

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  150009	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  07/10/2013
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NAME OF PROVIDER OR SUPPLIER  CLARK MEMORIAL HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 1220 MISSOURI AVE JEFFERSONVILLE, IN 47130
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S000000	<p>This visit was for a State Licensure Survey.</p> <p>Facility Number: 005009</p> <p>Dates: 07-08-13 through 07-10-13</p> <p>Surveyors:</p> <p>Billie Jo Fritch RN, MBA, MSN Public Health Nurse Surveyor</p> <p>Jennifer Hembree RN Public Health Nurse Surveyor</p> <p>KenZeigler Laboratory Surveyor</p> <p>QA: claughlin 07/18/13</p>	S000000		

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

TITLE

(X6) DATE

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

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S000606	<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><b>Based on personnel file document reviews and staff interview, the facility failed to document the immunization history for seven of twelve dietary/laboratory employees.</b> <b>Findings include;</b> <b>1. On 7/09/13 at 3:00 p.m. review of seven d/dietary and laboratory employee files were missing the following immunization:</b> <b>a. Four were missing annual Tuberculosis testing (#'s 2, 3, 4 &amp; 10)</b> <b>b. One was missing Rubella testing (# 7)</b> <b>c. Three were missing Rubeolla testing (#'s 3, 7, &amp; 8)</b> <b>d. Four were missing Varicella (#'s 7, 8, 10 &amp; 12)</b> <b>e. Two were missing Hepatitis B--either declined or accepted (#/s 7 &amp; 8)</b></p>	S000606	<p>1. All have been corrected: a. Tuberculosis testing completed: #2 completed on 5-18-13 (had been completed, not on file in Health Office/in team member file in department) #3 completed on 8-1-13 #4 completed on 7-26-13 #10 completed on 7-31-13 b. Rubella testing completed: #7 completed on 8-1-13 c. Rubeola testing completed: #3 completed on 8-1-13 #7 completed on 8-1-13 #8 completed on 7-17-13</p>	08/02/2013			

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	<b>2. On 7/09/13 at 3:45 p.m., staff member staff member # 13 indicated the above-missing documentation was observed.</b>		<p>d. Varicella testing completed: #7 completed on 8-1-13 #8 completed on 7-17-13 #10 completed on 7-31-13 #12 completed on 7-24-13</p> <p>e. Hepatitis B (either declined or excepted): #7 declined on 8-1-13 #8 declined on 7-24-13</p> <p>In order to prevent the deficiency from occurring in the future, monthly audits will be performed by the Manager of Team Member Health. Audits will be completed by the 10 th of the month for the prior month. Any team members found to be non-compliant will be removed from the Time and Attendance System and will not be allowed to work until the issue is corrected. Monitoring results will be forwarded to the Infection Prevention Committee for review, to include number of deficiencies, number of team members removed from Time and Attendance System, etc.</p> <p><u>Responsible Team Member:</u> Manager, Team Member Health</p>		

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S000932	<p>410 IAC 15-1.5-6 NURSING SERVICE 410 IAC 15-1.5-6 (b)(4)</p> <p>(b) The nursing service shall have the following:</p> <p>(4) The nursing staff shall develop and utilize an ongoing individualized plan of care based on standards of care for each patient.</p> <p>Based on document review and staff interview, the facility failed to ensure care plans were individualized for 6 of 8 care plans reviewed (patients #8, 9, 12, 13, 14, and 21).</p> <p>Findings include:</p> <p>1. Facility policy titled "Care Plan/Patient" last reviewed/revised 10/12 states under procedure on page 1: "RN Circles problem number, dates and initials nursing diagnosis. Circles appropriate intervention. Adds additional intervention based on patient needs."</p> <p>2. Facility policy titled "Fall Prevention" last reviewed/revised 12/12 does not include an intervention of falling leaf sign on the door.</p> <p>3. Review of the care plans for patients #8, 9, 12, and 21 indicated the following: (A) The care plan was a preprinted document with no interventions circled</p>	S000932	<p>1. The policy titled "Care Plan/Patient" dated: revised 10/12, is a current policy.</p> <p>2. The policy titled "Fall Prevention" dated: revised 12/12, is a current policy and (we agree) does not include an intervention of falling leaf sign on the door. The policy is correct, the care plan itself was in need of revision, which was completed (see below #4).</p> <p>3.(A) The chart audit on care plans indicated that care plans were not individualized on 4 patients. Education was conducted with nursing team members on 7-31-13 (<u>Educational Talking Points Attachment 1</u>). This will be reinforced during the months of August and September during the Team Member Unit Meetings. On 8-5-13, this issue was added to the monthly chart audits and will begin to be monitored in August, 2013. Each unit monitors 5 charts and results are sent to the Safe Practice/Quality Council for review and oversight. Additionally, in November, 2013</p>	08/05/2013			

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	<p>and the blanks associated with the interventions were not filled in.</p> <p>4. Review of the care plans for patients #13 and 14 indicated that every intervention was either checked or circled for the nursing diagnosis of "high risk for falls/injury". The care plan intervention included placing a falling leaf sign on the door which the facility no longer utilizes.</p> <p>5. Staff member #17 verified in interview beginning at 11:45 a.m. on 7/10/13 that the care plans were not individualized and that the facility no longer utilizes the falling leaf intervention.</p>		<p>Care Plans will be part of the EMR where they are individualized based on patient assessment data.</p> <p>4.The hospital no longer utilizes the intervention of placing a falling leaf sign on the patient's door if the patient is identified as high risk for falls/injury. The Falls Care Plan (<u>Attachment 2</u>) was updated on 8-1-13 to remove this intervention.</p> <p>- <u>Responsible Team Member:</u> Vice President of Inpatient Services/CNO</p>		

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S001014	<p>410 IAC 15-1.5-7 PHARMACEUTICAL SERVICES 410 IAC 15-1.5-7(c)</p> <p>(c) In order to provide patient safety, the director of pharmacy shall develop and implement written policies and procedures for the appropriate selection, control, labeling, storage, use, monitoring, and quality assurance of all drugs and biologicals.</p> <p>Based on document review, observation and staff interviews, the facility failed to ensure the policy for multi-dose vials was followed on 2 of 7 units toured.</p> <p>Findings include:</p> <p>1. Facility policy titled "Medication-Single Dose and Multi-Dose Ampules and Vials" states under policy on page 1: "The standard expiration for multidose vials will be 28 days after their initial use. This period time will be observed ONLY if the following conditions are met: .....3. the vial is <b>dated</b> and <b>timed</b> and <b>initialed</b> when it was first entered....."</p> <p>2. During tour of the critical care TCU unit beginning at 11:25 a.m. on 7/10/13 and accompanied by staff members #17 and RN #01, the following was observed: (A) One (1) opened multi-dose vial of Humulin 70/30 insulin was observed in the medication refrigerator. The vial was</p>	S001014	<p>1. The policy "Medication-Single Dose and Multi-Dose Ampules and Vials" is a current policy.</p> <p>2-4. [Observations concerning both single dose and multi-dose vials that were not properly timed/dated/initialed]. Education was conducted with nursing team members on 7-31-13 (<u>Educational Talking Points Attachment 1</u>). This will be reinforced during the months of August and September during the Team Member Unit Meetings. On 8-5-13, this issue was added to the monthly quality audits and will begin to be monitored in August, 2013. Each unit monitors 5 vials and results are sent to the Safe Practice/Quality Council for review and oversight.</p> <p>- <u>Responsible Team Member:</u> Vice President of Inpatient Services/CNO</p>	08/05/2013			

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	<p>not dated, timed, or initialed when it was opened per policy.</p> <p>3. During tour of the 3 SE medical/surgical unit beginning at 11:50 a.m. on 7/10/13 and accompanied by staff members #17 and RN #02, the following was observed:</p> <p>(A) One (1) opened multi-dose vial of Humulin 75/25 insulin was observed in the medication refrigerator. The vial was not dated, timed, or initialed when it was opened per facility policy.</p> <p>(B) One (1) opened multi-dose vial of Humulin N insulin was observed in the medication refrigerator. The vial was not dated, timed, or initialed when it was opened per facility policy.</p> <p>4. RN #01 verified the insulin observed on the TCU was not dated, initialed, and timed per policy during the tour which began at 11:25 a.m. on 7/10/13.</p> <p>5. RN #02 verified the insulin observed on the 3SE medical/surgical unit was not dated, initialed, and timed per policy during the tour which began at 11:50 a.m. on 7/10/13.</p>			

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S001118	<p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8 (b)(2)</p> <p>(b) The condition of the physical plant and the overall hospital environment shall be developed and maintained in such a manner that the safety and well-being of patients are assured as follows:</p> <p>(2) No condition shall be created or maintained which may result in a hazard to patients, public, or employees.</p> <p>Based upon observation and staff interview, the hospital had maintained a physical condition which may result in a hazard to employees for four areas.</p> <p>Findings include:</p> <p>1. On 7/08/13 at 11:30 a.m., and in the presence of two staff members (#s 5 &amp; 6), it was observed on the floor area immediately to the left of the main kitchen's walk aisle, a piece of welded angle iron attached to the floor. This iron had previously provided a means of preventing equipment from moving from their assigned position; however, its function also provided a hazard to employees to either trip or fall over its length when walking along the aisle.</p> <p>2. On 7/08/13 at 11:30 a.m. both staff member's #s 5 &amp; 6 indicated the presence</p>	S001118	<p>1. Welded angle iron attached to floor was removed on 8-6-13.</p> <p>3 The oxygen tank and the acetylene tank that were identified as "unsecured" were properly secured. The Engineering Department technician corrected this immediately after the tour on 7-9-2013.</p> <p>To prevent the deficiency from recurring on 7-31-13, the department team members were in-service on the facility policies HAZCOM Hazardous Materials Handling &amp; Storage and Policy F-004.0 Fire Extinguisher Testing &amp; Storage. (Attachment 3). These policies cover the proper storage requirements for compressed gas cylinders and fire extinguishers.</p> <p>1. Eyewash Station location.</p> <p>On the tour with surveyor in the</p>	08/06/2013			

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	of this potential physical hazard.		<p>boiler room area on 07-09-13 at 10:55 am the Department Director identified the location of the eyewash station. There was a station located in the department and was within the required distance as identified in the facility HAZCOM 1.15 Policy (<u>Attachment 4</u>), Use of Portable Eyewash Station. This station was also observed by and discussed with the powerhouse technician during this tour. The station location was within the 100 feet of the hazardous chemical area as required by policy, however, due to surveyor comments that station too difficult to get to (To far to get to if you can't see it-24 feet then turn, then go through door, go another 30 feet to get to it. Station was in an adjacent room with an open doorway), it was agreed upon that the station should be closer to the location of the chemicals for ease of availability if needed.</p> <p>This station was relocated by Powerhouse technician on 07-09-13 immediately after this observation. Station is presently within 30 feet of chemical location.</p> <p>An In-service with team members on eyewash station policy was conducted by supervisor by 07-31-2013.</p> <p><u>Responsible Team Members:</u></p>		

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	<p>3. While touring the facility on 07-09-13 at 0950 hours with B#16, 1 oxygen tank and 1 acetylene tank were observed unsecured on a work table in Room 321; at 1055 hours with B#16, 1 fire extinguisher was observed unsecured in the window of the boiler room.</p> <p>4. While touring the facility on 07-09-13 at 1055 hours with B#16, it was observed that the area where water testing is completed in the boiler room area, with the use of caustic chemicals, lacked an eye wash.</p> <p>5. Interviews were conducted with B#16 on 07-09-13 at 0950 hours and 1055 hours respectively and confirmed the presence of 1 oxygen tank and 1 acetylene tank unsecured on the work table in room 321 and 1 fire extinguisher unsecured in the window of the boiler room, each creating a safety hazard to the public and facility staff.</p> <p>6. An interview was conducted with B#16 on 07-09-13 at 1055 hours and confirmed there is no eye wash in the area where caustic chemicals are used for water testing in the boiler room area.</p>		Director of Engineering Department				

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S001810	<p>410 IAC 15-1.6-5 PSYCHIATRIC SERVICES 410 IAC 15-1.6-5(d)</p> <p>(d) If the service provided includes a psychiatric unit exempt from Medicare prospective payment system, it shall comply with 42 CFR Part 412, Subpart B, sections 412.25 and 42 CFR Part 412, Subpart B, Section 412.27 for the purposes of licensure.</p> <p>Based on document review and staff interview, the PPS excluded psychiatric unit failed to comply with 42 CFR Part 412, Subpart B, sections 412.25 and 42 CFR Part 412, Subpart B, Section 412.27 for the purposes of licensure.</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>Review of the PPS excluded behavioral health unit daily schedule indicated that a one hour group therapy would be conducted Monday-Friday by the social worker in addition to activity/recreation therapy.</li> <li>Facility policy titled "Therapeutic Milieu" last reviewed/revised 10/09 states under procedure: "HCP 2. Encourages all patients to participate in mission meetings and program groups, classes and activities as scheduled."</li> <li>Review of patients #16 and 17 medical record indicated they had not received</li> </ol>	S001810	<p>3 The Director of Behavioral Health acknowledged that due to the recent resignation of a social worker and the pending hire of a replacement, the schedule varied during the week of the survey. This was immediately corrected. The Director of Behavioral Health reviewed the scheduled groups and assigned a social worker to each group to ensure appropriate coverage.</p> <p>To ensure compliance, the Director of Behavioral Health will review the schedule each week for the following week and make any adjustments so that each group will be staffed appropriately.</p> <p>The Director of Behavioral Health will conduct chart reviews on 10 charts selected per random sample per month for 3 months (August/September/October). <u>(Monitoring Tool, Attachment 5)</u>. Results will be forwarded to the Safe Practice Quality Council. If compliance is met, each month for three months, the chart</p>	08/01/2013			

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	<p>group therapy provided by a social worker per the daily schedule on 7/8, 7/9, 7/10, or 7/11.</p> <p>4. Review of the psychiatric evaluations for patients #16, 17, 22, 23, and 24 indicated the following: (A) All five (5) patients had exactly the same information under strengths. Each evaluation stated "STRENGTHS: 1. Communicative. 2. Cooperative" (B) Patient #17 was not cooperative. He/she was documented on the same evaluation as being uncooperative. The document stated "staff reports that he has been having verbal altercation with other patients and having extreme agitation, irritability, and impulsivity." (C) Patients #16, 22, 23, and 24 psychiatric evaluation had the exact same information under problems. The document stated "PROBLEMS: 1. Chronic dysphoric symptoms. 2. Poor social support system." (D) Patient #16 had a good social support system. The psychosocial assessment completed for patient #16 indicated he/she had a supportive family and that the spouse, children, and grand children had a role in treatment.</p> <p>5. Staff member #7 indicated in interview beginning at 12:30 p.m. on 7/11/13 that he/she was covering for social services</p>		<p>reviews will then be conducted quarterly to ensure ongoing compliance. If not in compliance after the 3 months of monitoring, the matter will be referred to the Vice President for Inpatient Services/CNO for further action which could include re-education, initiation of a Performance Improvement Team, and/or team member disciplinary action (depending on the findings and reasons for non-compliance).</p> <p><u>Responsible Team Member:</u> Director of Behavioral Health Department</p> <p>3 (A) The Clark Memorial Hospital Medical Director met with the Psychiatrist who dictated the Psychiatric Evaluations on the Behavioral Health patients referred to in the State report. This meeting was held on 8-9-13. The Psychiatrist and the Medical Director reviewed the patient records together. The Psychiatrist stated that he has a mental template for dictation so that he does not forget any important components. Many times, the same or similar words are used to describe similar assessment findings. He gave an example: if a patient's attitude is cooperative, if speech is natural, if the patient is able to engage in meaningful conversation in a reasonable fashion with him, he often describes this assessment information with the same words:</p>				

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	the week of July 8th. He/she verified that the patients had not received group therapy proved by social services this week and the psychiatric evaluations contained the same information for the patients as indicated above.		communicative and cooperative. (B) The record for patient #17 was reviewed. Documentation stating the patient was uncooperative was written when the patient was on the Medical Surgical Unit. Once the patient was transferred to the Behavioral Health Unit, the admitting assessment completed by the Behavioral Health Nurse stated the patient was cooperative. The Director of Behavioral Health discussed this case with the Behavioral Health Nurse who confirmed that the patient was cooperative and her documentation was correct. The documentation on the Psychiatric Evaluation which was completed 19 hours after the Behavioral Health Nurse assessment also stated the patient was cooperative and matched the Behavioral Health Nursing assessment documentation. (C) Please see explanation under item 4-A regarding how similar words are used over throughout medical documentation to describe similar clinical presentation of patient information. (D) Upon review of patient #16, the Psychiatrist stated the social support was not known to him at the time the Psychiatric Evaluation was dictated. Additional information became available after the Psychiatric Evaluation was completed.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  150009	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  07/10/2013
NAME OF PROVIDER OR SUPPLIER  CLARK MEMORIAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 1220 MISSOURI AVE JEFFERSONVILLE, IN 47130		
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			<p>To ensure compliance, the Director of Behavioral Health will conduct chart reviews on 10 charts selected per random sample per month for at least 3 months (August/September/October). <u>(Monitoring Tool, Attachment 6)</u>. Results will be forwarded to the Medical Director. If compliance is met, each month for three months, the chart reviews will then be conducted quarterly to ensure ongoing compliance. If not in compliance after the 3 months of monitoring, the Medical Director will meet again with the Psychiatrist to determine next actions which could include re-education and/or referral to the Medical Staff physician quality committee.</p> <p>Responsible Team Member: Medical Director</p>		