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	005038	A. BUILDING: _____ B. WING _____	08/13/2020

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S 000	INITIAL COMMENTS This visit was for investigation of a state hospital complaint. Complaint # IN00333575, Substantiated: State deficiencies related to the allegations are cited. Unrelated deficiency cited. Survey Dates: 8/12/20 and 8/13/20 Facility Number: 005038 QA: 8/27/20	S 000		
S 556	410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(b) (b) There shall be an active, effective, and written hospital-wide infection control program. Included in this program shall be system designed for the identification, surveillance, investigation, control, and prevention of infections and communicable diseases in patients and health care workers. This RULE is not met as evidenced by: Based on document review, observation and interview, the hospital failed to develop a system for controlling COVID-19 and infections/communicable diseases in adherence to nationally recognized infection prevention and control precautions by CDC (Centers for Disease Control) in a facility with known positive cases. Findings include:	S 556		9/28/20

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S 556	Continued From page 1 1. Review of CDC website for COVID 19 https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/decontamination-reuse-respirators.html, updated 8/4/2020, indicates the following: The outer surface (of the mask), the surface furthest from the wearer's face, presents the highest risk for pathogen transfer to the wearer. A limited reuse strategy to reduce the risk of self-contamination One strategy to reduce the risk of contact transfer of pathogens from the FFR (filtering facepiece respirator) to the wearer during FFR reuse is to issue five N95 FFRs to each healthcare staff member who care for patients with suspected or confirmed COVID-19. The healthcare staff member can wear one N95 FFR each day and store it in a breathable paper bag at the end of each shift with a minimum of five days between each N95 FFR use, rotating the use each day between N95 FFRs. This will provide some time for pathogens on it to "die off" during storage [8]. This strategy requires a minimum of five N95 FFRs per staff member, provided that healthcare personnel don, doff, and store them properly each day. As a caution, healthcare personnel should treat reused FFRs as though they are contaminated. CDC recommends limiting the number of donnings for an N95 FFR to no more than five per device. It may be possible to don some models of FFRs more than five times. 2. On 8/12/20, between approximately 10:00 AM and 12:30 PM, the following was observed during hospital tour in the presence of A4, Chief Nursing Officer (CNO) : On the ICU, hanging on a wall, were multiple	S 556		

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S 556	Continued From page 2	S 556		

small (lunch bag size) open paper bags with staff names and dates. Inside the bags were PPE (personal protective equipment) items, including N95/FFRs, faceshields, surgical masks and hair nets. All PPE items of various types listed were inside each bag touching the other items, no separation of faceshields, FFRs or other items existed. Lying on a nursing station desk/counter, next to a computer, was a faceshield and N95 FFR.

On the rehabilitation unit, hanging on a wall, were multiple small (lunch bag size) open paper bags with staff names and dates. All PPE (personal protective equipment) items, including N95/FFRs, faceshields, surgical masks and hair nets, were in the bags together; no separation of faceshields, FFRs or other items was noted. During observation, a staff member was observed assisting a patient. The staff member was donned in PPE as follows: Gown, shoe covers, N95, faceshield and hairnet. Prior to exiting the room, the staff member removed their gloves and gown and performed hand hygiene. After exiting the room, the staff member removed the faceshield, N95 and hairnet; those items were placed all together in a small paper bag.

3. On 8/12/20, the following was indicated in interview:

Between approximately 10:45 AM and 11:00 AM, A4, CNO, verified that the bags contained PPE used by staff for interaction with COVID-19 positive patients and was the hospitals method for reuse of PPE. A4 indicated that PPE was placed in the bags each day for reuse at a later time. A4 indicated the bags were changed on a regular basis, described as "probably about every week". A4 indicated the policy on this process had not yet been approved. A4 verified that faceshields, FFRs and surgical masks all went in

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S 556	Continued From page 3 to the bag together, but that hairnets were only to be used for one shift. A4 indicated that the N95s could be reused for 3 shifts, no limit on number of uses per shift was noted. Between approximately 10:45 AM and 11:00 AM, S1, ICU RN (Registered Nurse), verified the faceshield and N95 on the counter were those of his/hers being used for that day/shift. S1 indicated that he/she uses the same N95 for 3 shifts. Between approximately 11:30 AM and 11:45 AM, S5, RN/charge nurse, indicated nursing staff reuse N95s for 3 days/shifts and at the end of each shift PPE is placed in a paper bag for reuse. Between approximately 12:15 PM and 12:30 PM, S7, Nurse Manager of Rehabilitation, verified the combined storage of potentially contaminated PPE following patient interaction.	S 556		
S 712	410 IAC 15-1.5-4 MEDICAL RECORD SERVICES 410 IAC 15-1.5-4 (c)(1) (c) An adequate medical record shall be maintained with documentation of service rendered for each individual who is evaluated or treated as follows: (1) Medical records are documented accurately and in a timely manner, are readily accessible, and permit prompt retrieval of information. This RULE is not met as evidenced by: Based on document review, the hospital failed to ensure documentation in 1 of 10 patients' medical	S 712		9/15/20

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S 712	Continued From page 4 records (MR) (#2) was accurately documented for 2 situations (confusion/orientation and seizure). Findings include: 1. Review of the MR for patient #2 had conflicting documentation for orientation, seizure activity and reason for additional restraint by intubation. A. The Hospitalist History and Physical (H&P) on 7/18/20 at 1240 hours indicated that the patient was awake, alert and cooperative upon evaluation. The psychological assessment within that note indicated the patient was awake, alert and oriented with good judgement. B. Progress Note dated 7/19/20 at 1100 hours indicated the following: Plan: - last night patient had 10 sec episode of seizure and was given diazepam... C. Consult note dated 7/19/20 at 1258 hours indicated he/she was admitted to the hospital he/she was quite agitated and confused last night... no seizures reported... D. Consult note dated 7/19/20 at 1832 indicated the following: Patient on arrival was quite confused... No history of seizure disorder... 2. On 8/13/20, between approximately 1100 - 1200 hours, A6, Registered Nurse/Senior EPIC Analyst and S8, Intensive Care Unit Shift Coordinator, verified MR findings.	S 712		
S 948	410 IAC 15-1.5-6 NURSING SERVICE 410 IAC 15-1.5-7 (c)(5) (c) Drugs and biologicals shall be prepared for administration and administered as follows:	S 948		9/30/20

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S 948	Continued From page 5 (5) In accordance with currently acceptable standards of practice. This RULE is not met as evidenced by: Based on document review and interview, the hospital failed to ensure drugs were administed in accordance with currently acceptable standards and/or policy related to allergy verification and medication orders by the practitioner responsible for the patient's care for 2 of 10 patients (#5 and #6). Findings include: 1. Review of facility policies indicated the following: The policy titled Medication Ordering and Administration, last approved 10/19, indicated: Medication Administration: If the potential for an allergy exists, the medication will be withheld and the prescribing physician contacted immediately. Sequence, Intervention/Scientific Rational: Check for any allergies listed in the computer, on the patient's bracelet, and ask the patient before any medications are administered. Assessment of Medication Effectiveness/Side Effects: Patients receiving PRN (as needed) or pre-procedure medication are to be assessed for the patient's initial response to the medication. The policy titled Medication: Adverse Drug Event (ADE) and Potential Adverse Drug Events (PADE), last approved 9/18, indicated: Adverse Drug Event (ADE): a deviation in the medication delivery system (transcribing, prescribing, dispensing, administering) or an undesirable clinical manifestation caused by the administration or omission of a medication.	S 948		

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S 948	Continued From page 6 Evaluation: Patient assessments documented in the patient record. 2. Medical record (MR) review indicated the following: Review of the MR for patient #5 indicated the patient presented to ED on 7/10/20 at 0101 hours and was discharged to home on 7/11/20 at 1200 hours. Allergies were first recorded and indicated as "Verified" on 7/10/20 at 1:03 AM as "No Active Allergies". "No Active Allergies" were recorded as "Verified" again on 7/10/20 at 5:07 AM, 2:43 PM and 2:51 PM. The entry lacked documentation of how or with whom the information was reviewed and verified. On 7/10/20 at 2:52 PM, Omnicef (Cefdinir) was recorded as an "Allergen" with a reaction of "Rash". The MR lacked documentation of why the allergy status was changed and/or of the patient having developed a rash. The MAR indicated that on 7/10/20 at 0334 hours, cefazolin was administered IV. Review of the MR for patient #6 indicated the patient presented to the ED on 7/12/20. Allergies included, but were not limited to Tramadol. MR documentation indicated that on 7/15/20 a nurse entered a verbal order for IV morphine with M1 as the ordering physician. The MR indicated that an alert requiring an override was created due to cross-sensitivity between morphine and Tramadol. The warning was indicated to have been overridden by the RN. The MR lacked documentation of the nurse having notified the physician of the warning/override or having consulted with the physician prior to overriding the alert. The MAR indicated the morphine was administered on 7/15/20 at 1005 hours. The MR lacked documentation of the administering nurse have checked for allergies with the patient before the medication was administered	S 948		

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S 948	Continued From page 7 3. On 8/13/20, between approximately 2:45 PM and 3:00 PM, M2, CMO (Chief Medical Officer) verified that if a patient had a noted allergy/allergen, when adding an order to the MR, an alert would pop up requiring an override be completed by the physician. M2 further indicated that if the order were put in the computer as a telephone or verbal order, he/she believed the process should be that the nurse inputting the order should contact the doctor/provider.	S 948		