

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151325	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/15/2012
NAME OF PROVIDER OR SUPPLIER ST MARY'S WARRICK HOSPITAL INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1116 MILLIS AVE BOONVILLE, IN 47601		
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S0000	<p>This visit was for a State licensure survey.</p> <p>Facility Number: 005111</p> <p>Dates: 5-14-12 through 5-15-12</p> <p>Surveyors:</p> <p>Billie Jo Fritch RN, BSN, MBA Public Health Nurse Surveyor/Administrator</p> <p>Jennifer Hembree RN Public Health Nurse Surveyor</p> <p>KenZeigler Laboratory Surveyor</p> <p>QA: claughlin 06/18/12</p>	S0000			

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

TITLE

(X6) DATE

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

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S0308	<p>410 IAC 15-1.4-1 GOVERNING BOARD 15-1.4-2 (c)(6)(B)</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>(B) Orientation of all new employees, including contract and agency personnel, to applicable hospital, department, service, and personnel policies.</p> <p>Based on document review and staff interview, the facility failed to ensure agency staff received orientation to department policies for 4 (#N1, N2, N3, and N4) agency personnel files reviewed and failed to ensure hospital and departmental orientation to all employees for 6 of 9 (BJ#1, 4, 5, 7, 8, 9) personnel records reviewed.</p> <p>Findings included:</p> <ol style="list-style-type: none"> Agency staff members #N1, N2, N3, and N4 personnel files lacked documentation of department specific policies including documented competencies per policy. Facility policy titled "Employment of Agency of Agency Personnel (Temporary 	S0308	All facility-employed and agency staff will be assessed for competence initially during the interview, during the orientation process, at the end of orientation, and also during specified or requested reference periods. Once a staff member is hired, he/she is assigned to orientation days with a preceptor. Orientation will be completed before an independent patient assignment is expected or accepted. Orientation includes Facility and Unit tours, Safety and Risk Management, event reporting, quality measures, department specific policies, infection control, equipment to be used on assigned unit, documentation and computer use, physician orders, medication administration, and skills checklist completion and other reviews as pertains to job	07/17/2012			

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	<p>Employees)" last reviewed/revised 2/15/12 states under procedure or staffing guidelines: ".....4. Every contract employee receives orientation sufficient to function in the position for which they have been hired. During this orientation time, competencies are reviewed and authenticated." Attachment to the above policy titled "Agency staff orientation consists of the following: ".....First Day of floor orientation: Authentication of competencies....."</p> <p>3. Staff member #H18 verified the above at 3:40 p.m. on 5/15/12.</p> <p>4. Review of personnel files on 5-15-12 lacked evidence that 5 of 9 employees had documentation of orientation to the hospital (BJ#1, 4, 5, 7, 9) and 6 of 9 employees lacked evidence of departmental orientation at the facility (BJ#1, 4, 5, 7, 8, 9).</p> <p>5. Interview with B#19 on 5-15-12 at 1600 hours confirmed the personnel files for 5 of 9 employees lacked documentation of orientation to the hospital (BJ#1, 4, 5, 7, 9) and 6 of 9 employees lacked evidence of departmental orientation at the facility (BJ#1, 4, 5, 7, 8, 9).</p> <p>6. Interview with B#10 on 5-15-12 at 1615 hours indicated portions of</p>		<p>expectations.Competencies will be reviewed and authenticated by the preceptor and/or charge nurse before a staff member is able or permitted to accept a patient assignment. The completed skills checklist and orientation checklist are given to the nurse manager to be authenticated and placed in the personnel file.To ensure that the checklists are complete and that the staff member is ready to accept an assignment, the preceptor/charge nurse signs off on the checklists and reviews them with the nurse manager.Responsible Parties: Nurse Managers</p>	

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	personnel records are available at the St. Mary's Hospital in Evansville and are not at the St. Mary's Warrick facility.			

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S0406	<p>410 IAC 15-1.4-2 QUALITY ASSESSMENT AND IMPROVEMENT 410 IAC 15-1.4-2(a)(1)</p> <p>(a) The hospital shall have an effective, organized, hospital-wide, comprehensive quality assessment and improvement program in which all areas of the hospital participate. The program shall be ongoing and have a written plan of implementation that evaluates, but is not limited to, the following:</p> <p>(1) All services, including services furnished by a contractor. Based on document review and interview, the facility failed to include all services in the facility's Quality Assurance and Performance Improvement (QAPI) program.</p> <p>Findings included:</p> <ol style="list-style-type: none"> 1. Review of facility documents on 5-15-12 lacked evidence that the services of cardiac rehabilitation, housekeeping, and pediatrics were included in the facility's QAPI program. 2. Interview with B#17 on 5-15-12 at 1405 hours confirmed that the services of cardiac rehabilitation, housekeeping, and pediatrics are not included in the facility's QAPI program. 	S0406	<p>All services identified in the ISDH deficiency tag are now included in the QA/PI process and are reporting to the CORE (Quality) Committee at St. Mary's Warrick Hospital on a scheduled basis. Cardiac Rehab has started a new PI project to test the effectiveness and understanding of the rehab education plan. Data collection started July1 and is being analyzed and reported to the CORE (Quality) Committee by the cardiac rehab nurses.</p> <p>Responsible party: Cardiac Rehab Team Housekeeping has begun a PI project looking at effective and appropriate discharge cleaning and readiness. All discharged rooms will be evaluated by the Environmental Services Coordinator. Data collection started July 1 and is being collected and reported by the ES Coordinator. Data will be reported to the CORE</p>	07/17/2012			

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			<p>Committee.</p> <p>Responsible Party: Environmental Services Coordinator Pediatric Patient Population PI. This PI project looks at every dose of medication ordered for pediatric patients (NB-age 16 yrs) to evaluate that all meds/doses ordered are correct, accurate, and/or adequate for weight. This includes pediatric patients who are treated in ED and in-patient. Data will be collected, analyzed, and reported to the over-sight quality committee by pharmacy department.</p> <p>Responsible party: Pharmacy designee The CNO is the CORE (Quality) Committee Chairperson and oversees the input to the quality committee.</p>	

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S0408	<p>410 IAC 15-1.4-2 QUALITY ASSESSMENT AND IMPROVEMENT 410 IAC 15-1.4-2 (a)(2)(A)(B)(C)(D)</p> <p>(a) The hospital shall have an effective, organized, hospital-wide, comprehensive quality assessment and improvement program in which all areas of the hospital participate. The program shall be ongoing and have a written plan of implementation that evaluates, but is not limited to, the following:</p> <p>(2) All functions, including but not limited to the following:</p> <p>(A) Discharge planning. (B) Infection control. (C) Medication therapy. (D) Response to emergencies as defined in 410 IAC 15-1.5-5(b)(3)(L)(i).</p> <p>Based on document review and interview, the facility failed to include discharge planning in the facility's Quality Assessment and Performance Improvement (QAPI) program.</p> <p>Findings included:</p> <p>1. Review of facility documents on 5-15-12 lacked evidence that discharge planning is included in the facility's QAPI program.</p> <p>2. Interview with B#17 on 5-15-12 at 1405 hours confirmed that discharge planning is not included in the facility's</p>	S0408	Discharge Planning is now a part of the QA/PI program and as such is being reported through the CORE (Quality) meeting on a scheduled basis. 100% of inpatients admitted to the medical surgical floor are assessed for discharge planning needs on admission either by nursing or case management. A referral to case management will be made for discharge planning needs if the assessment shows that patients have assistive or follow-up needs. 100% of all inpatient acute patients will be audited. Collection of data will be done by case management who	07/23/2012			

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	QAPI program.		will analyze and report data to CORE (QI oversight committee) on a bimonthly basis. Responsible Party: Case Managers		

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S0420	<p>410 IAC 15-1.4-2.2 QUALITY ASSESSMENT AND IMPROVEMENT 410 IAC 15-1.4-2.2 (a)(1)</p> <p>Reportable events</p> <p>Sec. 2.2. (a) The hospital's quality assessment and improvement program under section 2 of this rule shall include the following:</p> <p>(1) A process for determining the occurrence of the following reportable events within the hospital:</p> <p>(A) The following surgical events:</p> <p>(i) Surgery performed on the wrong body part, defined as any surgery performed on a body part that is not consistent with the documented informed consent for that patient. Excluded are emergent situations: (AA) that occur in the course of surgery; or (BB) whose exigency precludes obtaining informed consent; or both.</p> <p>(ii) Surgery performed on the wrong patient, defined as any surgery on a patient that is not consistent with the documented informed consent for that patient.</p> <p>(iii) Wrong surgical procedure performed on a patient, defined as any procedure performed on a patient that is not consistent with the documented informed consent for that patient. Excluded are emergent situations: (AA) that occur in the course of surgery; or (BB) whose exigency precludes obtaining informed consent; or both.</p> <p>(iv) Retention of a foreign object in a patient after surgery or other invasive procedure. The following are excluded: (AA) Objects intentionally implanted as part</p>			

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	<p>of a planned intervention.</p> <p>(BB) Objects present before surgery that were intentionally retained.</p> <p>(CC) Objects not present prior to surgery that are intentionally left in when the risk of removal exceeds the risk of retention, such as microneedles or broken screws.</p> <p>(v) Intraoperative or immediately postoperative death in an ASA Class I patient. Included are all ASA Class I patient deaths in situations where anesthesia was administered; the planned surgical procedure may or may not have been carried out.</p> <p>(B) The following product or device events:</p> <p>(i) Patient death or serious disability associated with the use of contaminated drugs, devices, or biologics provided by the hospital. Included are generally detectable contaminants in drugs, devices, or biologics regardless of the source of contamination or product.</p> <p>(ii) Patient death or serious disability associated with the use or function of a device in patient care in which the device is used or functions other than as intended. Included are, but not limited to, the following:</p> <p>(AA) Catheters.</p> <p>(BB) Drains and other specialized tubes.</p> <p>(CC) Infusion pumps.</p> <p>(DD) Ventilators.</p> <p>(iii) Patient death or serious disability associated with intravascular air embolism that occurs while being cared for in the hospital. Excluded are deaths or serious disability associated with neurosurgical procedures known to present a high risk of intravascular air embolism.</p> <p>(C) The following patient protection events:</p> <p>(i) Infant discharged to the wrong person.</p> <p>(ii) Patient death or serious disability</p>			

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	<p>associated with patient elopement.</p> <p>(iii) Patient suicide or attempted suicide resulting in serious disability, while being cared for in the hospital, defined as events that result from patient actions after admission to the hospital. Excluded are deaths resulting from self-inflicted injuries that were the reason for admission to the hospital.</p> <p>(D) The following care management events:</p> <p>(i) Patient death or serious disability associated with a medication error, for example, errors involving the wrong:</p> <p>(AA) drug; (BB) dose; (CC) patient; (DD) time; (EE) rate; (FF) preparation; or (GG) route of administration.</p> <p>Excluded are reasonable differences in clinical judgment on drug selection and dose. Includes administration of a medication to which a patient has a known allergy and drug-drug interactions for which there is known potential for death or serious disability.</p> <p>(ii) Patient death or serious disability associated with a hemolytic reaction due to the administration of ABO/HLA incompatible blood or blood products.</p> <p>(iii) Maternal death or serious disability associated with labor or delivery in a low-risk pregnancy while being cared for in the hospital. Included are events that occur within forty-two (42) days postdelivery. Excluded are deaths from any of the following:</p> <p>(AA) Pulmonary or amniotic fluid embolism. (BB) Acute fatty liver of pregnancy. (CC) Cardiomyopathy.</p> <p>(iv) Patient death or serious disability</p>			

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	<p>associated with hypoglycemia, the onset of which occurs while the patient is being cared for in the hospital.</p> <p>(v) Death or serious disability (kernicterus) associated with the failure to identify and treat hyperbilirubinemia in neonates.</p> <p>(vi) Stage 3 or Stage 4 pressure ulcers acquired after admission to the hospital. Excluded is progression from Stage 2 or Stage 3 if the Stage 2 or Stage 3 pressure ulcer was recognized upon admission or unstageable because of the presence of eschar.</p> <p>(vii) Patient death or serious disability resulting from joint movement therapy performed in the hospital.</p> <p>(viii) Artificial insemination with the wrong donor sperm or wrong egg.</p> <p>(E) The following environmental events:</p> <p>(i) Patient death or serious disability associated with an electric shock while being cared for in the hospital. Excludes events involving planned treatment, such as electrical countershock or elective cardioversion.</p> <p>(ii) Any incident in which a line designated for oxygen or other gas to be delivered to a patient:</p> <p>(AA) contains the wrong gas; or (BB) is contaminated by toxic substances.</p> <p>(iii) Patient death or serious disability associated with a burn incurred from any source while being cared for in the hospital.</p> <p>(iv) Patient death or serious disability associated with a fall while being cared for in the hospital.</p> <p>(v) Patient death or serious disability associated with the use of restraints or bedrails while being cared for in the hospital.</p> <p>(F) The following criminal events:</p> <p>(i) Any instance of care ordered by or</p>			

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	<p>provided by someone impersonating a physician, nurse, pharmacist, or other licensed healthcare provider.</p> <p>(ii) Abduction of a patient of any age.</p> <p>(iii) Sexual assault on a patient within or on the grounds of the hospital.</p> <p>(iv) Death or significant injury of a patient or staff member resulting from a physical assault, that is, battery, that occurs within or on the grounds of the hospital.</p> <p>Based on document review and interview, the facility's Quality Assessment and Performance Improvement Committee (QAPI) failed to include serious adverse events, reportable to the Indiana State Department of Health (ISDH), in the facility QAPI program.</p> <p>Findings included:</p> <ol style="list-style-type: none"> 1. Review of QAPI documents on 5-15-12 lacked evidence that serious adverse events, reportable to the Indiana State Department of Health, were included in the program. 2. Interview with B#17 on 5-15-12 at 1405 hours confirmed serious adverse events, reportable to the Indiana State Department of Health, are not included in the facility's QAPI program. 	S0420	<p>Serious safety events that are reportable to ISDH are now included in the QA/PI program and as such will be discussed at the CORE (Quality) committee meeting on a monthly basis. Serious safety events are reported to CORE (QI oversight committee). Because there has not been a serious event, it was not noted as an agenda item in the CORE minutes. This subject item is being added to the agenda and will be reported monthly as "serious safety events (reportable)" reflected by the agenda and the minutes. Any serious safety event will be discussed as an agenda item at this meeting. Responsible Party: QA Analyst, CNO, Responsible Department Heads</p>	07/19/2012	

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S0554	<p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(a)</p> <p>(a) The hospital shall provide a safe and healthful environment that minimizes infection exposure and risk to patients, health care workers, and visitors.</p> <p>Based on observation and staff interview, the facility failed to provide an environment that minimized risk to patients for 1 surgery department toured.</p> <p>Findings include:</p> <p>1. During tour of the surgery department beginning at 10:35 a.m. on 5/15/12 the following items were observed in the anesthesia cart located in the anesthesia work room: (A) Numerous personal items including, but not limited to, chewing gum, mints, lotion, coins, and mail, were stored with patient care items. (B) The only #2 LMA in the cart had an expiration date of 5/5/12.</p> <p>2. RN #1 verified during observation that the anesthesia cart was the only one at facility and that the personal items were not to be kept in the cart. He/she also indicated that the department did not have an additional #2 AMA available at the time of tour.</p>	S0554	<p>Personal items were removed from the anesthesia cart on the day of the surveyor tour (5/14/12). Anesthesia provider was made aware of finding and was told that he may not keep personal items in the anesthesia cart.</p> <p>Anesthesia provider was given a copy of the Indiana Code for his review, informing him of the infection control issues related to this deficiency. Unannounced checks every week x 4, then monthly to assure that infection control standards are met and that no personal items are placed in this cart. The Surgery Manager is responsible for ensuring compliance with this standard. Surgery does not do emergency pediatric surgery. Therefore, the LMA was removed from the supply cart the day of the survey and is no longer a stock item. Scheduled cases are evaluated for supply needs by a surgical nurse/tech at least one-four days prior to case and if an LMA may be required for safe care, one is delivered to the hospital from the main campus.</p>	05/16/2012			

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S0556	<p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(b)</p> <p>(b) There shall be an active, effective, and written hospital-wide infection control program. Included in this program shall be system designed for the identification, surveillance, investigation, control, and prevention of infections and communicable diseases in patients and health care workers.</p> <p>Based on observation, document review, and interview, the facility failed to have an effective infection control program in 1 of 1 departments (rehabilitation department) and for 3 of 9 personnel records reviewed (BJ# 3, 4, 9).</p> <p>Findings included:</p> <ol style="list-style-type: none"> 1. While touring the rehabilitation department on 5-15-12 with B#6, B#10, B#13, and B#14, it was observed that "Stride Fragrance Free Neutral Cleaner" was being used to clean equipment and table mats between patient use. 2. Review of personnel records on 5-15-12 lacked evidence of varicella immunity for 3 of 9 personnel records reviewed (BJ# 3, 4, 9) 3. Review of the manufacturer's documents for Stride Fragrance Free Neutral Cleaner on 5-15-12 indicated it is not a disinfectant. 	S0556	<p>All cleaning agents in the rehab department have been changed to Dispatch. Dispatch is on the list of approved cleaning products for St. Mary's Warrick and is the only cleaning agent available for use in this department. The Rehab Manager is responsible for making sure that this is the only product being used in this department. The Infection Preventionist will include this item on the rounds checklist.</p> <p>Responsible Party: Rehab ManagerAll records for employee health documentation were reviewed to assess for varicella immunity and reviews were completed June 30,2012. Employees who were not in compliance were contacted (done July 9th) to have documentation completed by the 23rd of July. Employee Health Coordinator at the main campus (St. Mary's Medical Center/Evansville) is responsible for data collection. To ensure future compliance, new hires will be screened for</p>	07/23/2012			

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	<p>4. Review of the hospital approved cleaning products on 5-15-12 did not include Stride Fragrance Free Neutral Cleaner.</p> <p>5. Interview with B#15 on 5-15-12, with B#10 present, confirmed Stride is the only product used in the rehabilitation department to clean equipment and table mats between patients.</p> <p>6. Interview with B#18 on 5-15-12 at 1455 hours confirmed all hospital staff must provide documented proof of immunity to varicella; B#18 confirmed BJ#3, 4, and 9 health records lacked documented proof of immunity to varicella.</p>		<p>varicella immunity and updates will be recorded at the time of hire. The Employee Health Coordinator at the main campus is responsible for data completion. Responsible Party: Employee Health Manager</p>		

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S0932	<p>410 IAC 15-1.5-6 NURSING SERVICE 410 IAC 15-1.5-6 (b)(4)</p> <p>(b) The nursing service shall have the following:</p> <p>(4) The nursing staff shall develop and utilize an ongoing individualized plan of care based on standards of care for each patient.</p> <p>Based on document review and staff interview, the facility failed to maintain an individualized care plan that included interventions to reach stated goals for 7 care plans reviewed.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Closed medical record care plans for patients #N2, N3, N6, N8, N9 and open medical record care plan for patient #N21 lacked documentation of interventions to reach stated goals. Additionally, the care plan/treatment plan for patient #N21 failed to specify the frequency of each treatment intervention and list the person/persons responsible per policy. 2. Open medical record for patient #N20 (admitted 5/14/12) lacked documentation of any care plan. 3. Facility policy titled "TREATMENT PLANNING PROCESS" last reviewed/revised 1/11 states on page 1, 	S0932	<p>Immediately following the 5/15/12 survey, the CNO took the electronic care planning module off-line and directed a return to the previously used manual format. (attached). A weekly survey of care plan completion will be done to ensure that care plans are complete, relevant and comprehensive, implemented with appropriate interventions, evaluated and current. The results of this survey will be reported to CORE (Quality) on a scheduled basis.</p> <p>Responsible Person(s): Nurse Managers A complete overhaul of the Nursing Care plan on-line document has begun and will not be uploaded for use until all care plan requirements are available for integrated documentation. Actions/interventions, short term goals, long-term goals, outcomes, and persons responsible for implementation are easy to document and view as a patient care team. Meetings are held bi-weekly with the Clinical IT team.Responsible Parties for On-line implementation: Nurse</p>	07/23/2012			

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	<p>under policy: "5. Treatment plans specify the frequency of each treatment intervention/procedure and name the disciplines and persons responsible for interventions."</p> <p>4. Staff members #2 and #5 verified the above in interview at 4:00 p.m. on 5/15/12.</p>		Managers, IT Clinical team members		

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S0952	<p>410 IAC 15-1.5-6 NURSING SERVICE 410 IAC 15-1.5-6(d)</p> <p>(d) Blood transfusions and intravenous medications shall be administered in accordance with state law and approved medical staff policies and procedures. If the blood transfusions and intravenous medications are administered by personnel other than physicians, the personnel shall have special training for these procedures in accordance with subsection (b)(6).</p> <p>Based on blood transfusion policy review, transfusion document chart reviews and staff interview, the hospital failed to administer blood transfusions in accordance with approved medical staff policies and procedure for three of ten patients.</p> <p>Findings include:</p> <p>1. On 5/14/12 at 1:30 p.m., the policy, "Administration of Blood Components", reviewed 5/14/12, read:</p> <p>"Record the patient's pre-transfusion temperature, pulse, and blood pressure on the Crossmatch Transfusion Report</p>	S0952	<p>All administering employees were given education and required to read the policy "Administration of Blood and Components" and signed that they understood the requirements of timing in regard to blood transfusion vital signs documentation. All blood transfusion slips are reviewed with each administering staff member and documentation will be recorded and kept in the employee's record. Compliance with this regulation will also become a part of the QI data collection and reporting.</p> <p>Responsible Party: Collection of this data will be done by the lab manager and nurse manager and will be reported at the CORE (QA oversight committee) meeting. Responsible Party(s): Lab Manager, Nurse Managers</p>	07/23/2012			

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	<p>within 30 minutes prior to the transfusion</p> <p>After the first 15 minutes, the vital signs should be taken.</p> <p>Check vital signs at completion and one hour after transfusion is completed."</p> <p>2. On 5/14/12 at 1:45 p.m., review of three patients receiving blood units indicated that four of these received-units did not have complete documentation, per policy, on the Crossmatch Transfusion Report form including:</p> <p>Patient #3 --Unit administered on 4/11/12 at 0750: The unit was started at 0750 and 15 minute vitals were documented at 0810 which was 20 minutes in lieu of 15 minutes. --Unit administered on 4/12/12 at 2145: The unit was completed at 1015 and the 1 hour vitals were documented at 1050 which was 45 minutes in lieu of 1 hour.</p> <p>Patient #5</p>						

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	<p>--Unit administered on 4/05/12 at 0920: The pretransfusion vitals were documented at 0840 and the unit started at 0920 which was at 40 minutes in lieu of before 30 minutes.</p> <p>Patient #8</p> <p>--Unit administered on 3/15/12 at 0305: The pretransfusion vitals were documented at 00230 and the unit started at 0305 which was at 35 minutes in lieu of before 30 minutes.</p> <p>3. On 5/14/12 at 2:15 p.m., staff member #5 acknowledged that the above-listed patient blood unit Crossmatch Transfusion report forms had not been documented, per policy, as required.</p>			

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S1162	<p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8(d)(2)(A)</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>(A) All mechanical equipment (pneumatic, electric, or other) shall be on a documented maintenance schedule of appropriate frequency and with the manufacturer's recommended maintenance schedule.</p> <p>A. Based upon manufacturer's recommendations and staff interview, the laboratory failed to document initial rotations per minute (rpm) testing for three of eight centrifuges used for patient testing, by the staff or per manufacturer.</p> <p>Findings included:</p> <p>1. On 5/15/12 at 10:45</p>	S1162	<p>The Laboratory has revised the listing of centrifuges and procedures to be done by our testing company, Trimedx. Trimedx performs the rpm and timer checks while the Lab manager is present. The Centrifuge/Timer report sheet is then given to the Lab manager after the procedures are completed. The Lab manager reviews the sheet and if all centrifuges and timers are within acceptable ranges, a copy is made for Trimedx. This ensures that the process is performed completely and both the lab and Trimedx have a copy of the process. The lab manager is responsible to see that this process is completed and documented accordingly. These tests will be performed quarterly by Trimedx</p>	07/23/2012
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	<p>a.m., review of the following centrifugation polices included:</p> <p>a. The policy, Microscopic Examination of the Urine, revised 1/11, used to spin down urine specimens in the Labofuge A centrifuge, read: "Centrifuge tubes for 5 minutes at 1500 rpm"</p> <p>b. The policy, Coagulation Test- PT and APTT (Prothrombin Time Test and Activated Partial Thromboplastic Time), adapted 5/04/11, used to spin down blood for PT and APTT specimens in both the Jouan B412 and State 60 centrifuges, read: "Centrifuge at 3700 rpm for 10 minutes in the Jouan centrifuge or with the STD setting on the Stat 60 centrifuge."</p> <p>2. Upon request on 5/15/12 at 11:00 a.m.,</p>		<p>and overseen by the Lab Manager, who is responsible for ensuring the testing cycle timing. The recorded warm and cold tests were not distinct enough in proving that the test being done was a deliberate test. The recommendation was that the test period be prolonged so that the recorded line would reveal a designated manual test had been done and recorded and that the machine did not show it as a possible accidental occurrence record. Lab has increased the testing time which has ensured a longer and distinct line on the testing wheel. The line is pronounced enough to show it as being deliberate. Responsible Party: The Lab manager is responsible for ensuring the correct process of increasing testing time and monitoring both warm and cold testing procedures.</p>		

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	<p>staff member #8 conferred that there was no documentation for either rpm or timer testing to indicate the above- listed centrifuges used for spinning down urine and blood specimens had been checked and tested for compliance with their respective policy.</p> <p>B. Based upon document review and staff interview, the laboratory failed to document preventative maintenance of its recording thermometer and alarm, used in blood bank to monitor required temperatures of its blood units, for three of three regular time periods.</p> <p>Finding(s) included:</p> <p>1. On 5/15/12 at 11:15 a.m., review of the policy,</p>			

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	<p>"Blood Storage", revised 3/07, read:</p> <p>"A recording thermometer with audible and/or visual alarm is required. The temperature must remain between 1 degree Centigrade (C) and 6 degrees C.</p> <p>The recording thermometer and alarms should be checked regularly.</p> <p>2. On 5/15/12 at 11:15 a.m., review of the Blood Bank Alarm Check</p> <p>Schedule read:</p> <table border="0"> <tr> <td>Month</td> <td>Week</td> <td>Temp/Check</td> <td></td> </tr> <tr> <td>Initials/Date</td> <td>Temperature</td> <td></td> <td></td> </tr> <tr> <td>February 3rd</td> <td>Cold</td> <td></td> <td>HL</td> </tr> <tr> <td>2/28/12</td> <td>1.4</td> <td></td> <td></td> </tr> <tr> <td>March 3rd</td> <td>Cold</td> <td></td> <td>VM</td> </tr> <tr> <td>3/19/12</td> <td>1.5</td> <td></td> <td></td> </tr> <tr> <td>April 3rd</td> <td>Cold</td> <td></td> <td>NJ</td> </tr> <tr> <td>4/19/12</td> <td>1.6</td> <td></td> <td></td> </tr> </table> <p>3. On 5/15/12 at 11:20 a.m., review of the Blood Bank</p>	Month	Week	Temp/Check		Initials/Date	Temperature			February 3rd	Cold		HL	2/28/12	1.4			March 3rd	Cold		VM	3/19/12	1.5			April 3rd	Cold		NJ	4/19/12	1.6					
Month	Week	Temp/Check																																		
Initials/Date	Temperature																																			
February 3rd	Cold		HL																																	
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4/19/12	1.6																																			

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	<p>recorder wheels failed to indicate the recorder had registered each of the above- listed (1.4, 1.5, & 1.6) cold degree temperature readings.</p> <p>4. On 5/15/12 at 11:30 a.m., staff member #8 acknowledged that the blood bank wheels had no recorder documentation of the cold temperature readings listed above.</p>			
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