

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150059	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/08/2012
NAME OF PROVIDER OR SUPPLIER RIVERVIEW HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 395 WESTFIELD RD NOBLESVILLE, IN 46060		
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S0000	<p>The visit was for a licensure survey.</p> <p>Facility Number: 005054</p> <p>Survey Date: 02-06-12 to 02-08-12</p> <p>Surveyors: Brian Montgomery, RN Public Health Nurse Surveyor Linda Plummer, RN Public Health Nurse Surveyor Janelli Salomon-Angeles Medical Surveyor 3</p> <p>QA: claughlin 02/20/12</p> <p>4/19/12 revised due to IDR</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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S0308	<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 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 document review and interview, the facility failed to ensure that orientation to applicable hospital and department policy/procedures was provided to contracted service housekeeping personnel.</p> <p>Findings:</p> <p>1. On 2-07-12 at 0930 hours, staff A2 was requested to provide a policy/procedure and documentation of orientation for housekeeping staff providing services at off-site locations and none was provided prior to exit.</p> <p>2. On 2-07-12 at 1530 hours,</p>	S0308	<p>Cleaning service vendors were notified of the need to provide documentation of orientation/training and competency for general cleaning and disinfecting of high touch surfaces at the off-site locations. The vendors were notified to supply documentation of orientation and competency for each employee who provides cleaning services at the Riverview locations. Documentation will be submitted to Riverview by the vendors within the next 30 days on forms provided by Riverview Hospital. The "Cleaning Vendor Orientation Form" is attached for your review. The "Off-site Contract Cleaning Requirements" policy was approved on March 1, 2012. The policy is attached for your review. Rick Whitton, Manager of Environmental Services is responsible for maintaining</p>	03/20/2012			

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	housekeeping manager A12 confirmed that the facility lacked documentation of orientation for the contracted housekeeping staff working at off-sites.		orientation and competency documents for each contracted cleaning employee.		

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S0318	<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: (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>Based on document review, the facility failed to ensure cardiopulmonary resuscitation (CPR) competency for all health care workers who provide direct patient care for 4 of 13 medical staff reviewed.</p> <p>Findings:</p> <p>1. The Medical Staff Bylaws (approved 11-8-11) indicated the following: [5.1.2 (b) 7] " Proof of current CPR certification when required by specialty/clinical privilege. "</p> <p>2. On 2-08-12 at 1045 hours, staff A14 confirmed that the bylaws failed to</p>	S0318	<p>Tag 318 - Response: <u>March 20, 2012</u> The Medical Staff Bylaws Committee will meet in April to discuss amending the CPR requirement stated in the current Medical Staff Bylaws. The proposed amendment to the Application Processing Requirements section of the Bylaws is as follows, "Physicians who provide direct patient care must show proof of current cardiopulmonary resuscitation (CPR) certification. Direct patient care physicians are those who administer moderate sedation, are expected to provide rescue therapy during cardiopulmonary events or when required by specialty/clinical privilege." See attached document titled "Medical Staff Bylaws-CPR". <u>April 20, 2012</u> The Bylaws Committee will submit the proposed revision for</p>	03/20/2012			

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	require CPR certification for all direct care staff.		review at the General Medical Staff meeting on May 8, 2012. The proposed revision includes the CPR statement, "Physicians who provide direct patient care must show proof of current cardiopulmonary resuscitation (CPR) certification. Direct patient care physicians are those who administer moderate sedation, are expected to provide rescue therapy during cardiopulmonary events or when required by specialty/clinical privilege." <u>May 20, 2012</u> The revised Medical Staff Bylaws were approved by the General Medical Staff and will be forwarded to the Board. <u>June 20, 2012</u> The revised Medical Staff Bylaws will be presented to the Board on June 26, 2012 for final approval. IDR Based on the inconsistency in interpretation of Tag S318 among ISDH surveyors, Riverview requests removal of Tag S 318 from our 2012 survey report. During Riverview's January 2003 ISDH survey, the Administrative Surveyor recommended language changes be made to the Medical Staff Bylaws to reflect compliance with Tag S318. In April 2003, the statement "Proof of current cardiopulmonary resuscitation (CPR) certification when required by specialty/clinical privilege" was added to the to the Application Processing Requirements section of the Medical Staff Bylaws. See Attachment A -Medical Staff Bylaws Meeting Minutes		

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			4-18-2003. The amendment was approved by the Bylaws Committee in April 2003 and the General Medical Staff in May 2003. The statement has remained unchanged in the Bylaws since 2003. ISDH and HFAP surveyors have accepted the CPR statement in the Medical Staff Bylaws at all surveys conducted between 2004 and 2011. The Suburban Health Organization conducted a query of other local area hospitals regarding the CPR requirement for physicians during the week of February 27, 2012. The survey revealed inconsistent CPR requirements for physicians. In addition, the other hospitals stated they had not received any ISDH deficiencies on the topic during their last survey.		

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S0332	<p>410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1(c)(6)(L)</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: (L) Demonstrating and documenting personnel competency in fulfilling assigned responsibilities and verifying inservicing in special procedures.</p> <p>Based on document review and interview, the facility failed to document contracted housekeeping personnel competency for cleaning and disinfecting areas at off-site locations for 4 contracted services.</p> <p>Findings:</p> <ol style="list-style-type: none"> On 2-06-12 at 1330 hours, staff A2 was requested to provide documentation of all agreements between the hospital and contracted housekeeping services and one was provided prior to exit. The agreement lacked a provision for housekeeping staff to clean high touch surfaces with a hospital-approved disinfectant. On 2-07-12 at 0930 hours, staff A2 was requested to provide documentation 	S0332	<p>Cleaning service vendors were notified of the need to provide documentation of employee orientation/training and competency for for general cleaning and disinfecting of high touch surfaces at the off-site locations. The vendors were notified to supply documentation of orientation and competency for each employee who provides cleaning services at the Riverview locations. Documentation will be submitted to Riverview Hospital by the vendors within the next 30 days on forms provided by Riverview Hospital. The Cleaning Vendor Competency Form is attached for your review. The "Off-site Contract Cleaning Requirements" policy was approved on March 1, 2012. The policy is attached for your review. Rick Whitton, Manager of Environmental Services is</p>	03/20/2012			

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	<p>of competency for all housekeeping staff providing services at off-site locations and none was provided prior to exit.</p> <p>3. During an interview on 2-07-12 at 1530 hours, staff A12 confirmed that the hospital lacked documentation of competency for 4 services providing housekeeping staff at off-site locations.</p>		<p>responsible for maintaining orientation and competency documents for each contracted cleaning employee.</p>		

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S0394	<p>410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1(f)(3)</p> <p>(f) The governing board is responsible for services delivered in the hospital whether or not they are delivered under contracts. The governing board shall insure the following:</p> <p>(3) That the hospital maintains a list of all contracted services, including the scope and nature of the services provided.</p> <p>Based on document review and interview, the facility failed to maintain a list of all contracted services, including the scope and nature of services provided for 14 contracted services.</p> <p>Findings:</p> <p>1. On 2-06-12 at 1430 hours, a list of contracted services was received from staff A2. The list of services failed to indicate a service provider for air exchange certification, commercial dishwasher, 2 electric/electronic services, elevators, exhaust hoods, 2 fire protection -related services, hemodialysis, medical gas manifold certification, medical physics calibration, pest control, and 2 contracted housekeeping services.</p>	S0394	The Riverview Hospital Contract Services List was updated to include all equipment maintenance and repair service vendors, clinical services, and environmental services. A copy of the Riverview Hospital Contract Services List is attached for your review. The Contract Services List will be updated by Executive Leaders as new services are added. The List was placed in a secured folder on the hospital network computer system to enable the Executive Leaders to update the list as needed. The list will be reviewed and updated annually. Larry Christman, Chief Operating Office is responsible for ongoing compliance.	03/01/2012			

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	<p>2. Review of facility documentation indicated the following: air exchange certification was provided by SP1, commercial dishwasher maintenance by SP2, call system testing by SP3, multiple electric maintenance by SP4, elevator service was provided by SP5, exhaust hoods were inspected by SP6, fire service providers included fire panel testing and extinguisher service by SP7 and sprinkler service by SP8, hemodialysis by SP9, medical gas manifold service by SP10, medical physics calibration by SP11, pest control service by SP12, and 2 off-site contracted cleaning services SP13 and SP14.</p> <p>3. On 2-08-12 at 1600 hours, staff A2 indicated that the list of contracted services lacked the providers identified through facility documentation.</p>						

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S0406	<p>410 IAC 15-1.4-2 QUALITY ASSESSMENT AND IMPROVEMENT 410 IAC 15-1.4-2(a)(1)</p> <p>(a) The hospital shall have an effective, organized, hospital-wide, comprehensive quality assessment and improvement program in which all areas of the hospital participate. The program shall be ongoing and have a written plan of implementation that evaluates, but is not limited to, the following:</p> <p>(1) All services, including services furnished by a contractor.</p> <p>Based on document review and interview, the Performance Improvement Plan (PI) failed to ensure that contracted services were included in the PI program for 10 services.</p> <p>Findings:</p> <p>1. The Performance Improvement Plan (approved 12-11) lacked a provision for monitoring, evaluating, and reporting contracted services provided at the facility.</p> <p>2. Review of program documentation failed to indicate standards and periodic reporting for 4 contracted housekeeping</p>	S0406	<p>A quality assurance tool was developed for evaluation of each contracted cleaning service vendor. See attached QA Form for Off-site Cleaning Services. The Manager of Environmental Services will perform the quality assurance audits for each cleaning vendor at least once per quarter. Implementation of the tool will begin in March 2012. Audit results will be reported to the Safety Committee and Infection Prevention Committee. A tool to evaluate the services provided by equipment maintenance/repair and pest control vendors was developed. See attached Service Provider Evaluation Tool. Vendor evaluations will begin in 2nd quarter 2012. Evaluation of the equipment maintenance/repair will be reported to the Safety Committee. Rick Whitton,</p>	03/20/2012	

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	<p>services, 5 repair/maintenance/certification services (commercial dishwasher maintenance by SP2, elevator service by SP5, fire protection providers SP7 and SP8, pest control provider SP12) and 1 professional/technical service (medical physics calibration by SP11).</p> <p>3. During an interview on 2-08-12 at 1600 hours, staff A2 indicated that the facility lacked documentation for evaluating and reporting contracted services through the PI program.</p>		<p>Manager of Environmental Services is responsible for ongoing evaluation of contracted cleaning services.Scott Tripp, Operations Director, Engineering, Environmental Services, Laboratory is responsible for ongoing evaluation of equipment maintenance/repair and pest control services.</p>		

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S0592	<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 limited to, the following:</p> <p>(i) Sanitation.</p> <p>Based on document review and interview, the infection control (IC) program failed to follow its policy/procedure and ensure that contracted housekeeping services were provided in a safe and effective manner.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. The Infection Control Program (approved 11-10) description lacked a provision for the IC committee oversight of cleaning services provided at locations other than the hospital. 2. The policy/procedure Cleaning Agents 	S0592	<p>On February 17, 2012, the Infection Prevention Committee reviewed the list of cleaning products used by the cleaning vendors to clean off-site offices. The Committee requested the Manager of Environmental Services contact the vendors to discuss use of cleaning products that have already been approved by the Infection Prevention Committee. The Operations Director of Environmental Services and the Manager of Environmental Services are in the process of specifying the use of cleaning products that have been approved by Riverview's Infection Prevention Committee as a condition of service for the cleaning vendors. See attached Infection Control Meeting Minutes-Cleaning Products</p>	03/20/2012			

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	<p>(approved 12-10) indicated the following: "All cleaning procedures and agents will be reviewed by the Infection Control Committee."</p> <p>3. On 2-06-12 at 1330 hours, staff A2 was requested to provide documentation of all agreements between the hospital and contracted housekeeping services and one was provided prior to exit. The agreement indicated that the contractor would provide the cleaning chemicals used for disinfecting surfaces at the off-site location and failed to indicate any pre-determined criteria for cleaning product selection or otherwise provide a list of hospital-approved products for use by the service.</p> <p>4. On 2-06-12 at 1330 hours, staff A2 was requested to provide documentation of IC approval for cleaning agents used by offsite cleaning services and none was received prior to exit.</p> <p>5. During an interview on 2-06-12 at 1420 hours, staff A4 confirmed that the infection control committee lacked oversight for the off-site contracted</p>		<p>Section-Feb 2012. Transition to the Hospital approved cleaning products is expected to be completed within the next 30 days. The request for proposal for future cleaning service contracts was revised to include the statement, "Cleaning staff must clean all high touch surfaces with a Riverview Hospital approved disinfectant." A quality assurance tool was developed for evaluation of the contracted cleaning services. The tool includes monitoring of the cleaning chemicals used by each vendor. See attached QA Form for Off-Site Cleaning Services. The Manager of Environmental Services will perform the quality assurance audits for each cleaning vendor at least once per quarter. Audit results will be reported to the Safety Committee and Infection Prevention Committee. Rick Whitton, Manager of Environmental Services is responsible for ongoing compliance.</p>		

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	housekeeping services and products used by contracted housekeeping providers.				

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S0596	<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 and interview, the infection control practitioner failed to ensure an effective infection control plan was in place related to the possibility of cross contamination between the clean and dirty sides of the endoscopy scope cleaning area. This same endoscopy area open pass through window was cited in 8/2010 with the ISDH licensure survey at that time. The facility lacked a policy procedure for cleaning and disinfecting respiratory therapy equipment if not performed in the department.</p> <p>Findings: 1. at 11:25 AM on 2/7/12, while on tour with staff members A2 and A7, it was observed that the pass through window</p>	S0596	<p><u>Endoscopy Scope Cleaning Room</u> On February 29, 2012, Endoscopy staff were re-educated on the infection prevention requirement of keeping the pass through window closed between the endoscopy scope cleaning room and the scope storage room. To ensure the deficiency does not recur, the Manager of the Endoscopy area will perform random observation of the pass through window as part of daily department rounds. Any observed incidents of non-compliance will be addressed with the individual staff members. In addition, a quality assurance tool, "Organizational Assessment of Quality/Compliance" was created and includes random observation of the scope cleaning room. The tool will be</p>	03/01/2012			

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	<p>was open between the clean and dirty sides of the endoscopy services area (while scope cleaning was in process) and no items were being passed through</p> <p>2. a return to the endoscopy clean/dirty areas at 2:10 PM on 2/7/12 in the company of staff members A2 and A7, found that the pass through window was still open between the clean and dirty sides</p> <p>3. on 2/7/12 at 11:25 AM, staff member A7 confirmed that the pass through window should only be open when disinfected items are being moved into the clean room for storage</p> <p>4. During a tour on 02-07-12 at 1130 hours, in the respiratory department, the following condition was observed: no provision for receiving, cleaning and disinfecting soiled equipment prior to placing into the clean storage area.</p> <p>5. During an interview on 2-07-12 at 1135 hours, staff A11 indicated that all department equipment was cleaned and disinfected in the patient room or unit prior to transport to the department for storage.</p> <p>6. On 2-08-12 at 0920 hours, staff A14 was requested to provide a</p>		<p>implemented on March 15, 2012 and completed at least every other month by each clinical department. The quality assurance reports will be reviewed by the Nurse Leadership Team. Suzanne Pipas, Manager Endo, SSC, & IV Team is responsible for continued compliance. <u>Respiratory Therapy Equipment</u> On February 22, 2012, the procedure for cleaning and storing of respiratory equipment was communicated to Respiratory Therapy staff during a department meeting. On March 1, 2012, the "Respiratory Equipment Cleaning and Supply Replacement" policy was approved and implemented to address the procedures for cleaning respiratory therapy equipment after patient use and storage of the clean equipment. A copy of the "Respiratory Equipment Cleaning and Supply Replacement" policy is attached for your review. The Respiratory Therapy Manager will perform random observation audits at least once per month to ensure staff's adherence to the new cleaning policy. Tricia Hall, Manager of Respiratory Therapy is responsible for continued compliance.</p>		

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	<p>policy/procedure indicating where soiled respiratory equipment will be cleaned and disinfected and none was received prior to exit.</p> <p>7. On 2-08-12 at 1410 hours, staff A14 confirmed that the hospital lacked a policy/procedure for cleaning soiled respiratory equipment outside of the department.</p>				

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S0608	<p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(f)(3)(D)(ix)</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>(ix) Requirements for personal hygiene and attire appropriate for work settings.</p> <p>Based on policy and procedure review, observation, and interview, the infection control practitioner failed to ensure standards of practice related to surgical masks were implemented in two observations of three staff members.</p> <p>Findings: 1. at 4:20 PM on 2/6/12, review of the policy and procedure "Surgical Attire", with an effective date of January 2011, indicated: a. under "Policy", on page 3, item #3., it reads: "All individuals entering restricted areas of the surgical environment must wear a mask when open sterile items are present...2. Masks should be removed carefully by handling only the ties and</p>	S0608	<p>On February 7, 2012, Cath Lab staff were re-educated on the "Surgical Attire" policy with emphasis on the removal of masks prior to leaving a procedure area. Re-education of the Endoscopy staff was completed on February 15, 2012. The "Surgical Attire" policy was reviewed with surgical staff during a department meeting on February 10, 2012. To ensure the deficiency does not recur, a quality assurance tool, "Organizational Assessment of Quality/Compliance" was created and includes random observation for proper use and removal of personal protective equipment. The tool will be implemented on March 15, 2012 and completed at least every other month by each</p>	02/15/2012			

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	<p>should be discarded immediately."</p> <p>2. at 11:25 AM on 2/7/12, while on facility tour with staff members A2 and A7, it was observed in the endoscopy disinfection room that the staff member/endo tech was in the process of gross decontamination and cleaning of endoscopes and had the PPE (personal protective equipment) out of place (surgical mask under chin/about the neck)</p> <p>3. at 11:50 AM on 2/7/12, while exiting an elevator in preparation of touring the ICU (intensive care unit) in the company of staff member NA, it was observed that two cath lab staff members were pushing an empty gurney onto the elevator with surgical masks down about the neck</p> <p>4. at 2:10 PM on 2/7/12, interview with staff member NJ indicated: a. even though it is not specific in the "Surgical Attire" policy and procedure, staff should not be wearing surgical masks about the neck (this is a new AORN-association of peri operative registered nurses-recommendation)</p>		clinical department. The quality assurance reports will be reviewed by the Nurse Leadership Team. Clinical Operations Directors are responsible for continued compliance.				

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S0718	<p>410 IAC 15-1.5-4 MEDICAL RECORD SERVICES 410 IAC 15-1.5-4 (c)(3)</p> <p>(c) An adequate medical record shall be maintained with documentation of service rendered for each individual who is evaluated or treated as follows:</p> <p>(3) The hospital shall use a system of author identification and record maintenance that ensures the integrity of the authentication and protects the security of all record entries. Each entry shall be authenticated promptly in accordance with the hospital and medical staff policies.</p> <p>Based upon document review, the facility lacked a policy/procedure authorizing use of electronic authentication for entries in the medical record (MR).</p> <p>Findings:</p> <p>1. On 2-06-12 at 1050 hours, staff A2 was requested to provide documentation of a hospital-approved electronic signature process for authenticating entries in the MR and none was provided prior to exit.</p> <p>3. On 2-08-12 at 1450 hours, staff A2 indicated that the MR policies lacked a provision for electronic authentication of entries in the patient record.</p>	S0718	<p>On March 1, 2012, the "Authentication of the Medical Record" policy was revised to further define the term "computer key". The revised policy states, "Authentication means to establish authorship by written signature, identifiable initials, or computer key. Computer key is the term used to denote a date and time stamped electronic signature. Electronic signatures require the use of a user password associated with the specific type of computer software used." A copy of the "Authentication of the Medical Record" policy is attached for your review. Policies will continue to be reviewed at least every three years to ensure content reflects regulatory requirements and current practice. Muriel Baldoni, Manager, Health</p>	03/01/2012			

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			Information Manager is responsible for ongoing compliance. Addendum May 30, 2012: Other components of Tag 718 are also addressed in various policies and the Medical Staff Bylaws. Examples are as follows: <u>Medical Record Entry Requirements</u> for physicians and allied health professionals are addressed in section 2.3.1 of the Medical Staff Bylaws and in the hospital policy "Documentation Guidelines for the Healthcare Record". <u>Author Identification & Authentication Integrity</u> are addressed in sections 2.8.1 – 2.8.3 of the Medical Staff Bylaws and in the hospital policy "Documentation Guidelines for the Healthcare Record". <u>Security of Medical Record Entries</u> is addressed in section 2.13.2 of the Medical Staff Bylaws and in the hospital policy "Confidentiality of Patient Information". <u>Prompt Authentication of Medical Record Entries</u> is addressed in section 2.4.3 of the Medical Staff Bylaws and in the hospital policy "Documentation Guidelines for the Healthcare Record". <u>Sanctions for Delinquent Records</u> are addressed in sections 2.1.2; 2.12.2; and 2.14.1-2.14.3 of the Medical Staff Bylaws. <u>Sanctions for Misuse of Electronic Authentication</u> are addressed in the hospital policies titled "Computer Network Resources" policy and "Unauthorized Access	

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			or Breach of Protected Health Information". IDR Riverview requests removal of Tag S 718 from our 2012 survey report. The current "Authentication of the Medical Record" policy meets the intent of author identification in the medical record as stated in Tag S 718. See attachment B-Authentication of the Medical Record. On February 7, 2012, the Administrative Surveyor was provided with a copy of the "Authentication of the Medical Record" policy. On February 8, 2012, the surveyor was directed to item #2 in the policy which states, "Authentication means to establish authorship by written signature, identifiable initials, or computer key." It was explained to the surveyor that "computer key" is the term used for electronic signature and a computer access code is required for the electronic signature to be used.		

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S0744	<p>410 IAC 15-1.5-4 MEDICAL RECORD SERVICES 410 IAC 15-1.5-4 (e)(1)</p> <p>(e) All entries in the medical record shall be:</p> <p>(1) legible and complete;</p> <p>Based on review of medical staff rules and regulations, patient medical record review, and staff interview, the facility failed to ensure the completion of ED (emergency department) medical records for 4 of 4 patients (N1, N2, N3 and N4) and the center lacked a policy/procedure ensuring that all entries in the medical record (MR) were legible.</p> <p>Findings:</p> <p>1. at 3:55 PM on 2/8/12, review of the Medical Staff Rules and Regulations, with an approved dated of November, 2011, indicated:</p> <p>a. under section 2.1 "MEDICAL RECORDS", it reads: "2.1.1. The attending Practitioner shall be responsible for the preparation of a complete and legible medical record for each patient..."</p> <p>2. at 1:15 PM on 2/6/12, while on tour of the ED, review of four patient medical records, of those who received care on 2/6/12, indicated:</p> <p>a. pt. N1 lacked documentation of the "MD Time" and "Severity 1 - 10" pain</p>	S0744	<p><u>Legible Medical Record March 20, 2012</u> The "Documentation Guidelines for the Healthcare Record" policy was revised to include a provision for verifying illegible information in the medical record. The revision included the addition of the statement, "All medical record entries must be legible. Any entry determined by the end user to be illegible must be clarified by the author of the original entry. Clarification options include, but are not limited to, amending the record with another hand-written entry or dictating the entry for transcription and placement in the medical record. " The policy will be reviewed by the designated committees and persons as part of the formal approval process. A copy of the revised "Documentation Guidelines for the Healthcare Record" policy is attached for your review. See page 3, #5. The Organizational Improvement Department will perform random medical records audits at least once per quarter to track and trend physician specific legibility issues. Individual physician trends of illegibility will be addressed with the physician by the appropriate</p>	03/20/2012			

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	<p>level on the "Emergency Department Physician Medical Record" form (nursing had noted a pain level of 5 out of 10)</p> <p>b. pt. N2 lacked documentation of the "MD Time" and "Severity 1 - 10" pain level on the "Emergency Department Physician Medical Record" form</p> <p>c. pt. N3:</p> <p>A. lacked documentation in the area of "Severity 1 - 10" pain level on the "Emergency Department Physician Medical Record" form (nursing documented the patient's pain level as a 10 out of 10)</p> <p>B. lacked an admission B/P (blood pressure) check on both the "Emergency Department Physician Medical Record" form and the "Emergency Center Nursing Record" form (no B/P was taken/documentated on admission or on discharge--patient noted as having a history of hypertension)</p> <p>d. pt. N4:</p> <p>A. lacked documentation of the "MD Time", "Chief Complaint", and "Severity 1 - 10" pain level on the "Emergency Department Physician Medical Record" form</p> <p>B. lacked documentation by nursing on the "Emergency Center Nursing Record" form in the "Pain scale.....(Rate 0 - 10)" section in the Triage area (there was also no pain documentation in the computer/electronic medical record)</p>		<p>Medical Staff Department Chairperson, Chief Medical Officer, or designee. The hospital continues to move forward with a complete electronic medical record and elimination of the paper record. Implementation of the electronic record will eliminate legibility issues in the future. Overall medical record audit results for legibility will be reviewed at least two times per year by the Quality Review Committee. John Paris, MD, Chief Medical Officer is responsible for continued compliance. <u>April 20, 2012</u> As part of the formal policy approval process the Documentation Guidelines for the Healthcare Record" policy will be reviewed by the Multidisciplinary Policy Committee, Nursing Leadership, HR Director, HIM Manager, and Operations Directors. <u>May 20, 2012</u> The Documentation Guidelines for the Healthcare Record" policy will be approved by June 1, 2012. <u>Complete Medical Record - Physician March 20, 2012</u> On Feb. 8, 2012, the Emergency Center physicians were notified of the need to document the time seen by the physician on the paper copy of the "Emergency Department Physician Medical Record" form. In addition, the EC physicians were notified of the need to document the chief complaint, assessment of pain status, and why pain medication</p>				

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	<p>e. patients N1, N2, N3 and N4 were all lacking completion in the lower portion of the "Emergency Center Nursing Record" form related to discharge vital signs</p> <p>3. interview with staff members NF and NG at 2:15 PM on 2/6/12, indicated:</p> <p>a. the physician doesn't always complete the "MD Time" seen by the practitioner on the "Emergency Department Physician Medical Record" form, as the practitioner enters into the computer an "assigned/accepted" time (when he/she accepts the patient) and considers this a "time seen"</p> <p>b. it cannot be determined that an accepted time is a time seen</p> <p>c. some of the nursing documentation is in the electronic medical record and not on the paper documentation, making it difficult to determine that all areas of an assessment were completed</p> <p>d. patients N1, N2, N3 and N4 were triaged at a level 4 and did not require discharge vital signs</p> <p>e. there is nothing in writing (no policy/procedure statement), but it is the practice of the ED, to only do discharge vital signs on patients who triaged at a level 1, 2 or 3</p> <p>4. On 2-06-12 at 1050 hours, staff A2 was requested to provide a</p>		<p>was not administered for any patient presenting with pain. The hospital continues to move forward with a complete electronic medical record and elimination of the paper record. Once the migration occurs, physicians and nurses will have computers available in each Emergency Center patient room to facilitate "real time" documentation and enhance the communication of patient status between healthcare providers. In the meantime, the Emergency Center Manager will perform random medical record audits at least once per quarter to determine continued compliance with documentation of time seen, chief complaint, pain status, and why pain medication was not administered if patient presented to the EC with pain. The audits will include records completed by each Emergency Center Physician. Any occurrences of non-compliance will be addressed with the individual physician. The medical record audit results will be reviewed each quarter by Tammi Nash, Clinical Operations Director of Emergency, Heart & Vascular Center, Respiratory and Critical Care Services. Jill McKinney, Emergency Center Manager is responsible for continued compliance. <u>Complete Medical Record- Nursing March 20, 2012</u> The "Vital Signs in the Emergency Center" policy was developed and reviewed with the</p>				

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	<p>policy/procedure for verifying entries of questionable legibility and none was provided prior to exit.</p> <p>5. On 2-08-12 at 1450 hours, staff A2 confirmed that the MR policies lacked a provision for verifying illegible information in the patient record.</p>		<p>Emergency Center Medical Director and Chief Nursing Officer. As part of the formal policy approval process, the policy will be reviewed by the Emergency Medicine Medical Staff Committee. A copy of the "Vital Signs in the Emergency Center" policy is attached for your review. On March 1, 2012, Emergency Center nurse education was initiated to re-educated nurses on the need to document all patient vital signs and pain status assessments in the medical record. The "Riverview Hospital Legal Health Record" policy defines the legal medical record as a combination of electronic documentation and paper documents. A copy of the "Riverview Hospital Legal Health Record" policy is attached for your review. The hospital continues to move forward with a complete electronic medical record and elimination of the paper record. Once the migration occurs, physicians and nurses will have computers available in each Emergency Center patient room to facilitate "real time" documentation and enhance the communication of patient status between healthcare providers. The Emergency Center Manager will perform random medical record audits at least once per quarter to determine continued compliance with documentation of vital signs and pain status. Any occurrences</p>		

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			of non-compliance will be addressed with the individual nurse. The medical record audit results will be reviewed each quarter by Tammi Nash, Clinical Operations Director of Emergency, Heart & Vascular Center, Respiratory and Critical Care Services. Jill McKinney, Emergency Center Manager is responsible for continued compliance. <u>April 20, 2012</u> The "Vital Signs in the Emergency Center" policy will be reviewed at the next Emergency Medicine Committee meeting on May 1, 2012. <u>May 20, 2012</u> The "Vital Signs in the Emergency Center" policy was approved by the Emergency Medicine Committee on May 1, 2012.		

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S0912	<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> <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, observation, and staff interview, the nurse executive failed to ensure the implementation of policies related to Glucometer control solutions and the lack</p>	S0912	<p><u>Glucose Control Solution</u> On February 6, 2012, expiration dates of all Accu-Chek glucose control solutions on the Medical-Surgical units were checked. No other instances of</p>	02/08/2012			

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	<p>of Fall prevention safety precautions implementation for 1 of 2 patients on the 3 West medical surgical nursing unit (Pt. N5).</p> <p>Findings:</p> <p>1. at 9:25 AM on 2/7/12, review of the policy and procedure "Accu-Chek Inform Whole Blood Glucose" policy indicated:</p> <p>a. on page 3 under "Accu-Chek Comfort Curve Glucose control solutions..", it reads: "...The glucose control solutions are stable 3 months after opening the bottles or until the expiration date, whichever comes first. The open date and new expiration date must be recorded on the vial label."</p> <p>2. at 4:20 PM on 2/6/12, review of the policy and procedure "Fall Prevention Program", with an effective date of November, 2010, indicated:</p> <p>a. Under "Procedure:", it reads on page 3., "1. Determine risk to fall category by adding the total points from the assessment or reassessment, as appropriate 1. Risk to fall = 9 points or greater...2. Implementation of Fall Prevention Program 1. Risk to fall patients will have a 'falling star' placed on the door frame and place a yellow wrist band on patient..."</p> <p>3. at 3:10 PM on 2/6/12, while on tour of</p>		<p>incorrect labeling were discovered. In addition, on March 1, 2012, all Accu-Chek glucose control solutions in use throughout the hospital were checked for correct labeling of the expiration date. Nursing staff were re-educated on the process for labeling Accu-Chek glucose control solutions. As part of the orientation process, Accu-Check training is provided for new employees who will perform bedside glucose monitoring. Annual competency checks are conducted for staff who perform Accu-Checks. To ensure the deficiency does not recur, a quality assurance tool, "Organizational Assessment of Quality/Compliance" was created and includes routine inspection of the Accu-Check control solutions. The tool will be implemented on March 15, 2012 and completed at least every other month by each clinical department. The quality assurance reports will be reviewed by the Nurse Leadership Team. The Clinical Operations Directors are responsible for ensuring monthly monitoring and corrective actions are performed. <u>Fall Prevention</u> On February 7, 2012, all patients on the Medical-Surgical units identified as at risk to fall were observed for the presence of a yellow arm band on their wrist and a yellow star on the doorway. Fall prevention interventions were implemented as needed. The Fall</p>		

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	<p>the 3 West medical surgical nursing unit in the company of staff members NA and NI, it was observed that the Accu-Chek glucometer control solutions were dated/labeled as opened on 11/21/11 and to expire on 6/21/12</p> <p>4. interview with staff members NA and NI at 3:10 PM on 2/6/12 indicated the expiration date for the control solutions after being opened on 11/21/11 should have been noted as 2/21/12</p> <p>5. at 3:15 PM on 2/6/12, while on tour of the 3 West medical surgical nursing unit in the company of staff members NA and NI, it was observed that pt. N2:</p> <ul style="list-style-type: none"> a. had a yellow falling star symbol placed on the door frame b. was assessed as a fall risk with a score of 15 (score of 9 or greater = high risk for falls) c. lacked the placement of a yellow fall risk wrist band as a fall precaution measure <p>6. interview at 3:30 PM on 2/6/12 with staff members NA and NI indicated pt. N2 should have had a yellow wrist band on as part of the implementation of fall precautions with a score of 15 points</p>		<p>Prevention Program requirements were reviewed with clinical staff during the department daily briefings that occurred at shift change. The electronic learning program titled, "Fall Prevention Program" was assigned to all clinical nurses. Nurses are required to complete the module before March 30, 2012. The learning module is included as part of new nurse orientation. To ensure the deficiency does not recur, a quality assurance tool, "Organizational Assessment of Quality/Compliance" was created and includes random observation for the use of yellow wrist bands and yellow stars for patients assessed as at risk to fall. The tool will be implemented on March 15, 2012 and completed at least every other month by each clinical department. The quality assurance reports will be reviewed by the Nurse Leadership Team. The Clinical Operations Directors are responsible for ensuring monthly monitoring and corrective actions are performed.</p>				

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S1118	<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 policy and procedure review, observation, document review, and staff interview, the facility failed to ensure that no condition was created that might result in a hazard to patients in relation to dirty refrigerators and one ice machine.</p> <p>Findings: 1. at 4:20 PM on 2/6/12, review of the policy and procedure "Refrigerators", with an effective date of August, 2010, indicated: a. under "Purpose", it reads: "To insure that all refrigerators are maintained in a manner to provide a safe environment for patients and employees." b. under "Policy", it reads: "...2. Refrigerators are to be kept clean and free of frost. The frequency of cleaning and defrosting is governed by the size of the refrigerator and/or freezer. Cleaning is to be documented on the temperature grid."</p>	S1118	<p><u>Ice Machine</u> On Feb. 10, 2012, the gasket was replaced in the ice machine located in the Express Care area. The Work Order for the Ice Machine Gasket is attached for your review. All ice machines in the hospital are inspected every 6 months by the Engineering Department as part of the preventative maintenance check. Inspection of the gaskets is included on the task list. Clinical staff were reminded to report dirty or malfunctioning ice machine issues to the Engineering Department. To ensure the deficiency does not recur, a quality assurance tool, "Organizational Assessment of Quality/Compliance" was created and includes inspection of ice machines for cleanliness. The tool will be implemented on March 15, 2012 and completed every other month by each clinical department. The quality assurance reports will be</p>	02/10/2012			

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	<p>2. at 1:50 PM on 2/6/12, while in the company of staff members NA and NG, it was observed in the Express Care (emergency department) area that the patient food/snack refrigerator had:</p> <ul style="list-style-type: none"> a. dirty shelves in the refrigerator door b. a vegetable drawer (in the lower portion) of the freezer that was dirty both inside the drawer and under the drawer with debris and red liquid that had spilled and soiled several areas (appeared to have been from melted popsicles) <p>3. review of the December, 2011 and January, February (to date), 2012 "Nutrition Refrigerator Temperature (Patient Food Items)" log/grid indicated:</p> <ul style="list-style-type: none"> a. item #7 at the top of the page reads: "Place a * under the date when the refrigerator/freezer is cleaned and/or defrosted." b. there is no indication on the 2 1/2 months of logs that cleaning of the Express Care refrigerator had been cleaned <p>4. interview with staff members NA and NG at 2:00 PM on 2/6/12 indicated:</p> <ul style="list-style-type: none"> a. the refrigerator was dirty and needed to be cleaned b. it is unknown when was the last time the refrigerator had been cleaned 		<p>reviewed by the Nurse Leadership Team. The Clinical Operations Directors are responsible for ensuring monthly monitoring and corrective actions are performed. In addition, random monitoring of ice machines will be performed by representatives of the Safety Committee during the monthly departmental Safety Tours. Incidents of non-compliance will be reported to the Safety Committee. Scott Tripp, Operations Director, Engineering, Environmental Services, Laboratory is responsible to ensure preventative maintenance of ice machines is performed. <u>Refrigerators</u> On Feb. 7, 2012, refrigerators and freezers in the Express Care and Maternity areas were cleaned. Refrigerators and freezers in all other clinical areas were inspected and cleaned as needed. To ensure the deficiency does not recur, a quality assurance tool, "Organizational Assessment of Quality/Compliance" was created and includes inspection of refrigerator and freezer cleanliness. The tool will be implemented on March 15, 2012 and completed every other month by each clinical department. The quality assurance reports will be reviewed by the Nurse Leadership Team. The Clinical Operations Directors are responsible for ensuring monthly</p>				

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	<p>5. at 11:00 AM on 2/7/12, while on tour of the out patient surgery area in the company of staff members NA and NJ, it was observed that the ice machine had a gasket that was dirty with debris making it unclear whether it was a dried out gasket that needed replacing, or if it was just dirty</p> <p>6. interview with staff members NA and NJ at 11:10 AM on 2/7/12, indicated:</p> <p>a. this ice machine is not used for drinks, but for ortho patients</p> <p>b. the gasket on the ice machine was dirty</p> <p>7. at 3:15 PM on 2/7/12, while on tour of the maternity area in the company of staff members NA and NM, it was observed that the post partum pantry freezer portion of the refrigerator/freezer had a dirty lower level (vegetable) drawer and the side slots that the drawer slides in and out of were also dirty</p> <p>8. interview with staff members NA and NM indicated:</p> <p>a. the temperature logs/grids did not indicate the last time the refrigerator/freezer had been cleaned</p> <p>b. facility policy only indicates refrigerators need to be cleaned as needed, it does not dictate a routine expectation for cleaning</p>		monitoring and corrective actions are performed.	

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S1510	<p>410 IAC 15-1.6-2 EMERGENCY SERVICES 410 IAC 15-1.6-2(b)(2)(A)(B)(C)</p> <p>(b) The emergency service shall have the following:</p> <p>(2) Written policies and procedures governing medical care provided in the emergency service are established by and are a continuing responsibility of the medical staff. The policies shall include, but not be limited to, the following:</p> <p>(A) Provision for the care of the disturbed patient.</p> <p>(B) Provision for immediate assessment of all patients presenting for emergency and obstetrical care.</p> <p>(C) Provision for transfer of patients when care is needed which cannot be provided.</p> <p>Based on policy and procedure review, patient medical record review, and staff interview, the facility failed to follow policy and procedure for patient care/assessments for 3 of 4 patients (N2, N3 and N4).</p> <p>Findings: 1. at 9:00 AM on 2/7/12, review of the policy and procedure "Aerosol Treatments", with an effective date of December, 2010, indicated: a. under "Procedure", in item 9., it reads: "Initiation of therapy...8. Check</p>	S1510	<p><u>Aerosol Treatments March 20, 2012</u> On Feb. 22, 2012 during a Respiratory Staff meeting, Respiratory staff were re-educated on the procedure for documenting heart rate, respiratory rate, and breath sounds before and after respiratory treatments. On March 1, 2012 the revised "Aerosol Treatments" policy was implemented. The revised policy defines "BS" as breath sounds. A copy of the "Aerosol Treatments" policy is attached for your review. See page 3. The Respiratory Therapy Manager will perform random medical record audits at</p>	03/20/2012

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	<p>HR (heart rate) and RR (respiratory rate) before and after treatment..."</p> <p>b. under "Procedure", in item 10., it reads: "Charting 1. All charting must indicate:...4. RR, HR, BS,(blood sugar) before and after treatment..."</p> <p>2. review of ED (emergency department) medical records, while on tour of the ED at 1:15 PM on 2/6/12, indicated:</p> <p>a. pt. N2:</p> <p>A. received an aerosol treatment of Albuterol at 7:53 AM on 2/6/12</p> <p>B. had documentation in the medical record of a heart rate of 104 and a respiratory rate of 22 prior to the aerosol treatment</p> <p>C. lacked documentation of the patient's heart rate and respiratory rate following the aerosol treatment</p> <p>3. at 4:20 PM on 2/6/12, review of the policy and procedure "Multidisciplinary Plan for Assessment/Reassessment/Continuum and Plan of Care", policy number HPP 05-18, indicated:</p> <p>a. under "Procedure", it reads: "1. Initial Assessment 1. An initial admission assessment is performed on patients in all clinical areas prior to the initiation of any treatment or procedure..."</p> <p>4. at 1:15 PM on 2/6/12, while on tour of</p>		<p>least once per quarter to determine continued compliance. The audits will include a sample of records completed by each Respiratory Therapist. Any occurrences of non-compliance will be addressed with the individual Therapist. The medical record audit report will be reviewed each quarter by Tammi Nash, Clinical Operations Director of Emergency, Heart & Vascular Center, Respiratory and Critical Care Services. In addition, the Respiratory Therapy annual competency checklist was revised to include pre and post respiratory treatment assessment. Tricia Hall, Manager of Respiratory Therapy is responsible for continued compliance. <u>Vital Signs & Pain Status March 20, 2012</u> The Emergency Center "Vital Signs in the Emergency Center" policy was developed and reviewed with the Emergency Center Medical Director. As part of the formal policy approval process, the policy will be reviewed by the Emergency Medicine Medical Staff Committee. A copy of the "Vital Signs in the Emergency Center" policy is attached for your review. On March 1, 2012, Emergency Center nurse education was initiated to re-educated nurses on the need to document patient vital signs and pain status in the medical record. The "Riverview Hospital Legal Health Record" policy</p>				

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	<p>the ED, review of four patient medical records, of those who received care on 2/6/12, indicated:</p> <p>a. pt. N3 lacked an admission B/P (blood pressure) check on both the "Emergency Department Physician Medical Record" form and the "Emergency Center Nursing Record" form (no B/P was taken/documented on admission or on discharge--patient noted as having a history of hypertension)</p> <p>b. pt. N4 lacked documentation by nursing on the "Emergency Center Nursing Record" form in the "Pain scale.....(Rate 0 - 10)" section in the Triage area (there was also no pain documentation in the computer/electronic medical record)</p> <p>5. interview with staff members NA and NB at 3:55 PM on 2/8/12, indicated:</p> <p>a. pt. N2 lacked ED staff documentation of vital signs post aerosol treatment, as per facility policy</p> <p>b. pts. N3 and N4 lacked completion of an assessment in regards to a B/P for pt. N3 and assessment of pain for pt. N4</p> <p>c. the policy, HPP 05-18 is not specific to vital signs and pain assessment, but these are expected, per standards of practice, to be included in an initial assessment and a reassessment</p>		<p>defines the legal medical record as a combination of electronic documentation and paper documents. A copy of the "Riverview Hospital Legal Health Record" policy is attached for your reference. The hospital continues to move forward with a complete electronic medical record and elimination of the paper record. Once the migration occurs, physicians and nurses will have computers available in each Emergency Center patient room to facilitate "real time" documentation. The Emergency Center Manager will perform random medical record audits at least once per quarter to determine continued compliance with documentation of vital signs and pain status. Any occurrences of non-compliance will be addressed with the individual nurse. The medical record audit results will be reviewed each quarter by Tammi Nash, Clinical Operations Director of Emergency, Heart & Vascular Center, Respiratory and Critical Care Services. Jill McKinney, Emergency Center Manager is responsible for continued compliance. <u>April 20, 2012</u> The "Vital Signs in the Emergency Center" policy will be reviewed at the next Emergency Medicine Committee meeting on May 1, 2012. <u>May 20, 2012</u> The "Vital Signs in the Emergency Center" policy was approved by the Emergency Medicine Committee</p>				

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S2022	<p>410 IAC 15-1.6-7 RESPIRATORY CARE SERVICES 410 IAC 15-1.6-7(d)(2)</p> <p>(d) Respiratory care services shall be; (2) documented in the medical record; and</p> <p>Based on policy and procedure review, patient medical record review, and staff interview, the facility failed to ensure the implementation of the respiratory therapy policy related to aerosol treatments and documentation of vital signs for 1 of 1 ED (emergency department) patient who received an aerosol treatment (N2).</p> <p>Findings: 1. at 9:00 AM on 2/7/12, review of the policy and procedure "Aerosol Treatments", with an effective date of December, 2010, indicated: a. under "Procedure", in item 9., it reads: "Initiation of therapy...8. Check HR (heart rate) and RR (respiratory rate) before and after treatment..." b. under "Procedure", in item 10., it reads: "Charting 1. All charting must indicate:...4. RR, HR, BS,(blood sugar) before and after treatment..."</p> <p>2. review of ED medical records, while on tour of the ED at 1:15 PM on 2/6/12, indicated: a. pt. N2:</p>	S2022	<p>On Feb. 22, 2012, during a Respiratory Staff meeting, Respiratory staff were re-educated on the procedure for documenting heart rate, respiratory rate, and breath sounds before and after respiratory treatments. On March 1, 2012, the revised "Aerosol Treatments" policy was implemented. The revised policy defines "BS" as breath sounds. A copy of the "Aerosol Treatments" policy is attached for your review. In addition, the Respiratory Therapy annual competency checklist was revised to include pre and post respiratory treatment assessment. The Respiratory Therapy Manager will perform random medical record audits at least once per quarter to determine continued compliance. The audits will include a sample of records completed by each Respiratory Therapist. Any occurrences of non-compliance will be addressed with the individual Therapist. The medical record audit report will be reviewed each quarter by Tammi Nash, Clinical Operations Director of Emergency, Heart & Vascular Center, Respiratory and Critical</p>	03/01/2012

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	<p>A. received an aerosol treatment of Albuterol at 7:53 AM on 2/6/12</p> <p>B. had documentation in the medical record of a heart rate of 104 and a respiratory rate of 22 prior to the aerosol treatment</p> <p>C. lacked documentation of the patient's heart rate and respiratory rate following the aerosol treatment</p> <p>3. interview with staff member NB at 9:05 AM on 2/7/12, indicated:</p> <p>a. after reviewing the electronic medical record, as well as the paper portion of the medical record, for patient N2, it was found that there was no post procedure HR or RR documented for the patient as required by policy</p> <p>b. the BS, stated as required (see 1. b. above) by policy, prior to and after an aerosol treatment, was thought to be a typo</p> <p>c. it was thought that perhaps the patient left before the respiratory therapy staff member could check post treatment vital signs, but discharge time was noted as being 8:30 AM, so that there was ample time for a re check of vital signs</p>		Care Services. Tricia Hall, Manager of Respiratory Therapy is responsible for continued compliance.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150059		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/08/2012	
NAME OF PROVIDER OR SUPPLIER RIVERVIEW HOSPITAL				STREET ADDRESS, CITY, STATE, ZIP CODE 395 WESTFIELD RD NOBLESVILLE, IN 46060			
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S2136	<p>410 IAC 15-1.6-8 SURGICAL SERVICES 410 IAC 15-1.6-8 (c)(7)</p> <p>(c) Surgical services shall have policies governing surgical care designed to assure the achievement and maintenance of standards of medical practice and patient care, as follows:</p> <p>(7) An operative report describing techniques, findings, and tissue removed or altered shall be written or dictated immediately following surgery and authenticated by the surgeon.</p> <p>Based on medical staff rules and regulations review, patient medical record review, and staff interview, the medical staff failed to ensure the implementation of its rules and regulations in regards to dictation of the operative note immediately following the procedure for 1 of 2 out patient surgery patients (N20).</p> <p>Findings: 1. at 3:55 PM on 2/8/12, review of the Medical Staff Rules and Regulations, with an approved dated of November, 2011, indicated: a. under section "2.5 OPERATIVE REPORTS", it reads: "Operative reports shall be written or dictated immediately following surgery for outpatients and inpatients and promptly made a part of the patient's current medical record..."</p>	S2136	<p>A random review of all surgical cases performed on 2/28/2012 indicated an operative report was completed at the conclusion of the surgical procedure for 100% of the surgical cases. The Surgical Services Department will implement quarterly quality assurance monitoring to ensure surgeon compliance with completion of an operative report at the conclusion of surgical procedures. Quality assurance results will be reviewed by the Surgical Section Committee and Quality Review Committee. Tara Daege, Clinical Operations Director, Surgical & Maternity Services is responsible for ongoing monitoring, reporting, and continued compliance. <u>IDR</u> Riverview requests removal of Tag S2136 from our 2012 survey report. Further research of medical record #233926 revealed the surgeon had completed a</p>	02/28/2012			

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	<p>2. review of out patient surgical records N18 and N20 at 4:00 PM on 2/7/12 indicated:</p> <p>a. pt. N20 had a surgical procedure performed on 12/22/11</p> <p>b. the operative note for N20 was dictated on 12/26/11</p> <p>3. interview with staff member NA at 4:30 PM on 2/7/12, indicated:</p> <p>a. it was thought that the surgeon had 24 hours to dictate an operative report</p> <p>b. the operative note/report for pt. N20 was dictated 4 days after the procedure and therefore was dictated late</p> <p>4. interview with staff member NA at 3:45 PM on 2/8/12 indicated:</p> <p>a. the medical staff rules and regulations do not specify a time frame for the operative report, but does state "immediately following" the surgery procedure</p>		<p>hand-written operative report on the Operating Room Record immediately after surgery was completed on 12/22/2011. Per Tag S2136 the operative report must describe techniques, findings, and tissue removed or altered. The surgeon's operative note addressed the requirements. Technique (procedure) was described as a laparoscopic repair of an inguinal hernia. Findings (Post-op Diagnosis) were described as an incarcerated inguinal hernia. Tissue removal/alteration (specimens) was marked on the Operating Room Record as "N/A" indicating no specimens were removed.</p>		