

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151310	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/29/2012
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S000000	<p>This visit was for a State hospital licensure survey.</p> <p>Dates: 8/27/2012 through 8/29/2012</p> <p>Facility Number: 005094</p> <p>Surveyors: Albert Daeger, CFM, SFPIO Medical Surveyor</p> <p>Saundra Nolfi, RN PH Nurse Surveyor</p> <p>QA: cloughlin 08/31/12</p>	S000000	We trust this plan of correction will reflect our compliance with any of the deficiencies identified during our recent survey.	
S000278	<p>410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1(b)(2)(A)(B)(C)(D)</p> <p>(b) The governing board is responsible for the conduct of the medical staff. The governing board shall do the following: (2) Ensure that: (A) the requests of practitioners, for appointment or reappointment to practice in the hospital, are acted upon, with the advice and recommendation of the medical staff; (B) reappointments are acted upon at least biennially;</p>			

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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	<p>(C) practitioners are granted privileges consistent with their individual training, experience, and other qualifications; and</p> <p>(D) this process occurs within a reasonable period of time, as specified by the medical staff bylaws.</p> <p>Based on document review and interview, the facility failed to ensure 1 (one) Surgery Scrub Technician had approved privileges filed in the allied health staff member's credential file (#16).</p> <p>Findings included:</p> <p>1. Wabash County Hospital policy #MS 6 on Dependent Allied Health Professionals (AHPs), last reviewed April 2012, states, "They may be assigned limited privileges to perform specified services in the hospital under the direction of their supervising physician. Dependent AHPs may include, but are not limited to Nurse Practitioners, Physician Assistants, or clinical assistants. Clinical Assistants may include but are not limited to physician (or physician group)</p>	S000278	<p>1) Task list for Scrub Tech Dependent Allied Health Professional developed in accordance with credentialing and privileging. Completed with AHP on 9/28/12. 2) Approved by MS Leader / Administration 9/27/12. Will go to MEC for approval 10/1/12 and Board of Trustees 10/16/12. Will become part of the AHP privileges packet for Scrub Techs going forward.3)Medical Staff Support Leader / Credentialing support staff 4) Correction completed 9/27/12.</p>	09/27/2012

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	<p>employed scrub assistants." The policy notes an Allied Health Professional Privilege Request Form needs to be filled out for AHPs.</p> <p>2. A memorandum dated April 18, 2012 from Wabash County Hospital stated, "It is our pleasure to inform you that upon recommendation of the Medical Staff and the Board of Trustees, you (staff member #16) have been approved for the Advance Clinical Privileges..."</p> <p>3. Review of staff member #16's credential files indicated lack of evidence of privileges that the AHP was approved to perform within the hospital.</p> <p>4. At 2:30 PM on 8/27/2012, staff member #3 indicated that staff member #16 does not have a list of privileges because he/she works directly under a physician. Staff member #3 confirmed the Surgical Scrub Technician #16 does not</p>			

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S000332	<p>have assigned limited privileges on file in his/her credential personnel file.</p> <p>410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1(c)(6)(L)</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:</p> <p>(L) Demonstrating and documenting personnel competency in fulfilling assigned responsibilities and verifying inservicing in special procedures.</p> <p>Based on observation, facility documentation, manufacturer's literature, and interview, the governing board failed to ensure policies and procedures were in place to ensure patient safety with the use of heated supplies.</p> <p>Findings included:</p> <p>1. During the tour of the Special Care Unit at 9:50 AM on 08/28/12, accompanied by staff members #A2 and</p>	S000332	<p>1) The policy for Warmers was revised to include the warming of blankets as well as fluids according to manufacturer's recommendations. The policy was approved by the Department Leader / Administration on 9/27/12. The policy will go to Med Staff Quality for approval Oct. 17, 2012 and Medical Exec. Committee for approval Nov. 5, 2012 and Board of Trustees Nov. 20, 2012. Nursing staff were re-educated electronically on the process and policy of blanket</p>	11/20/2012

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	<p>A6, a Pedigo blanket warmer was observed in the clean utility room. A label on the cabinet indicated "Not to exceed 110 degrees", but the temperature registered 155 degrees Fahrenheit (F). At 10:00 AM, the charge nurse on the unit, staff member #A11, indicated the knob had been removed from the cabinet so the temperature would stay set. He/she indicated the charge nurse checked it every day, but did not document it anywhere. He/she also indicated the temperature was kept around 98.6 degrees F. to prevent any patient burns.</p> <p>At 10:15 AM on 08/28/12, staff member #A9 indicated the label was placed on the cabinet by the facility to ensure the temperature was kept at a safe range.</p> <p>2. During the tour of the recovery area at 10:50 AM on 08/28/12, accompanied by staff member A13, an Amsco blanket warming cabinet was observed with the heating dial set on "Medium", but without any actual temperature registering.</p> <p>3. During the tour of the surgical area at 11:00 AM on 08/28/12, accompanied by staff member #A13, an Amsco warming cabinet was observed with blankets in the top cabinet and fluids in the bottom cabinet. Bags of irrigating solution were</p>		<p>warmer checks and usage on 9/27/12. 2) A Warmer Log to include Blankets and Solution columns, will be completed daily beginning immediately. The log will be monitored monthly and will be reported quarterly with the departmental PI, beginning next quarter. 3) OR / Acute/SCU Leader or designee 4) Correction complete on 11/20/12.</p>		

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S000406	<p>marked with a 60 day expiration date, but there were several other bags of intravenous fluid that were not marked. Staff member #A13 indicated the cabinet with fluids was monitored daily and kept at the temperature recommended by Baxter, the manufacturer of the irrigating solution. Documentation from Baxter indicated the fluid could be kept in the warmer for 60 days. Staff member #A13 indicated the other fluids were removed daily and therefore, not marked.</p> <p>4. The manufacturer's directions for the warming cabinets did not specify a safe temperature for the blankets and recommended following the fluid manufacturer's directions for any fluids.</p> <p>5. At 11:00 AM on 08/29/12, staff members #A2 and A3 indicated the facility did not have a policy regarding the warming cabinets.</p> <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</p>						

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	<p>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 staff interview, the facility failed to ensure Bioengineering, Housekeeping, Laundry/Linen, Biohazardous Waste, Maintenance, and Sleep Lab services were part of its comprehensive quality assessment and improvement (QA&I) program.</p> <p>Findings included:</p> <p>1. 2012 Wabash County Hospital Performance Improvement Plan defines the structure of the committees and which committee oversees the entire QA&I program. The Safety/Risk Management/Infection Control Committee monitors housekeeping, Laundry/Linen, Biohazardous Waste, Maintenance services. Performance Improvement Committee monitor Sleep Lab Services. The two committees</p>	S000406	<p>1) Provide Facility Services Leader forms to complete PI plan for areas noted. These were completed and returned to PI Coordinator 9/27/12. Sleep Lab already completed Performance Improvement [PI] Plan and started reporting to Medical Staff [MS] Quality 9/19/12. 2) Placed these departments on regular schedule for PI Council / MS Quality reporting on 9/27/12. 3) Quality / PI Coordinator 4) Correction completed 9/27/12.</p>	09/27/2012

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	<p>forward their data and outcomes to the Medical Staff Quality committee. The Medical Staff Quality Committee analysis the data from the other two committees for quality recommendations to the Governing Board.</p> <p>2. At 3:45 PM on 8/27/2012, staff member #3 indicated the Safety/Infection Control Committee and Performance and Improvement Committee reports to the Medical Staff Quality Committee. The Medical Staff Quality Committee monitors the entire QA&I program. The staff member confirmed housekeeping, Laundry/Linen, Biohazardous Waste, Maintenance services were not reported to the Medical Staff Quality committee. Sleep Lab services was a contracted service and the staff member confirmed neither the Performance and Improvement Committee or the Medical Staff Committee have been monitoring the service.</p>			

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S000554	<p>3, At 11:00 AM on 3/28/2012, staff member #9 indicated the Safety Committee has been monitoring housekeeping, Laundry/Linen, Biohazardous Waste, Maintenance services; however, the staff member confirmed the data and outcome the Safety Committee discovered has never been forward to Medical Staff Quality Committee for review and recommendations.</p> <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, manufacturer's directions, and interview, the staff failed to ensure a safe environment for patients by checking supplies to prevent outdated usage.</p>	S000554	<p>1) Checklists for Pediatric crash carts (ED and Acute Care) modified 9/27/12. One with items that will outdate to document the expiration date and a second checklist to verify that non dated items are present in the crash cart in the appropriate volume. Staff educated electronically on</p>	11/20/2012

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	<p>Findings included:</p> <p>1. During the tour of the Emergency Department at 9:00 AM on 08/28/12, accompanied by staff members #A2 and A7, the following expired items were observed in the pediatric crash cart:</p> <p>A. Purple drawer- 2 of 2 Trochar catheters (12 Fr.) expired 02/2012, 1 of 1 Trochar catheter (16 Fr.) expired 02/2012, 1 of 1 Trochar catheter (20 Fr.) expired 03/2010.</p> <p>B. Yellow drawer- 2 of 2 Trochar catheters (10 Fr.) expired 12/2009, 2 of 2 Trochar catheters (20 Fr.) expired 03/2012, 1 of 1 Trochar catheter (24 Fr.) expired 02/2012.</p> <p>C. White drawer- 2 of 2 Trochar catheters (20 Fr.) expired 03/2010, 1 of 1 Trochar catheter (24 Fr.) expired 02/2012.</p> <p>D. Blue drawer- 1 of 1 Trochar catheter (24 Fr.) expired 07/2009, 1 of 1 Trochar catheter (32 Fr.) expired 03/2012.</p> <p>E. Orange drawer- 1 of 1 Trochar catheter (20 Fr.) expired 03/2010, 1 of 1 Trochar catheter (24Fr.) expired 07/2009, 1 of 1 Trochar catheter (28 Fr.) expired 09/2011, 2 of 2 Trochar catheter (32 Fr.) expired 03/2012.</p> <p>F. Green drawer- 1 of 1 Trochar catheter (32 Fr.) expired 01/2010.</p> <p>G. Red drawer- 3 of 3 Trochar catheters (10 Fr.) expired 12/2009, 3 of 3 Trochar</p>		<p>change in process on 9/27/12.2) The log will be monitored monthly and compliance will be reported quarterly on the Departmental PI log. 3) The ED / Acute Care Department Leader(s) or Designee 4) Correction was completed on 9/27/12.1) Stock supplies in the ACC Clean Supply Room are checked for outdates by Materials Management on a monthly basis, beginning immediately. 2) The Materials Management Leader will spot check the Clean Supplies monthly and report finding to PI quarterly beginning next quarter. 3) Materials Management Leader or Designee 4) Completed 9/27/121) Cidex Plus policy #2000.1.09 has been revised to include test strip manufacturer's instructions for dating and discarding – approved by Dept. Leader and Administration 9/25/12. To Med Staff Quality for approval Oct. 17th and on to Medical Exec. Committee for final approval Nov. 5 th , 2012, Board of Trustees Nov. 20, 2012. 2) Cidex Log revised 9/25/12. Added column, container dated. The log will be monitored monthly and will be reported quarterly on the OR PI log, beginning next quarter. 3)Central Supply Tech / OR Leader 4) Correction was completed 11/20/12.</p>		

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	<p>catheters (12 Fr.) expired 02/2010, 1 of 1 bone marrow needle expired 10/2011.</p> <p>2. At 9:10 AM on 08/28/12, staff member #A7 indicated the crash carts were checked monthly to ensure medications and supplies were not outdated.</p> <p>3. During the tour of the Acute Care Unit at 10:20 AM on 08/28/12, accompanied by staff members #A2 and A6, the following expired items were observed in the pediatric crash cart:</p> <p>A. Red drawer- 2 of 2 Bard catheters expired 03/2012.</p> <p>B. Purple drawer- 4 of 4 Bard catheters, 2 expired 03/2012 and 2 expired 04/2012.</p> <p>C. Yellow drawer- 2 of 2 Bard catheters expired 04/2012.</p> <p>D. White drawer- 4 of 4 Bard catheters, 2 expired 04/2012 and 2 expired 06/2012.</p> <p>E. Blue drawer- 4 of 4 Bard catheters, 2 expired 04/2012 and 2 expired 06/2012.</p> <p>F. Orange drawer- 2 of 2 Bard catheters expired 06/2012.</p> <p>G. Green drawer- 2 of 2 Bard catheters expired 06/2012.</p> <p>The storage cart in the clean supply room on the unit contained an additional 6 catheters, 2 expired 07/2011, 2 expired 04/2012, and 2 expired 07/2012.</p>				

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S000781	<p>4. At 10:30 AM on 08/28/12, staff member #A6 indicated the crash carts and supply areas were checked monthly to ensure medications and supplies were not outdated.</p> <p>5. During the tour of the surgical area at 11:15 AM on 08/28/12, accompanied by staff member #A13, an open, but not dated, container of Cidex test strips were observed on a shelf in the decontamination area. Manufacturer instructions indicated the strips were to be dated and discarded 90 days after opening.</p> <p>410 IAC 15-1.5-4 MEDICAL RECORD SERVICES 410 IAC 15-1.5-4(i)(2)</p> <p>(i) Emergency service records shall document and contain, but not be limited to, the following:</p> <p>(2) Time of arrival, means of arrival, time treatment is initiated, and time examined by physician, if applicable.</p> <p>Based on policy review, medical record review, and interview, the facility failed to ensure the Emergency Department Record was complete regarding the time seen by the physician for 7 of 13 patients treated in the Emergency Department</p>	S000781	<p>1) ED Medical Director educated all ED physicians of need to be compliance with documentation of time they see the patient on or before 9/26/12.</p> <p>Physician documentation for time patient is seen will be audit daily by ER unit secretary and</p>	09/27/2012

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	(#N2, N6, N7, N8, N9, N13, and N16). Findings included: 1. The facility policy "Charting/Legal Documentation", last revised 04/12, indicated, "...All entries in the medical record must be dated, timed when required and authenticated. ...Do not leave blank lines on any medical record forms. ...Every entry will be authenticated. All paper charting must be authenticated with a signature followed by title." 2. The medical record for patient #N2, treated in the Emergency Department (ED) on 05/24/12, indicated a physician signature, but lacked documentation in the "time seen" space on the form. 3. The medical record for patient #N6, treated in the ED on 07/05/12, indicated a physician signature, but lacked documentation in the "time seen" space on the form. 4. The medical record for patient #N7, treated in the ED on 07/04/12, indicated a physician signature, but lacked documentation in the "time seen" space on the form. 5. The medical record for patient #N8,		incomplete charts will be returned to the physician to complete the documentation. 2) Three random charts will be audited for nursing and physician documentation completion daily by ER Leader, beginning 9/25/12. This information will be reported quarterly with ER PI to PI Council and MS Quality beginning next quarter. 3) ER unit secretary and ER leader or designee. 4) Correction was completed on 9/25/12.		

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S000787	<p>treated in the ED on 07/03/12, indicated a physician signature, but lacked documentation in the "time seen" space on the form.</p> <p>6. The medical record for patient #N9, treated in the ED on 06/24/12, indicated a physician signature, but lacked documentation in the "time seen" space on the form.</p> <p>7. The medical record for patient #N13, treated in the ED on 05/09/12, indicated a physician signature, but lacked documentation in the "time seen" space on the form.</p> <p>8. The medical record for patient #N16, treated in the ED on 06/22/12, indicated a physician signature, but lacked documentation in the "time seen" space on the form.</p> <p>9. At 9:00 AM on 08/29/12, staff member #A7 indicated the time could sometimes be found in the nurse's charting, but confirmed the form was incomplete.</p> <p>410 IAC 15-1.5-4 MEDICAL RECORD SERVICES 410 IAC 15-1.5-4(i)(8)</p> <p>(i) Emergency service records shall</p>				

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	<p>document and contain, but not be limited to, the following:</p> <p>(8) Diagnostic impression and condition on discharge documented by the practitioner, and disposition of the patient and time of dismissal. Based on policy review, medical record review, and interview, the facility failed to ensure the Emergency Department Record was complete regarding the condition on discharge by the physician for 9 of 13 patients treated in the Emergency Department (#N2, N6, N8, N9, N11, N13, N14, N16, and N18).</p> <p>Findings included:</p> <p>1. The facility policy "Charting/Legal Documentation", last revised 04/12, indicated, "...All entries in the medical record must be dated, timed when required and authenticated. ...Do not leave blank lines on any medical record forms. ...Every entry will be authenticated. All paper charting must be authenticated with a signature followed by title."</p> <p>2. The medical record for patient #N2, treated in the Emergency Department (ED) on 05/24/12, indicated a physician signature, but lacked documentation in the "Discharge Condition" space on the form.</p>	S000787	<p>1) ED Medical Director educated all ED physicians of need to be compliance with documentation of the patient's condition upon discharge before 9/26/12. Physician documentation for discharge condition will audited daily by ER unit secretary and incomplete charts will be returned to the physician to complete the documentation.</p> <p>2) Three random charts will be audited for nursing and physician documentation completion daily by ER Leader, beginning 9/25/12. This information will be reported quarterly with ER PI to PI Council and MS Quality beginning next quarter.</p> <p>3) ER unit secretary and ER leader or designee.</p> <p>4) Correction was completed on 9/25/12.</p>	09/27/2012

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	<p>3. The medical record for patient #N6, treated in the ED on 07/05/12, indicated a physician signature, but lacked documentation in the "Discharge Condition" space on the form.</p> <p>4. The medical record for patient #N8, treated in the ED on 07/03/12, indicated a physician signature, but lacked documentation in the "Discharge Condition" space on the form. The patient was transferred to another hospital and there was a "Condition" marked on that form, but not on the ED record.</p> <p>5. The medical record for patient #N9, treated in the ED on 06/24/12, indicated a physician signature, but lacked documentation in the "Discharge Condition" space on the form.</p> <p>6. The medical record for patient #N11, treated in the ED on 03/28/12, indicated a physician signature, but lacked documentation in the "Discharge Condition" space on the form.</p> <p>7. The medical record for patient #N13, treated in the ED on 05/09/12, indicated a physician signature, but lacked documentation in the "Discharge Condition" space on the form.</p>			

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S000870	<p>8. The medical record for patient #N14, treated in the ED on 03/25/12, indicated a physician signature, but lacked documentation in the "Discharge Condition" space on the form.</p> <p>9. The medical record for patient #N16, treated in the ED on 06/22/12, indicated a physician signature, but lacked documentation in the "Discharge Condition" space on the form.</p> <p>10. The medical record for patient #N18, treated in the ED on 01/31/12, indicated a physician signature, but lacked documentation in the "Discharge Condition" space on the form.</p> <p>11. At 9:00 AM on 08/29/12, staff member #A7 indicated the condition could sometimes be found in other charting, but confirmed the form was incomplete.</p> <p>410 IAC 15-1.5-5 MEDICAL STAFF 410 IAC 15-1.5-5(b)(3)(N)</p> <p>(b) The medical staff shall adopt and enforce bylaws and rules to carry out its responsibilities. These bylaws and rules shall:</p>						

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	<p>(3) include, but not be limited to, the following:</p> <p>(N) A requirement that all physician orders shall be:</p> <p>(i) in writing or acceptable computerized form; and</p> <p>(ii) shall be authenticated by the responsible individual in accordance with hospital and medical staff policies.</p> <p>Based on policy review, medical record review, and interview, the facility failed to ensure all physician verbal/telephone orders were authenticated according to policy in 7 of 9 inpatient closed medical records reviewed (#N12, N13, N14, N15, N16, N17, and N18).</p> <p>Findings included:</p> <p>1. The facility policy "Orders", last revised 03/10, indicated, "...Verbal Orders- ...Documentation of the order will include order was 'Read Back and Verified' (R & V'd). b. The nurse should be aware of the responsibility she/he has accepted when executing such an order. c. Subsequently, the physician will be requested to write or sign the dictated order within 48 hours of order. ...2. It is the physician's responsibility to countersign Verbal/Telephone orders. ...d. The verbal order will be reviewed by the attending physician within 48 hours."</p>	S000870	<p>1a) Revision of Medical Staff Rules and Regulations Section 6.3.1 "Orders, regarding: Verbal / Telephone orders which have been "read back and verified" shall be authenticated by the ordering practitioner within 30 days. Approved by Medical Executive Committee on 9/10/12 and Board of Trustees on 9/18/12. 1b) Medical Staff Rules and Regulations Section 5.2 "Discharge Summary" has been revised to state "A completed, signed, and dated discharge summary or discharge note must be in the medical record within thirty (30) days of discharge. " Approved by Medical Executive Committee on 9/10/12 and Board of Trustees on 9/18/12.2) HIM will review Charts starting in September 2012, by auditing 10% of charts for authentication of verbal orders and completion of discharge summaries within 30 days of discharge date. The review will be on Inpatient/outpatient charts and will include a breakdown by physician and clinical staff. The audit will be reported to PI Council and MS</p>	09/18/2012	

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	<p>2. The medical record for patient #N12 indicated a telephone order from the physician on 03/01/12 that was not authenticated by the physician until 04/19/12.</p> <p>3. The medical record for patient #N13 indicated a telephone order from the physician on 05/09/12 that was not authenticated by the physician until 06/12/12.</p> <p>4. The medical record for patient #N14 indicated 2 separate telephone orders from the physician on 03/25/12 that were not authenticated by the physician until 04/11/12.</p> <p>5. The medical record for patient #N15 indicated a telephone order from the physician on 02/25/12 that was not authenticated by the physician. There were 2 other telephone orders from the physician on 02/26/12 that were not authenticated by the physician until 03/16/12.</p> <p>6. The medical record for patient #N16 indicated a telephone order from the physician on 06/22/12 that was authenticated by the physician, but not dated or timed, making it unable to determine adherence to policy. Another telephone order was received on 06/22/12</p>		<p>Quality quarterly beginning next quarter.3) Health Information staff 4) Correction was completed 9/18/12.</p>		

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	<p>and authenticated by the physician on "08/29/12". A third telephone order from 06/22/12 was authenticated "6/". One last telephone order was received on 06/29/12 and authenticated by the physician on 08/01/12.</p> <p>7. The medical record for patient #N17 indicated a verbal order from the physician on 03/08/12 that was not authenticated by the physician until 05/03/12. The record also indicated a telephone order from the physician on 03/14/12 that was not authenticated by the physician until 05/07/12.</p> <p>8. The medical record for patient #N18 indicated a telephone order from the physician on 01/31/12 that was not authenticated by the physician until 02/22/12. Another telephone order was received on 02/04/12, but not authenticated by the physician until 02/20/12. The record indicated a verbal order from the physician on 02/08/12 that was not authenticated by the physician until 03/11/12.</p> <p>9. At 11:30 AM on 08/29/12, staff members #A2, A6, and A18 confirmed the medical record findings.</p>			

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S000952	<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 policy and procedure review, medical record review, and interview, the facility failed to follow their established procedure for blood transfusion administration in 5 of 5 patients who received blood (#N1, N2, N3, N4, and N15).</p> <p>Findings included:</p> <p>1. The facility policy "Blood, Product", last revised 01/10, indicated, "...2. Obtain baseline V/S, including breath sounds, this will be documented in the chart. Baseline Vital Signs should be within 60 minutes of transfusion. ...Blood may be returned to the lab within 30 minutes of issue. ...c. ...Documentation of vital signs and breath sounds after baseline should be at the following intervals: Start of transfusion, 15 minutes after start of infusion, 1 hour after the start of transfusion, 2 hours after</p>	S000952	<p>1) All nursing staff re-educated on the current policy #7000.2.10 for transfusion of Blood Products regarding completion of documentation on 9/27/12 electronically.</p> <p>2) The nurse leader will monitor documentation monthly and if errors continue staff will go through one on one training for compliance, specific to individual need. Documentation of Blood Transfusion compliance is reported quarterly in PI report and to MS Quality, beginning next quarter.</p> <p>3) Nurse Educator / Nurse Leader</p> <p>4) Correction was completed on 9/27/12.</p>	09/27/2012			

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	<p>the start of transfusion, 3 hours after the start of transfusion, at the end of the transfusion, 30 minutes post transfusion. To reduce the risk of bacterial contamination, RBCs (Red Blood Cells) must be transfused within 4 hours of leaving the blood bank."</p> <p>2. The medical record for patient #N1 indicated a unit of RBCs left the blood bank at 7:09 AM on 03/10/12 and was started at 0740. The unit was completed at 1140, four hours and 31 minutes since leaving the blood bank. The baseline vital signs were taken at 0630, one hour and 10 minutes prior to the start of the transfusion. The one hour vital signs were taken at 0855, one hour and 15 minutes after the start of the transfusion.</p> <p>A second unit of RBCs was started at 1310 on 03/10/12 and the one hour vital signs were taken at 1425, one hour and 15 minutes after the start of the transfusion.</p> <p>3. The medical record for patient #N2 indicated a unit of RBCs left the blood bank at 11:39 PM on 05/29/12, but the start time was scribbled out/written over making it unclear.</p> <p>4. The medical record for patient #N3 indicated a unit of RBCs left the blood</p>						

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	<p>bank at 5:07 PM on 03/22/12 and was started at 1725. The unit was completed at 2130, four hours and 23 minutes since leaving the blood bank. The times for the start time and the 15 minute vital signs were written over/changed.</p> <p>5. The medical record for patient #N4 indicated a unit of RBCs left the blood bank at 12:10 PM on 03/02/12 and was started at 1220. The baseline vital signs were taken at 1100, one hour and 20 minutes prior to the start of the transfusion. On 03/15/12, a unit of RBCs was started at 1300 and the one hour vital signs were taken at 1415, one hour and 15 minutes after the start of the transfusion. Another unit of RBCs was started at 1700 on 03/15/12 and the one hour vital signs were taken at 1815, one hour and 15 minutes after the start of the transfusion. The time for the baseline vital signs was written over/changed.</p> <p>6. The medical record for patient #N5 indicated a unit of RBCs left the blood bank at 10:10 PM on 02/25/12 and was started at 2220. The baseline vital signs were taken at 1928, almost 3 hours before the start of the transfusion. The start time and 15 minute vital signs time were marked out/changed. The form also lacked documentation of date/time stopped and whether or not there was a</p>				

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S001022	<p>transfusion reaction. A second unit of RBCs was started at 0040 on 02/26/12 and completed at 0310, but the form lacked documentation of the 30 minute post transfusion vital signs.</p> <p>7. Some of the records were reviewed offsite, but the findings for patients #N1, N2, and N15 were confirmed by staff members #A2, A6, and A18 at 11:30 AM on 08/29/12.</p> <p>410 IAC 15-1.5-7 PHARMACEUTICAL SERVICES 410 IAC 15-1.5-7 (d)(2)(B)</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>(B) Appropriate storage conditions. Based on observation, policy and procedure review, and interview, the facility failed to ensure all medications were stored according to policy.</p> <p>Findings included:</p> <p>1. During the tour of the Acute Care Unit at 10:20 AM on 08/28/12, accompanied by staff members #A2 and A6, an open,</p>	S001022	Acute Care Response1a) On 9/25/12, Pharmacy posted a sign on countertop of Acute Care med room which states "Do not leave partial vials on counter. No unattended meds on counter. Place in patient drawer and lock." The pharmacy has provided a "Witness to Waste" labeled drawer for nursing to lock meds waiting for a witness to waste. The nursing staff educator has	09/28/2012

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	<p>half full, single dose 1 milliliter vial of Hydromorphone was observed in a plastic medicine cup on the counter of the locked medication room.</p> <p>2. Staff member #A6 indicated the medication was probably waiting to be wasted and required 2 nurses to do that, but confirmed this was a controlled substance that should be stored in a locked cabinet.</p> <p>3. During the tour of the surgical area at 11:15 AM on 08/28/12, accompanied by staff member #A13, a 20 milliliter vial of Propofol, an anesthetic agent, was observed sitting on top of the anesthetic cart in an unoccupied operating room. Staff member #A13 indicated the surgical suite was a secured area, but confirmed the medication should be secured until needed for use.</p> <p>4. The facility policy "Controlled Medications", last revised 09/10, indicated, "...9. Controlled drugs must always be kept in a secure location, even when awaiting return to the pharmacy."</p>		<p>reviewed with nursing the proper procedure for securing medications if they cannot be wasted immediately on 9/13-14/12. Policy & Procedure 7730.1.19 and 7730.1.69 address the proper storage and handling of medications. 2a) Pharmacy technician is to collect data monthly on the Medication Quality Assurance Inspection. Technicians will check the medication storage area every time they enter the area and report to the medication event hotline any failure to follow procedure on a daily basis. The Pharmacy Leader will check the quality assurance reports monthly and record on the P&T Spreadsheet as unsecured medications as of September 25, 2012. Results will be reported quarterly to Medical Staff Quality Committee as Pharmacy PI (on P&T Spreadsheet) beginning 4 th quarter of 2012. The Nursing Leader for Acute Care will spot check the med room and report findings on the med event hotline. 3a) Pharmacy and Acute Care Nursing Leader 4a) Correction was completed on 9/25/12.Surgical Care Center Response1b) All medications will be stored in the medication drawer before leaving the surgical suite. Policy & Procedure 7730.1.19 and 7730.1.69 address the proper storage and handling of these medications. Anesthesiology and OR staff</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 on observation and staff interview, the facility failed to maintain the hospital environment and equipment in such a manner that the safety and well-being of patients, visitors, and/or staff are assured in three (3) instances: Laboratory; Maintenance Shop; and Dietary Department.</p>	S001118	<p>were re-educated on medication safety on 9/28/12. 2b) Pharmacy staff will check the surgical suites on a monthly basis as part of the QA and report quarterly on the Pharmacy PI log beginning next quarter. Surgery staff will perform spot checks that all medications are secured. Unsecured medications are a reportable event. 3b) Pharmacy and OR Leader 4b) Correction was completed on 9/28/12.</p> <p>LAB 1) Handwashing sink in lab, electrical safety concern of cords running behind faucets. 2) To correct this deficiency a splash guard has been installed behind the sink to protect the electrical devices and user. All lab sinks were assessed 9/24/12 for the same safety concern. No problems found. This will be repeated during annual environmental rounds going forward. 3) Lab Leader /</p>	09/25/2012

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	<p>Findings included:</p> <p>1. Safety Management Plan #1000.1.02, last reviewed and approved March 2012, indicates the Wabash County Hospital is committed to a Safety Management Plan designed to provide a physical, environment free of hazards and to manage staff activities to minimize the risk of human injury. The Safety Management Plan adheres to Life Safety Codes and OSHA regulations for safety of the staff, patients, and visitors.</p> <p>2. At 9:45 AM on 8/28/2012, the Dietary Department was toured. A large pedestal fan located in the warewashing room was observed with its electric cord draped through the handles of three flush wall mounted electrical panels and the plug was connected to an outlet on the other side of the electrical panels. This draping of the fan's electrical wire prevented easy</p>		<p>Coordinator 4) Correction was completed on 9-24-12.</p> <p>DIETARY 1) Electrical cord to fan draped over electrical panel door handles. 2) The fan was removed from the area. All department members educated regarding this change on 8/30/12. 3) The Department Leader / Shift Leader will assure cords are never draped across the electrical panel door handles. 4) Correction was completed on 9/24/12. MTC 1) Grinder was missing protective shield. To correct this deficiency the grinder has been replaced with a device with proper guards. 2) Monitoring the grinder guards has been added to the weekly department check off list. Leader will check compliance monthly and report to Safety / PI quarterly. 3) Facilities Services Leader / designee 4) Correction was completed on 9/25/12.</p>		

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	<p>access to the electrical breakers behind the door of the electrical boxes.</p> <p>3. At 12:05 PM on 8/28/2012, the Laboratory Department was toured. The designated handwashing sink was located behind a tower computer. The electrical wiring from the computer was within inches from the water faucets of the hand washing sink. Wiring from the computer were draping above the faucet handles and running along behind the hand sink counter. A plastic shield was installed but it was falling down and was not separating the electrical components of the computer to possible splashes from hand washing. The electric equipment was not free from recognized hazards that could cause serious physical harm to employees.</p> <p>4. OSHA 29 CFRb1915.134 Floor stand and bench mounted abrasive wheels used for external grinding</p>				

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	<p>shall be provided with safety guards (protection hoods). The maximum angular exposure of the grinding wheel periphery and sides shall be not more than 90 degrees, except that when work requires contact with the wheel below the horizontal plane of the spindle, the angular exposure shall not exceed 125 degrees. In either case the exposure shall begin not more than 65 degrees above the horizontal plane of the spindle. Safety guards shall be strong enough to withstand the effect of a bursting wheel.</p> <p>5. At 12:55 PM on 8/28/2012, the Maintenance Shop was toured. A work table was observed with two bench mounted grinding/abrasive wheels. Each item had a grinding and an abrasive wheel on them. One abrasive wheel was missing a safety guard to protect against metal flakes or sparks. The other wheels safety guards were observed with the wheels either cracked or not in a position to protect the operator from sparks or</p>			

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S001164	<p>flying particles.</p> <p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8(d)(2)(B)</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>(B) There shall be evidence of preventive maintenance on all equipment.</p> <p>Based on documentation review, the facility failed to ensure the Cryostat was routinely cleaned as per hospital policy.</p> <p>Findings included:</p> <p>1. Wabash County Hospital Policy Procedure on routine decontamination #7020.1.032, last reviewed and approved 3/12/12, stated under Quality Control, "All fresh tissue is potentially contaminated. The cryostat is</p>	S001164	<p>1) Revised Histology Instrument & Equipment policy #7020.1.034. Added daily cleaning and Fumigation/Decontamination according to user manual. New Histology policy #7020.1.061: Routine Decontamination of Cryotome: routine cleaning and preventive maintenance. Both policies approved by Pathologist on 8/28/12. 2) Cryotome Decontamination Log revised with columns: bi-annual defrosting, quarterly fumigation/decontamination, problems. Also revised log developed for Frozen Section to include daily cleaning/after each use (Cryo). The log swill be monitored monthly and will be</p>	08/29/2012

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	<p>cleaned with 70% alcohol after each frozen section. Routine decontamination of the cryostat is required to be kept free of the infection hazard posed by debris. Follow all procedures for daily cleaning include the following: clean air vents, wipe chamber with 100% ethanol, thoroughly dry the inside chamber, etc. The cryostat should be defrosted and decontaminated with a tuberculocidal disinfectant not less than every six months. Record, date, and initial on appropriate log."</p> <p>2. The 2012 Frozen Section log reveals that the cryostat was used 26 frozen section specimens and 43 Frozen section blocks for the first 8 months.</p> <p>3. The Cryostat Maintenance Log reveals 1/20/12 the cryostat was cleaned and defrosted. On 4/18/12, the Cryostat was cleaned only. On 7/12/12, the Cryostat was cleaned and defrosted. The cryostat was</p>		<p>reported quarterly on the Lab PI log, beginning next quarter. Both logs approved by Pathologist on 8/28/12. 3) Histology Tech / Lab Leader 4) Correction completed 8/28/12 - date of survey exit 8/29/12.</p>	

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S001168	<p>defrosted every quarter instead the minimum of once a month as stated in the hospital policy. The Cryostat Maintenance Log did not evidence daily cleaning as stated in the hospital policy and procedure.</p> <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 and staff interview, the facility failed to discharge and perform recommended checks and procedures for every shift the Zoll M-series defibrillators were located.</p> <p>Findings included:</p> <p>1. The Zoll M-series operator's guide recommended checks and</p>	S001168	<p>1) Defibrillator checks will be changed from daily checks to shift checks immediately. Additional column added to daily monitor check list so that checks can be done every shift instead of daily. Nursing staff were re-educated on the form electronically 9/27/12.</p> <p>2) Department Leader(s) or designee will spot check for compliance and report quarterly with departmental PI, beginning next quarter.</p> <p>3) Acute Care / ED and OR Leaders</p> <p>4) Correction was completed on 9/27/12.</p>	09/27/2012

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	<p>procedures to be performed at the start of each shift. The shift checks include discharging the machine, check the paddles, inspect for damages, check the batteries, check on disposable supplies, etc.</p> <p>2. The Special Care Unit (SCU) Crash Cart/Defibrillator Checklist evidenced only daily checks of the defibrillator. In the first 27 days of August, the defibrillator for the SCU's crash cart was not checked and procedures performed for 7 of the days. Therefore, the form did not evidence shift checks for the defibrillator.</p> <p>3. At 3:05 PM on 8/28/2012, staff member #9 indicated the Zoll M-series defibrillators are located in ER and other patient floors. The logs in all those areas were the same, only performing daily checks with the defibrillators. The staff member thought the logs were changed to reflect shift checks instead of daily checks and daily discharges. The staff member</p>						

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	confirmed the staff who have the Zoll M-series defibrillator are not adhering to the manufacturer's recommendations.				