

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 10/01/2013
NAME OF PROVIDER OR SUPPLIER RIVERVIEW HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 395 WESTFIELD RD NOBLESVILLE, IN 46060		
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S000000	<p>The visit was for a licensure survey.</p> <p>Facility Number: 005054</p> <p>Survey Date: 9-30-13 to 10-01-13</p> <p>Surveyors: Brian Montgomery, RN Public Health Nurse Surveyor</p> <p>Linda Plummer, RN Public Health Nurse Surveyor</p> <p>Steve Poore, BS MLT Medical Surveyor 3</p> <p>QA: claughlin 10/16/13</p>	S000000			

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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S000912	<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, pediatric medical record review, observation, and staff interview, the nurse executive failed to ensure that nursing personnel implemented the</p>	S000912	Pediatric Assessment of Length and Head Circumference Oct. 25, 2013 The Maternity Center Manager reviewed the "Pediatric Assessment Reassessment Plan of Care" policy with the pediatric	10/25/2013

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	<p>facility policy related to admission assessment of length and head circumference for 1 of 2 patients less than 2 years of age (pt. #13), and failed to ensure the implementation of the Accu-chek Inform policy related to the dating of glucometer control solutions.</p> <p>Findings:</p> <p>1. at 12:30 PM on 10/1/13, review of the policy and procedure " Pediatric Assessment/Reassessment Plan of Care ", with an effective date of December, 2010, indicated:</p> <p>a. on page 2 under section 7. " Data collection may include: ", it reads: "...3. Weight and height. The infant scale or standing scale will be used to weigh and measure the patient. Document head circumference on patients 0-2 years of age..."</p> <p>2. review of pediatric medical records indicated:</p> <p>a. pt. #13 was a 7 month old admitted on 6/12/13 who lacked documentation of " Height " and " OFC " (occipital frontal circumference) on the " Pediatric Admission Assessment " form (these areas were blank on the form)</p> <p>3. interview with staff member #58, the RN (registered nurse) pediatric unit nurse manager, at 12:05 PM on 10/1/13,</p>		<p>nurses. The review focused on the nurse's responsibility for documenting the length/height of pediatric patients and occipital frontal circumference for patients less than 2 years old. Medical record audits will be performed each month to ensure the deficiency does not recur. The Maternity Center Manager will address any recurring deficiencies individually with the admitting nurse. The Clinical Operations Director of Emergency, Heart & Vascular Center, Respiratory, Critical Care and Surgical Services is responsible for ensuring monthly monitoring and corrective actions are performed. Glucose Control Solution Oct. 1, 2013 The manufacturer of the Accu-chek control solutions was contacted regarding the problem of dates smudging/rubbing off of the label. The manufacturer recommended covering the handwritten dates with a piece of scotch tape. The recommendation was implemented immediately in all departments that use Accu-chek machines. Oct. 29, 2013 Accu-chek glucose control solutions in use throughout the hospital were checked for legibility of date opened and expiration dates. No instances of illegible labeling were discovered. Clinical Managers reviewed the Accu-chek control labeling procedure with their staff. The review focused on writing the</p>				

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	<p>indicated:</p> <p>a. the height/length and head circumference (OFC) for pt. #13 was not completed on the pediatric admission assessment form, as is required</p> <p>b. after on line review of the medical record for pt. #13, a height/length and head circumference could not be found in that format, either</p> <p>4. at 11:50 AM on 10/1/13, review of the policy and procedure " Accu-chek Inform II Whole Blood Glucose " , with a date of 8/16/13, indicated:</p> <p>a. on page two under " Reagent Storage and Handling " , it reads: " ...Accu-chek Inform II glucose control solutions - Level 1..., Level 2...3. The glucose control solutions are stable 3 months after opening the bottles or until the " Use by " , whichever comes first.</p> <p>4. The open date and new expiration date must be recorded on the vial label... "</p> <p>5. at 2:20 PM on 9/30/13, while on tour of the ICU (intensive care unit) in the company of staff members #51, the Clinical operations director, and #64, the RN manager of cardiovascular services, it was observed that there were no opened, or 90 day expiration dates, written on the Level 1 and Level 2 glucometer control solutions found at</p>		<p>date opened and expiration date on the control solution bottles, covering the handwritten dates with scotch tape, and discarding bottles with illegible dates. Oct. 29, 2013 Signs were placed on the Accu-chek cases to remind staff to place scotch tape over the handwritten dates on the control solutions. To ensure the deficiency does not recur, the quality assurance tool "Organizational Assessment of Quality/Compliance" was modified to include legibility of the opened/expiration dates on the Accu-chek control solutions. The frequency of completing the QA tool will be increased to monthly versus every other month for each clinical department. Clinical Operations Directors are responsible for ensuring monthly monitoring and corrective actions are performed.</p>				

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S000954	<p>the nursing station</p> <p>6. interview with staff member #64 at 2:25 PM on 9/30/13, indicated:</p> <p>a. the Accu-chek Inform II system was just implemented on the nursing units in August</p> <p>b. it was thought that the control solutions had been dated when put into use in August, but have been smudged/rubbed off since that time</p> <p>c. a method of maintaining the opened and expiration dates on the control solutions needs to be instituted</p> <p>410 IAC 15-1.5-6 NURSING SERVICE 410 IAC 15-1.5-6(e)</p> <p>(e) Emergency equipment and emergency drugs shall be available for use on all nursing units.</p> <p>Based on document review, observation and interview, emergency equipment was not maintained and available for use if needed for 2 outpatient departments.</p> <p>Findings:</p> <p>1. The policy/procedure Crash Cart Policy (reviewed 5-13) indicated the following: " Defibrillators and equipment checks shall be performed by the department housing the crash cart; checks shall be performed each day ...</p>	S000954	Oct. 1, 2013 Expired defibrillator pads and ambu-bags were removed from the crash carts and replaced. Oct. 28, 2013 – Materials Management The Director of Materials Management reviewed the "Supply Management" policy with the Materials Management Clerks. The review focused on requirements for PAR levels, removing expired items, and rotating items with the earliest expiration date to the front of the bin/shelf for first use. Beginning in November 2013, Materials Management Clerks will	10/01/2013			

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	<p>[and] ...The Automatic External Defibrillator (AED) check validated [that] defibrillator pads have not expired ... "</p> <p>2. During a tour on 10-01-13 at 1450 hours of the outpatient physical therapy off-site location, one adult and one pediatric Ambu-Bag with the expiration date of 9-2011 were observed with the department crash cart and AED.</p> <p>3. During an interview on 10-01-13 at 1450 hours, staff A7 confirmed that the emergency equipment was expired.</p> <p>4. During a tour on 10-01-13 at 1510 hours of the hospital outpatient imaging and laboratory department, two sets of adult defibrillator pads with the expiration date of 5-2012 and two sets of infant defibrillator pads with the expiration date of 8-2012 were observed with the Phillips Heartstream AED and crash cart.</p> <p>5. During an interview on 10-01-13 at 1510 hours, staff A7 confirmed that the equipment had not been maintained by staff.</p>		<p>document on a department specific spreadsheet the location, type, and number of expired PAR level items. The spreadsheet will be monitored by the Materials Management Director or designee. In addition, at least once per month the Materials Management Director or designee will perform random audits of PAR areas to ensure expired items are not stocked. The Materials Management Director is responsible for continued compliance. Oct. 9-30, 2013Managers for all departments with crash carts reviewed the "Crash Cart" policy with their staff. The review focused on the removal and replacement of crash cart/AED items prior to the expiration date. To ensure the deficiency does not recur, the quality assurance tool "Organizational Assessment of Quality/Compliance" was revised to include AEDs. The frequency of completing the tool will be increased to monthly versus every other month for each clinical department. Operations Directors and are responsible for ensuring monthly monitoring and corrective actions are performed in their departments.</p>				

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S001014	<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 policy and procedure review, observation, and staff interview, the facility failed to ensure the secure storage of multi dose vials of medication and failed to implement facility policy related to the expiration of multi dose vials once opened for use.</p> <p>Findings: 1. at 11:40 AM on 10/1/13, review of the policy and procedure " Medication Storage Area, and Medication Storage Area Inspections ", policy number Rx 007, with an effective date of October, 2010, indicated: a. under " Procedure for storage: ", it reads: " The following criteria should be used in maintaining drug storage areas on the nursing floor and all off site areas:...2. Medication cabinets should be kept locked and the keys should be available only to authorized personnel... "</p>	S001014	<p>Medication Security Sept. 30, 2013The Physician Assistant who stored the Sensorcaine was instructed on the need to secure all medications. The vials were discarded. The quality assurance tool "Organizational Assessment of Quality/Compliance" was revised to include the assessment of medication security. The frequency of completing the tool will be increased to monthly versus every other month for each clinical department. In addition, departments will be inspected for medication security during routine Safety Tours performed by Safety Committee members. Clinical Managers will provide ongoing monitoring and address individual staff compliance as needed. Clinical Operations Directors are responsible for ensuring monthly monitoring and corrective actions are performed. Multi-dose VialsClinical Managers instructed their staff on the procedure for labeling multi-dose vials with the</p>	10/29/2013			

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	<p>2. at 11:40 AM on 10/1/13, review of the policy and procedure "Expiration Dates", policy number INF.0018, with an effective date of September 2010, indicated:</p> <p>a. under "Purpose", it reads: "To provide a standard for expiration dates based on recommendations of USP 797, the FDA and APIC."</p> <p>b. under "Multi-dose Vials", it reads: "...2. Multi-dose vials usage may not exceed 28 days after the vial has been opened unless specific references are made in the package insert. Multi-dose vials need to be labeled when they are opened..."</p> <p>3. at 11:20 AM on 9/30/13, while on tour of the ED (emergency department) in the company of staff members #51, the clinical operations director, and #56, the RN (registered nurse) ED manager, it was observed in the practitioner computer area that one plastic container, belonging to a PA (Physician's assistant), contained 5 opened, unsecured, multi-dose vials of Sensorcaine 0.25 mg and 0.5 mg in 10 and 30 ml vial sizes that were not dated when opened, nor were they dated with a 28 day expiration date</p> <p>4. interview with staff members #51 and #56 at 11:25 AM on 9/30/13 indicated:</p>		<p>28 day expiration date after opening. The "Expiration of Medications and Medical Supplies" policy was revised to clarify that multi-dose vials expire 28 days after opening and the expiration date must be marked on the vial. The policy is pending approval by the Infection Prevention Committee. The next Infection Prevention Committee meeting is scheduled for Nov. 15, 2013. To ensure the deficiency does not recur, the quality assurance tool "Organizational Assessment of Quality/Compliance" was revised to include monitoring of the expiration date on multi-dose vials. The frequency of completing the tool will be increased to monthly versus every other month for each clinical department. Clinical Operations Directors are responsible for ensuring monthly monitoring and corrective actions are performed.</p>				

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S001118	<p>a. Sensorcaine has been in short supply, thus the PA was storing them for use when needed</p> <p>b. it is inappropriate for staff to "stash" supplies of medications in areas that are not secure</p> <p>c. the 5 vials found were not dated when opened, nor were they dated with a 28 day expiration date, as required for multi-dose vials</p> <p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8 (b)(2)</p> <p>(b) The condition of the physical plant and the overall hospital environment shall be developed and maintained in such a manner that the safety and well-being of patients are assured as follows:</p> <p>(2) No condition shall be created or maintained which may result in a hazard to patients, public, or employees.</p> <p>Based on policy and procedure review, observation, and interview, the facility failed to ensure that no condition was created that might result in a hazard to patients or employees regarding pantry refrigerators on two nursing units, and regarding accumulated lint/dust in two nursing unit blanket warmers.</p>	S001118	Refrigerators Oct. 29, 2013 Refrigerators and freezers in clinical areas were inspected and determined to be clean and without frost/ice build-up. Clinical Managers reviewed the "Refrigerators" policy with their staff. The review focused on staff responsibilities for keeping the refrigerators clean, documentation of cleaning and	10/29/2013
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	<p>Findings:</p> <p>1. at 4:45 PM on 10/1/13, review of the policy and procedure "Refrigerators", with a policy number INF.0017, and an effective date of September 2010, indicated:</p> <p>a. 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> <p>2. at 2:35 PM on 10/1/13, review of the policy and procedure "Expired or Recalled Products", policy number FNS.0011, with an effective date of November, 2010, indicated expiration dates for nutrition products is addressed, but the removal of labeled patient food items after discharge was not addressed, nor was the removal of unlabeled (opened) items addressed</p> <p>3. review of a document provided by nutritional services (with no title or number) indicated how pantry refrigerators are to be stocked by using a scanner and following "par levels", but fails to address removal of labeled patient food items after discharge or the removal unlabeled opened items</p>		<p>defrosting, removal of patient specific food items when patient is discharged, and removal of food items that have been opened or are unlabeled. The "Refrigerators" policy was revised to include discarding of patient specific food items when the patient is discharge and discarding of unlabeled or expired food items in the refrigerator. The policy is pending approval by the Infection Prevention Committee. The next Infection Prevention Committee meeting is scheduled for Nov. 15, 2013. To ensure the deficiency does not recur, the quality assurance tool "Organizational Assessment of Quality/Compliance" was modified to include assessment of the refrigerator for food items of discharged patients. The frequency of completing the tool will be increased to monthly versus every other month for each clinical department. Clinical Operations Directors are responsible for ensuring monthly monitoring and corrective actions are performed. Linen Warming Cabinets Oct. 21, 2013All linen warming cabinets were inspected and determined to be free of dust and lint. Oct. 29, 2013The "Warming Cabinets for Linens and Fluids" policy was revised and approved. The revision designated responsibility to the Clinical Engineering Department for routine cleaning of the cabinets. To ensure the</p>				

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	<p>4. while on tour of the ED (emergency department) on 9/30/13 at 11:15 AM in the company of staff members #51, the clinical operations director, and #56, the RN (registered nurse) ED manager, it was observed that there was an accumulation of crumbs under the vegetable drawers and the pantry refrigerator shelves were dirty, as well</p> <p>5. interview with staff member #56 at 11:20 AM on 9/30/13 indicated:</p> <p>a. it is nursing 's responsibility to keep the refrigerator clean</p> <p>b. it was thought that the refrigerator was on a monthly cleaning routine</p> <p>c. there is no checklist/log or other documentation of the cleaning processes performed for the pantry refrigerator</p> <p>d. it is unknown when the pantry refrigerator was last cleaned</p> <p>6. while on tour of the 3 West med/surg nursing unit on 10/1/13 at 1:20 PM in the company of staff members #51, the clinical operations director, and #65, the RN manager for 3 West, it was observed that the pantry refrigerator had:</p> <p>a. an accumulation of built up ice in two areas of the freezer compartment (at least 4 inch diameter chunks of ice in two areas)</p> <p>b. crumbs on the lower shelf (left side) of the refrigerator compartment</p>		<p>deficiency does not recur, the frequency of completing the "Organizational Assessment of Quality/Compliance" tool will be increased to monthly versus every other month for each clinical department. The tool includes assessment of the cleanliness of the linen and fluid warming cabinets. Clinical Operations Directors are responsible for ensuring monthly assessments and corrective actions are performed.</p>				

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	<p>c. a labeled patient water bottle with the patient having been discharged the previous day</p> <p>d. an unlabeled, opened bottle of water (with a hair attached to it) found in the refrigerator</p> <p>7. interview with staff member #65 at 1:25 PM on 10/1/13 indicated:</p> <p>a. it is unknown whose responsibility it is to remove patient food items once they are discharged</p> <p>b. it was unknown when the refrigerator/freezer had last been cleaned</p> <p>d. the opened, unlabeled bottle of water should not have been in the refrigerator</p> <p>8. interview with staff member #62, the general manager of food services, at 2 PM on 10/1/3, indicated:</p> <p>a. it is not clear in either the refrigerator policy or the floor stocking document:</p> <p>A. how kitchen staff are to check for patient items that need to be discarded after a patient has been discharged</p> <p>B. that kitchen staff should be discarding any opened, unlabeled items in pantry refrigerators</p> <p>9. at 11:40 AM on 10/1/13, review of the policy and procedure " Warming Cabinets for Linens and Fluids ", policy</p>			

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	<p>number HPP.193, with an effective date of February 2013, indicated the policy did not address any expected, or routine, cleaning of the warming cabinets within the facility</p> <p>10. while on tour of ICU (intensive care unit) at 2:15 PM on 9/30/13 in the company of staff members #51, the clinical operations director, and #63, an ICU RN, it was observed that the blanket warmer had an accumulation of dust under the lower shelf of the unit</p> <p>11. interview with staff members #51 and #63 at 2:20 PM on 9/30/13 indicated:</p> <ul style="list-style-type: none"> a. there is no known scheduled cleaning of the blanket warmer b. it is a fire hazard, as well as an infection control issue, with accumulated dust build up in the blanket warmer <p>12. while on tour of the out patient surgery area at 2:50 PM on 9/30/13, in the company of staff members #51, the clinical operations director, and #66, the outpatient surgery manager, it was observed that there was an accumulation of dust under the lower shelf of the Skytron blanket warmer.</p> <p>13. interview with staff members #51</p>			

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 10/01/2013
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NAME OF PROVIDER OR SUPPLIER RIVERVIEW HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 395 WESTFIELD RD NOBLESVILLE, IN 46060
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	and #66 at 2:55 PM on 9/30/13 indicated: a. it was unknown that the blanket warmer would build up dust under the lower shelf b. the accumulated dust could become a fire hazard and is an infection control concern			