which is greater than 30 days.</p> <p>B. one open vial of Novolin 70/30, lot #BZF0055, expiration date 5/14, opened date 9/29/12, which is greater than 30 days.</p> <p>C. one open vial of Humulin 70/30, lot</p>			

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	<p>#A889292G, expiration date 5/14, lacked opened date.</p> <p>D. one open vial of Novolog, lot #BZF0227, expiration date 8/14, lacked opened date.</p> <p>E. one open vial of Novolog, lot #BZF0202, expiration date 7/14, lacked opened date.</p> <p>F. one open vial of Lantus, lot #A2408, expiration date 4/14, lacked opened date.</p> <p>G. one open vial of Lantus, lot #A2457, expiration date 6/14, lacked opened date.</p> <p>H. one open vial of Lantus, lot #A2479, expiration date 8/14, lacked opened date.</p> <p>I. one open vial of Lantus, lot #1F255A, expiration date 10/13, lacked opened date.</p> <p>J. one open vial of Lantus, lot #2F020A, expiration date 6/14, lacked opened date.</p> <p>K. five vials of Haloperidol 5 mg/ ml for injection, lot #6103657, expiration date on vial 3/14 but on label on box 1/14.</p> <p>L. 3 bottles of Sterile Water 10 ml for injection. lot #05-003-DK, expiration date on bottle 5/14 but on label on box 1/13.</p> <p>M. five vials of Promethazine HCI 25 mg/ml for injection, lot #061438, expiration date on vial 6/13 but on label on box 12/13.</p> <p>N. two vials of Tigan 200 mg/2 ml for injection, lot #148667, expiration date on vial 7/13 but on label on box 11/13.</p> <p>O. three vials of Benztropine Mesylate 2 mg/ ml for injection, lot #L071212,</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 154052	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/06/2013
NAME OF PROVIDER OR SUPPLIER PORTER-STARKE SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 701 WALL ST VALPARAISO, IN 46383		
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	<p>expiration date on vial 7/14 but on label on box 1/14.</p> <p>4. Personnel P1 was interviewed on 2/6/13 at approximately 11:35 AM, and confirmed the above-mentioned medications were mislabeled: more than 30 days had passed since the date opened; lacked a date the medication was opened; and/or expiration date on label on box did not match the expiration date on the medication. Facility policy and procedure was not followed related to labeling and/or not using outdated medications.</p>				

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A000701	<p>482.41(a) MAINTENANCE OF PHYSICAL PLANT The condition of the physical plant and the overall hospital environment must be developed and maintained in such a manner that the safety and well-being of patients are assured.</p> <p>Based on document review and staff interview, the facility failed to evidence a coordinated comprehensive emergency preparedness plan. Thus the facility failed to assure the safety and well being of all patients.</p> <p>Findings:</p> <p>1) Upon interview on February 5, 2013 at 11:30am, Employee # A2 indicated that documentation was not available giving a comprehensive plan for emergency preparedness. Employee #A2 further indicated no participation in Emergency Disaster Preparedness Planning groups on either a local, state or federal level; and further indicated evidence of exercising a plan was not available for review.</p> <p>Thus the facility failed to ensure a coordinated comprehensive emergency disaster plan.</p> <p>2) No further documentation was made available prior to survey exit.</p>	A000701	<p>To comply with this standard, Porter -Starke Services, Inc. met with Porter County Emergency Management team on March 8, 2013 and with the Porter County Health Department on February 28, 2013 so Porter-Starke Services, Inc. can be a part of their meeting. Second, Porter-Starke Services is attending the Local Emergency Planning Commission so we can be involved in community exercises. Third, a member of our safety team will be attending a seminar titled "When it Happens" which focuses on the Joplin, Missouri tornado and what the community did right and wrong during this crisis. Fourth, a member of our safety team is involved with the District 1 exercise and training committee which meets on the first Tuesday of each month. Last, a member of the safety team met with the Porter County Health Department on February 28, 2013 to discuss being a part of chemical/biological emergency response plan. Also, the scope of Porter-Starke Services, Inc. disaster plan is being revised to include the information provided in these meetings above. Responsible for</p>	03/08/2013

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			this correction is: David Czekaj, Facilities Director	