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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150172 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 06/12/2012 |
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| S0000 | <p>This visit was for a State hospital licensure survey.</p> <p>Dates: 06/11/12 through 6/12/2012</p> <p>Facility Number: 011352</p> <p>Surveyors: Albert Daeger, CFM, SFPIO Medical Surveyor</p> <p>Jennifer Hembree, RN PH Nurse Surveyor</p> <p>Ken Ziegler Medical Surveyor</p> <p>QA: claughlin 06/18/12</p> <p>8//17/12 revised due to IDR</p> | S0000 | | |

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

TITLE

(X6) DATE

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

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| 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 staff interview, the facility failed to ensure a foodservice contract was part of the Physicians' Medical Center Contracts and Service Agreements manual.</p> <p>Findings included:</p> <ol style="list-style-type: none"> The Physicians' Medical Center Contracts and Service Agreements manual index revealed contracted foodservice (MC) was not listed or in the manual itself. On 9/27/2010, Physicians' Medical Center Contracted Services Statement states, "The Governing Body has approved all contracted services and ascertains that all contractor services provided in the hospital are in compliance with the Conditions of Participation for hospitals. The patient care services provided under contract will be subject to | S0394 | The contract for the Foodservice was placed in the Contract and Service Agreements Manual on 6/12/12. Updates to the index, and creation of a new identification tab, was completed on 6/13/12. The Contract was reviewed by the Board of Managers on 6/20/12. The administrative assistant will review the Contract and Service Agreements Manual periodically and will have responsibility to ensure all contracts are included in the Manual and index properly. | 06/20/2012 | | | |

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| | <p>the same hospital-wide quality assurance evaluation as other services provided directly by the hospital."</p> <p>2. At 1:30 PM on 6/12/12, staff member #5 indicated all contracted services in the contracted book are evaluated annually; however, the foodservice contract was not inserted in the contacted manual. The contract was maintained in the Dietary Policy and Procedure manual. The staff member indicated the foodservice contract has not been reviewed by the Governing Body as the others that are listed in the contract manual.</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. Based on document review and staff interview, the facility failed to ensure Tissue Transplant and a contracted foodservice were part of the hospital's comprehensive quality assessment and improvement (QA&I) program.</p> <p>Findings included:</p> <p>1. The 2011 Quality Improvement Performance Improvement Plan indicated all hospital services and contracted are to be part of it's QA&I program. The Patient Care Committee (PCC) is established as a mechanism by which Quality Improvement Performance Improvement Plan may be implemented. The PCC shall meet monthly.</p> <p>2. The PCC meeting minutes were</p> | S0406 | <p>QA monitors for Tissue Transplant and Foodservice were added to the QA&I program on 6/12/12, and will be evaluated during the Patient Care Committee (PCC) on 7/9/12. Evaluation of the contracted foodservice will be completed by the Inpatient Nurse Manager and submitted to the PCC on 7/9/12. The evaluation will be reviewed by the Board of Managers on 7/23/12. Continued review of the QA monitors will be reviewed monthly at the PCC meetings and quarterly at the Medical Executive Committee and Board of Managers.</p> | 07/09/2012 |

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| | <p>reviewed for 2011 and 2012. The contracted foodservice and Tissue Transplant were not evaluated in the PCC. "The patient care services provided under contract will be subject to the same hospital-wide quality assurance evaluation as other services provided directly by the hospital."</p> <p>3. At 2:15 PM on 6/12/2012, staff member #5 indicated Tissue Transplant service was not evaluated in 2011 or 2012. The staff member indicated the contracted foodservice was not part of the QA&I program.</p> | | | |

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| S0536 | <p>410 IAC 15-1.5-1 DIETETIC SERVICES 410 IAC 15-1.5-1 (d)(1)(2)(3)</p> <p>(d) Menus shall meet the needs of the patients as follows:</p> <p>(1) Therapeutic diets shall be prescribed by the practitioner responsible for the care of the patient.</p> <p>(2) Nutritional needs shall be met in accordance with recognized dietary standards of practice and in accordance with the orders of the responsible practitioner.</p> <p>(3) A current therapeutic diet manual approved by the dietitian and medical staff shall be readily available to all medical, nursing, and food service personnel.</p> <p>Based on documentation review, the facility failed to ensure a therapeutic menu was provided for 1 instance (patient record N1).</p> <p>Findings included:</p> <p>1. Meal Service to Patients policy last reviewed November 2011 states, "All diet orders, as prescribed by a physician, are given to the Director of Nutritional Services/Patient Care Coordinator. Meals may be contracted to an outside distribution company and delivered daily according to the patients's menu selections and dietary restrictions and/or orders."</p> | S0536 | <p>A menu for "no concentrated sweets" was created for each of the daily meals. Documentation supporting prepackaged meals which qualify as "no concentrated sweets" was provided by the facility dietitian on 6/19/12. Revisions to the policy to include a "no concentrated sweets" diet were completed on 6/20/12 and will be reviewed by the Patient Care Committee on 7/9/12, Medical Executive Committee on 7/19/12, and the Board of Managers on 7/23/12. The inpatient nurses' will notify the nurse manager and dietitian when a physician order does not meet any of the provided menus. The nurse manager will monitor physician dietary orders weekly.</p> | 06/20/2012 | | | |

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| | <p>2. Dietary policies and procedures last reviewed June 2011 notes under menus to hospital's approved diets: regular diet, diabetic diets; vegetarian diets; carbohydrate controlled diets; clear liquid diets; low fat diets; low fiber diets; low sodium diets; and soft diets. The dietary policies and procedures manual does not identify diet 'No Concentrated Sweets'.</p> <p>3. On 3/7/12 at 1600 hours, patient's medical record N1 indicated change diet to No Concentrated Sweets.</p> <p>4. The approved therapeutic menus and prepackaged meals were reviewed and they do not specify they meet the requirements for a 'No Concentrated Sweet' diet.</p> <p>5. At 10:00 AM on 6/12/12, staff member #3 indicated the prepackaged meals provided by a contracted foodservice should meet the 'No Concentrated Sweets' medical diets. However, the staff member confirmed the hospital does not have any documentation confirming the prepackaged food provided by the contracted foodservice meets the a 'No Concentrated Sweets' diets.</p> <p>6. At 1:15 PM on 6/12/12, staff member #4 indicated the hospital does not have an</p> | | | | | | |

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| | approved menu for a 'No Concentrated Sweets'. | | | |

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| S0554 | <p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(a)</p> <p>(a) The hospital shall provide a safe and healthful environment that minimizes infection exposure and risk to patients, health care workers, and visitors.</p> <p>Based on observation and staff interview, the facility failed to maintain an environment that minimized risk to patients for 2 of 2 units toured.</p> <p>Findings include:</p> <p>1. During tour of the medical/surgical unit beginning at 10:00 a.m. on 6/12/12 and accompanied by staff member #1 the following was observed:</p> <p>(A) Numerous expired items in the crash cart including, but not limited to, four (4) 24 GA .56 in I.V. catheters with an expiration date of 3/12, one (1) 18 GA 1.16 in I.V. catheter with an expiration date of 6/11.</p> <p>(B) The housekeeping cleaning carts which had clean rags and mopheads on top of them were stored in the soiled utility room with trash, biohazard waste, and the hopper.</p> <p>(C) A sign was posted on the papertowel dispenser in the nutrition room indicating that patients polar packs could be emptied in the sink in the room. The sink is next to a coffee pot and ice/water machine</p> | S0554 | <p>All expired items were removed from service on 6/12/12 and disposed of. Housekeeping carts, flowers for patient at discharge, and the cardboard box for donations were removed from the soiled utilities on 6/12/12. Signage posted on the nutrition room regarding emptying polar packs was removed on 6/12/12. Department managers will assign staff to monitor expirations dates on supplies monthly. Department managers will randomly audit the soiled utility rooms and report findings via occurrence report to the Safety Committee. Safety Committee findings are reported monthly to the Patient Care Committee, Medical Executive Committee and on to the Board of Managers. The Director of Nursing will ensure plan of correction is implemented.</p> | 06/12/2012 | | | |

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| | <p>used for patients. The polar packs would be considered a contaminated item after removed from a patients room.</p> <p>2. During tour of the surgical area beginning at 11:00 a.m. and accompanied by staff member #5, the following was observed:</p> <p>(A) Numerous expired items in a drawer in the clean storage room including, but not limited to, four (4) 24 GA .56 in. I.V. catheters with an expiration date of 1/12, two (2) 18 GA 1.16 in. I.V. catheters with an expiration date of 3/11.</p> <p>(B) Flowers in a vase were sitting in the sink of the soiled utility room next to the hopper. Staff member #2 indicated in interview (see below) that the flowers are sent home with patients upon discharge. The flowers could become contaminated due to their close proximity to the hopper and storage in a soiled utility room.</p> <p>(C) Items to be donated were observed in a cardboard box on the floor in the soiled utility room. The items could become contaminated due to storage in the room.</p> <p>(D) All (18/18) of the CRE fixed wired esophageal dilation catheters stored in procedure room B were expired. Five (5) expired 3/12, three (3) expired 4/12, and ten (10) expired 5/12.</p> <p>(E) Both (2/2) arterial blood sampler packs were expired in the malignant hyperthermia kit. Both expired 3/12.</p> | | | | | | |

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| | 3. Staff member #2 indicated in interview during tour of the surgical area that the flowers observed in the sink were delivered 1-2 times a week to the facility and distributed to patients upon discharge. | | | |

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| S0590 | <p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(f)(3)(C)</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>(C) Reviewing employee exposure incidents and making appropriate recommendations to minimize risk.</p> <p>Based on document review and interview, the facility failed to ensure TB testing were conducted according to hospital policy for 7 of 11 employees (A10, A12, A13, A14, A15, A16, and A17).</p> <p>Findings included:</p> <ol style="list-style-type: none"> 1. Surveillance Plan for Prevention and Control of Infections policy last reviewed November 2011 indicates Infections will be defined by the CDC criteria for nonsocomial infections and TB skin testing meets the state requirements. 2. CDC guidelines specifies the Purified Protein Derivative (PPD) timed skin test responses should be measured 48-72 hours after administration. 3. At 12:30 PM on 6/12/2012, staff member #4 indicated all hospital staff and contracted employees are required to meet | S0590 | All staff files, contracted and facility; will be reviewed by the department managers by 7/2/12. Identified staff, that does not have a noted time of administration or time of interpretation will be required to have their test repeated by 7/12/12. Education will be provided by each department manager on the requirement of identifying the time when a PPD test is administered and interpreted. The Infection Control nurse will monitor and review each PPD test results before it is placed into staff files. | 07/12/2012 | | | |

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| | <p>Surveillance Plan for Prevention and Control of Infections policy guidance as it relates to annual TB testing. The staff member indicated TB testing are required to be completed annually.</p> <p>4. The ppd skin tests were reviewed with staff member #4 on 6/12/2012 at 11:00 AM and he/she confirmed the readings that were observed in the employee's health care records for employees: A10, A11, A12, A13, A14, A15, A16, A17, A18, A19, and A20.</p> <p>5. Staff member A10 ppd was placed on 8/30/11 at 3:00 PM and it was read on 9/14/2010; no time was recorded. Without recording the time when the ppd was placed, the 48 to 72 hours could not be assured.</p> <p>6. Staff member A12 ppd was placed on 8/15/11 (no recorded time) and it was read on 8/17/11 at 10:25 AM. Without recording the time when the ppd was administered, the 48 to 72 hours could not be assured.</p> <p>7. Staff members A13 and A14 ppd were last placed on 7/23/10 and they were read on 7/23/10. The last record of the employees' TB testing were exceeding 22 months and the last record of TB testing did not have a recorded time values with the recorded dates. Without recording the time when the ppd was administered, the 48 to 72 hours could not be assured.</p> <p>8. Staff member A15 ppd was last</p> | | | |
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| | <p>placed on 2/25/11 and it was read on 3/28/11. The last record of the employees' TB testing were exceeding 15 months and the last record of TB testing did not have a recorded time values with the recorded dates. Without recording the time when the ppd was administered, the 48 to 72 hours could not be assured.</p> <p>9. Staff members A16 and A17 health care records were reviewed. Neither staff members' records identified TB testing results to be reviewed.</p> | | | |

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| S0606 | <p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(f)(3)(D)(viii)</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>(viii) An employee health program to determine the communicable disease history of new personnel as required by state and federal agencies.</p> <p>Based on document review and staff interview, the hospital failed to provide reliable documented evidence for immune status of 6 of 11 health care workers related to Rubella, Rubeola, Varicella, and provide documentation of offering Hepatitis B vaccination for 3 of 11 health care workers (A13, A14, A15, A16, A17, and A18).</p> <p>Findings: 1. Surveillance Plan for Prevention and Control of Infections policy last reviewed November 2011 indicates Infections will be defined by the CDC criteria for nonsocomial infections. The policy indicates Hepatitis B vaccinations are recommended. The policy also indicates</p> | S0606 | <p>Contracted staff immunizations have been reviewed as of 7/2/12. Contracted companies have been notified by 7/3/12 to provide additional documentation from a reliable source to confirm immunization, such as school records or a Physician. Documentation will be submitted to the facility by 7/12/12. All staff, contracted or facility, will have a delineation for, or evidence of, Hepatitis-B vaccination by 7/12/12. To prevent further deficiencies documentation will be required during orientation. The Inpatient nurse manager will monitor this process.</p> | 07/12/2012 | | | |

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| | <p>employees will be required to show documentation of previous vaccination, the need for vaccination will be documented and series initiated or documentation of the need for titer draw if proof of immunization is unavailable or a signed declination.</p> <p>2. CDC guidelines specifies health care personnel (HCP) who work in medical facilities should be immune to measles, mumps, and rubella. CDC recommended For HCP who have no serologic proof of Varicella immunity, prior vaccination, or history of varicella disease, give 2 doses of varicella vaccine, 4 weeks apart.</p> <p>3. At 12:30 PM on 6/12/2012, staff member #4 indicated all hospital staff and contracted employees are required to meet Surveillance Plan for Prevention and Control of Infections policy guidance as it relates to immunizations criteria.</p> <p>4. The Rubella, Rubeola, Varicella, and Hepatitis-B documentation were reviewed with staff member #4 on 6/12/2012 at 11:00 AM and he/she confirmed the readings that were observed in the employee's health care records for employees: A10, A11, A12, A13, A14, A15, A16, A17, A18, A19, and A20.</p> <p>5. Staff members A13, A14, A15, A16, A17, and A18 health care records did not identify the staff members were screened for Rubella, Rubeola, and Varicella. However, three of the health care</p> | | | |

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| | <p>personnel (A13, A14, and A15) had a self-screen for Rubella, Rubeola, and Varicella. The self-screen was signed by the employee only and not confirmed by a reliable source such as: school records, Physician, etc.</p> <p>6. Staff members A16, A17, and A18 personnel health records did not have documented evidence of vaccination or a delineation for Hepatitis-B.</p> | | | | |

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| S0610 | <p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(f)(3)(D)(x)</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>(x) A program of food preparation and storage for all personnel involved in food handling which includes, but is not limited to, the following:</p> <p>(AA) Storage of employee food in patient refrigerators.</p> <p>(BB) Medications in nutrition refrigerators.</p> <p>(CC) Refrigerator and freezer temperature monitoring.</p> <p>Based on documentation review and interview, the facility failed to ensure the Dietary Department was complying with basic sanitation practices specified in 410 IAC 7-24, Retail Food Establishment Sanitation Requirements.</p> <p>Findings included:</p> <p>1. Food Storage policy last reviewed</p> | S0610 | Per discussion with ISDH, the IDR submitted was approved and this Deficiency has been removed. | 10/12/2012 | | | |

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| | <p>November 2011 requires the department to comply with local, state, and federal laws.</p> <p>2. Retail Food Establishment Sanitation Requirements Title 410 IAC 7-24 effective November 13, 2004 states, " " The person-in-charge of the retail food establishment shall ensure the following: (1) Employees are visibly observing foods as they are received to determine that they are from approved sources, delivered at the required temperatures, protected from contamination, unadulterated, and accurately presented by routinely monitoring the employees' observations and periodically evaluating foods upon their receipt; (2) Employees are properly cooking potentially hazardous food, being particularly careful in cooking those foods known to cause severe foodborne illness and death, such as eggs and comminuted meats, through daily oversight of the employees' routine monitoring of the cooking temperatures using appropriate temperature measuring devices properly scaled and calibrated as specified under sections 206 and 260 of this rule; (3) Employees are using proper methods to rapidly cool potentially hazardous foods that are not held hot or are not for consumption within four 4 hours, through daily oversight of the employees' routine monitoring of food temperatures during</p> | | | |

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| | <p>cooling; (4) Employees are properly sanitizing cleaned multiuse equipment and utensils before they are reused, through routine monitoring of solution temperature and exposure time for hot water sanitizing, and chemical concentration, pH, temperature, and exposure time for chemical sanitizing; (5) Employees are preventing cross contamination of ready-to-eat food from unwashed hands and are properly using suitable utensils (deli tissue, spatulas, tongs, single-use gloves, or dispensing equipment when such items can be used.); and (6) Employees are properly trained in food safety as it relates to their assigned duties. "</p> <p>3. The Dietary Department was toured at 11:15 AM on 6/11/2012. The handwashing sink faucet was only dispensing water out of the faucet at 87 F and not the required hot water temperature of 100 F. The prepackaged food provided by the contracted foodservice did not have the mandatory labeling requirement on the packages. The Dietary Department was observed with a chemical Dispatch that was not an approved chemical sanitizer for food contact surfaces in the kitchen. The thermometer was tested and it read 4 degrees Fahrenheit shy of 32 F when tested in a ice bath. The Food Director</p> | | | |

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| | <p>failed to cover his/her hair when entering the kitchen. The contracted foodservice prepackaged food label for 2 sample trays (Parmesan Talapia, Lemon Chicken Breast) stated, "Microwave Oven: Pierce plastic on tray. Heat on high 3-5 minutes. Let stand 2 minutes. Heat to internal temp. of 165 F." The Food Director failed to allow the meals to set for 2 minutes prior monitoring it's temperature. However, after 8 minutes, the Food Director tempted the lemon pepper chicken at 160 degrees F. Therefore, the lemon pepper chicken was not cooked to the required temperature of 165 F in a microwave.</p> <p>4. At 12:30 PM on 6/11/12, staff member #3 indicated he/she was not trained on proper sanitation practices in the kitchen. The staff member indicated a copy of 410 IAC 7-24 was not accessible because the staff member was unaware of the regulation. The staff member indicated the owner of the contracted foodservice told the hospital the prepackaged food that was provided was fully cooked. However, after the inspection of the Dietary Department, the staff member did not realize the food was not fully cooked as noted on the prepackaged labels. The staff member indicated he/she thought Dispatch was okay to use in the kitchen. The staff</p> | | | |

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| | member said the utensils that are washed are done in the 2-compartment sink with detergent and followed by rinsing. | | | |

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| S0771 | <p>410 IAC 15-1.5-4 MEDICAL RECORD SERVICES 410 IAC 15-1.5-4(g)(7)</p> <p>(g) A short stay record form used for inpatients hospitalized for less than forty-eight (48) hours, observation patients, ambulatory care patients and ambulatory surgery patients shall document and contain, but not be limited to, the following:</p> <p>(7) Final progress note, including instructions to the patient and family with dismissal diagnosis and disposition of patient.</p> <p>Based on document review and staff interview, the facility failed to ensure a short stay summary or final progress note was completed for patients with stays less than 48 hours for 7 of 15 medical records (patients #N2, N5, N7, N10, N14, N16, and N17).</p> <p>Findings include:</p> <p>1. Facility policy titled "Medical Records" last reviewed/revised 11/28/11 states: "I. For patient stays under 48 hours, the final progress notes may serve as the discharge summary and must contain the outcome of hospitalization, the case disposition, and any provisions for follow-up care."</p> <p>2. Patient #N2 was admitted on 10/26/11 and discharged on 10/27/11. His/her</p> | S0771 | <p>Education to all medical staff will be completed by 7/12/12 regarding the requirement of a final progress note, use of a short stay form, or dictated report that summarize the patients hospitalization, case disposition, and provisions for follow-up care. Monthly chart audits will be completed and reported to the Patient Care Committee, Medical Executive Committee, and the Board of Managers. Completion of the audits will be monitored by the Director of Nursing.</p> | 07/12/2012 |

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| | <p>medical record lacked a final progress noted dated on day of discharge or after discharge.</p> <p>3. Patient #N5 was admitted on 11/11/11 and discharged on 11/13/11. His/her medical record lacked a final progress noted dated on day of discharge or after discharge.</p> <p>4. Patient #N7 was admitted on 2/29/12 and discharged on 3/1/12. His/her medical record lacked a final progress noted dated on day of discharge or after discharge.</p> <p>5. Patient #N10 was admitted on 12/28/11 and discharged on 12/29/11. His/her medical record lacked a final progress noted dated on day of discharge or after discharge.</p> <p>6. Patient #N14 was admitted on 3/21/12 and discharged on 3/22/12. His/her medical record lacked a final progress noted dated on day of discharge or after discharge.</p> <p>7. Patient #N16 was admitted on 1/11/12 and discharged on 1/12/12. His/her medical record lacked a final progress noted dated on day of discharge or after discharge.</p> | | | |

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| | <p>8. Patient #N17 was admitted on 2/7/12 and discharged on 2/8/12. His/her medical record lacked a final progress noted dated on day of discharge or after discharge.</p> <p>9. Staff member #5 verified the above medical record information at 3:00 p.m. on 6/12/12.</p> | | | |

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| S0952 | <p>410 IAC 15-1.5-6 NURSING SERVICE 410 IAC 15-1.5-6(d)</p> <p>(d) Blood transfusions and intravenous medications shall be administered in accordance with state law and approved medical staff policies and procedures. If the blood transfusions and intravenous medications are administered by personnel other than physicians, the personnel shall have special training for these procedures in accordance with subsection (b)(6). Based on document review and staff interview, the facility failed to ensure competencies were maintained for 2 of 3 registered nurses (RN) administering blood products.</p> <p>Findings include:</p> <ol style="list-style-type: none"> Staff members #2 and #6 (RN's) personnel files lacked current competencies to administer blood. Staff member #4 verified the above at 2:00 p.m. on 6/12/12. | S0952 | <p>In prior practice, only nurses that may administer blood or blood products had been in-serviced. Following the survey, All RN's will complete a competency to administer blood. All RN's that have not completed the competency have identified by 7/2/12. Competencies will be conducted and completed by 7/31/12. All RN's will participate in the annual blood administer competency review provided by the Inpatient Nurse Manager. Completion of competencies will be reported to the Director of Nursing and Patient Care Committee, by the Inpatient Nurse Manager.</p> | 07/31/2012 | | | |

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| S1024 | <p>410 IAC 15-1.5-7 PHARMACEUTICAL SERVICES 410 IAC 15-1.5-7 (d)(2)(C)</p> <p>(d) Written policies and procedures shall be developed and implemented that include the following:</p> <p>(2) Ensure the monthly inspection of all areas where drugs and biologicals are stored and which address, but are not limited to, the following:</p> <p>(C) Detection and quarantine of outdated or otherwise unusable drugs and biologicals from general inventory pursuant to their return to the manufacturer, distributor, or destruction.</p> <p>Based on observation and staff interview, the facility failed to ensure unusable drugs were removed from stock for 1 of 2 patient refrigerators observed.</p> <p>Findings include:</p> <p>1. During tour of the medical/surgical area beginning at 10:00 a.m. on 6/12/12, the following was observed in the medication room refrigerator: (A) One (1) vial of Lantus insulin labeled for patient #N21.</p> <p>2. Staff member #1 indicated during the tour that patient #N21 had been discharged from the facility the previous week.</p> | S1024 | <p>The vial of medication labeled for patient #N21 was removed from the refrigerator and placed in the quarantine area on 6/11/12. The inpatient nurses will conduct a daily check of the medication refrigerator to ensure that medications of discharged patients that require refrigeration will be removed from stock and placed in the quarantine area. The inpatient nurse manager will conduct and document weekly audits.</p> | 06/12/2012 | | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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