

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150167	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/10/2012
NAME OF PROVIDER OR SUPPLIER ORTHOPAEDIC HOSPITAL AT PARKVIEW NORTH LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 11130 PARKVIEW CIRCLE DR FORT WAYNE, IN 46845		
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S0000	<p>The visit was for a licensure survey.</p> <p>Facility Number: 005845</p> <p>Survey Date: 04-09-12 to 04-10-12</p> <p>Surveyors: Brian Montgomery, RN Public Health Nurse Surveyor</p> <p>Linda Plummer, RN Public Health Nurse Surveyor</p> <p>QA: claughlin 04/18/12</p>	S0000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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S0322	<p>410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1(c)(6)(H)</p> <p>(c) The governing board is responsible for managing the hospital. The governing board shall do the following: (6) Require that the chief executive officer develops policies and programs for the following: (H) Requiring all services to have policies and procedures that are updated as needed and reviewed at least triennially.</p> <p>Based on document review and interview, the facility failed to ensure that all policy/procedures in use including affiliate and network policies have been updated as needed and reviewed and approved for use by an authorized representative of the facility.</p> <p>Findings:</p> <p>1. The Parkview Ortho Hospital (POH) policy titled: Administrative Policy Manual (revised 1-12) failed to authorize use of affiliate and network hospital policy/procedures at the hospital, failed to ensure that adopted policy/procedures were reviewed at least triennially by a named representative of POH, and failed to indicate the individual authorizing the revision in 2011.</p>	S0322	<p>How are you going to correct the deficiency? If already corrected, include the steps taken and the date of correction. Parkview Ortho Hospital policy titled "<u>Administrative Policy Manual</u>" was reviewed and updated to include the names "Laura Ferrell, RN Director of Nursing and Julie Fleck, RN COO of Parkview Ortho Hospital as the authorizing representatives for Parkview Ortho Hospital.</p> <p>How are you going to prevent the deficiency from recurring in the future? A policy and procedure review schedule will be developed, that includes the above listed policy, and the next review date to ensure policies and</p>	05/25/2012			

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	<p>2. The Parkview Health policy/procedure titled: Policy Development (revised 4-03) indicated the following: " All policies and procedures are reviewed annually... " The policy/procedure failed to indicate an annual review per policy or at least every three years as required by State law and failed to indicate review by a named representative of POH.</p> <p>3. The Parkview Health policy titled: Code Blue Policy (revised 10-11) failed to indicate approval by POH, failed to indicate the Parkview Physician Group as the current POH Medical Staff Executive Committee (MSEC) designated Emergency Response provider for POH and failed to indicate a responsible POH MSEC member and POH administrative representative authorizing the revision.</p> <p>4. The Parkview Department of Pharmacy policy titled: Prescribing/Ordering General Practices (reviewed 1-12) indicated the names of 8 affiliate facilities (Parkview Regional Medical Center, Parkview Hospital, Orthopedic Hospital at Parkview North, Parkview Behavioral Health, Parkview Huntington Hospital, Parkview Noble Hospital, Parkview Whitley Hospital, and Parkview LaGrange Hospital) and lacked a provision indicating a review date and name of an administrative representative</p>		<p>procedures are current. Who is going to be responsible for steps A and B above? The Director of Nursing has oversight and is accountable for this process. By what date are you going to have the deficiency corrected? 5/21/12</p> <p>How are you going to correct the deficiency? If already corrected, include the steps taken and the date of correction. Parkview Health policy/procedure titled "<u>Policy Development</u>" was developed as a Parkview Ortho Hospital policy/procedure. The policy was reviewed and authorized by Laura Ferrell, RN Director of Nursing and Julie Fleck, RN COO of Parkview Ortho Hospital.</p> <p>How are you going to prevent the deficiency from recurring in the future? A policy and procedure review schedule will be developed, that includes the above listed policy, and the next review date to ensure policies and procedures are current. Who is going to be responsible for steps A and</p>		

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	<p>for POH or the affiliates that acknowledged the revision if accepted for use by the facility.</p> <p>5. The Parkview Health policy/procedure titled: Orientation (revised 5-26-07) failed to indicate a review at least every three years as required by State law.</p> <p>6. During an interview on 4-10-12 at 1100 hours, staff A1 confirmed that the Parkview Orthopedic Hospital policy titled: Administrative Policy Manual (revised 1-12) failed to ensure that all network policy/procedures were reviewed at least every 3 years by an administrative representative of POH.</p>		<p>B above? The Director of Nursing has oversight and is accountable for this process. By what date are you going to have the deficiency corrected? 5/21/12</p> <p>How are you going to correct the deficiency? If already corrected, include the steps taken and the date of correction. Parkview Health policy/procedure "<u>Code Blue Policy</u>" has been updated to reflect the new coverage arrangement with Parkview Hospitalists Group . The policy was updated to include the name of Laura Ferrell, RN Director of Nursing as authorized for Parkview Ortho Hospital</p> <p>How are you going to prevent the deficiency from recurring in the future? The above policy will be included in the policy review schedule, with the next review date to ensure policies and procedures are current.</p> <p>Who is going to be responsible for steps A and B above? The Director of Nursing has oversight and is</p>				

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			<p>accountable for this process.</p> <p>By what date are you going to have the deficiency corrected? 5/25/12</p> <p>How are you going to correct the deficiency? If already corrected, include the steps taken and the date of correction. The Parkview Department of Pharmacy policy titled "<u>Prescribing/Ordering General Practices</u>" has been reviewed by Laura Ferrell, RN Director of Nursing The policy was also updated to include the name of Laura Ferrell, RN Director of Nursing as authorized for Parkview Ortho Hospital</p> <p>How are you going to prevent the deficiency from recurring in the future? A policy and procedure review schedule will be developed that includes the above listed policy, and the next review date to ensure policies and procedures are current.</p> <p>Who is going to be responsible for steps A and B above? The Director of Nursing has oversight and is</p>		

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			<p>accountable for this process. By what date are you going to have the deficiency corrected? 5/25/12</p> <p>How are you going to correct the deficiency? If already corrected, include the steps taken and the date of correction. The Parkview Health policy titled "Orientation" was developed as a Parkview Ortho Hospital policy/procedure and was reviewed and authorized by Laura Ferrell, RN Director of Nursing and her name and title were added to the policy . How are you going to prevent the deficiency from recurring in the future? A policy and procedure review schedule will be developed, that includes the above listed policy, and the next review date to ensure policies and procedures are current.</p> <p>Who is going to be responsible for steps A and B above? The Director of Nursing has oversight and is accountable for this process. By what date are you going</p>		

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			to have the deficiency corrected? 5/25/12	

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S0348	<p>410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1(d)(3)(A)(B)(i)(ii)</p> <p>(d) The governing board is responsible for assuring that quality patient care is provided. In accordance with hospital policy, the governing board shall do the following:</p> <p>(3) Provide the following for any patients requiring emergency care:</p> <p>(A) In hospitals with at least one hundred (100) acute care staffed beds, a licensed physician on the premises at all times who has the responsibility to respond to patients requiring emergency care as defined in 410 IAC 15-1.5-5(b)(3)(L)(i).</p> <p>(B) In hospitals of less than one hundred (100) acute care staffed beds,</p> <p>(i) a licensed physician on the premises as in clause (A); or</p> <p>(ii) a licensed physician who has the responsibility to respond to patients requiring emergency care as defined in 410 IAC 15-1.5-5(b)(3)(L)(i) and who is on call at all times and immediately available by phone and then available on the premises within thirty (30) minutes, if necessary, and in accordance with hospital and medical staff policies.</p> <p>Based on contract document review and staff interview, the governing board failed to ensure quality patient care for the possibility of an emergency situation with</p>	S0348	<p>How are you going to correct the deficiency? If already corrected, include the steps taken and the date of correction. The Parkview</p>	06/04/2012			

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	<p>regard to 24 hour availability of a physician.</p> <p>Findings:</p> <p>1. review of the contract for physician coverage in the case of an emergency, such as a code blue, titled "Hospitalist Services and Other Services Agreement", indicated:</p> <p style="padding-left: 40px;">a. on page 2 in "Section 2. Provision of Emergency and Code Blue Services by the Group...", it reads: "...At least one Provider Physician shall be present at Parkview Regional Medical Center to respond to the Hospital's emergency service needs and/or for code responses, at all times, and must respond to a page for assistance within approximately five (5) minutes, or as soon thereafter as is possible, understanding that the responsibility of the Provider Physicians, is in caring for emergencies of patients, at the Hospital and at their primary site at the adjoining Parkview Regional Medical Center location. As identified herein, it is understood and agreed that the Provider Physician(s) shall be available to provide emergency and code responses at the Hospital after assuring that emergency coverage at their primary site at the adjoining Parkview Regional Medical Center location, is available."</p> <p>2. interview with staff member #50 at</p>		<p>Hospitalists Contract will be amended to include the addition of the Intensivist physicians who will provide backup coverage to the Hospitalists should they be delayed in providing coverage at Parkview Ortho Hospital How are you going to prevent the deficiency from recurring in the future? Each emergency response will be reviewed by the Director of Nursing and the manager of Inpatient services to verify that the Hospitalist/Intensivist group responded in a timely manner. Issues will be tracked in the hospital internal event reporting system and reviewed for trends. Who is going to be responsible for steps A and B above? The Director of Nursing and COO of the hospital have oversight and are accountable for this process. By what date are you going to have the deficiency corrected? Although we anticipated that the contract could be updated quickly, the hospital determined that using the Parkview Intensivists Group for backup to the Hospitalists during code situations would ensure that the needs of the patient would be best met in this manner. The ammendment to the contract will be handled by the Legal department. We anticipate that this will be accomplished by 6/25/12</p>				

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	<p>9:20 AM on 4/10/12 indicated:</p> <ul style="list-style-type: none"> a. this hospital relies on contracted services for 24 hour physician coverage in the case of an emergency b. the contracted physicians are allowed, per contractual arrangement, to provide services to their primary site first, and would only be available to this facility once those duties were completed c. delays in physician emergency response could occur if the contracted physician was unavailable due to emergency issues at their primary work location, which takes precedence 				

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S0356	<p>410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1(d)(4)(A)(B) (i)(ii)(iii)</p> <p>(d) The governing board is responsible for assuring that quality patient care is provided. In accordance with hospital policy, the governing board shall do the following:</p> <p>(4) Ensure either of the following: (A) If the hospital does provide community emergency services to the public, it shall provide that service in compliance with 410 IAC 15-1.6-2 (B) If the hospital does not provide community emergency services to the public, it shall do the following:</p> <p>(i) Have written medical staff policies and procedures for appraisal of emergencies, initial treatment, and referral when appropriate.</p> <p>(ii) Provide immediate lifesaving measures within the scope of services available to all persons who appear for emergency care which includes, but is not limited to, the following:</p> <p>(AA) Timely assessments. (BB) Stabilization. (CC) Treatment prior to transfer.</p> <p>(iii) Arrange for transfer of the patient, with copies of records of treatments provided, to another hospital which does provide appropriate clinical services.</p> <p>Based on staff interview, the governing</p>	S0356	How are you going to correct	06/04/2012			

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	<p>board failed to ensure that there was a policy or procedure in place for the appraisal of a patient emergency, for the provision of initial treatment and the referral of a patient, if required, for patients presenting to the hospital with an emergency complaint or issue.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. at 9:45 AM on 4/9/12, interview with staff member #50 indicated: <ol style="list-style-type: none"> a. the facility closes when no patients are within b. two of the most recent dates of closure were: 4/8/12 from 11:30 AM to 4/9/12 at 10:30 AM and 2/26/12 when the last patient was discharged at 12:50 PM and then the hospital re opened on Monday, 2/27/12 at 10:30 AM c. a RN (registered nurse) is on call when the hospital is closed, but not on site d. the hospital doors are locked from 8:00 PM each night until 4:30 AM the next morning e. anyone presenting to the hospital doors after 8 PM would read the sign on the door saying to go to the adjoining hospital's emergency department (ED) for care f. all patients discharged from out patient surgery, or from an inpatient status, are told to return to the adjoining hospital's ED for any care needed after 		<p>the deficiency? If already corrected, include the steps taken and the date of correction. Additional staff nurses will be hired to cover the hospital 24/7 including during times when no patients are present in the hospitalA telephone will be installed at the entrance to the hospital that will connect to a hospital staff member should a patient come to hospital entrance during the overnight hours and/or when there are no patients in the hospital The staff will be educated to respond immediately to the front entrance of the hospital to provide assessment, stabilization and transferHow are you going to prevent the deficiency from recurring in the future? The hospital will be staffed 24/7 with an RN who will respond to a patient who presents to the front entrance of the hospitalWho is going to be responsible for steps A and B above? The Director of Nursing and the COO have oversight and are accountable for this process. By what date are you going to have the deficiency corrected?ADDENDUM 6/4/12:The hospital anticipates the additional FTE coverage will be hired by 7/25/12The additional staff member will be oriented and trained for the additional duties by 8/25/12DISPUTE: The hospital is a specialty hospital and does not</p>				

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	discharge g. there is no provision for assessing/triaging a patient if they should present to the hospital after hours, nor for any initial treatment that might be needed, or for the transfer of a patient, if required, by this facility		have an Emergency RoomThe hospital is staffed with at least one RN during times when there are patients in the hospital, who can respond to a patient who presents at the front entrance of the hospital for care. Patients are given discharge instructions that direct them to present to the nearest emergency room during an emergent situation. The surgeon and his office at Orthopaedics Northeast provide pre surgery education that directs patients to the nearest hospital emergency room after discharge The hospital has a sign at the front entrance to the hospital directing anyone who arrives at the front door of the hospital to report to the nearby Parkview Regional Medical Center Emergency Room. This process provides superior 24/7 care during an emergent situation		

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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 8 contracted services (biohazardous waste, elevators, 2 fire services, generators, laundry, medical gas system certification and pest control).</p> <p>Findings:</p> <p>1. On 4-09-12 at 1430 hours, a list of all contracted services was received from staff A3. The list of services failed to indicate a service provider for biohazardous waste, elevators, 2 fire services, generators, laundry, medical gas system certification and pest control.</p> <p>2. Review of facility documentation indicated the following: biohazardous waste disposal by CS1, elevator service</p>	S0394	<p>How are you going to correct the deficiency? If already corrected, include the steps taken and the date of correction. The Administrative Contract Service Log was updated to include all contracted services and outlines the scope and nature of each service (bio hazardous waste disposal, elevator service, fire services provider, fire panel monitoring, generator service, laundry, medical gas system certification, and pest control) How are you going to prevent the deficiency from recurring in the future? All department managers will be required to inform Administration of new contracted services and will ensure that the Contract Services Log is current Who is going to be responsible for steps A and B above? The Director of Nursing and the COO have oversight and are accountable for this process. By</p>	05/25/2012			

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	<p>by CS2, fire service providers included CS3 and fire panel monitoring by CS4, generator service by CS5, laundry services by CS6, medical gas certification by CS7 and pest control by CS8.</p> <p>3. On 4-10-12 at 1345 hours, staff A3 confirmed the list of contracted services failed to include the indicated service providers.</p>		<p>what date are you going to have the deficiency corrected? 5/25/12</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 facility failed to include 8 contracted services (biohazardous waste removal, elevator maintenance, fire alarm monitoring services, fire sprinkler services, emergency generator service, laundry services, medical gas systems certification and pest control services) in its Quality Assessment and Improvement (QA&I) program.</p> <p>Findings:</p> <p>1. The Parkview Safety and Quality Strategic Plan (approved 1-17-12) indicated the following: "The Parkview Safety and Quality Strategic Plan serves as the framework for clinical and non-clinical Safety and Quality activities..." The plan lacked a process</p>	S0406	<p>How are you going to correct the deficiency? If already corrected, include the steps taken and the date of correction. The list of contracted services metrics was updated to include the 8 contracted services listed above As applicable, managers will establish metrics and evaluate the contracted service on a quarterly basis. All managers were informed of this process on 5/21/12 and they are accountable for the process How are you going to prevent the deficiency from recurring in the future? Quarterly audits will be reviewed by the hospital Quality (QPIC) Committee on the contracted service metrics to ensure compliance By what date are you going to have the deficiency corrected? 5/21/12</p>	05/21/2012			

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	<p>ensuring that all non-clinical (including contracted) services would be provided in a safe and effective manner and are included in the QA&I program.</p> <p>2. The document Parkview Ortho Hospital Metrics failed to indicate ongoing monitoring for the contracted services of biohazardous waste removal, elevator maintenance, fire alarm monitoring services, fire sprinkler services, emergency generator service, laundry services, medical gas systems certification and pest control services.</p> <p>3. During an interview on 4-10-12 at 1400 hours, staff A3 confirmed that the 8 contracted services were not being monitored by the QA&I program.</p>						

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S0422	<p>410 IAC 15-1.4-2.2 QUALITY ASSESSMENT AND IMPROVEMENT 410 IAC 15-1.4-2.2(a)(2)</p> <p>(2) A process for reporting to the department each reportable event listed in subdivision (1) that is determined by the hospital's quality assessment and improvement program to have occurred within the hospital.</p> <p>(b) Subject to subsection (e), the process for determining the occurrence of the reportable events listed in subsection (a)(1) improvement program shall be designed by the hospital to accurately determine the occurrence of any of the reportable events listed in subsection (a)(1) within the hospital in a timely manner.</p> <p>(c) Subject to subsection (e), the process for reporting the occurrence of a reportable event listed in subsection (a)(1) shall comply with the following:</p> <p>(1) The report shall:</p> <p>(A) be made to the department;</p> <p>(B) be submitted not later than fifteen (15) working days after the serious adverse event is determined to have occurred by the hospital's quality assessment and improvement program;</p> <p>(C) be submitted not later than four (4) months after the potential reportable event is brought to the program's attention; and</p> <p>(D) identify the reportable event, the quarter of occurrence, and the hospital, but shall not include any identifying information for any:</p> <p>(i) patient;</p> <p>(ii) individual licensed under IC 25; or</p> <p>(iii) hospital employee involved; or any other information.</p> <p>(2) A potential reportable event may be identified by a hospital that:</p>			

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	<p>(A) receives a patient as a transfer; or</p> <p>(B) admits a patient subsequent to discharge;</p> <p>from another health care facility subject to a reportable event requirement. In the event that a hospital identifies a potential reportable event originating from another health care facility subject to a reportable event requirement, the identifying hospital shall notify the originating health care facility as soon as they determine an event has potentially occurred for consideration by the originating health care facility's quality assessment and improvement program.</p> <p>(3) The report, and any documents permitted under this section to accompany the report, shall be submitted in an electronic format, including a format for electronically affixed signatures.</p> <p>(4) A quality assessment and improvement program may refrain from making a determination about the occurrence of a reportable event that involves a possible criminal act until criminal charges are filed in the applicable court of law.</p> <p>(d) The hospital's report of a reportable event listed in subsection (a)(1) shall be used by the department for purposes of publicly reporting the type and number of reportable events occurring within each hospital. The department's public report will be issued annually.</p> <p>(e) Any reportable event listed in subsection (a)(1) that:</p> <p>(1) is determined to have occurred within the hospital between:</p> <p>(A) January 1, 2009; and</p> <p>(B) the effective date of this rule; and</p> <p>(2) has not been previously reported;</p>			

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	<p>must be reported within five (5) days of the effective date of this rule. (Indiana State Department of Health; 410 IAC 15-1.4-2.2)</p> <p>Based on document review and interview, the facility failed to have a policy/procedure for reporting to the Indiana State Department of Health (ISDH) each reportable event determined by the quality assessment and improvement program to have occurred within the hospital.</p> <p>Findings:</p> <ol style="list-style-type: none"> The Parkview Health policy/procedures titled: Event Reporting (reviewed 2-08), Serious Adverse Events, Sentinel Events (reviewed 2-08) and Disclosure Policy (origination date 7-03, no revision or review date) failed to indicate a process for reporting each reportable event per 410 IAC 15-1.4-2.2(a)(2). During an interview on 4-10-12 at 1310 hours, staff A3 and A6 confirmed that the policy/procedures lacked a provision for reporting an event to ISDH. 	S0422	<p>How are you going to correct the deficiency? If already corrected, include the steps taken and the date of correction.</p> <p>The Health system policy "<u>Serious Adverse Events, Sentinel Events</u>, page 4 of 7 outlines the process for reporting appropriate events to the State Department of Health. The policy was developed as a Parkview Ortho Hospital policy and it was reviewed for Parkview Ortho Hospital and authorized by L. Ferrell, RN Director of Nursing and her name and title were added to the policy on 5/21/12.</p> <p>How are you going to prevent the deficiency from recurring in the future?</p> <p>A policy and procedure review schedule will be developed, that will include the above listed policy, and the next review date to ensure policies and procedures are current.</p> <p>Who is going to be responsible for steps A and B above? The Director of Nursing has oversight and is accountable for this process.</p>	05/21/2012			

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			By what date are you going to have the deficiency corrected? 5/21/12	

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S0570	<p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2 (f)(1)(A)(b)(C)(D)(E) (f) The hospital shall establish an infection control committee to monitor and guide the infection control program in the facility as follows: (1) The infection control committee shall be a hospital or medical staff committee that meets at least quarterly, with membership that includes, but is not limited to, the following: (A) The person directly responsible for management of the infection surveillance, prevention and control program. (B) A representative from the medical staff. (C) A representative from nursing service. (D) A representative from administration. (E) Consultants from other appropriate services within the hospital, as needed.</p> <p>Based on staff interview, the facility failed to provide it's own infection control committee.</p> <p>Findings: 1. during the entrance conference at 9:45 AM on 4/9/12, interview with staff members #50, #52, and #53 indicated the facility infection control committee meetings are held along with the safety committee meetings 2. interview with the contracted infection control committee at 10:35 AM on 4/10/12, included staff members #61, #63, #64 and #65, and indicated: a. all of the staff acting as the infection control committee are from the contracted hospital and are</p>	S0570	<p>How are you going to correct the deficiency? If already corrected, include the steps taken and the date of correction. A separate and distinct hospital Infection Control Committee will be created that will meet on a quarterly basis. The committee membership will include a physician liaison and hospital leadership. The committee will function as a separate and distinct committee which will be led by the Infection Control practitioner. How are you going to prevent the deficiency</p>	06/04/2012			

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	<p>not employees of the hospital being surveyed</p> <p>3. interview with staff members #53 and #55 at 12:50 PM on 4/10/12 indicated:</p> <p>a. the facility does not have designated staff members as a part of it's infection control committee, it relies on the contracted hospital for these services</p>		<p>from recurring in the future?</p> <p>The committee will meet on a quarterly basis and will have oversight of infection Control activities. Who is going to be responsible for steps A and B above? The hospital medical staff has oversight and is responsible ADDENDUM 6/4/12:An Ortho Hospital active staff physician has agreed to be a member of the Infection Control committee.The committee anticipates that the first meeting will be held on July 9, 2012The committee will be led by the Infection Control practitioner and will also include hospital leaders.The committee meeting minutes will initially be forwarded to the Medical Executive committee on July 17, 2012 and monthly thereafter.</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 observation and staff interview, the infection control practitioner failed to ensure the limitation of items entering the semi restricted areas, and failed to maintain the sanitation, of the surgery unit.</p> <p>Findings:</p> <p>1. at 2:10 PM on 4/9/12, while touring the surgery area in the company of staff members #52 and #59, it was observed that the housekeeping closet in the hallway outside the OR (operating room) suites was lacking a housekeeping cart</p> <p>2. interview with staff member #59 at 2:10 PM on 4/9/12 indicated:</p> <p>a. the housekeeping staff bring a cart from outside the surgery area to clean in the surgery hallways, etc. after hours</p> <p>3. interview with staff member #52 at 2:10 PM on 4/9/12 indicated:</p> <p>a. it was thought that a housekeeping cart was</p>	S0592	<p>How are you going to correct the deficiency? If already corrected, include the steps taken and the date of correction.</p> <p>The director of Housekeeping services has ensured that a dedicated EVS (environmental services) cart has been placed in the OR suite. Housekeeping and Operating Room staff have been educated regarding the exclusive use of this cart in the Operating Room.</p> <p>How are you going to prevent the deficiency from recurring in the future? Infection Prevention will</p>	05/25/2012			

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	<p>maintained in the surgery area and did not leave the area for cleaning elsewhere</p> <p>4. interview with the contracted infection control committee at 10:35 AM on 4/10/12, included staff members #61, #63, #64 and #65, and indicated:</p> <p>a. it was unknown that the housekeeping cart was being brought into the semi restricted area of the surgery unit</p> <p>b. to maintain proper sanitation, and to prevent the possibility of transporting bacteria/organisms into the semi restricted area, a housekeeping cart should be maintained within the surgery area and not brought from the pre/post operative areas for cleaning after hours</p>		<p>conduct monthly rounds to ensure that the EVS cart remains in the Operating Room</p> <p>Who is going to be responsible for steps A and B above? The Director of Housekeeping services and the Infection Control practitioner have oversight and accountability</p> <p>By what date are you going to have the deficiency corrected? 5/25/12</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 staff interview, the infection control practitioner failed to implement the facility policy related to perioperative dress code.</p> <p>Findings: 1. at 10:50 AM on 4/9/12, review of the policy and procedure "Dress Code Perioperative", indicated: a. on page one under section II. "Definitions", it reads: "...B. Semi-restricted areas: All surgical service corridors, scrub sink areas, sub-sterile areas, and non-sterile operating or procedure rooms,..." b. on page one under section II. "Definitions", it reads: "...C. Restricted areas: All sterile areas (operating rooms with opened and unopened sterile instruments and supplies)." c. in section III. "Procedure:", it reads in section "C. Restricted Areas", "...4. Masks:...b. A new mask must be worn for each operative</p>	S0608	<p>How are you going to correct the deficiency? If already corrected, include the steps taken and the date of correction.</p> <p>The Surgery One Anesthesia (SOA) physicians and CRNA's have been educated by Dr. R. Johnston, medical director for Anesthesiology, regarding the covering of earrings and the proper application of surgical masks.</p> <p>The Operating Room staff have been educated regarding the need to remove the surgical mask at the end of the surgery case and to apply a new mask for each operative procedure</p>	05/25/2012

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	<p>procedure..."</p> <p>d. on page 5, it reads in section IV. "References", "AORN Recommended Practices for Surgical Attire: AORN Recommended Practices for Perioperative Nursing..."</p> <p>2. while on tour of the restricted area of the surgery unit on 4/9/12 at 2:15 PM in the company of staff members #52 and #59, it was observed in OR (operating room) suite #8 that the CRNA (certified registered nurse anesthetist):</p> <p>a. failed to cover their earrings with the bouffant head covering</p> <p>b. failed to tie the surgical mask properly as there was venting on both sides of the mask</p> <p>3. while on tour of the semi restricted area of the surgery unit on 4/9/12 at 2:35 PM in the company of staff members #52 and #59, it was observed in the inner core:</p> <p>a. one RN (registered nurse) moving in and about the hallway between OR suites and supply rooms with a surgical mask dangling about the neck</p> <p>4. interview with staff member #59 at 2:15 PM and 2:40 PM on 4/9/12, indicated that per AORN (Association of PeriOperative Registered Nurses) standards:</p> <p>a. earrings are to be covered by the surgical cap/hat, per recommended standards of practice</p> <p>b. surgical masks are to be tied so that no venting occurs at the sides of the mask</p> <p>c. surgical masks should not be left dangling about the neck once staff exit the OR suite(s), per recommended standards</p>		<p>How are you going to prevent the deficiency from recurring in the future?</p> <p>Observation audits will be conducted on ten OR team members per month to determine compliance with the policy. The results will be tracked in the department Measures of Success (MOS) dashboard. Compliance will be rported and tracked through the hospital Quality committee (QPIC)</p> <p>Who is going to be responsible for steps A and B above? The Operating Room manager, the Medical Director of Anesthesiology and the Director of Nursing have direct oversight and accountability</p> <p>By what date are you going to have the deficiency corrected?</p> <p>5/25/12</p>	
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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 policy and procedure review, patient medical record review, and staff interview, the facility failed to ensure complete documentation, by anesthesia staff, for two of two pediatric surgery patient records. (pts. #5 and #6)</p> <p>Findings:</p> <p>1. at 5:10 PM on 4/9/12, review of the policy and procedure "Parkview Ortho Medical Staff" "Rules and Regulations: Inpatient Medical Record Completion", indicated in section II. "Responsibilities:" a. "...3. A medical record will be created and maintained for each patient. Documentation will be complete..."</p> <p>2. at 3:35 PM on 4/10/12, review of the medical records for patients #5 and #6 indicated: a. pt. #5, a 15 year old, had surgery on 1/6/10 and lacked completion of the time of a pre-anesthesia evaluation on page 2 of the "Anesthesia Record" form b. pt. #6, a 2 year old, had surgery on 2/23/12 and lacked completion of the anesthesia stop time on page 1 of the "Anesthesia Record" form</p> <p>3. interview with staff member #52 at 3:40 PM on 4/10/12 indicated: a. anesthesia staff failed to complete documentation for patients #5 and #6 as stated in 2. above</p>	S0744	<p>How are you going to correct the deficiency? If already corrected, include the steps taken and the date of correction.</p> <p>The Surgery One Anesthesia (SOA) physicians and CRNA's have been educated by Dr. R. Johnston, medical director for Anesthesiology, regarding the requirement for completion of the time of the pre-anesthesia evaluation and the anesthesia stop time on the Anesthesia record.</p> <p>The physician committee, Quality Resource Management Advisory Board, will review the documentation requirements at the July 10, 2012 meeting.</p> <p>How are you going to prevent the deficiency from recurring in the future? Quality Management/Accreditation</p>	05/25/2012			

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			<p>department will begin auditing 10 charts per month for the time of the pre-anesthesia evaluation and anesthesia stop time on the Anesthesia record on June 1, 2012 The metric will be placed in the medical staff department PI dashboard and audits will be ongoing. Audit results will be reviewed at the Quality Resource Management (QRM) Advisory Board on a quarterly basis beginning July 10, 2012 Individual physician/CRNA deficiencies will be addressed in the committee who will determine appropriate follow-up action as defined in the Quality Resource Management plan</p> <p>Who is going to be responsible for steps A and B above? The Director of Nursing and the chair of the Medical Staff Executive Committee have oversight and accountability for this process</p> <p>By what date are you going to have the deficiency corrected? 5/25/12</p>		

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S0871	<p>410 IAC 15-1.5-5 Medical Staff 410 IAC 15-1.5-5(b)(3)(O)</p> <p>(b) The medical staff shall adopt and enforce bylaws and rules to carry out its responsibilities. These bylaws and rules shall:</p> <p>(3) include, but not be limited to, the following:</p> <p>(O) A requirement that all verbal orders must be authenticated by the responsible individual in accordance with hospital and medical staff policies. The individual receiving a verbal order shall date, time, and sign the verbal order in accordance with hospital policy. Authentication of a verbal order must occur within forty-eight (48) hours unless a read back and verify process described under items (i) and (ii) is utilized. If a patient is discharged within forty-eight (48) hours of the time that the verbal order was given, authentication shall occur within thirty (30) days after the patient's discharge.</p> <p>(i) As an alternative, hospital policy may provide for a read back and verify process for verbal orders. Any read back and verify process must require that the individual receiving the order shall immediately read back the order to the ordering physician or other responsible individual who shall immediately verify that the read back order is correct.</p> <p>(ii) The individual receiving the verbal order shall document in the patient's medical record that the order was read back and verified. Where the read back and verify process is followed, the hospital shall require authentication of the verbal order not later than thirty (30) days after the patient's discharge.</p>						

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	<p>Based on document review and interview, the facility failed to ensure that a verbal order was dated and timed when authenticated to validate compliance with the medical staff rule.</p> <p>Findings:</p> <ol style="list-style-type: none"> The Medical Staff Rules and Regulations policy titled: Inpatient Medical Record Completion (approved 11-10) failed to indicate a requirement to date and time the medical record order when authenticated by the medical staff member to validate compliance with the medical staff rule. During an interview on 4-10-12 at 1545 hours, staff A1 confirmed that the medical staff rule lacked a provision for validating compliance by the medical staff. 	S0871	<p>How are you going to correct the deficiency? If already corrected, include the steps taken and the date of correction. Medical Staff Rules & Regulations policy titled: Inpatient Medical Records Completion will be revised to include the requirement to date and time the authentication of verbal/telephone orders. This policy addition will be reviewed and approved at the upcoming Medical Executive Committee on June 18, 2012</p> <p>How are you going to prevent the deficiency from recurring in the future? Policies will be periodically reviewed to verify appropriateness Who is going to be responsible for steps A and B above? Medical Staff Executive Committee has direct oversight and accountability By what date are you going to have the deficiency corrected? The committee will review and approve the changes at the June 18, 2012 meeting.</p>	06/04/2012	

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S0904	<p>410 IAC 15-1.5-6 NURSING SERVICE 410 IAC 15-1.5-6(a)(1)</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>(1) An organizational plan which delineates the responsibilities for patient care.</p> <p>Based on staff interview, the facility failed to ensure twenty-four (24) hour nursing services when the facility chose to close in February and April, 2012.</p> <p>Findings:</p> <p>1. at 9:45 AM on 4/9/12, interview with staff member #50 indicated:</p> <p>a. the hospital was closed from 11:30 AM on Sunday, April 8, 2012 until the admission of a patient on 4/9/12 at 10:30 AM (nursing staff in at 9:30 AM to prep for patient admissions after surgery)</p> <p>b. this staff member is a RN (registered nurse) and was on call during the time of closing, but was not on site, nor was any other RN on site during the "closed" period</p> <p>c. the hospital was also closed on some days between Christmas 2011 and January 1, 2012, due to lack of census</p> <p>2. at 12:25 PM on 4/9/12, interview with staff member #57 indicated:</p> <p>a. the hospital "closing", most recent to the 4/8/12 closing, was on 2/26/12 when the last patient was discharged at 12:50 PM and then the hospital re opened on Monday, 2/27/12 at 10:30</p>	S0904	<p>How are you going to correct the deficiency? If already corrected, include the steps taken and the date of correction. Staffing will be increased to provide additional coverage for 24/7 operation, including times when there are no patients in the hospital How are you going to prevent the deficiency from recurring in the future? Staffing plans will be updated to include nursing services coverage during times of zero hospital census Who is going to be responsible for steps A and B above? The Chief Executive Officer and Director of Nursing have direct oversight and accountability By what date are you going to have the deficiency corrected? ADDENDUM 6/4/12: The hospital anticipates that the additional staff member will be hired by 7/25/12. The staff member will then be orientaed and trained to</p>	06/04/2012

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	AM (with RN staff in about 9:30 AM to prep for patient admissions after surgery) b. RNs are not present in the hospital when patients are not present (as inpatients)		the additional duties by 8/25/12 DISPUTE: The hospital is a specialty hospital and as such closes when there are no patients in the hospital The hospital does not have an Emergency Room Patients are given discharge instructions that direct them to present to the nearest Emergency Room during an emergent situation. The surgeon and his office at Orthopaedics Northeast provide pre surgery education that directs patients to the nearest hospital Emergency Room after discharge The hospital has a sign at the front entrance of the hospital directing anyone who arrives at the front door of the hospital when the facility has no patients and is closed to report to the nearby Parkview Regional Medical Center Emergency Room. This process provides superior 24/7 care during an emergent situation, when patients are not currently in the Parkview Ortho Hospital.		

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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, document/log review, and interview, the nurse executive failed to ensure policy implementation related to the cleaning of refrigerators, and ice maker delivery chutes as well as monthly checks for expired supplies in two</p>	S0912	<p>1. All departmental cleaning logs have been updated to include cleaning of the food and medication refrigerators and ice machine delivery chutes.2. The two expired grey top blood tubes</p>	05/25/2012

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	<p>units, PACU (post anesthesia care unit--or Recovery) and SAU (surgical admission unit).</p> <p>Findings:</p> <p>1. at 12:00 PM on 4/10/12, review of the policy and procedure "Manual: Infection Prevention & Control"--"Housekeeping Responsibilities-Unit Personnel", indicated:</p> <p>a. on page 2 in section "IV. Procedure - Nursing Unit", indicates in the graph that "Food and Medication Refrigerators" are to be cleaned by "Unit Personnel" in the following frequency: "Every month and as needed"</p> <p>b. on page 2 in section "IV. Procedure - Nursing Unit", indicates in the graph/algorithm that "Ice Delivery Chutes" are to be cleaned by "Unit Personnel" in the following frequency: "Every month and as needed"</p> <p>2. at 1:35 PM on 4/9/12, while on tour of the SAU it was observed that:</p> <p>a. the pantry refrigerator, and pyxis medication refrigerator, logs did not indicate the last time either refrigerator had been cleaned</p> <p>b. there were 2 grey topped lab tubes found to be expired 3/12 in a storage cabinet of the SAU</p> <p>3. interview with staff member #58 at 1:40 PM on 4/9/12 indicated:</p> <p>a. it is unknown when the refrigerators in SAU were last cleaned as there is no place to document this on the current log posted on these appliances</p> <p>b. it is assumed the expired lab tubes were left in the cabinet by lab personnel as the SAU staff do not draw any lab tests that require the use of grey topped tubes</p> <p>c. SAU staff should have found and discarded the expired lab tubes during their monthly supply check</p> <p>4. at 12:30 PM on 4/10/12, interview with staff</p>		<p>were removed from the unit during the survey.3. The unit staff have been educated on the cleaning expectations and the requirement to document the checking of supply dates 4. Unit managers and Infection Control will conduct monthly rounds to assure that the above cleaning is being completed.5. The unit managers and director of nursing have direct oversight and accountability</p>				

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	<p>member #52 indicated:</p> <ul style="list-style-type: none"> a. the accrediting body also found the monthly cleaning of ice chutes and refrigerators to be lacking in August of 2011 b. a new log was developed for this documentation, but it has been found that these logs are not being utilized as expected <p>5. at 12:35 PM on 4/10/12, review of monthly logs for Recovery and SAU indicated:</p> <ul style="list-style-type: none"> a. in 2011, the ice delivery chutes were not documented as being cleaned in February, April, July, August, September, October and December b. The Recovery room log for 2012 indicated the ice delivery chute was not documented as being cleaned in January and the refrigerator lacked documentation of cleaning for January, February, and March c. the SAU log for 2012 indicated the ice delivery chute was not documented as being cleaned in January and February, and the refrigerator lacked documentation of cleaning in January d. the SAU log for 2012 is lacking documentation having checked "supply dates" for March of 2012 e. the 2011 monthly checklist for 2011 for recovery and SAU are lacking documentation for the "supply dates" checks for January, March, April, May, September, November, and December 				

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S0954	<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 and interview, the facility failed to ensure that emergency equipment and medications were available for use if needed.</p> <p>Findings:</p> <ol style="list-style-type: none"> The policy/procedure Crash Cart/Defibrillator/AED Checks (reviewed 2-12) failed to indicate a list of emergency equipment and medications and failed to indicate a list of respiratory supplies. The Parkview Health Department of Pharmacy policy/procedure Emergency Medications Including Emergency Drug Boxes and Crash Carts failed to indicate the following: <ol style="list-style-type: none"> a date of approval or review by a responsible person at Parkview Orthopedic Hospital (POH) a list of emergency equipment a list of emergency medications a list of respiratory supplies During an interview on 4-10-12 at 1035 hours, staff A1 and A6 confirmed 	S0954	<p>How are you going to correct the deficiency? If already corrected, include the steps taken and the date of correction.</p> <p>The hospital policy- Crash Cart/Defibrillator/AED Checks has been revised to include a list of emergency equipment, medications and respiratory supplies Parkview Health System Pharmacy Policy – Emergency Medications including Drug Boxes and Crash carts was reviewed and authorized by L. Ferrell, Director of Nursing for Parkview Ortho Hospital. A list of emergency equipment, medications and respiratory supplies was added to the policy on 5/21/12.</p> <p>How are you going to prevent the deficiency from recurring in the future?</p> <p>A policy and procedure review schedule will be developed, that will include the above listed policy, and the next</p>	05/21/2012			

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	that the policy/procedures failed to indicate specific emergency equipment and supplies and failed to ensure that emergency equipment and medications are available for use if needed.		review date to ensure policies and procedures are current. Who is going to be responsible for steps A and B above? The Director of Nursing has oversight and is accountable for this process By what date are you going to have the deficiency corrected? 5/21/12		

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S1160	<p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8(d)(1)</p> <p>(d) The equipment requirements are as follows:</p> <p>(1) All equipment shall be in good working order and regularly serviced and maintained.</p> <p>Based on observation, policy and procedure review, and interview, the facility failed to create clear policy related to the maximum temperature range for blanket warmers.</p> <p>Findings:</p> <p>1. at 2:15 PM on 4/10/12, review of the policy and procedure "Warming Cabinets", indicated:</p> <p>a. in section II. on page one, it reads: "Definition of Terms ECRI (economic cycle research institute) recommendations state that to reliably eliminate the risk of injuries from overheated fluids and blankets, a uniform limit of 110 degrees Fahrenheit [F] for both solutions and blanket warmers must be applied..."</p> <p>b. in section III. on page one, it reads: "Procedure...D. Blanket Warmers 1. In order to prevent patient injury from burns: a. Warming cabinet temperatures shall not exceed 110 degrees Fahrenheit in chambers utilized for blanket warming..."</p> <p>2. at 2:20 PM on 4/10/12, review of the policy and procedure "Manual: Infection Prevention & Control" with "Title: Temperature Controlled Device Monitoring", indicated:</p> <p>a. under section "V. Temperature Ranges", it reads in section D. "Warmers 1. Blanket 130 F/54C (Celsius) maximum..."</p> <p>3. at 1:45 PM on 4/9/12, while on tour of the</p>	S1160	<p>How are you going to correct the deficiency? If already corrected, include the steps taken and the date of correction.</p> <p>The Parkview Ortho Hospital "Warming Cabinets" was updated to match the Infection Control policy "Temperature Controlled Device Monitoring" policy that indicates maximum temperature range for blanket warmers is 130 degrees F</p> <p>How are you going to prevent the deficiency from recurring in the future?</p> <p>A policy and procedure review schedule will be developed to ensure policies and procedures are current and reviewed accordingly.</p> <p>Who is going to be responsible for steps A and B above?</p> <p>The Director of Nursing has oversight and is accountable</p>	05/21/2012			

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	<p>SAU (surgical admissions unit), in the company of staff members #52 and #58, it was observed that the Bryton warming cabinet was maintained at a temperature of 130 degrees F</p> <p>4. at 2:00 PM on 4/9/12, while on tour of the Recovery room area, in the company of staff members #52 and #58, it was observed that the Blickman warming cabinet was maintained at a temperature of 130 degrees F</p> <p>5. Interview with staff members #52 and #58 at 2:05 PM on 4/9/12 indicated:</p> <p>a. the warming cabinets used to be kept at a lower temperature setting than 130 degrees, but it was found that the blankets were not warm enough for patient comfort</p> <p>6. at 1:15 PM on 4/10/12, while on tour of the East side 12 bed med/surg nursing unit, in the company of staff members #52 and #57, it was observed that the Bryton warming cabinet was maintained at a temperature of 130 degrees F</p> <p>7. interview with staff member #53 at 2:30 PM on 4/10/12 indicated:</p> <p>a. the blanket warming cabinet polices are in conflict for the facility recommended temperature desired (one lists the maximum temperature is to be 110 degrees F, and another has a maximum temperature requirement of 130 degrees F)</p>		<p>for this process</p> <p>By what date are you going to have the deficiency corrected?</p> <p>5/21/12</p>		

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S1166	<p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8(d)(2)(C)</p> <p>(d) The equipment requirements are as follows: (2) There shall be sufficient equipment and space to assure the safe, effective, and timely provision of the available services to patients, as follows:</p> <p>(C) Appropriate records shall be kept pertaining to equipment maintenance, repairs, and current leakage checks.</p> <p>Based on document review and interview, the facility failed to maintain appropriate documentation of preventive maintenance (PM), repairs, and ground current leakage testing on all equipment for 9 items at the hospital.</p> <p>Findings:</p> <ol style="list-style-type: none"> On 4-09-12 at 0945 hours, staff A1 was requested to provide a policy/procedure regarding electrical safety and none was provided prior to exit. On 4-09-12 at 0945 hours, staff A1 was requested to provide documentation of preventive maintenance including evidence of ground current leakage testing for patient beds in use at the hospital and none was provided prior to 	S1166	<p>Dispute: Parkview Health System has a Biomedical Electronics Inspection Procedure for each piece of equipment that outlines the steps for checking electrical safety. Each piece of equipment also has a Detailed Equipment History report, that records the history of preventative maintenance and corrective maintenance checks over time. It is a matter of this rule's interpretation as to if actual logging of the electrical leakage current and grounding resistance is required to be recorded. Parkview Biomedical Services does not log these readings, but we do test for them in our procedures. Exception documentation practices for electrical leakage and grounding have been accepted by many regulatory agencies, including The Joint Commission as well as section 10.5.6.2 of NFPA 99 2012</p>	06/04/2012			

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	<p>exit.</p> <p>3. The Parkview Health policy/procedure Scheduled Medical Equipment Inspections (revised 4-12) lacked a provision to validate performance of ground current leakage testing per State law 410 IAC 15-1.5-8(d)(2)(C).</p> <p>4. PM documentation provided for review (C-arm, CT scanner, defibrillators, EKG machine, OR lights and sterilizers) failed to validate performance of ground current leakage testing for equipment serviced by hospital personnel.</p> <p>5. During an interview on 4-10-12 at 1135 hours, staff A14 confirmed that the policy/procedure lacked a provision for documenting the current leakage testing performed on equipment and confirmed that the PM documentation failed to indicate evidence of ground current leakage testing to comply with State requirements and validate that the equipment was safe for use.</p>		<p>edition Our written PMI (Preventative Maintenance Inspections) procedures for equipment clearly state a procedural step if electrical leakage or grounding integrity testing is required during our testing process. Our current procedural standard for a passes electrical leakage and grounding integrity is based upon the NFPA 99 (1993) 7-5.1.3.5 ADDENDUM 6/4/12:A procedure for Biomedical inspection has already been submitted as an attachment to the dispute.Documentation of preventive maintenance of selected equipment has already been provided as an attachment to the dispute.Evidence of the ground current leakage testing has already been provided on the preventive maintenance documents. This information is provided as a pass/fail test, rather than a rate. Subsequent equipment follow-up action was also provided on each pm log, if indicated on any equipment that failed the ground current leakage test.</p>		

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S1168	<p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 150-1.5-8 (d)(3)</p> <p>(d) The equipment requirements are as follows:</p> <p>(3) Defibrillators shall be discharged at least in accordance with manufacturers recommendations and a discharge log with initialed entries shall be maintained.</p> <p>Based on document review, observation and interview, the facility policy/procedure failed to ensure that defibrillator inspection and testing was performed as recommended by the manufacturer and failed to ensure that the equipment was properly maintained and available for use if needed.</p> <p>Findings:</p> <p>1. The Phillips M4735A HeartStart XL Defibrillator/Monitor (2006) operators manual indicated the following: " perform a Shift/System Check every shift ...along with visual inspection of the device and all cables, controls, accessories and supplies. Also regularly check expiration dates of all supplies, such as multifunction defib electrode pads ... "</p>	S1168	<p>How are you going to correct the deficiency? If already corrected, include the steps taken and the date of correction.</p> <p>The Parkview Ortho Hospital policy: Crash Cart/Defibrillator/AED Checks has been revised to include system check every shift, perform a visual inspection of the device, check expiration dates of supplies, test every shock delivery method used with the unit, checklist for recording shift/system checks and additional checks for manufacturers' recommendations.</p> <p>The shift checklist also includes visual inspection and check for supply outdates The expired defibrillator pads were discarded immediately during the survey Staff were re-educated on completion of the system</p>	05/25/2012			

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	<p>2. The policy/procedure Crash Cart/Defibrillator/AED Checks (reviewed 2-12) failed to indicate the following:</p> <p>A. perform a shift/system check every shift (page 11-3)</p> <p>B. perform a visual inspection of the device (page 11-6)</p> <p>C. check expiration dates of all supplies including multifunction defib electrode pads (page 11-3)</p> <p>D. test every shock delivery method that is used with the unit - if you use both external paddles (page 11-4) and pads (page 11-5), test both</p> <p>E. Checklist for recording the Shift/System Checks and additional checks (page 11-6) per manufacturers ' recommendations.</p> <p>3. During a tour on 4-09-12 at 1400 hours, the following condition was observed: expired multifunction defib pads with the statement ' use by 3-12 ' on the east unit crash cart.</p> <p>4. During an interview on 4-09-12 at 1401 hours, staff A4 and A6 confirmed that the defib pads had expired.</p>		<p>check every shift and the check for supply outdates</p> <p>How are you going to prevent the deficiency from recurring in the future? The nurse assignment sheet has been updated to include checking the crash cart every shift. The department manager is auditing weekly to ensure that the checks are completed</p> <p>Who is going to be responsible for steps A and B above? The Inpatient manager has oversight and is accountable for this process</p> <p>By what date are you going to have the deficiency corrected? 5/25/12</p>	
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	5. During an interview on 4-10-12 at 1050 hours, staff A1 reviewed the operators manual for the Phillips M4735A defibrillator and confirmed that the policy/procedure lacked the indicated provisions.			

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S1172	<p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8(e)(1)(A)(B)(C)</p> <p>(e) The building or buildings, including fixtures, walls, floors, ceiling, and furnishings throughout, shall be kept clean and orderly in accordance with current standards of practice as follows:</p> <p>(1) Environmental services shall be provided in such a way as to guard against transmission of disease to patients, health care workers, the public, and visitors by using the current principles of the following:</p> <p>(A) Asepsis (B) Cross-infection; and (C) Safe practice.</p> <p>Based on observation, policy and procedure review, manufacturer's manual review, and staff interview, the facility failed to ensure the cleanliness of its blanket warming cabinets in two areas toured. (SAU = surgical admissions unit and Recovery room)</p> <p>Findings:</p> <p>1. at 1:45 PM on 4/9/12, while on tour of the SAU in the company of staff members #52 and #58, it was observed that there was a large accumulation of dust/lint, from the blankets being warmed, in the Bryton blanket warmer, under the lower shelf of the upper unit</p> <p>2. interview with staff members #52 and #58 at 1:50 PM on 4/9/12 indicated:</p> <p>a. it had never been thought of to clean under the lower shelf units</p> <p>b. one of the staff members had recently read of</p>	S1172	<p>How are you going to correct the deficiency? If already corrected, include the steps taken and the date of correction.</p> <p>The dust under the lower shelves of the blanket warmers in SAU and PACU was removed immediately during the survey Monthly cleaning of the blanket warmers has been added to the SAU and PACU cleaning schedules Staff have been educated on the importance of regular cleaning of the blanket warmers</p>	05/25/2012
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	<p>a blanket warmer fire occurring for a hospital and now, it is understood how that could happen</p> <p>3. at 2:00 PM on 4/9/12, while on tour of the Recovery area with staff members #52 and #59, it was observed that there was a large accumulation of dust/lint, from the blankets being warmed in the Blickman blanket warmer, under the lower shelf of blankets</p> <p>4. at 2:15 PM on 4/10/12, review of the policy and procedure "Warming Cabinets", indicated: a. there is no direction for periodic cleaning of the warming cabinets in this policy</p> <p>5. at 2:20 PM on 4/10/12, review of the policy and procedure "Manual: Infection Prevention & Control" with "Title: Temperature Controlled Device Monitoring", indicated: a. there is no direction for periodic cleaning of the warming cabinets in this policy</p> <p>6. review of both the Blickman and Bryton manufacturer's manual at 2:10 PM on 4/10/12 indicated: a. there is no direction for periodic cleaning of the warming cabinets in either of the manuals</p> <p>7. interview with the director of nursing, staff member #52, and the safety director, staff member #53, at 2:30 PM on 4/10/12 indicated: a. even though the facility policies and the manufacturer's manuals do not give direction for periodic lint removal of the blanket warmers, it is a safety concern that these have not been done previously</p>		<p>How are you going to prevent the deficiency from recurring in the future? The department manager will complete monthly audits to ensure compliance</p> <p>Who is going to be responsible for steps A and B above? The SAU/PACU department manager has oversight and is accountable for this process</p> <p>By what date are you going to have the deficiency corrected? 5/25/12</p> <p>Dispute: The operations manual from the manufacturer of the Bryton Digital Warming Cabinet does not specify cleaning requirements. The operations and maintenance manual for the Blickman Digital Warming Cabinet stated on page 3 "Periodically, lint or threads may accumulate in the heater compartment. Removing the false bottom permits access to this area for vacuuming or cleaning."</p>				

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S1906	<p>410 IAC 15-1.6-6 REHABILITATION SERVICES 410 IAC 15-1.6-6(b)</p> <p>(b) The services shall be under the direction of a physician qualified by training or experience and supervised by a qualified person or persons.</p> <p>Based on document review and interview, the facility failed to ensure that the rehabilitation services were provided under the direction of a physician qualified by training and experience.</p> <p>Findings:</p> <p>1. On 4-09-12 at 0945 hours, staff A1 was requested to provide documentation that the rehabilitation services (physical therapy) were under the direction of a qualified physician approved by the medical staff and none was provided prior to exit.</p> <p>2. During an interview on 4-09-12 at 1145 hours, staff A1 indicated that the inpatient rehabilitation services lacked a medical director.</p>	S1906	<p>How are you going to correct the deficiency? If already corrected, include the steps taken and the date of correction.</p> <p>A physician member of the medical staff has accepted the role of medical director for the Rehab unit and will function in this role The medical staff will be informed of this assignment at the June, 2012 Medical Executive committee meeting</p> <p>How are you going to prevent the deficiency from recurring in the future? The Medical Staff services department will track the assignment of a medical director for the Rehab department on a yearly basis</p> <p>Who is going to be responsible for steps A and B above? Hospital medical staff</p>	05/25/2012	

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			<p>By what date are you going to have the deficiency corrected? 5/25/12</p>	

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S2104	<p>410 IAC 15-1.6-8 SURGICAL SERVICES 410 IAC 15-1.6-8(a)</p> <p>(a) If the hospital provides inpatient or ambulatory surgical services, the services shall meet the needs of the patients served, within the scope of the service offered, and in accordance with acceptable standards of practice and and safety.</p> <p>Based on observation and interview, the facility failed to maintain a full complement of drugs for emergency medication, in the case of malignant hyperthermia, for surgery patients, per the standards of practice, in the surgical care area.</p> <p>Findings:</p> <ol style="list-style-type: none"> at 2:25 PM on 4/9/12, while on tour of the surgery area's inner core, it was observed that only 12 vials of Dantrolene were present in the malignant hyperthermia cart interview with staff members #52 and #59 at 2:30 PM on 4/9/12, indicated: <ol style="list-style-type: none"> it is known by surgical staff that 36 vials of Dantrolene are the MHA (Malignant Hyperthermia Association) requirement it was assumed that it was OK for this hospital to be able to go next door to the adjacent hospital to acquire the remaining 24 vials of Dantrolene, if the need arose 	S2104	<p>How are you going to correct the deficiency? If already corrected, include the steps taken and the date of correction.</p> <p>24 additional vials of Dantrolene were obtained from Pharmacy on 5/21/12 The additional vials were placed in the medication dispensing system (Pyxis) Unit staff were educated on 5/25/12 regarding the location of the additional vials OR staff will continue to monitor the malignant hyperthermia cart for medication outdates Pharmacy will monitor the expiration dates of the vials in the Pyxis</p> <p>How are you going to prevent the deficiency from recurring in the future?</p> <p>The Pharmacy manager and Operating Room manager</p>	05/25/2012			

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			<p>updated the par level and the malignant hyperthermia contents list The Pharmacy process has been modified to assure that medications are ordered and restocked a month in advance of the expiration date</p> <p>Who is going to be responsible for steps A and B above? The Operating Room manager and the Director of Nursing have oversight and are accountable for this process</p> <p>By what date are you going to have the deficiency corrected? 5/25/12</p>		