

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150101	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/25/2013
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NAME OF PROVIDER OR SUPPLIER PARKVIEW WHITLEY HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 1260 E SR 205 COLUMBIA CITY, IN 46725
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S000000	<p>The visit was for a licensure survey.</p> <p>Facility Number: 005090</p> <p>Survey Date: 6-24-13 to 6-25-13</p> <p>Surveyors: Brian Montgomery, RN Public Health Nurse Surveyor</p> <p>Linda Plummer, RN Public Health Nurse Surveyor</p> <p>Steve Poore, BS MLT Medical Surveyor 3</p> <p>QA: cloughlin 07/17/13</p>	S000000	Survey 6/24/2013 to 6/25/2013	

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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S000178	<p>410 IAC 15-1.3-2 POSTING OF LICENSE 410 IAC 15-1.3-2(a)</p> <p>(a)The license shall be conspicuously posted on the hospital premises in an area open to patients and public. A copy shall be conspicuously posted in an area open to patients and public on the premises of each separate hospital building of a multiple hospital building system.</p> <p>Based upon observation and interview, the facility failed to post a valid license copy in a common public area for each hospital services off-site location for 3 of 5 off-sites.</p> <p>Findings:</p> <p>1. While on tour of the off site radiology and lab site in South Whitley, on 6/25/13 at 9:00 AM in the company of staff members #52, the vice president of patient services, and #57, the radiology manager, it was observed that there was no posted license at the off site located several miles from the main hospital facility.</p> <p>2. Interview at 9:00 AM on 6/25/13 with staff members #52 and #57 indicated it was unknown that the license needed to be posted at the off site location.</p>	S000178	<p>The following constitutes Parkview WhitleyHospital's response to the findings of the Department of Health Services and does not constitute an admission of guilt or agreement of the facts alleged or conclusions set forth on the summary statements of deficiencies.WHO: · The deficiencies cited within this survey report were reviewed via in-person meetings by senior leadership including the COO, VP of Patient Services and Department Managers. As a result of this review, a directive was issued to develop and implement a plan of correction to address and clarify the findings as listed in the report. · Quality Accreditation Specialist is ultimately responsible for the corrective action and for overall and ongoing compliance. WHAT: Concisely describe the actions completed. During the survey the current license was posted in the lobby of the HOPD off-site radiology/lab, physical therapy,</p>	06/25/2013			

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	<p>3. During a tour on 6-24-13 at 1245 hours, an expired facility license was observed in the public area of the physical therapy outpatient services.</p> <p>4. During a tour on 6-24-13 at 1250 hours, an expired facility license was observed in the common area of the sleep lab outpatient services.</p> <p>5. During an interview on 6-24-13 at 1250 hours, staff A5 confirmed that the posted licenses on display for the two off-sites were expired.</p>		<p>and the Sleep Lab. WHEN: Please indicate the dates each action was completed. 07/18/13 – Quality Accreditation and Executive Management met to review the Survey Report and Findings. 06/24/2013-License was posted. HOW: Please describe how compliance will be sustained. Each year when new license is received QM will provide copy to the HOPD units for posting in the lobby.</p>				

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S000318	<p>410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1(c)(6)(F)</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>(F) Ensuring cardiopulmonary resuscitation (CPR) competence in accordance with current standards of practice and hospital policy for all health care workers, including contract and agency personnel, who provide direct patient care. Based on document review, credential file review and interview, the facility failed to ensure cardiopulmonary resuscitation (CPR) competency for all credentialed medical staff and health care workers who provide direct patient care.</p> <p>Findings:</p> <p>1. The Medical Staff Bylaws (board approved 3-13) failed to require CPR competency for all medical staff who provide direct patient care and failed to indicate physicians exempted from the State rule 410 IAC 15-1.4-(c)(6)(F) by training or experience.</p>	S000318	<p>The following constitutes Parkview Whitley Hospital's response to the findings of the Department of Health Services and does not constitute an admission of guilt or agreement of the facts alleged or conclusions set forth on the summary statements of deficiencies.WHO: · The deficiencies cited within this survey report were reviewed via in-person meetings by senior leadership including the COO, VP of Patient Services and Department Managers. As a result of this review, a directive was issued to develop and implement a plan of correction to address and clarify the findings as listed in the report. · The VP</p>	10/29/2013			

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	<p>2. The policy/procedure Cardiopulmonary Resuscitation Competence (approved 2-12) indicated the following: " Physicians with demonstrated CPR competence will be present at any time a patient may require CPR in our facility ...an Emergency Room physician is present at all times ...It is a requirement that these physicians either be board certified in Emergency Medicine or have current ACLS (Advanced Cardiac Life Support) certification. Emergency Room physicians are required to attend all Code Blues (situations requiring CPR) at our facility ... " The policy/procedure failed to indicate a requirement for all credentialed medical staff to maintain current documentation of competency for CPR and failed to indicate physicians exempted from the requirement if indicated.</p> <p>3. Review of 10 medical staff credential files (two anesthesiologists, one general surgeon, one orthopedic surgeon, an obstetrician/gynecologist, two internal medicine providers, a family practice provider, a podiatrist and a pathologist) failed to indicate current CPR competency for any medical staff.</p> <p>4. On 6-25-13 at 1300 hours, the human resources director A16 was requested to</p>		<p>Patient Services is ultimately responsible for the corrective action and for overall and ongoing compliance. WHAT: Concisely describe the actions completed. The Hospital and Medical Staff policies will be reviewed for current standards of practice to clarify and define "Direct patient care" with inclusions and/or exclusions for CPR. WHEN: Please indicate the dates each action was completed. First 30-days (8/1/13 to 8/31/13) · 07/18/13 – Quality Accreditation and Executive Management met to review the Survey Report and Findings. · Hospital and Medical Staff Policy Review Second 30-days: (9/1/13 to 9/30/13): Policies will be updated as needed. Third 30-days: (9/30/13 to 10/29/13): Policy implementation HOW: Please describe how compliance will be sustained. All policies are to be reviewed triennially at minimum and are to have approval for use at Parkview Whitley Hospital by an authorized representative, committee, or designee.</p>	

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	<p>provide a policy/procedure regarding CPR competency for all health care personnel who provide direct patient care and none was provided prior to exit.</p> <p>5. During an interview on 6-25-13 at 1530 hours, staff A16 confirmed that no facility policy/procedure regarding CPR competency for all direct care personnel was available.</p> <p>6. On 06/24/13 between 2:28 pm and 3:30 pm, review of personnel file (SP7 and SP13), revealed no CPR documentation.</p> <p>7. On 06/25/13 between 1:05 pm and 1:20 pm, staff member SP15, provided documentation of CPR competency for staff member SP13, that expired on 6/2011.</p> <p>8. On 06/25/13 between 1:05 pm and 1:20 pm, review of job description titled, "Lab CRC Representative" states the following: "In addition, the CRC Rep may help or routinely rotate to other support services areas of the laboratory including Phlebotomy..."</p> <p>9. In interview on 06/25/13 at 4:20 pm, staff member SP3, confirmed staff member SP13 was performing phlebotomy duties.</p>			

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	10. In interview on 06/24/13 at 3:55 pm, staff member SP7, confirmed he/she had direct patient interactions and no CPR documentation (diet consultations).			
	11. In interview on 06/25/13 at 1:55 pm, staff member SP16, confirmed the facility does not have a CPR policy for hospital staff, who are not part of the medical executive board.			

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S000322	<p>410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1(c)(6)(H)</p> <p>(c) The governing board is responsible for managing the hospital. The governing board shall do the following: (6) Require that the chief executive officer develops policies and programs for the following:</p> <p>(H) Requiring all services to have policies and procedures that are updated as needed and reviewed at least triennially.</p> <p>Based on document review and interview, the facility failed to ensure that all services update and/or review all policies and procedures at least triennially</p> <p>Findings:</p> <p>1. On 6-25-13 at 1445 hours, staff A8 was requested to provide a policy/procedure regarding administration of contrast media by radiologic staff. The policy/procedure Contrast Media Injections (reviewed 1-12) failed to indicate that a responsible person had reviewed and approved the policy.</p> <p>2. On 6-25-13 at 1445 hours, staff A8 confirmed that the policy/procedure lacked documentation of review and approval by a representative for radiology services.</p>	S000322	<p>The following constitutes Parkview Whitley Hospital's response to the findings of the Department of Health Services and does not constitute an admission of guilt or agreement of the facts alleged or conclusions set forth on the summary statements of deficiencies.WHO: · The deficiencies cited within this survey report were reviewed via in-person meetings by senior leadership including the COO, VP of Patient Services and Department Managers. As a result of this review, a directive was issued to develop and implement a plan of correction to address and clarify the findings as listed in the report. · The Radiology Manager is ultimately responsible for the corrective action and for overall and ongoing compliance. WHAT: Concisely describe the actions completed.</p>	09/30/2013			

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			<p>First 30-days (08/01/13 to 08/31/13) · Meet with department manager to identify and discuss a plan of correction to address the issue of review and approval of policies for use at Parkview Whitley Hospital. Ensure the following hospital policies have review and approval for use at Parkview Whitley Hospital: o Contrast Media Injections policy</p> <p>Second 30-days (9/1/13 to 9/30/13) · Ensure all Radiology hospital policies actively in use at Parkview Whitley Hospital are up to date and reflect review by a hospital representative. The Radiology Manager will notify their system departments of policies that need updated to identify hospital specific approval. The Radiology Manager will work to ensure system policies for their department are reviewed for appropriateness and have approval for use by an authorized representative, committee, or authorized designee for Parkview Whitley Hospital. WHEN: Please indicate the dates each action was completed. · 07/18/13 – Quality Accreditation and Executive Management met to review the Survey Report and Findings. · 07/23/13 – Met with the Radiology manager to review the policy approval process · 09/30/13 - Develop a structured system for Radiology department policy review and approval by Parkview Whitley Hospital. HOW: Please describe how compliance</p>	

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			will be sustained: All policies are to be reviewed triennially at minimum and are to have approval for use at Parkview Whitley Hospital by an authorized representative, committee, or designee.	

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S000332	<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 policy and procedure review, personnel file review, and interview, the governing board failed to ensure that the off site contracted cleaning staff demonstrated competency in fulfilling their responsibilities in one personnel file reviewed (N15).</p> <p>Findings: 1. at 12:25 PM on 6/24/13, review of the policy and procedure "Infection Control Plan", (no policy number), with a last date approved of 8/11 (on last page), indicated: a. under section "III. Procedure:", it reads in section "G. Parkview Health Infection Prevention and Control Departments", in item "17. Environmental surveillance": "...Environmental surveillance activities will be performed by the IPC (infection prevention control)</p>	S000332	<p>The following constitutes Parkview Whitley Hospital's response to the findings of the Department of Health Services and does not constitute an admission of guilt or agreement of the facts alleged or conclusions set forth on the summary statements of deficiencies.WHO: · The deficiencies cited within this survey report were reviewed via in-person meetings by senior leadership including the COO, VP of Patient Services and Department Managers. As a result of this review, a directive was issued to develop and implement a plan of correction to address and clarify the findings as listed in the report. · The Infection Control Practitioner is ultimately responsible for the corrective action and for overall and ongoing compliance. WHAT:</p>	09/30/2013			

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	<p>staff,...or designated persons within specified departments with evaluation being done by, or having input from, IPC personnel..."</p> <p>2. review of the one contracted agency housekeeping personnel (N15) file provided at 11:30 AM on 6/25/13, indicated:</p> <p>a. staff member N15 signed a "Work Rules Acknowledgment Form" on 3/8/11, as a term of conditions upon hire, indicating this was the "hire date"</p> <p>b. present in the file were two logs (for April and May 2013), of self attestation for cleaning at the off site radiology/lab facility, completed by staff member N15</p> <p>3. interview with staff member #61, the infection preventionist, at 10:45 AM on 6/25/13 indicated:</p> <p>a. this staff member does visual observation of cleanliness of the off site during monthly EOC (environment of care) walk arounds</p> <p>b. this staff member has not observed staff member N15 in their cleaning process at the off site to determine that the appropriate cleaners and disinfectants are being utilized in the correct manner, such as application process, kill time of the product, appropriate PPE (personal protective equipment)</p> <p>c. observation of staff member N15 for</p>		<p>Concisely describe the actions completed. · Infection Prevention Control (IPC) and the Housekeeping Supervisor met to review the current policy and process which includes information on training of off-site contracted cleaning vendors. · IPC and Housekeeping will meet with the contracted cleaning vendors to review the policy and procedure, including staff competencies, for appropriate cleaning of off-site locations. · A cleaning competency form, cleaning evaluation form, and a cleaning verification form was developed by IPC and Housekeeping to validate appropriate asepsis is occurring by contracted cleaning staff. The policy and process were approved the hospital Clinical Committee (which serves as the Infection Control Committee) · Contracted Cleaning Staff will be trained by their direct supervisor or hospital staff member. Competency will be documented. · The above process will be added to the 2013 IPC Control Plan with approval by the Clinical Committee (which serves as the Infection Control Committee) WHEN: Please indicate the dates each action was completed. First 30-days</p>	
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	"demonstrated competency" is delegated to their supervisor d. only self attestation of cleaning by the staff member was submitted--there was no documentation provided by the supervisor for N15 regarding any observations of competency in providing expected competencies related to the cleaning/housekeeping services at the off site		(8/1/13 to 8/31/13) · 07/18/13 – Quality Accreditation and Executive Management met to review the Survey Report and Findings. · IPC and the Housekeeping Supervisor met to review the current process and adopt a cleaning evaluation and validation form Second 30-days (9/17/13 to 9/30/13) · Policy and Process will be approved by the Clinical Committee (which serves as the Infection Control Committee) · An appointment has been set to meet with the contracted cleaning vendor. The purpose of the meeting is to review policy requirements. · 09/30/13 – Contracted housekeeping staff training completed HOW: Please describe how compliance will be sustained. · Validation of the cleaning process will be incorporated into routine rounding by IPC and Housekeeping twice each year. · Once per quarter, for the next year, we will validate that all currently contracted cleaning staff have all appropriate training and competencies on file. Audit results will be tracked and trended on the Measures of Success (MOS) Dashboard. Compliance will be reviewed at Patient Care Committee. Compliance issue will be referred to	

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			administration for resolution.	

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S000394	<p>410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1(f)(3)</p> <p>(f) The governing board is responsible for services delivered in the hospital whether or not they are delivered under contracts. The governing board shall insure the following:</p> <p>(3) That the hospital maintains a list of all contracted services, including the scope and nature of the services provided.</p> <p>Based on document review and interview, the facility failed to maintain a list of all contracted services, including the scope and nature of services provided for 8 contracted services.</p> <p>Findings:</p> <p>1. On 6-24-13 at 1600 hours, a list of all contracted services was received from staff A3. The list of services failed to indicate a service provider for anesthesia machines, computerized tomography (CT) equipment, fire extinguishers, gamma camera equipment, annual generator maintenance, mammography and magnetic resonance imaging (MRI) equipment and radiation exposure monitoring.</p> <p>2. Review of facility documentation indicated the following: anesthesia machine service by CS1, CT service by</p>	S000394	<p>The following constitutes Parkview WhitleyHospital's response to the findings of the Department of Health Services and does not constitute an admission of guilt or agreement of the facts alleged or conclusions set forth on the summary statements of deficiencies.WHO: · The deficiencies cited within this survey report were reviewed via in-person meetings by senior leadership including the COO, VP of Patient Services and Department Managers. As a result of this review, a directive was issued to develop and implement a plan of correction to address and clarify the findings as listed in the report. · The President is ultimately responsible for the corrective action and for overall and ongoing compliance. WHAT: Concisely describe the actions completed. · Service contracts for Parkview Health, which includes Parkview</p>	09/30/2013			

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	<p>CS2, fire extinguisher service by CS3, gamma camera service by CS4, generator service by CS5, mammography service by CS6, MRI service by CS7 and radiation badge service by CS8.</p> <p>3. On 6-25-13 at 1250 hours, staff A3 and A7 confirmed the list of contracted services failed to include the indicated service providers.</p>		<p>Whitley, are managed internally by Parkview Health System departments. A request was submitted to the appropriate departments to submit a contracted services list specific for Parkview Whitley Hospital. · The contract services list will be updated and made available as needed to the Hospital President. WHEN: Please indicate the dates each action was completed. First 30-days (08/01/13 to 8/31/13) · 07/18/13 – Quality Accreditation and Executive Management met to review the Survey Report and Findings. · Parkview Health System Departments were notified by QM of the need for a complete list of contracted services specific to this facility · A meeting was set with Parkview Health System Departments to review the process with the hospital executive leadership Second 30-days (09/01/13 to 09/30/13) · An updated contracted services list to be provided, specific for this hospital. HOW: Please describe how compliance will be sustained. Once per quarter, for the next year, we will ensure that the services listed below are accurately listed on the hospitals contracted services report. Audit results will be tracked and trended on the Measures of Success (MOS) Dashboard. Compliance will be reviewed at Patient Care Committee. Compliance issue will be referred</p>		

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			to administration for resolution. · Anesthesia Machine Service · CT Equipment · Fire Extinguishers · Gamma Camera equipment · Generator Maintenance · Mammography and MRI · Radiation exposure monitoring	

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S000422	<p>410 IAC 15-1.4-2.2 QUALITY ASSESSMENT AND IMPROVEMENT 410 IAC 15-1.4-2.2(a)(2)</p> <p>(2) A process for reporting to the department each reportable event listed in subdivision (1) that is determined by the hospital's quality assessment and improvement program to have occurred within the hospital.</p> <p>(b) Subject to subsection (e), the process for determining the occurrence of the reportable events listed in subsection (a)(1) improvement program shall be designed by the hospital to accurately determine the occurrence of any of the reportable events listed in subsection (a)(1) within the hospital in a timely manner.</p> <p>(c) Subject to subsection (e), the process for reporting the occurrence of a reportable event listed in subsection (a)(1) shall comply with the following:</p> <p>(1) The report shall:</p> <p>(A) be made to the department;</p> <p>(B) be submitted not later than fifteen (15) working days after the serious adverse event is determined to have occurred by the hospital's quality assessment and improvement program;</p> <p>(C) be submitted not later than four (4) months after the potential reportable event is brought to the program's attention; and</p> <p>(D) identify the reportable event, the quarter of occurrence, and the hospital, but shall not include any identifying information for any:</p> <p>(i) patient;</p> <p>(ii) individual licensed under IC 25; or</p> <p>(iii) hospital employee involved; or any other information.</p> <p>(2) A potential reportable event may be</p>			

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	<p>identified by a hospital that:</p> <p>(A) receives a patient as a transfer; or</p> <p>(B) admits a patient subsequent to discharge;</p> <p>from another health care facility subject to a reportable event requirement. In the event that a hospital identifies a potential reportable event originating from another health care facility subject to a reportable event requirement, the identifying hospital shall notify the originating health care facility as soon as they determine an event has potentially occurred for consideration by the originating health care facility's quality assessment and improvement program.</p> <p>(3) The report, and any documents permitted under this section to accompany the report, shall be submitted in an electronic format, including a format for electronically affixed signatures.</p> <p>(4) A quality assessment and improvement program may refrain from making a determination about the occurrence of a reportable event that involves a possible criminal act until criminal charges are filed in the applicable court of law.</p> <p>(d) The hospital's report of a reportable event listed in subsection (a)(1) shall be used by the department for purposes of publicly reporting the type and number of reportable events occurring within each hospital. The department's public report will be issued annually.</p> <p>(e) Any reportable event listed in subsection (a)(1) that:</p> <p>(1) is determined to have occurred within the hospital between:</p> <p>(A) January 1, 2009; and</p> <p>(B) the effective date of this rule; and</p>			

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	<p>(2) has not been previously reported; must be reported within five (5) days of the effective date of this rule. (Indiana State Department of Health; 410 IAC 15-1.4-2.2) Based on document review and interview, the facility failed to ensure that potential reportable events were submitted to the Indiana State Department of Health (ISDH).</p> <p>Findings:</p> <p>1. The Parkview Health policy/procedure Serious Adverse Events, Sentinel Events (revised 5-13) failed to indicate a provision for submitting each potentially reportable event brought to the attention of the quality assessment and improvement program to the ISDH per 410 IAC 15-1.4-2.2(a)(2) including a timeframe for submission.</p> <p>2. During an interview on 6-25-13 at 1340 hours, staff A7 confirmed that the policy/procedure lacked a provision for submitting a potentially reportable event to ISDH.</p>	S000422	<p>The following constitutes Parkview WhitleyHospital's response to the findings of the Department of Health Services and does not constitute an admission of guilt or agreement of the facts alleged or conclusions set forth on the summary statements of deficiencies.WHO: · The deficiencies cited within this survey report were reviewed via in-person meetings by senior leadership including the COO, VP of Patient Services and Department Managers. As a result of this review, a directive was issued to develop and implement a plan of correction to address and clarify the findings as listed in the report. · VP Patient Services is ultimately responsible for the corrective action and for overall and ongoing compliance. WHAT: Concisely describe the actions completed. · Quality Accreditation notified Legal of the need to review and update the current policy to add clarity for reporting timeframes that reflect the ISDH regulations. · The hospital policy will be updated as needed to reflect regulatory requirements, including timelines for reporting of events. WHEN: Please indicate the dates each action was completed. First 30-days (08/01/13 to 8/31/13) ·</p>	09/30/2013

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			07/18/13 – Quality Accreditation and Executive Management met to review the Survey Report and Findings. · 07/18/13 - Quality Accreditation notified Legal of the survey findings and the need to review and clarify the policy. Second 30-days (09/01/13 to 09/30/13) · Policy updates to be reviewed and approved by senior leadership · Policy implementation HOW: Please describe how compliance will be sustained. The policy will be reviewed, at minimum, every three years.		

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S000592	<p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(f)(3)(D)(i)</p> <p>(f) The hospital shall establish an infection control committee to monitor and guide the infection control program in the facility as follows: (3) The infection control committee responsibilities shall include, but not be limited to, the following:</p> <p>(D) Reviewing and recommending changes in procedures, policies, and programs which are pertinent to infection control. These include, but are not limited to, the following:</p> <p>(i) Sanitation. Based on document review and interview, the infection prevention and control (IPC) committee failed to periodically review and maintain the housekeeping policy/procedure for terminal surgery (OR) cleaning.</p> <p>Findings:</p> <p>1. The policy/procedure Infection Control Plan (reviewed 8-11) indicated the following: " The IPC department reviews departmental policies and procedures that are pertinent to infection prevention and/or control at a minimum of every three years. "</p> <p>2. The policy/procedure Terminal Surgery Cleaning (reviewed 6-12) lacked</p>	S000592	<p>The following constitutes Parkview Whitley Hospital's response to the findings of the Department of Health Services and does not constitute an admission of guilt or agreement of the facts alleged or conclusions set forth on the summary statements of deficiencies.WHO: · The deficiencies cited within this survey report were reviewed via in-person meetings by senior leadership including the COO, VP of Patient Services and Department Managers. As a result of this review, a directive was issued to develop and implement a plan of correction to address and clarify the findings as listed in the report. · The Housekeeping Supervisor is ultimately responsible for the</p>	09/30/2013
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	<p>documentation indicating that the facility IPC committee [Patient Care Committee] had performed a review since 4-83 and indicated that the plant operations and housekeeping manager A5 was responsible for policy revision and review.</p> <p>3. On 6-25-13 at 1215 hours, the infection prevention nurse A10 was requested to provide documentation indicating that the terminal surgery cleaning policy had been reviewed by the IPC committee within the last three years and none was provided prior to exit.</p> <p>4. During an interview on 6-25-13 at 1500 hours, staff A10 confirmed that the policy/procedure lacked documentation of periodic review by the IPC committee and no additional documentation was available.</p>		<p>corrective action and for overall and ongoing compliance. WHAT: Concisely describe the actions completed. · The Terminal Surgery Cleaning Policy was reviewed by the OR Manager, the Housekeeping Supervisor and Infection Control. · Policy will be reviewed by Clinical Committee, which serves as the Infection Control Committee · Ensure staff are appropriately trained on the updated policy and process WHEN: Please indicate the dates each action was completed. First 30-days (08/01/13 to 8/31/13) · Quality Accreditation and Executive Management met to review the Survey Report and Findings. Second 30-days (09/01/13 to 9/30/13) · The Terminal Surgery Cleaning Policy will be submitted to Clinical Committee for approval and authorized use. · Staff training, as applicable will be completed. HOW: Please describe how compliance will be sustained. The Terminal Cleaning Policy will be reviewed triennial (minimum) and approved/authorized for use at Parkview Whitley Hospital by an authorized representative, committee, or designee.</p>		

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S000604	<p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(f)(3)(D)(vii)</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>(vii) A system, which complies with state and federal law, to monitor the immune status of health care workers exposed to communicable diseases. Based on policy and procedure review, personnel file review, and staff interview, the infection control committee failed to implement its policy related to Hepatitis B for 1 of 3 tech files reviewed (N3) and one contracted housekeeper (N15).</p> <p>Findings: 1. 3:40 PM on 6/25/13, review of the policy and procedure "Exposure Control Plan", with no number and no indication of a most recent approval date, indicated: a. on page 30 under "General", it reads: "The employer shall make available the hepatitis B vaccine and vaccination series to all employees who have occupational exposure,..."</p>	S000604	<p>The following constitutes Parkview Whitley Hospital's response to the findings of the Department of Health Services and does not constitute an admission of guilt or agreement of the facts alleged or conclusions set forth on the summary statements of deficiencies.WHO: · The deficiencies cited within this survey report were reviewed via in-person meetings by senior leadership including the COO, VP of Patient Services and Department Managers. As a result of this review, a directive was issued to develop and implement a plan of correction to address and clarify the findings as listed in the report. · The VP</p>	09/30/2013

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	<p>b. on page 31 it reads: "...Made available at no cost to the employee;...Made available to the employee at a reasonable time and place;...Hepatitis B Vaccination...Hepatitis B vaccination shall be made available after the employee has received the training required in paragraph (g)(2)(vii)(I) and within 10 working days of initial assignment to all employees who have occupational exposure..."</p> <p>2. at 1:25 PM on 6/25/13, review of the health file for employee N3 indicated:</p> <p>a. the employee signed a request for initiation of the Hepatitis B series on 11/13/12, at the time of hire</p> <p>b. there was no documentation related to the initiation of the series in the employee's file</p> <p>3. interview with staff member # 59, the occupational/employee health nurse, at 3:15 PM on 6/25/13 indicated:</p> <p>a. there was no documentation related to staff member N3 having received any of the Hepatitis series injections as requested on 11/13/12</p> <p>b. there was no documentation of contacts made with employee N3 in reminding them of the need to begin the series, or to see if they indeed wished to have this provided (or had changed their</p>		<p>of Patient Services is ultimately responsible for the corrective action and for overall and ongoing compliance. WHAT: Concisely describe the actions completed. · Quality Accreditation and Executive Management met to review the Survey Report and Findings. · Quality Accreditation notified Occupational Health, HR, and Housekeeping of the survey findings. · The contracted housekeeping staff will be required to have training related to the possibility of occupational exposure and risk for Hepatitis B, as part of their occupational risk as a housekeeper. The vendor will maintain documentation of the staff member's acceptance of, or declination of, the Hepatitis B series. · A process was implemented to track and trend employees: o Have been offered the Hepatitis B series o If the employee desires the vaccine series they will receive it upon their first Occupational Health appointment. Occupational Health will schedule remaining dose and track and trend until completed. o Occupational Health will document declinations WHEN: Please indicate the dates each action was completed. First 30-days (8/1/13 to 8/31/13) · Quality Accreditation and Executive Management met to review the Survey Report and Findings. QM notified Occupational Health, HR, and Housekeeping of the survey</p>				

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	<p>mind and wished to sign a declination form)</p> <p>c. it was unknown that the facility policy required beginning a requested Hepatitis B series within 10 working days of initial assignment of a new employee</p> <p>4. at 11:30 AM on 6/25/13, review of the contracted housekeeper file (N15), with a hire date of 3/18/11, indicated:</p> <p>a. there was no documentation of training related to the possibility of occupational exposure and risk for Hepatitis B, as part of their occupational risk as a housekeeper</p> <p>b. there was no form in the file indicating this staff member's acceptance of, or declination of, the Hepatitis B series</p>		<p>findings. Second 30-days (09/1/13 to 09/30/13) · The contracted housekeeping staff will be required to have training related to the possibility of occupational exposure and risk for Hepatitis B, as part of their occupational risk as a housekeeper. The vendor will maintain documentation of the staff member's acceptance of, or declination of, the Hepatitis B series. · Occupational Health implemented the new process HOW: Please describe how compliance will be sustained. · Once per quarter, for the next year, we will validate that all currently contracted cleaning staff has all appropriate Occupational Exposure Training and Hepatitis B vaccine status on file. Audit results will be tracked and trended on the Measures of Success (MOS) Dashboard. Compliance will be reviewed at Patient Care Committee. Compliance issue will be referred to administration for resolution. · Occupational Health Nurse will audit all new hires for completion appropriate documentation and completion or declination of the Hepatitis B vaccines series. Audit results will be tracked and trended on the Measures of Success (MOS) Dashboard. Compliance will be reviewed at Safety Committee. Compliance issue will be referred to administration for resolution.</p>	

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S000608	<p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(f)(3)(D)(ix)</p> <p>(f) The hospital shall establish an infection control committee to monitor and guide the infection control program in the facility as follows: (3) The infection control committee responsibilities shall include, but not be limited to, the following: (D) Reviewing and recommending changes in procedures, policies, and programs which are pertinent to infection control. These include, but are not limited to, the following:</p> <p>(ix) Requirements for personal hygiene and attire appropriate for work settings.</p> <p>Based on review of policy/procedure, the Indiana Retail Food Code (410 IAC 7-24-134), and staff interview, the facility failed to have proper requirements for personal attire appropriate for kitchen staff, for one of one facilities surveyed.</p> <p>Findings include:</p> <p>1). On 06/24/13 between 1:45 pm and 2:02 pm, review of policy titled:</p> <p>"Nutrition Services Policy/Procedure Title: Dress Code Policy Category/Subtopic: Management of Human Resources", ...states on page 3,</p> <p>..."III. Hygiene, 2. Jewelry: Food/Beverage personnel will not wear...</p> <ul style="list-style-type: none"> - Dangling or hoop earrings. Earrings are limited to one post style per ear. - Excessive rings. One set of wedding rings 	S000608	<p>The following constitutes Parkview Whitley Hospital's response to the findings of the Department of Health Services and does not constitute an admission of guilt or agreement of the facts alleged or conclusions set forth on the summary statements of deficiencies.WHO: · The deficiencies cited within this survey report were reviewed via in-person meetings by senior leadership including the COO, VP of Patient Services and Department Managers. As a result of this review, a directive was issued to develop and implement a plan of correction to address and clarify the findings as listed in the report. · The Nutrition Services Supervisor is</p>	08/30/2013

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	<p>or engagement ring only.</p> <ul style="list-style-type: none"> - Visible necklaces. - Bracelets or dangling watches. - Jewelry in pierced visible body parts (ie. eyebrow, tongue, nose, etc.) must be covered..." <p>2). On 06/24/13 between 1:45 pm and 2:02 pm, review of the Indiana Retail Food Code (7-24-134), states the following:</p> <p>"410 IAC 7-24-134 Jewelry prohibition</p> <p>Authority: IC 16-42-5-5 Affected: IC 16-42-5</p> <p>Sec. 134. (a) While preparing food, a food employee shall not wear jewelry, including medical jewelry and watches, on their arms and hands. This section does not apply to a plain ring, such as a wedding band..."</p> <p>3). In interview on 06/24/13 at 2:02 pm, staff member SP4, confirmed the hospital's policy violated the requirements stated, in the above Retail Food Code (410 IAC 7-24-134), for proper attire worn by kitchen staff.</p>		<p>ultimately responsible for the corrective action and for overall and ongoing compliance. WHAT: Concisely describe the actions completed. · Quality Accreditation will meet with the Nutrition Services Supervisor to review current policy · The Dress Code Policy will be reviewed and updated as needed to accurately reflect the IN food code. · Policy Implementation WHEN: Please indicate the dates each action was completed. 07/18/13 – Quality Accreditation and Executive Management met to review the Survey Report and Findings. 8/30/13 – Policy updated and implemented HOW: Please describe how compliance will be sustained. The Nutrition Services Dress Code Policy will be reviewed triennial (minimum) and approved/authorized for use at Parkview Whitley Hospital by an authorized representative, committee, or designee.</p>		

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S000668	<p>410 IAC 15-1.5-3 LABORATORY SERVICES 410 IAC 15-1.5-3(c)</p> <p>(c) The medical staff and a pathologist shall determine which tissue specimens require a macroscopic examination only and which require both macroscopic and microscopic examinations. Categories of specimens removed during surgical procedures which are determined to require only macroscopic examination shall be specified in the laboratory policies and the medical staff rules. The medical staff and a pathologist shall determine the qualified licensed health professional responsible for macroscopic examination.</p> <p>Based on document review and staff interview, the facility failed to maintain an approved list of tissues exempt from laboratory examination.</p> <p>Findings:</p> <p>1. The Parkview Health Laboratories policy/procedure Medical Staff Guidelines for Department of Pathology (no facility approval) indicated the following: " The pathology department will bring forth recommendations ...regarding gross tissue exemption list for review ...and for final approval of the Medical Staff Executive Committee (MEC)See Addendum A: Tissue Exempt List. "</p> <p>2. On 6-25-13 at 1320 hours, staff A3 was requested to provide documentation of MEC or Medical Staff approval for the Tissue Exempt List and none was provided prior to exit.</p> <p>3. In 6-25-13 at 1620 hours, staff A3 confirmed</p>	S000668	<p><i>The following constitutes Parkview WhitleyHospital's response to the findings of the Department of Health Services and does not constitute an admission of guilt or agreement of the facts alleged or conclusions set forth on the summary statements of deficiencies.WHO:</i> · The deficiencies cited within this survey report were reviewed via in-person meetings by senior leadership including the COO, VP of Patient Services and Department Managers. As a result of this review, a directive was issued to develop and implement a plan of correction to address and clarify the findings as listed in the report. · Medical Staff Services Coordinator is ultimately responsible for the</p>	09/30/2013

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	that no documentation of Medical Staff approval of the Tissue Exempt List was available.		corrective action and for overall and ongoing compliance. WHAT: Concisely describe the actions completed. · The tissue exempt list will be sent to the Medical Staff for approved WHEN: Please indicate the dates each action was completed. First 30-days (8/1/13 to 8/30/13) 07/18/13 – Quality Accreditation and Executive Management met to review the Survey Report and Findings. Second 30-days (9/1/13 to 09/30/13) The tissue exempt list will be sent to the Medical Staff for approved HOW: Please describe how compliance will be sustained. The Tissue Exempt list will be reviewed triennial (minimum) and approved/authorized for use at Parkview Whitley Hospital by the hospital medical staff.	

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S000751	<p>410 IAC 15-1.5-4 MEDICAL RECORD SERVICES 410 IAC 15-1.5-4(f)(2)</p> <p>(f) All inpatient records, except those in subsections (g), shall document and contain, but not be limited to, the following:</p> <p>(2) The medical history and physical examination of the patient done within the time frames as prescribed by the medical staff rules and section 5 (b)(3)(M) of this rule.</p> <p>Based on review of the medical staff rules and regulations, patient medical record review, and staff interview, the medical staff failed to ensure the rules and regulations, related to admission history and physical reports, were implemented for 1 of 2 CCU (coronary care unit) patient records (pt. #4), and for 1 of 1 medical/surgical patient records (#6).</p> <p>Findings:</p> <p>1. at 3:25 PM on 6/24/13, review of the medical staff rules and regulations with a last date revised of February 2011, indicated:</p> <p>a. on page 9 in section 4. "The History and Physical", it reads: "A. A History and Physical (H & P) is required for all inpatient admissions, observation patients, and outpatients undergoing invasive procedures. B. The History and Physical must be completed within 24 hours after admission, or readmission, and before any invasive procedure is performed..."</p> <p>2. while on tour of the CCU on 6/24/13 at 2:20 PM, review of open medical record #4 indicated:</p> <p>a. this patient was admitted on 6/23/13 at 1333 hours</p> <p>b. there was no H & P (history and physical) in</p>	S000751	<p>The following constitutes Parkview WhitleyHospital's response to the findings of the Department of Health Services and does not constitute an admission of guilt or agreement of the facts alleged or conclusions set forth on the summary statements of deficiencies.WHO: · The deficiencies cited within this survey report were reviewed via in-person meetings by senior leadership including the COO, VP of Patient Services and Department Managers. As a result of this review, a directive was issued to develop and implement a plan of correction to address and clarify the findings as listed in the report. · Community Hospital Medical Director is ultimately responsible for the corrective action and for overall and ongoing compliance. WHAT: Concisely describe the actions completed. · Quality Accreditation, The Hospital</p>	08/16/2013
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	<p>the medical record</p> <p>c. the progress notes of 6/23/13 (no time noted) read: "H & P done ER..." (emergency room)</p> <p>3. while on tour of the medical/surgical nursing unit on 6/24/13 at 1:45 PM, review of open medical record #6 indicated:</p> <p>a. this patient was admitted on 6/20/13</p> <p>b. there was no H & P in the medical record</p> <p>c. the progress notes of 6/20/13 at 1000 hours indicated: "H & P done..."</p> <p>4. interview with staff member #55, the CCU and med/surg nursing manager/director, at 2:30 PM on 6/24/13 indicated:</p> <p>a. in checking with medical records, there have been no dictations performed by the attending physician for either patient #4 or #6</p> <p>5. interview with staff member #52, the vice president of patient services, at 3:25 PM on 6/24/13 indicated:</p> <p>a. it is expected that the admitting/attending physician will dictate, or write, an admitting history and physical for their patients within 24 hours, as per the medical staff rules and regulations</p> <p>b. it is not acceptable to utilize the emergency physician assessment as the admitting H & P, as was done by the physician for pts. #4 and #6 with notations in their progress notes (as documented in 2 and 3 above)</p>		<p>Medical Director met to review the Survey Report and Findings.</p> <ul style="list-style-type: none"> · One physician during the survey was identified as not having a timely H&P completion. The physician was notified on the day of the survey. The H&P was completed. · A plan was made to track and trend physician compliance for the next 4 months. Compliance and follow up will be discussed at the physician quality meeting. WHEN: Please indicate the dates each action was completed. First 30-days (7/17/13 to 8/16/13) · Quality Accreditation, The Hospital Medical Director met to review the Survey Report and Findings. · The physician was informed of the delinquency issues for a timely History and Physical documentation and provide a copy of Medical Staff Rules and Regulations for his review. · Place physician on Quality Resource Management Focused Physician Performance Evaluation for four months. · For the next four months, we will perform concurrent audits of patient records, for this physician for a timely History and Physical documentation until compliance is at 90%. HOW: Please describe how compliance will be sustained. · On a quarterly basis, Quality Management monitors and provides to the physician quality committee, a report for timely H&P documentation. Physicians with identified trends will be 				

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			notified and monitored.	

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S000912	<p>410 IAC 15-1.5-6 NURSING SERVICE 410 IAC 15-15-6 (a)(2)(B)(i)(ii)(iii)(iv)(v)</p> <p>(a) The hospital shall have an organized nursing service that provides twenty-four (24) hour nursing service furnished or supervised by a registered nurse. The service shall have the following:</p> <p>(2) A nurse executive who is: (B) responsible for the following: (i) The operation of the services, including, but not limited to, determining the types and numbers of nursing personnel and staff necessary to provide care for all patient care areas of the hospital. (ii) Maintaining a current nursing service organization chart. (iii) Maintaining current job descriptions with reporting responsibilities for all nursing staff positions. (iv) Ensuring that all nursing personnel meet annual in-service requirements as established by hospital and medical staff policy and procedure, and federal and state requirements. (v) Establishing the standards of nursing care and practice in all settings in which nursing care is provided in the hospital.</p> <p>Based on policy and procedure review, observation, and staff interview, the nursing executive failed to ensure the implementation of the nursing unit cleaning policy in 3 areas toured. (Med/Surg, ED (emergency department), and the Surgery department)</p>	S000912	<i>The following constitutes Parkview WhitleyHospital's response to the findings of the Department of Health Services and does not constitute an admission of guilt or</i>	08/31/2013

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	<p>Findings:</p> <p>1. at 1:15 PM on 6/25/13, review of the policy and procedure "Housekeeping Responsibilities - Unit Personnel", with no policy number and a review/revision date of 8/11, indicated:</p> <p>a. on page 3 it reads: "Food and Medication Refrigerators and freezer compartments, microwaves..." "Every month and as needed...a. Remove all food and drinks b. Clean and sanitize all interior surfaces..."</p> <p>b. on page 3 it reads: "Clean Utility Rooms, Patient Supply Storage...Blanket Warmers" "Annually, or more frequently if needed..."</p> <p>2. on 6/24/13 at 11:45 AM, while on tour of the ED in the company of staff members #52, the vice president of patient services, and #54, the ED nurse manager, it was observed that:</p> <p>a. the was dirty with dirty with dried splatters from food being heated within</p> <p>3. on 6/24/13 at 2:20 PM, while on tour of the medical/surgical nursing unit in the company of staff members #52, the vice president of patient services, and #55, the nurse manager, it was observed that:</p> <p>a. the pantry microwave glass tray was crusted with dried liquids that had escaped from foods being heated</p> <p>b. the pantry refrigerator was dirty under the two vegetable drawers at the bottom</p> <p>c. the "Monthly Cleaning Log" posted on the pantry refrigerator indicated the refrigerator and microwave were cleaned each month from January through June 2013 (according to the documentation of initials by nursing staff)</p> <p>4. interview with staff member #55, the med/surg nurse manager at 2:25 PM on 6/24/13 indicated:</p> <p>a. even though nursing staff are documenting</p>		<p>agreement of the facts alleged or conclusions set forth on the summary statements of deficiencies.WHO: · The deficiencies cited within this survey report were reviewed via in-person meetings by senior leadership including the COO, VP of Patient Services and Department Managers. As a result of this review, a directive was issued to develop and implement a plan of correction to address and clarify the findings as listed in the report. · The VP of Patient Services is ultimately responsible for the corrective action and for overall and ongoing compliance. WHAT: Concisely describe the actions completed.</p> <p>1. Managers will ensure/ monitor cleaning of the refrigerator, microwave and blanket warmer within their department by inspecting the equipment. 2. Managers will monitor completion of the department cleaning log. 3. Re-educated staff regarding the policy and procedure for equipment cleaning with emphasis on cleaning spills immediately upon occurrence.</p> <p>WHEN: Please indicate the dates each action was completed. First 30-days (8/1/13 to 8/31/13) · 07/18/13 – Quality Accreditation and Executive Management met to review the Survey Report and Findings. · Staff education HOW: Please describe how compliance will be sustained. · Infection control will monitor equipment</p>				

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	<p>cleaning of the appliances, they may not be doing a thorough job</p> <p>b. possibly the cleaning routine will need to be more frequently than monthly</p> <p>5. on 6/25/13 at 10:05 AM, while on tour of the surgery department in the company of staff members #52, the vice president of patient services, and #56, the surgery nurse manager, it was observed that:</p> <p>a. in the substerile room, the lowest shelf of the Bryton blanket warmer had substantial dust that when swiped caused a floating of large amounts of dust in the semi restricted area</p> <p>6. interview with staff member #56, the nurse manager of surgery, at 10:10 AM on 6/25/13 indicated:</p> <p>a. it is unknown when the blanket warmer had last been cleaned</p> <p>b. the amount of dust in the warmer was unacceptable and created an infection control hazard</p>		<p>cleanliness as part of their department rounding. Identified issues will be corrected at the time. · Managers will validate equipment cleanliness via weekly audits for a period of 45 days. Audit results will be tracked and trended on the Measures of Success (MOS) Dashboard. Compliance will be reviewed at Patient Care Committee. Compliance issues will be referred to administration for resolution. · The department manager will validate that the monthly cleaning logs are appropriately completed.</p>	

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S001234	<p>410 IAC 15-1.5-9 RADIOLOGIC SERVICES 410 IAC 15-1.5-9(d)(1)</p> <p>(d) A full-time, part-time, or consulting radiologist or physician qualified by education and experience in the service provided as determined by the medical staff shall do the following:</p> <p>(1) Supervise the service provided. Based on document review and interview, the facility lacked documentation indicating that the radiology policy/procedures were periodically reviewed and approved by the physician responsible for supervising the service.</p> <p>Findings:</p> <ol style="list-style-type: none"> On 6-24-13 at 1130 hours, staff A2 and A3 were requested to provide documentation indicating that the radiology medical director had reviewed and approved the radiology department policy/procedures and none was received prior to exit. On 6-25-13 at 1445 hours, staff A8 was requested to provide a policy/procedure regarding administration of contrast media by radiologic staff. The policy/procedure Contrast Media Injections (reviewed 1-12) failed to indicate that the radiology medical director had reviewed and approved the policy. On 6-25-13 at 1445 hours, staff A8 confirmed that the policy/procedure lacked documentation of review and approval by the medical director for radiology services. 	S001234	<p>The following constitutes Parkview WhitleyHospital's response to the findings of the Department of Health Services and does not constitute an admission of guilt or agreement of the facts alleged or conclusions set forth on the summary statements of deficiencies.WHO: · The deficiencies cited within this survey report were reviewed via in-person meetings by senior leadership including the COO, VP of Patient Services and Department Managers. As a result of this review, a directive was issued to develop and implement a plan of correction to address and clarify the findings as listed in the report. · The Radiology Manager is ultimately responsible for the corrective action and for overall and ongoing compliance. WHAT: Concisely describe the actions completed. · Meet with department manager to identify and discuss a plan of correction to address the issue of review and approval of policies</p>	09/30/2013	

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			<p>for use at Parkview Whitley Hospital. · The Radiology Manager met with the Radiology Medical Director to review policy and procedure oversight. · Ensure all Radiology hospital policies actively in use at Parkview Whitley Hospital are reviewed and approved by the Radiology Medical Director.</p> <p>WHEN: Please indicate the dates each action was completed. First 30-days (08/01/13 to 08/31/13) · 07/18/13 – Quality Accreditation and Executive Management met to review the Survey Report and Findings. · Met with the Radiology manager to review the policy approval process Second 30-days (9/1/13 to 9/30/13) · Develop a structured system for the Radiology Medical Director to review and approve Radiology policies. HOW: Please describe how compliance will be sustained. All policies are to be reviewed triennially at minimum and are to have approval for use at Parkview Whitley Hospital by an authorized representative, committee, or designee.</p>		