

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150058	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/22/2011
NAME OF PROVIDER OR SUPPLIER MEMORIAL HOSPITAL OF SOUTH BEND			STREET ADDRESS, CITY, STATE, ZIP CODE 615 N MICHIGAN ST SOUTH BEND, IN46601		
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S0000	<p>This visit was for a standard licensure survey.</p> <p>Facility Number: 005053</p> <p>Survey Date: 09/19-22/2011</p> <p>Surveyors: ReBecca Lair, LCSW Medical Surveyor</p> <p>Jacqueline Brown, RN Public Health Nurse Surveyor</p> <p>Lynnette Smith Laboratorian/Medical Surveyor</p> <p>Linda Plummer, RN Public Health Nurse Surveyor</p> <p>QA: claughlin 10/06/11</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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S0178	<p>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 on observation, the facility failed to post the hospital license in an area conspicuous and open to patients and the public in 2 instances.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. On September 21, 2011 at 10am, in the presence of Employee #A1 and Employee #A16, at the Navarre Radiology offsite area of the facility, it was observed that the hospital license was posted in a hallway area through a doorway and away from the patient receiving area. 2. On September 21, 2011 at 10:15am, in the presence of Employee #A1 and Employee #A17, at the Breast Care Center offsite area of the facility, it was observed that there was no posting of the hospital license. 	S0178	S178 License has been posted in 100 Navarre Radiology and The Breast Care Center. Risk Manager Director will assure that all areas listed on license have license posted in public.	09/22/2011			

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S0330	<p>410 IAC 15-1.4-1(c)(6)(K)</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: (K) Maintaining personnel records for each employee of the hospital which include personal data, education and experience, evidence of participation in job related educational activities, and records of employees which relate to post offer and subsequent physical examinations, immunizations, and tuberculin tests or chest x-ray, as applicable.</p> <p>Based on review of personnel policies and procedures, post offer physical examination records and staff interview, the governing board failed to ensure post offer physicals were performed by a licensed practitioner for 4 of 5 personnel records reviewed.</p> <p>Findings included:</p> <p>1. Review of personnel policies and procedures on 9-22-11 between 10:45 AM and 11:00 AM revealed a policy titled: "Post Job Offer Physical", policy number unknown, last revised on "05/01/2009",</p>	S0330	<p>S330 The post job offer physical policy is being reviewed and revisions will be made based upon final recommendation from the Medical Director of Occupational Health and the Infection Control Committee. Additionally, all licensed staff will be re-educated on all changes to the policy and procedure by November 15, 2011. Director of HR will monitor compliance. 11-14-11ADDENDUM: COMPLIANCE WITH POLICY AND PROCEDURE WILL BE MONITORED BY THE DIRECTOR OF HUMAN RESOURCES. THE DIRECTOR WILL REVIEW ALL JOB</p>	11/30/2011

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	<p>which did not indicate who performs a post offer physical.</p> <p>2. Review of employee post offer physical examinations records revealed the following:</p> <p>a. A place on the "Memorial Occupational Physical Examination" post offer physical form read: "Signature of Examining Physician".</p> <p>b. The "examining physician" did not sign the "Memorial Occupation Physical Examination" for for the following employees: "Staff Member #L11 (hire date 7-15-10); Staff Member #L17 (hire date 4-21-09); Staff Member #L18 (hire date 10-8-09); and Staff Member #L20 (hire date 4-26-10).</p> <p>3. In interview of 9-21-11 between 12:54 PM and 4:15 PM, Staff Member #L32 acknowledged the above findings.</p>		<p>OFFERS TO DETERMINE PRESENCE OF POST JOB OFFER PHYSICAL HAVING TAKEN PLACE AND BEING SIGNED BY A LICENSED PHYSICIAN. THE DIRECTOR WILL MONITOR ALL PHYSICALS FOR THE NEXT 3 MONTHS OR UNTIL SATISFIED THAT WE ARE IN COMPLIANCE 100%. IF NECESSARY THE HR DIRECTOR WILL DO RANDOM SAMPLING OF AT LEAST 10% OF POST JOB OFFERS TO ASSURE COMPLINACE. laCK OF COMPLIANCE WILL BE REPORTED TO THE COO OF THE HEALTH SYTEM RESPONSIBLE FOR HR.</p>		

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S0332	<p>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, patient medical record review, personnel file review and staff interview, the governing board failed to ensure that two security officers were competent in CPI (crisis prevention intervention) prior to participating in an ESI (emergency safety intervention) for 1 gero psych patient (pt. N8).</p> <p>Findings: 1. At 11:45 AM on 9/22/11, review of the policy "Therapeutic Physical Management Procedures (TPM)", indicated: a. under "Purpose", it read: "To provide various descriptions of the various safe and therapeutic methods of physically managing an aggressive/combatative patient." b. under "Procedure", it read: "While there may be other methods of physically</p>	S0332	<p>S332 CPI training was previously scheduled and took place on Sept 22, Sept 29, October 3, October 20 and will take place on October 27. All security officers have been certified. In addition the Director of Security and a second instructor are scheduled for train the trainer classes on CPI for autistic patients and geriatric patients and staff working on the Behavioral health units will have appropriate additional training. All staff currently have an 8 hour CPI class. Director of Security is responsible for monitoring CPI certification and renewal for security officers. 11-14-11 ADDENDUM: CHIEF SAFETY OFFICER CONFIRMED THAT ALL OFFICERS CURRENTLY HIRED HAVE BEEN CPI CERTIFIED. THE DIRECTOR OF SECURITY WILL REPORT TO THE CSO UPON EVERY NEW HIRE THAT CPI CERTIFICATION HAS</p>	10/20/2011	

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	<p>managing patients, the procedures described in this document are known to be both effective and safe and are the only techniques approved for use for adult units at Memorial Hospital...this procedure is to be used only after appropriate education, including demonstration and practice in using Physical Management Procedures."</p> <p>2. At 12:00 PM on 9/22/11, review of the "Restraint and Seclusion" policy dated effective 7/11/11 indicated:</p> <p>a. in the section titled: "CPI - Crisis Intervention", it read: "Nonviolent Crisis Intervention is a type of physical restraint used in emergency situations...It is addressed in the Nonviolent Crisis Intervention Training Program and only practiced by persons trained in these activities."</p> <p>b. in the section titled "Behavioral Restraint", "Staffing and Staff Competence", it read: "Staff members who restrain or provide care to restrained patients have been trained to do so..."</p> <p>3. At 9:30 AM on 9/21/11, review of the medical record for one gero psych patient, N8, indicated:</p> <p>a. an order for a "physical hold" was written by nursing staff at 2110 hours on 9/20/11</p>		<p>BEEN COMPLETED. THE DIRECTOR OF SECURITY WILL ALSO PROVIDE THE CSO WITH A CURRENT LIST OF ALL SECURITY OFFICERS AND THE DATE OF THEIR CPI CERTIFICATION EXPIRATION. CPI CERTIFICATION EXPIRATION DATE WILL BE ADDED TO ACTIVE STAFFER SYSTEM WHICH IS OUR ELECTRONIC STAFFING AND SCHEDULING SYSTEM. THE SYSTEM SENDS AN ALERT PRIOR TO EXPIRATION OF CERTIFICATION OR LICENSE. THIS WILL ALLOW FOR AUTOMATIC NOTIFICATION FAR ENOUGH IN ADVANCE TO SCHEDULE RECERTIFICATION. THE DIRECTOR OF SECURITY WILL MONITOR THIS STANDARD MONTHLY AND REPORT TO THE CHIEF SAFETY OFFICER.</p>		

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	<p>b. the "R&S Staff Debriefing Record" form, page 1, listed security staff members P6 and P7 as "involved in the "Restraint/Seclusion" event.</p> <p>c. on the "R&S Staff Debriefing Record" form, in the section "Staff Responsible (specific)", it read: "...[P6] held upper torso steady, [P7] held legs steady..."</p> <p>4. At 10:45 AM on 9/22/11, review of the personnel files for staff members P6 and P7 indicated:</p> <p>a. the job description for a security officer states that these staff members may:</p> <p>A. need to respond to: "...duress alarms...and patient behavioral health related requests for assistance." (in the "Essential Functions" section)</p> <p>B. these staff members are required to have "...the physical ability and stamina (i.e., to stand...climb stairs, restrain individuals,...to perform the essential functions of the position." (in the "Knowledge, Skills, and Abilities" section)</p> <p>b. staff member P6 was hired 8/12/11 and lacked any documentation of training in restraint, CPI, Nonviolent Crisis Intervention, or Therapeutic Physical Management Procedures, as stated in the policies in 1. and 2. above</p> <p>c. staff member P7 was hired 2/5/96 and</p>				

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	<p>had documentation of CPI training that was dated 10/19/09 (and expired in 2010), and lacked any documentaiton of training related to restraints</p> <p>5. Interview at 10:00 AM on 9/21/11 with staff member NC indicated:</p> <ul style="list-style-type: none"> a. security officers respond to requests for assistance in restraining psych patients c. security officers are all trained in CPI prior to participating in ESI events <p>6. Interview at 12:45 PM on 9/22/11 with staff members NA and NP indicated:</p> <ul style="list-style-type: none"> a. no recent training in CPI could be found for staff member P7 b. no training in CPI could be found for staff member P6 c. the next CPI training is scheduled for 10/14/11 d. the security officer job description does not address restraint and/or CPI training as required prior to assisting with an ESI, as the policies listed in 1. and 2. above indicate are required e. the policies listed in 1. and 2. above are in conflict with the type of restraint education that will be required of staff in the use of restraint for facility patients f. according to the policies listed on 1. and 2. above, the security officers were not trained to assist in the ESI of 9/20/11 			

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S0362	<p>410 IAC 15-1.4-1(d)(6)(A)(B)(C)(D)(E)(F)</p> <p>(d) The governing board is responsible for assuring that quality patient care is provided. In accordance with hospital policy, the governing board shall do the following:</p> <p>6) Ensure that the hospital does the following:</p> <p>(A) Establish written protocols to identify potential organ and tissue donors.</p> <p>(B) Has written policies and procedures for the facilitation of organ and tissue donations, including procurement.</p> <p>(C) Inform families or authorized persons of potential organ and tissue donors of the option of donation on admission or at the time of death of a potential donor.</p> <p>(D) Use discretion and sensitivity in contacts with potential organ donor families.</p> <p>(E) Notify the appropriate procurement organization of potential organ donors.</p> <p>(F) Establish membership in the organ procurement and transplantation network if the hospital performs transplants.</p> <p>Based on document review and interview, the facility failed to notify the appropriate organ procurement organization, per contract, of all hospital deaths. Thus the facility failed to notify procurement organization of potential</p>	S0362	S362 The one case that was not reported in a timely manner was a trauma patient who died in the operating room. Memorial has a stellar record with IOPO and has been recognized nationally for our conversion rate. We train dozens of staff each year	10/14/2011			

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	<p>organ donors.</p> <p>Findings:</p> <p>1. Review of the contract between the hospital and the Indiana Organ Procurement Organization indicated the "Hospital shall provide Timely Referral to IOPO as soon as possible of every individual whose death is imminent or who has died (including calling prior to the time Brain Death is declared), in the Hospital. "</p> <p>2. Review of the Donation Activity Report for June 2010 indicated 40 deaths occurred and only 39 deaths were reported. Thus the hospital failed to show evidence that all deaths are reported.</p> <p>3. Employee #A3 was interviewed on September 20, 2011 at 2:15pm and verified the IOPA contract documentation and the June 2010 reporting data.</p>		<p>including physicians, social workers, nurses, and chaplains who take a class developed with IOPO for designated requestors. We have a team that meets monthly with IOPO and the Indiana Lion's Eye Bank to review every death and to assure that we are exceeding benchmarks and state requirements. This case was highly unusual. Our policy and procedure are sound. In the rare event when notification is not timely we perform an in depth analysis to determine any corrective action that can be taken. This was a human error under extreme circumstances. Our staff were re-educated at the time we discovered the variance. We will continue our current policy and have shared with leadership the request to remind all staff of our policy and procedure. 11-14-11 ADDENDUM THIS CASE WAS SELF REPORTED BY THE HOSPITAL TO IOPO INITIALLY. AT THE TIME WE REVIEWED THE ROOT CAUSE OF THE SYSTEM FAILURE AND REMINDED ALL STAFF OF THE REQUIREMENT. THE TRAUMA TEAM WAS RE-EDUCATED TO ASSURE PREVENTION OF FURTHER FAILURES TO NOTIFY. WE HAVE HAD NO FAILURES TO NOTIFY SINCE THIS INCIDENT. THE MONTHLY REPORT GOES TO THE CNO</p>		

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S0390	<p>410 IAC 15-1.4-1(f)(1)</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>(1) That a contractor of any service furnishes those services in such a manner as to permit the hospital to comply with all applicable statutes and rules.</p> <p>Based on document review and staff interview, the facility failed to demonstrate quality monitor indicators for 3 (Laundry/Linen, Renal Dialysis and Mobile Services) of 8 contracted services.</p> <p>Findings:</p> <p>1. Upon document review of the hospital quality monitor indicators on September 22, 2011 at 12pm, three contracted services were not included in the quality monitor: Laundry/Linen; Renal Dialysis; and Mobile Services.</p> <p>2. Interview with Employee #A1,</p>	S0390	<p>WHO IS RESPONSIBLE FOR COMPLIANCE.</p> <p>S390 The contracts for Linen/Laundry, Renal Dialysis and Mobile Services will be added to our annual review of contracts to be reviewed by the Hospital Quality Committee and Medical Executive Committee. Director of Quality Management is responsible to place for regular review on the appropriate agendas. Linen and Renal Linen Linen and Renal Dialysis issues are currently reported to Infection Control. Our plan is to add them to Hospital Quality for review as well beginning with the November meeting. ADDENDUM: THE DIRECTOR OF QUALITY MANAGEMENT IS RESPONSIBLE FOR THE PALN OF CORRECTION AND FOR ASSURING THAT ALL CONTRACTS ARE ON THE APPROPRIATE AGENDAS FOR REVIEW.</p>	11/30/2011
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S0598	<p>Employee #7 and Employee #18 on September 22, 2011 at 12pm verified these findings.</p> <p>410 IAC 15-1.5-2(f)(3)(D)(iv)</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>(iv) Aseptic technique, invasive procedures, and equipment usage. Based on policy and procedure review, observation, and interview, the infection control practitioner failed to implement its policy related to surgical attire for 6 staff members observed.</p> <p>Findings: 1. At 5:20 PM on 9/19/11, review of the policy "Surgical Attire", with an approval date of 5/27/2009, indicated: a. under "Purpose", it read: "Surgical attire is one facet of environmental control and is worn to promote high-level cleanliness and hygiene within the surgical environment."</p>	S0598	S598 The scrub policy addressing surgical attire was redistributed to all management, leadership and education staff. Reviews of the policy are underway and required to be completed at staff meetings with support from educators and Infection Prevention no later than November 15, 2011. All staff are expected to provide peer feedback when they observe fellow staff out of compliance. Managers are expected to take appropriate corrective action when observing staff out of compliance. Infection Prevention will do regular/random	10/22/2011

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	<p>b. under "Procedure", it read in item g.: "Surgical masks should cover the mouth and nose...Masks are either on or off. They are not be saved by hanging around the neck or tucking into a pocket for future use..."</p> <p>2. During 9/19/11 to 9/22/11, it was observed:</p> <p>a. at 12 PM on 9/19/11, in the facility first floor main lobby area, a staff member in surgical scrubs with a surgical mask dangling about the neck</p> <p>b. at 12:45 PM on 9/19/11, in the first floor area near the gift shop, a staff member in surgical scrubs with a surgical mask dangling about the neck</p> <p>c. at 9:25 AM on 9/20/11, a radiology technician in the OR (operating room) semi restricted hallway, entering and exiting surgery suites with a surgical mask dangling about the neck</p> <p>d. at 9:45 AM on 9/20/11, 2 staff members in the OR semi restricted hallway, entering and exiting surgery suites with a surgical mask dangling about the neck</p> <p>e. at 12:30 PM on 9/20/11, in the facility first floor cafeteria, a radiology technician with a surgical mask dangling about the neck</p> <p>3. Interview with staff member NM at 9:30 AM on 9/20/11, while on tour of the</p>		<p>observations of staff and report to the Infection Control Committee and appropriate leadership.</p>		

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S0606	<p>surgical area, indicated:</p> <p>a. hospital policy requires surgical staff to remove surgical masks after exiting the OR suite, they are not to be worn dangling about the neck</p> <p>b. staff were noted to have surgical masks dangling about the neck in the semi restricted hallway in the presence of this staff member</p> <p>410 IAC 15-1.5-2(f)(3)(D)(viii)</p> <p>(f) The hospital shall establish an infection control committee to monitor and guide the infection control program in the facility as follows: (3) The infection control committee responsibilities shall include, but not be limited to, the following: (D) Reviewing and recommending changes in procedures, policies, and programs which are pertinent to infection control. These include, but are not limited to, the following:</p> <p>(viii) An employee health program to determine the communicable disease history of new personnel as required by state and federal agencies. Based on manufacturer's recommendation review, personnel health file review, CDC (centers for disease control and prevention) document review, American Thoracic Society document review, and staff interview, the infection control committee failed to ensure the reading of</p>	S0606	S606 We reviewed our current policy with the Medical Director of Infectious Diseases and other members of our Infection Control Committee in the matter of TB skin tests and how they are documented. We believe our policy stating tests are administered and read within 2-3	10/03/2011

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	<p>TB (tuberculosis) Mantoux tests per standards of practice and professional recommendations for 3 of 4 traveler nurses (P1, P2, and P4) and for 3 staff files reviewed by the medical surveyor (L11, L20 and L23). The infection control committee also failed to ensure that another traveling nurse was immune for Varicella (P3).</p> <p>Findings:</p> <p>1. Review of the document "Diagnostic Standards and Classification of Tuberculosis in Adults and Children"...the "Official Statement of the American Thoracic society and the Centers for Disease Control and Prevention" dated September 1999 indicated:</p> <p>a. in section VI. "Tuberculin Skin Test" in the area of "C. Administration and Reading of Tests", it read: "...Tests should be read between 48 and 72 h after injection when the induration is maximum..."</p> <p>2. Review of the MMWR (Morbidity and Mortality Weekly Report) dated December 30, 2005, titled "Guidelines for Preventing the Transmission of Mycobacterium tuberculosis..., 2005" indicated on page 81 in the FAQ (frequently asked questions) section:</p> <p>a. "If a person does not return for a TST (tuberculin skin test) reading within 48-72</p>		<p>working days of administration meets the requirement and is not the strength of any TB prevention program. Our strength lies in our annual gathering of information of latent and active TB cases from St. Joseph County, and our surrounding counties in both Indiana and Michigan. This allows us the opportunity to determine risk of TB disease and possible exposures for our staff and patients. We have a strong isolation program for respiratory disease symptoms and in the last five years have not had any skin conversions in any post exposure follow up. Two to three days falls within the 48-72 hours and we do not exceed 3 days in reading TST. Our plan is to continue to monitor our outcomes, review our policy and procedure periodically and make changes if needed. Medical Director of Infectious Diseases and Infection Control Practitioner are responsible for ongoing monitoring. 11-14-11 ADDENDUM EFFECTIVE IMMEDIATELY WE HAVE REVISED OUR FORM TO INCLUDE BOTH THE DATE AND TIME OF THE READING OF RESULTS OF TB TESTS. THE INFECTION CONTROL PRACTITIONER IS RESPONSIBLE FOR ASSURING THIS STANDARD IS MET. SHE WILL MONITOR IN COLLABORATION WITH EMPLOYEE HEALTH DEPT.</p>		

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	<p>hours, when can a TST be placed on them again?"---"...If the second step of a two-step TST is not read within 48-72 hours, administer a third test as soon as possible...and ensure that the result is read within 48-72 hours."</p> <p>3. At 4:15 PM on 9/21/11, review of the product literature by the manufacturer of Aplisol (the product used for TSTs at the facility), indicated:</p> <p>a. in the section "Standard Method (Mantoux Test)", it read: "...The result is read 48 to 72 hours later..."</p> <p>b. in the section "Interpretation of Tuberculin Reaction", it read: "Readings of Mantoux reactions should be made by a trained health professional during the period from 48 to 72 hours after the injection..."</p> <p>4. Review of employee health files during 9/19/11 to 9/22/11 indicated:</p> <p>a. staff member P1 was a traveling nurse who was hired 7/13/11 and:</p> <p>A. had a first step TST done previously on 10/13/10 and read 10/09/09 (actual date on form) that was lacking a time given and a time read to determine if read between 48 and 72 hours</p> <p>B. had a second step TST done on 11/5/10 and read on 11/8/10 that was lacking a time given and a time read to determine if read between 48 and 72</p>		NON COMPLIANCE WILL BE REPORTED TO THE COO OF THE SYSTEM WHO IS THE EXECUTIVE RESPONSIBLE FOR EMPLOYEE HEALTH.		

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	<p>hours</p> <p>b. staff member P2 was hired 5/2/11 and was given a TST on 5/2/11 that was read on 5/5/11 and was lacking a time given and a time read to determine if read between 48 and 72 hours</p> <p>c. staff member P4 was hired 4/25/11 and was given a TST on 4/25/11 that was read on 4/27/11 that was lacking a time given and a time read to determine if read between 48 and 72 hours</p> <p>d. staff member P3 was a traveling nurse hired 5/2/11 who had a self reported history of Varicella in the employee health file</p> <p>5. Review of personnel records between 1:30 PM and 4:15 PM on 9/21/11 and between 11:00 AM and 12:45 PM on 9/22/11 indicated:</p> <p>a. staff member L11 was given a TB test on 9/27/10 but lacked a time of the test for either giving or reading the test to indicate reading between 48 and 72 hours</p> <p>b. staff member L20 was given TB tests on 4/8/10 and 6/11/10 and was lacking a time given and a time read to determine the tests were read between 48 and 72 hours</p> <p>c. staff member L23 was given a TB test on 10/19/10 that was lacking a time of the test for either giving or reading the test to indicate reading between 48 and 72 hours</p>				

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S0744	<p>6. Interview with staff member NO at 3:00 PM on 9/20/11 indicated:</p> <p>a. the facility was cited in 2008 by ISDH (Indiana State Department of Health) for lacking the time given and the time read for TSTs and the infection control committee decided to change the policy to read that it was OK to read these tests in 2 to 3 business days rather than to follow the manufacturer's recommendations, the MMWR/CDC recommendations, and the standard of practice for reading TSTs in 48 to 72 hours post injection</p> <p>b. per facility policy, staff member P3 should have had a titer showing immunity, not a self reported history of Varicella disease</p> <p>410 IAC 15-1.5-4 (e)(1)</p> <p>(e) All entries in the medical record shall be:</p> <p>(1) legible and complete; Based on review of medical staff rules and regulations, policy and procedure review and patient medical record review, the facility failed to ensure that medical records were legible and complete for 4 of 9 patient records reviewed (pts. N2, N4, N6 and N9).</p>	S0744	S744 The ECC staff are being re-educated on the appropriate completion of Patient Transfer Authorization. Director will monitor for ongoing compliance. All nursing staff will be re-educated on the appropriate process for noting errors in documentation. This re-education will take place at	10/22/2011

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	<p>Findings:</p> <p>1. At 5:20 PM on 9/19/11, review of the Medical Staff Rules and Regulations indicated:</p> <p>a. on page 11 under section "3. Authentication:", it read: "The parts of the medical record that are the responsibility of the practitioner must be legible, complete, dated, timed, and authenticated promptly in written or electronic form by the practitioner."</p> <p>2. At 5:00 PM on 9/21/11, review of the policy "Security, Confidentiality, and Training Related to Patient Health Information", indicated:</p> <p>a. on page 3 under section "H. Other Security Measures", it read: "1. Error Correction: Paper medical records...If a staff member makes an error when recording information, the error should be corrected in the following matter: A single line should be made through the incorrect entry. The word "error" should be entered above the lined out data. The initials of the person making the entry and the date the correction was made should be entered in the nearest margin. Document the correct information with the current date and time..."</p> <p>3. Review of open and closed patient medical records throughout 9/19/11 to 9/22/11 indicated:</p>		<p>Nursing Shared Governance nursing councils and at unit meetings. All staff and physicians are being reminded of the importance of legible documentation. Quarterly chart audits are conducted and feedback is provided to all managers to assure 1:1 feedback is carried out with both staff and physicians who are identified to be non compliant with polices and procedures related to documentation. CNO, CMO, and Director of Records Management share responsibility for this standard. All nursing staff will be re-educated no later than November 25. Medical staff will be reminded in the monthly medical staff newsletter, e-mail and monthly or quarterly department meetings. Results of the ISDOH survey are also shared at MEC and Hospital Quality and Board Committees.</p> <p>11-14-11 ADDENDUM EFFECTIVE 11-15-11 ALL HOSPITAL PHYSICIANS WILL BE ENTERING ORDERS ON THE CERNER ELECTRONIC MEDICAL RECORD. THIS MEANS ALL ORDERS AND RECORDS COMPLETED WILL BE AUTOMATICALLY DATED AND TIMED STAMPED BY THE ELECTRONIC MEDICAL RECORD SYSTEM. THE DIRECTOR OF RECORDS MANAGMENT IS ULTIMATELY RESPONSIBLE FOR MONITORING COMPLIANCE</p>	

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	<p>a. pt. N2 had a notation by nursing staff on the "ECC (emergency care center) Narrative Notes" form in the "narrative" section that is crossed out two times and lacked any other notations as required in the policy listed in 2. above</p> <p>b. pt. N4:</p> <p>A. lacked completion of the "Physician Order Sheet" on page 1 of "Patient Transfer Authorization" in the areas of: Physician name; Medical Benefits; and Medical Risks</p> <p>B. lacked completion of the "Patient Consent/Refusal/Request To Be Transferred" form in the areas of: Physician (advising transfer) and risks and benefits of the transfer</p> <p>C. had two areas of obliteration of practitioner notes in the "Physician Assessment" section of the "ECC Patient Care Record" form</p> <p>c. pt. N6 had an order written on the "Physician Order Sheet" that is crossed out, but lacks other notations as required by the policy noted in 2. above</p> <p>d. pt. N9 lacked legibility of the following notations made on the "Anesthesia Graphic Record" form as follows: on page one: illegible notations in the top portion of the page titled "Post - operative anesthesia notes"; and on page 2: patient's name at the top of the page; notes made at the bottom of the page in the notes section</p>		WITH THIS STANDARD.		

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S0748	<p>410 IAC 15-1.5-4 (e)(3)</p> <p>(e) All entries in the medical record shall be:</p> <p>(3) authenticated and dated promptly in accordance with subsection (c)(3). Based on review of medical staff rules and regulations and patient medical record review, the facility failed to ensure that authentication of medical records by practitioners included the time of authentication for 1 closed pediatric pt. record (N1), 1 closed ICU (intensive care unit) pt. record (N6), and 1 newborn pt. record (N10).</p> <p>Findings:</p> <p>1. At 5:20 PM on 9/19/11, review of the Medical Staff Rules and Regulations indicated:</p> <p>a. on page 11 under section "3. Authentication:", it read: "The parts of the medical record that are the responsibility of the practitioner must be legible, complete, dated, timed, and authenticated promptly in written or electronic form by the practitioner."</p> <p>2. Review of open and closed patient medical records through out the survey process of 9/19/11 to 9/22/11 indicated:</p> <p>a. pt. N1 had a hand written history and physical performed by both a resident and</p>	S0748	<p>S748 In November 600 medical staff members will be going live on Cerner electronic documentation. Dating and timing of medical record entries will be automatic. Meanwhile we are continuing to educate the all staff and physicians of the importance and necessity for dating and timing all entries. Most paper forms have been revised to include lines for both date and time. Re-education on dating and timing of written notes is also included in the education mentioned above in tag S744. ADDENDUM EFFECTIVE NOVEMBER 15 ALL PHYSICIANS WILL BE ENTERING ORDERS ELECTRONICALLY. THE CERNER SYSTEM AUTOMATICALLY DATES AND TIMES ALL ENTRIES. OUR CURRENT PRACTICE OF QUARTERLY CHART AUDITS WILL CONTINUE TO ASSURE ALL ORDERS ARE DATED AND TIMED. THE DIRECTOR OF RECORDS MANAGEMENT IS RESPONSIBLE FOR MONITORING COMPLIANCE WITH THIS STANDARD.</p>	10/22/2011

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S0750	<p>a physician with both dated 9/18/11 and both lacking a time of the performance of the histories and physicals as well as the time authenticated on the document(s)</p> <p>b. pt. N6 had authentication and dating by the practitioner on the "Swallow Function Study Summary" form, but lacked a time of authentication</p> <p>c. pt. N10 had a newborn physical examination dated 9/20/11 and the discharge exam dated 9/21/11, but lacked a time for each examination and lacked a time of the physician's authentication at the bottom portion of the page titled "Newborn Admission /Discharge Summary"</p> <p>410 IAC 15-1.5-4(f)(1)</p> <p>(f) All inpatient records, except those in subsections (g), shall document and contain, but not be limited to, the following:</p> <p>(1) Identification data.</p> <p>Based on policy and procedure review, medical record review and staff interview, the facility failed to ensure accurate patient identification data was used for 1 of 1 (N12) closed patient medical record reviewed.</p> <p>Findings:</p>	S0750	S750 Patient identification is an issue we take extremely seriously. It is a key performance indicator that we track daily on all units. Every patient label ID error discovered is immediately evaluated using 5-WHY's methodology. Corrective action is taken whenever an error is discovered. We are reviewing	10/28/2011

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	<p>1. Policy titled, "Patient Identification" reviewed on 9/22/11 at 11:13 AM, indicated on:</p> <p>a. pg. 1, under Policy section, "Each patient will be properly identified before receiving patient care."</p> <p>2. Review of closed patient medical records on 9/21/11 at 12:18 PM, indicated patient N12:</p> <p>a. was admitted on 8/18/11 and had different patient identification labels on forms in their medical record. The labels had the same patient name, but different dates of birth, ages, dates of admission, and medical record numbers.</p> <p>3. Personnel P8 was interviewed on 9/21/11 at approximately 10:33 AM, and confirmed it appeared that the incorrect patient identification label was used on some of the forms in the above-mentioned closed patient medical record and did not follow facility policy and procedure.</p>		<p>our policy and will continue to focus daily attention to patient identification errors. This will also be addressed in the nursing education to take place no later than November 30. Responsibility for this standard is shared by CNO, CMO and Director of Medical Records.</p> <p>11-14-11: ADDENDUM: PATIENT IDENTIFICATION ERRORS ARE REPORTED DAILY ON ALL UNITS IN ALL DEPARTMENTS THAT TOUCH PATIENTS IN ANY WAY. THE RESULTS OF THE DAILY REPORTING AND FOLLOW UP ARE REPORTED TO HOSPITAL LEADERSHIP, HOSPITAL QUALITY, AND ULTIMATELY TO THE THE BOARD OF DIRECTORS AND MEC. INCREASED USE OF THE ELECTRONIC MEDICAL RECORD BEGINNING ON NOVEMBER 15, 2011 WILL SIGNIFICANTLY REDUCE THE NUMBER OF PAPER CHART PIECES THAT HAVE POTENTIAL TO BE MISFILED IN THE WRONG CHART. THE CNO IS ULTIMATELY RESPONSIBLE FOR COMPLIANCE WITH THIS STANDARD.</p>		

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S0788	<p>410 IAC 15-1.5-4(i)(9)</p> <p>(i) Emergency service records shall document and contain, but not be limited to, the following:</p> <p>(9) Copy of transfer form, if patient is referred to the inpatient service of another hospital. If care is not furnished to a patient or if the patient is referred elsewhere, the reasons for such action shall be recorded.</p> <p>Based on medical record review, policy and procedure review, and staff interview, the facility failed to ensure a transfer form was completed for 4 of 4 (N18, N19, N20 and N25) patients transferred to the inpatient services of another facility.</p> <p>Findings:</p> <p>1. Review of closed patient medical records on 9/21/11 at 12:18 PM, indicated:</p> <p>a. N18 was transferred to another inpatient facility on 3/19/11 and the Patient Transfer Authorization (Acute Care) Physician Order Form was lacking: the date and time of notification and phone number of the receiving facility; time of nurse authentication; and transfer mode.</p> <p>b. N19 was transferred to another inpatient facility on 6/16/11 and the Patient Transfer Authorization (Acute Care) Physician Order Form was lacking:</p>	S0788	<p>Social Workers, Nursing staff, and physicians are all being reminded of requirement and importance of completing, dating and timing all information on transfer forms. All re-education will be complete no later than November 30, 2011. 11-14-11 ADDENDUM EFFECTIVE NOVEMBER 15, 2011 ALL ORDERS WILL BE ENTERED INTO THE CERNER ELECTRONIC MEDICAL RECORD. ALL ENTRIES ARE ELECTRONICALLY DATED AND TIME STAMPED. THE DIRECTOR OF RECORDS MANAGMENT IS ULTIMATELY RESPONSIBLE FOR COMPLIANCE WITH THIS STANDARD. OUR QUARTERLY CHART AUDITS WILL CONTINUE AND RESULTS REPORTED TO HOSPITAL LEADERSHIP, HOSPITAL QUALITY, THE BOARD OF DIRECTORS AND MEC.</p>	10/22/2011

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	<p>the time of physician authentication.</p> <p>c. N20 was transferred to another inpatient facility on 6/8/11 and the Patient Transfer Authorization (Acute Care) Physician Order Form was lacking: the diagnosis; the name of the physician in the certification section; the medical benefits and risks; and the time of physician authentication.</p> <p>d. N25 was transferred to another inpatient facility on 8/28/11 and lacked a Patient Transfer Authorization (Acute Care) Physician Order Form.</p> <p>2. Policy titled, "Patient Transfers" reviewed on 9/22/11 at 11:30 AM, indicated on pg. 3, under:</p> <p>a. Special Instructions section, "In all circumstances, prior to transfer, a physician or other responsible person at the receiving facility must agree to accept the patient...All staff physicians and hospital personnel should be aware of and comply with state and federal regulations regarding patient transfers."</p> <p>b. Procedure for Transfer to Another Facility section, "A written consent for transfer is obtained...If the patient's emergency medical condition has not been stabilized, a Certification of Medical Necessity is completed which indicates the benefits and risks of transfer, and certifies that the benefits are believed to outweigh the risks."</p>			

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	3. Personnel P6 was interviewed on 9/22/11 at approximately 9:30 AM, and confirmed the above-mentioned closed patient medical records lacked a completed transfer form according to facility policy and procedure.				

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S0912	<p>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 facility policy/procedure review, manufacturer's recommendation, medical record review, observation of nursing practices and staff interview, the nurse executive failed to ensure staff implemented its blood glucose testing</p>	S0912	The hospital recently changed vendors for Blood Glucose monitors. The new policy includes the requirement to date the opening and expiration date for the blood glucometer control solutions. An addendum to the education has been created in	10/22/2011

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	<p>policy throughout the facility and failed to establish the standards of nursing care and practice related to restraint/seclusion documentation for 1 of 1 (N12) closed patient medical record reviewed.</p> <p>Findings:</p> <p>1. At 4:30 PM on 9/19/11, review of the policy "Blood Glucose Testing - Abbott Precision Xceed Pro..." with an effective date of 5/3/11, indicated:</p> <p>a. on page 2 under "II. Reagents", in section B., it read: "Control Solutions 1. Store the control solutions...2. Controls expire 90 days after opening. When opening a new bottle of controls, write the open date as well as the expiration date on the bottle. The expiration date written on the bottle will be 90 days after the opening date...."</p> <p>2. At 5:00 PM on 9/19/11, review of the informational brochure from Abbott related to the Precision Xceed Pro glucometer used through out the facility, indicated:</p> <p>a. on page 24, it read: "...Check that the bottles of control solutions have not been open for more than 90 days..."</p> <p>3. During tour 9/19/11 to 9/22/11,it was observed:</p> <p>a. at 3:45 PM on 9/19/11, on the PICU</p>		<p>the form of a self learning packet and is mandatory for all nursing staff housewide using glucometers and control solutions. The patient safety coordinator is adding the checking of control solutions to monthly safety observations and audits. CNO is responsible for this standard. Education is underway and will cbe completed no later than November 30, 2011 Restraint and Seclusion-Our policy had been under review with the arrival of a new Medical Director for Psychiatric Services. Forms were also in process of being reviewed and revised. The form is being re-printed to included the time limit for the order for Restraint and Seclusion. All types of restraint are identified on the forms and require the nurse to indicate date time for starting and stopping each form of restraint. In addition we are in the process of building our electronic forms for restraint and seclusion and all required fields will be mandatory and have hard stops meaning the nurse cannot continue or complete charting without the required fields being completed. Meanwhile the CNS and educator for the 4 behavioral health units are providing re-education on the current forms and the new forms to assure all staff understand the requirement and importance of complete and accurate documentation related</p>		

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	<p>(pediatrics intensive care unit), the glucometer control solutions (both the high and the low solutions) indicated:</p> <p>A. there was only one set of dates written on the solutions by staff when opened</p> <p>B. the dates were smeared and unreadable making it impossible to determine the 90 day expiration date of the control solutions</p> <p>b. at 10:35 AM on 9/20/11, it was observed in the "Major" PACU (post anesthesia care unit), that only one date was written on the control solutions</p> <p>c. at 12:25 PM on 9/21/11, on the 3rd floor mother baby post partum unit, the control solutions were dated only once with 7/30/11 (unable to determine if this was the date opened or the 90 day expiration date)</p> <p>d. at 12:45 PM on 9/21/11 on the 4th floor mother baby post partum unit, the control solutions were dated only once with 7/30/11 (unable to determine if this was the date opened or the 90 day expiration date)</p> <p>e. at 1:10 PM on 9/21/11, on the CBU (child birth unit), the glucometer control solutions had no date opened or date of expiration (after opening) written on the high and low control solution bottles (only the manufacturer pre printed expiration date was on the opened control solutions)</p>		<p>to Restraint and Seclusion. In addition beginning November 7, 2011 Restraint and seclusion will be a key performance indicator and each incident will be reviewed daily and reported. Any incomplete charting will be addressed immediately and appropriate action taken. The Executive Director of Psychiatric and Behavioral Health is responsible for this standard. Re-education is underway and will be completed no later than November 30.11-14-11</p> <p>ADDENDUM THE RECORDS OF ALL RESTRAINT AND SECLUSION ARE BEING AUDITED 100% OF THE TIME FOR COMPLETENESS OF DOCUMENTATION. INCIDENTS OF RESTRAINT AND SECLUSION ARE REPORTED DAILY TO HOSPITAL LEADERSHIP. THE AUDITS WILL CONTINUE AT 100% FOR AT LEAST 3 MONTHS AND BEYOND IF WE DO NOT DEMONSTRATE 100% COMPLIANCE.</p>	

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	<p>f. at 10:00 AM on 9/22/11, on the 3rd floor Cardio Vascular nursing unit, the glucometer control solutions were dated only with the 90 day expiration date (written by staff) of the solutions and were lacking a date of the opening of the solutions</p> <p>4. Interview with various staff members on the units toured indicated that staff were unaware:</p> <p>a. that any dating of the control solutions was required</p> <p>b. that the solutions expired 90 days after opening</p> <p>c. that the solutions were not good to the manufacturer's expiration date on the bottles</p> <p>d. that an open date and a 90 day expiration date were required to be noted on the bottles when opened</p> <p>5. Interview with staff members NA and ND at 9 AM on 9/20/11 indicated that nursing staff are unaware of the policy requirements related to the glucometer control solution dating process when first opened for use</p> <p>6. Policy titled, "Restraint and Seclusion" reviewed on 9/22/11 at 11:30 AM, indicated on:</p> <p>a. pg. 4, under Behavioral Restraint section, point 1., "The physician's order</p>				

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	<p>must be time limited..."</p> <p>b. pg. 5, under Actual Restraint Process, point 1., "Patients in 4-point restraints should usually also have a waist restraint to prevent 'buckling'..."</p> <p>7. Review of closed patient medical records on 9/21/11 at 12:18 PM indicated patient N12:</p> <p>a. order for "Give Geodon 20 mg IM (intramuscular) stat. Physical restraint, seclusion - open door" on 9/6/11 at 2120, lacked a time frame and specific type of hold.</p> <p>b. order for "Place in soft restraints in seclusion - four point." on 9/6/11 at 2135, lacked a time frame.</p> <p>c. per R&S Patient Debriefing Questionnaire:</p> <p>A. on pg. 1, "Length of Event: 2 hours...Type of Event: Seclusion, Physical Escort, Team Control, Therapeutic Hold, Mechanical Restraints Soft, Mechanical Restraints Lock, and Chemical Restraint.</p> <p>B. on pg. 3, "Released soft restraint on left wrist, right ankle at 2215. Released soft restraint on right wrist, left ankle at 2315. Out of seclusion on 9/6/11 at 2315."</p> <p>d. per R&S Nursing Fact to Face Evaluation Record, "At 2215, released soft restraint left wrist and right ankle..."</p> <p>e. per R&S Clinical Observation Record, restraint codes and 1:1 codes are</p>			

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S1022	<p>lacking for 9/6/11 at 2200, 2300, and 2307.</p> <p>8. Personnel P8 was interviewed on 9/21/11 at approximately 10:33 AM, and confirmed facility policy and procedure was not being followed for the above-mentioned restraint/seclusion. The time limit and the type of restraint for the restraint order was lacking and documentation on the R&S Clinical Observation Record was also lacking as described above.</p> <p>410 IAC 15-1.5-7 (d)(2)(B)</p> <p>(d) Written policies and procedures shall be developed and implemented that include the following:</p> <p>(2) Ensure the monthly inspection of all areas where drugs and biologicals are stored and which address, but are not limited to, the following:</p> <p>(B) Appropriate storage conditions. Based on observation, policy and procedure review, and staff interview, the facility failed to ensure appropriate storage conditions according to facility policy and procedure for 5 of 11 (Emergency Department {ED}, Oncology, Ortho-Neuro, Cardiac-Stroke, Medical-Surgical) units toured.</p>	S1022	The policies and procedures for safe medication handling, storage and administration were reviewed and found to be appropriate. All nursing staff are being re-educated on the safe handling, storage and administration of medications. In addition medication storage is being added to the patient safety	10/22/2011

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	<p>Findings:</p> <p>1. While on tour of facility on 9/19/11 at approximately 2:48 PM, 9/20/11 at 1:09 PM and 2:11 PM, and 9/21/11 at 12:55 PM and 1:50 PM, in the company of P6, P13, P14, P16, P17, P19 and P26, the following was observed:</p> <p>a. ED medication room with no door, one opened vial of Hydromorphone HCI 2 mg/ml, lot #041453A, exp. 4/1/13, with clear liquid still in vial sitting unsecured on the counter.</p> <p>b. ED patient room #10:</p> <p>i. one bottle of Nitrostat 0.4 mg, lot #V110985, exp. 6/14, sitting unsecured on the counter, patient was in ancillary department and no staff in room.</p> <p>ii. one syringe, with a needle attached, filled half way with clear liquid and no label lying unattended on a mayo stand.</p> <p>c. Oncology Department, room 1040, unattended in an unlocked patient server/closet:</p> <p>i. one syringe, with a needle attached, filled half way with clear liquid and no label.</p> <p>ii. one open bottle of sodium chloride injectable with an adapter attached.</p> <p>iii. multiple packages of insulin needles.</p> <p>d. Ortho-Neuro hallway, unsecured insulin needles and heparin needles on a mobile computer stand.</p>		<p>monitoring observations that are conducted monthly on all units. The CNO is the person responsible for assuring the nursing staff are following policy and procedure on medication management, with support from the Patient Safety Coordinator, the Chief Safety Officer, and the Director of Pharmacy Services. Re-education will be completed no later than November 30, 2011. ADDENDUM 11/15/11 THE HOSPITAL IS CURRENTLY IN THE MIDDLE OF A 1.7 MILLION DOLLAR PROJECT INSTALLING 84 PYXIS AUTOMATED MEDICATION DISPENSING CABINETS HOUSEWIDE WITH AN ADDITIONAL 21 CABINETS BEING INSTALLED IN THE OR SUITES. MORE THAN 90% OF MEDICATIONS WILL BE ACCESSED FROM THE PYXIS GREATLY INCREASING THE ABILITY TO MONITOR AND TRACK MEDICATION MANAGEMENT. THE DIRECTOR OF PHARMACY SERVICES IS ULTIMATLEY RESPONSIBLE FOR THIS STANDARD. IN ADDITION TODAY 11/15/11 WE ARE GOING LIVE HOSUEWIDE WITH CPOE ON THE CERNER SYSTEM.</p>	

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	<p>e. Cardiac-Stroke hallway, unsecured sharps on 4 medication carts with morphine syringes and fentanyl vials in them.</p> <p>f. Medical-Surgical:</p> <p>i. crash cart box on top of the crash cart was unsecured with insulin and IV (intravenous) start needles in it.</p> <p>ii. medication cart in the hallway had tuberculosis needles and insulin needles in an unlocked drawer.</p> <p>2. Policy titled, "General Safety Guidelines" reviewed on 9/22/11 at 11:30 AM, indicated on:</p> <p>a. pg. 1, under Medication in Syringes section, "A medication must never be drawn up in a syringe and unlabeled. The medication label needs to include the medication name and dose, if the medication comes in various doses. Medication must be used by the same person who drew it up and used or discarded prior to that person leaving that shift of work."</p> <p>b. pg. 7:</p> <p>i. under Medication Storage section, "All medications must be stored securely. Medications cannot be unlocked in public places or areas with easy public access. Patient servers in patient rooms must be locked unless a staff member is using the server. Medication carts must be locked unless a staff member is using the cart. (It</p>			

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	<p>must be locked when the staff member leaves the cart).</p> <p>ii. under Controlled Substances section, "Controlled medications, like narcotics, must have access of the medication strictly limited..."</p> <p>3. Personnel P6, P13, P14, P16, P17, P19 and P26 were interviewed on 9/19/11 at approximately 2:48 PM, 9/20/11 at 1:09 PM and 2:11 PM, and 9/21/11 at 12:55 PM and 1:50 PM, and confirmed facility policy and procedure was not being followed and:</p> <p>a. there were unsecured narcotics/medications and unsecured needles.</p> <p>b. filled syringes were not properly labeled and were unsecured.</p> <p>c. there were unsecured sharps containers located in hallways with access to patients, visitors, and staff.</p> <p>d. medication carts located in hallways with access to patients, visitors, and staff were unlocked.</p>			

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S1024	<p>410 IAC 15-1.5-7 (d)(2)(C)</p> <p>(d) Written policies and procedures shall be developed and implemented that include the following:</p> <p>(2) Ensure the monthly inspection of all areas where drugs and biologicals are stored and which address, but are not limited to, the following:</p> <p>(C) Detection and quarantine of outdated or otherwise unusable drugs and biologicals from general inventory pursuant to their return to the manufacturer, distributor, or destruction.</p> <p>Based on observation, policy and procedure review, and staff interview, the facility failed to ensure detection and quarantine of outdated or otherwise unusable drugs and biologicals from general inventory according to facility policy and procedure for 6 of 13 (Emergency Department {ED}, Oncology, Child/Adolescent Behavioral Medicine, Adult Behavioral Medicine, Operating Room {OR}, Outpatient Surgery Center) units toured.</p> <p>Findings:</p> <p>1. While on tour of facility on 9/19/11 at approximately 2:48 PM; 9/20/11 at 9:50 AM, 9:55 AM, 10:45 AM, and 1:09 PM; and 9/21/11 at 10:05 AM, in the company of P6, P8, P13, P14, P17, P25, and P27 the following was observed:</p>	S1024	<p>The policy for outdated and expired supplies was reviewed and determined to be appropriate. Staff are being re-educated on the importance of verifying the integrity of any medication or supply that is subject to expiration or outdated. Re-education will take place no later than November 30, 2011. The CNO with support from Materiels Management, Pharmacy, and Safety is responsible for this standard. Monitoring of laboratory tubes, culture products, and medications will be added to the monthly safety monitoring rounds carried out on all units. 11-14-11 ADDENDUM ALL OUTDATES ARE IMEDIATELY REPORTED TO THE MANAGER OF THE UNIT. IN ADDITION MATERIELS MANAGMENT REPORST ON THEIR LEAN</p>	10/22/2011

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	<p>A. ED medication room fridge, one opened vial of Humulin R Insulin, lot #A857286D, exp. date unknown because there was no sticker labeled with the date opened.</p> <p>B. ED medication room eye tray/ortho tray cabinet:</p> <p>i. eleven BBL Culture Swabs, lot #029F28, exp. 10/10.</p> <p>ii. one opened bottle 1% Lidocaine 10 mg/ml, lot #94-547-DK, exp. 7/30/year unknown.</p> <p>C. Oncology Department, crash cart, one 500 ml bag 0.9% Sodium Chloride for injection, lot #C800870, exp. 7/11.</p> <p>D. Child/Adolescent Behavioral Medicine, five Microtest Transport collection tubes, lot #806030, exp. 2/8/11.</p> <p>E. Adult Behavioral Medicine supply cabinet, one bottle of sterile water for irrigation, lot #G093427, opened on 9/2/11, exp. 24 hours after opening.</p> <p>F. OR Inner Core:</p> <p>i. crash cart, one vial of Flumazenil 10ml, exp. 3/11.</p> <p>ii. pediatric crash cart, one bottle of #3-8.4 bicarb injectable, exp. 8/1/11.</p> <p>iii. pain cart:</p> <p>a. one 5 ml vial of 1.5% Lidocaine, exp. 6/1/11.</p> <p>b. one bottle of Sodium Bicarbonate, exp. 4/1/11.</p> <p>G. Outpatient Surgery Center, anesthesia room with PYXIS, one 10 ml</p>		<p>DAILY MANAGEMENT KEY PERFORMANCE INDICATOR BOARD ANY OUTDATES. THIS DATA IS REPORTED TO THE HOSPITAL LEADERSHIP COMMITTEE AND EACH DIRECTOR IS RESPONSIBLE FOR FOLLOW UP ON OUTDATES. THE PHARMACY DIRECTOR IS RESPONSIBLE FOR ASSURING THE REMOVAL OF ALL OUTDATED MEDICATION. THE DIRECTOR OF MATERIELS MANAGMENT IS RESPONSIBLE FOR ALL OUTDATED SUPPLIES.</p>	

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	<p>vial of Methylene Blue, opened but not dated.</p> <p>2. Policy titled, "Beyond Use Dating for Multiple Dose Containers" reviewed on 9/22/11 at 12:00 PM, indicated on:</p> <p>a. pg. 1, under Multiple Dose Parenteral Container section, point 2, "If the multiple dose vial is to be reused, an auxiliary label containing a beyond use date must be affixed to the container...Beyond use dating for opened or entered (e.g., needle-punctured) multiple dose containers is 28 days per USP Chapters <51> and <797>, unless otherwise specified by the manufacturer."</p> <p>3. Policy titled, "Outdated Pharmaceuticals, Monitoring for and Disposal of" reviewed on 9/22/11 at 12:13 PM, indicated on:</p> <p>a. pg. 1, under Procedure section, point C. "Any product exceeding the manufacturer's expiration date, or the Department expiration date assigned to repackaged products, will be removed from stock and placed in the area designated for outdated products."</p> <p>4. Review of sign posted to ED PYXIS indicated, "Insulin products and injectables beyond use date 28 days."</p> <p>5. Personnel P6 and P8 were interviewed</p>				

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S1026	<p>on 9/22/11 at approximately 12:22 PM, and confirmed facility policy and procedure was not being followed related to insulin beyond use dating and the removal of expired medications and biologicals from general stock.</p> <p>410 IAC 15-1.5-7 (d)(2)(D)</p> <p>(d) Written policies and procedures shall be developed and implemented that include the following:</p> <p>(2) Ensure the monthly inspection of all areas where drugs and biologicals are stored and which address, but are not limited to, the following:</p> <p>(D) Documentation and accountability for an accurate accounting of controlled substances from the time of receipt in the institution through the administration to the patient or subsequent removal from general stock and reporting of all abuses and losses of controlled substances.</p> <p>Based on observation, document review, policy and procedure review, and staff interview, the facility failed to ensure accurate documentation and accountability of controlled substances stored in 1 of 11 (Regional Cancer Center Radiation Oncology) units toured.</p> <p>Findings:</p> <p>1. While on tour of facility on 9/22/11 at</p>	S1026	The Director of Pharmacy, Director of the Regional Oncology Center are reviewing policy and procedure for controlled substances in the Center. The revised policy and procedure will be completed, implemented and staff educated no later than November 18. Director of Pharmacy is responsible for assuring correction plan is	10/22/2011

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	<p>approximately 10:00 AM, in the company of P22 and P23, it was observed in the Regional Cancer Center Radiation Oncology medication storage room medication cabinet:</p> <ul style="list-style-type: none"> a. 8 vials of Fentanyl 0.1mg/2ml. b. 5 Fentanyl 200 mcg lollipops. c. 5 Morphine Oral 20mg/ml concentrated solution. <p>2. Review of Controlled Substances Administration Record dated:</p> <ul style="list-style-type: none"> a. 9/1/11, indicated a balance of 9 vials of Fentanyl 0.1mg/2ml, in the medication cabinet. b. 9/20/11, indicated a balance of 4 Fentanyl 200 mcg lollipops, in the medication cabinet. c. 6/10/11, indicated a balance of 1 Fentanyl 200 mcg lollipops, in the medication cabinet. The order of administration of this medication was not in chronological order. It read: 9/16/11 at 1600, balance 3; then 9/19/11 at 1130, balance 2; and 9/15/11 at 1030, balance 1. d. 7/29/11, indicated a balance of 5 Morphine Oral 20mg/ml concentrated solution. <p>3. Review of Narcotic Count log:</p> <ul style="list-style-type: none"> a. title was "2009 Narcotic Count". b. handwritten date of 9/12/11 through 9/22/11, indicated 8 vials of Fentanyl 0.1mg/2ml, in the medication cabinet. 		<p>implemented. ADDENDUM 11-14-11 A PYXIS AUTOMATED CABINET IS BEING INSTALLED AS PART OF A HOUSEWIDE CONVERSION CURRENTLY UNDERWAY TO THE NEWEST VERSION OF PYXIS AUTOMATED DISPENSING CABINET. THIS WILL ALLOW FOR CONTINUOUS MONITORING OF CONTROLLED SUBSTANCES IN THE CANCER CENTER. THE DIRECTOR OF PHARMACY CONTINUES TO BE RESPONSIBLE FOR THIS STANDARD COMPLIANCE.</p>	

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	<p>c. dated 9/22/11, indicated 5 Fentanyl 200 mcg lollipops (documented as Actiq 200 mcg), in the medication cabinet.</p> <p>d. handwritten date of 9/12/11 through 9/22/11, indicated 4 Morphine Oral 20mg/ml concentrated solution, in the medication cabinet.</p> <p>4. Policy titled, "Controlled Substances - Medication Distribution and Handling" reviewed on 9/22/11 at 11:30 AM, indicated on pg. 3, under Counting of Controlled Substances section, points 6.c. and 7.a., d., and e., "The counting process includes verifying that all medications present correspond with the documented inventory remaining...Upon discovery of a discrepancy the individual discovering the discrepancy must notify the Charge Nurse for their area immediately. This notification must be a direct communication to the Charge Nurse either in person or via telephone...Upon notification of a discrepancy the Charge Nurse, Nurse Manager, or Unit Director must resolve the discrepancy immediately...No nursing staff will leave the unit until the Charge Nurse, Nurse Manager, or Unit Director has resolved any and all controlled substance discrepancies."</p> <p>5. Policy titled, "Medication, Safe Administration" reviewed on 9/22/11 at</p>				

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	<p>11:37 AM, indicated on pg. 4, under Controlled Substances section, point 3.b., "the nurse removing the controlled substance will verify that the number of doses remaining corresponds to the documented number of doses remaining. If there is a discrepancy, the charge nurse or other appropriate person must be notified to assure immediate reconciliation of discrepancy."</p> <p>6. Personnel P22 was interviewed on 9/22/11 at 10:52 AM and indicated there were discrepancies in the Controlled Substances Administration Record, Narcotic Count Log, and the actual amount of controlled substances in the medication cabinet for the medications documented above. Also, the Narcotic Count Log should read 2011, not 2009. Facility policy and procedure was not followed related to accurate documentation and accountability of controlled substances.</p>				

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S1118	<p>410 IAC 15-1.5-8 (b)(2)</p> <p>(b) The condition of the physical plant and the overall hospital environment shall be developed and maintained in such a manner that the safety and well-being of patients are assured as follows:</p> <p>(2) No condition shall be created or maintained which may result in a hazard to patients, public, or employees.</p> <p>Based on policy review, observations, and interviews, the facility failed to implement facility policy related to expired lab tubes and other supplies in various areas toured, creating a possible hazard to patients in regard to unreliable lab test results and the possibility of non sterile supplies being used for patients, failed to ensure a sharps container in the morgue was properly maintained to assure a hazardous condition was not created for employees during three days of observation and failed to provide an environment that may not result in a hazard to patients, public, or employees in 2 of 11 (Immediate Care Unit {ICU} and OR) areas toured.</p> <p>Findings:</p> <p>1. At 5:00 PM on 9/21/11, review of the policy and procedure "General Safety Guidelines", indicated:</p>	S1118	<p>expired lab tubes and other medical surgical supplies are addressed as above in S1024. re-education is underway and will be completed housewide no later than November 30. CNO with support from Materiels Management, Lab, Pharmacy and Safety responsible for this standard. The issue of the sharps and saw blade in the morgue were resolved on 9/22/11. The South Bend Medical Foundation and their staff carry out autopsies and handle all instruments and sharps. The nursing staff go into the morgue following use to assure supplies are restocked and cleaning has taken place. Staff have been instructed to notify the Hospital Administrative Supervisor immediately if they discover sharps or any other instrument not properly handled or disposed of. The South Bend Medical Foundation staff have also been reminded to follow policy and procedure for</p>	10/22/2011	

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	<p>a. in section V. "Sterile Supplies", and specifically, "Sterile Supplies packaged by Vendors": "...Sterile Supplies which <u>have expiration dates</u> are <i>only Sterile to the extent labeled on the package</i>... Vendor supplied sterile products with expiration dates...may not be used beyond the expiration date even if intact..."</p> <p>b. in section VI. "<u>Lab Tubes and Bottles</u>", indicated: "(Like Vacutainer tubes, Culture smear tubes, Pap Test bottles, Blood Culture bottles, etc.) "Nearly all lab tubes and bottles with media in them have an expiration date. These products must be checked, rotated, and discarded to assure specimens are well handled...Expired supplies of these items must be removed from unexpired ones in order to assure that only unexpired supplies are used..."</p> <p>2. While on tour throughout 9/19/11 to 9/22/11, it was observed that:</p> <p>a. at 2:55 PM on 9/19/11, in the Pediatric unit treatment room, 1 anaerobic lab tube expired 8/31/11</p> <p>b. at 3:55 PM on 9/19/11, in the pediatric unit medication room, a package of Smith's skin temp sensor (one) that expired 5/10</p> <p>c. at 1:20 PM on 9/21/11, in the CBU (child birth unit) malignant hyperthermia box/kit, the following lab tubes and IV</p>		<p>appropriate disposal of sharps. The Administrative Nursing Supervisor will inspect the morgue regularly after EACH use to assure compliance with safety and infection control precautions. 11-14-11 NON COMPLIANCE WILL IMMEDIATELY BE REPORTED TO THE SOUTH BEND MEDICAL FOUNDATION FOR IMMEDIATE REMEDY. Gas cylinders in OR and ICU- policy and procedure were reviewed and determined to be appropriate. Staff in OR and ICU are being re-educated on the importance of securing all gas cylinders. Management in those areas are responsible to visually inspect regularly to assure compliance with the policy as written. Staff will be re-educated no later than November 30. 11-14-11 ADDENDUM SURGICAL SERVICES MANAGMENT, UNIT DIRECTORS WILL DO DAILY ROUNDS TO ASSURE ABSENCE OF UNSECURE GAS CYLINDERS. ANY FAILURE TO COMPLY WITH POLICY AND PROCEDURE WILL RESULT IN APPROPRIATE CORRECTIVE ACTION. MONITORING ON THE MOTNHLY SAFETY ROUNDS IS REPORTED TO THE HOSPITAL SAFETY AND QUALITY COMMITTEE AND ULTIMATELY UP TO THE BOARD. THE CNO IS ULTIMATELY RESPONSIBLE</p>		

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	<p>solution were expired:</p> <p>I. 2 pink topped lab tubes that expired 2/11</p> <p>II. 2 yellow topped lab tubes that expired 3/10</p> <p>III. 2 green topped tubes that expired 11/10</p> <p>IV. 2 purple topped tubes that expired 7/10</p> <p>V. 1 red topped lab tube that expired 5/11</p> <p>VI. 1 1000 cc IV solution of sterile water that expired 4/10</p> <p>d. at 1:40 PM on 9/21/11, in the CBU, in OR (operating room) suite #1 a Perifix continuous epidural kit that expired 7/11</p> <p>e. at 12:30 PM on 9/19/11, on the 3rd floor mother baby post partum unit on the crash/code cart, 1 package of 3M defibrillator pads that expired 3/11 and 2 packages of ConMed ECG (electrocardiogram) electrodes that expired 6/11</p> <p>f. at 12:40 PM on 9/19/11, on the 3rd floor mother baby post partum unit, in the circumcision area, >6 povidone iodine solution packets that expired 3/10</p> <p>g. at 10:45 AM on 9/20/11, in the "Major" PACU (post anesthesia care unit) storage room, Arrow brand Cath/Epidural trays that expired one on 1/11 and one on 7/11</p> <p>h. at 10:15 AM on 9/20/11, in the OSC (out patient surgery center) storage room,</p>		FOR COMPLINACE ON NURSING UNITS, THE PHARMACY DIRECTOR FOR PHARMACY RELATED ITEMS AND THE MATERIELS MANAGER FOR SUPPLY ISSUES.	

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	<p>1 Perifix continuous epidural anesthesia tray that expired 5/11</p> <p>i. at 1:09 PM on 9/20/11, on the oncology unit crash cart, one package of adult defibrillator pads that expired 12/10</p> <p>j. at 10:30 AM on 9/21/11, on both the adult inpatient behavioral unit and the adolescent behavioral unit, 2 packages of defibrillator pads that expired 11/28/10</p> <p>3. iInterview with staff member NN at 10:20 AM on 9/20/11 indicated that supply distribution and checking for expiration dates is the responsibility of materials management</p> <p>4. Interview with various staff members on the units (listed in 2. above) indicated that nursing staff are to check their areas/units for expired products routinely and to remove them from service</p> <p>5. On 9-19-11 between 3:00 PM and 3:30 PM, 9-20-11 between 3:15 PM and 3:30 PM and on 9-21-11 between 12:45 PM and 1:30 PM, approximately 2 inches of a saw blade was observed protruding from the top of a sharps container in the morgue.</p> <p>6. In interview on 9-19-11 between 3:00 PM and 3:30 PM, Staff Member #L23 acknowledged the above finding.</p>				

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	<p>7. While on tour of the ICU and OR Units, on 9/19/11 at approximately 4:07 PM and 9/20/11 at 10:00 AM, accompanied by Personnel P6, P27 and P28, the following was observed:</p> <ul style="list-style-type: none"> a. an unsecured Argon Gas cylinder in the OR semi-restricted hallway. b. an unsecured Helium Gas cylinder in the ICU pulmonary supply room. <p>8. Policy titled, "General Safety Guidelines" reviewed on 9/22/11 at 11:30 AM, indicated on:</p> <ul style="list-style-type: none"> a. pg. 1, under Compressed Air Tanks section, "Compressed air tanks must be secured in an appropriate holder. Appropriate holders include single tank portable upright holder, multi-tank upright holder, chaining to a wall in such a way that the tank can not fall, secured in the holder on a cart or bed where the tank can not fall off, or other Safety Committee approved means of securing a tank." <p>9. Personnel P27 and P28 were interviewed on 9/19/11 at approximately 4:16 PM and 9/20/11 at approximately 10:28 AM, and confirmed the above-mentioned compressed air tanks were not secured according to facility policy and procedure.</p>				

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S1168	<p>410 IAC 150-1.5-8 (d)(3)</p> <p>(d) The equipment requirements are as follows:</p> <p>(3) Defibrillators shall be discharged at least in accordance with manufacturers recommendations and a discharge log with initialed entries shall be maintained.</p> <p>Based on document review, policy and procedure review, and staff interview, the facility failed to ensure discharge of defibrillators in accordance with manufacturer's recommendations for 46 of 77 defibrillators (model #'s M4735A and M1722A) and maintenance of an accurate discharge log for 2 of 2 off-site (Gero-Psych 2 South) units toured.</p> <p>Findings:</p> <p>1. Review of Equipment Listing Record for Defibrillators on 9/22/11 at 12:05 PM indicated:</p> <p>a. 33 model #M4735A defibrillators are being checked daily. They are located in multiple locations throughout the facility.</p> <p>b. 13 model #M1722A defibrillators are being checked daily. They are located in</p>	S1168	<p>S1168 The Policy on Defibrillators and AED's was reviewed and determined to need revision. Biomedical Engineering and nursing did a housewide inventory of Defibrillator/AED manuals, batteries and other disposable items required for Defibrillation or use of AED. New back-up batteries were provided to assure availability while the policy is currently being revised to include the specific checks needed on all machines as well as securing specific manufacturers recommendations on each cart that give nursing staff detailed instruction for determining battery strength and appropriate checking process on the specific machines in their department. Manufacturer's recommendation will determine the frequency of</p>	10/22/2011

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	<p>multiple locations throughout the facility.</p> <p>2. Review of manuals on 9/22/11 at 12:15 PM titled: a. "M4735A HeartStart XL Defibrillator/Monitor", indicated on pg. 11-3, under Operational Checks section, "Every Shift: Perform a 'Shift/System Check' every shift to verify that the HeartStart XL is functioning properly and to ensure that necessary supplies and accessories are present and ready for use..." b. "M1722/M1723 CodeMaster XL Series Defibrillator/Monitor Service Manual", indicated on pg. 8-8, under Operational Checks section, "Every Shift: Perform the following checks every shift..."</p> <p>3. Policy titled, "Code Cart, AED (Automatic External Defibrillator), and Defibrillator Monitor Checks" reviewed on 9/22/11 at 12:22 PM, indicated on pg. 1, under If a Defibrillator is Present section, point 15., "Perform the following functional tests per manufacturer's recommendations...a. Paddles Shock Button Functional Test; b. Accessory Cable Functional Test; c. Pacemaker Functional Test (if applicable)."</p> <p>4. Review of Code Cart, AED, and Defibrillator Checklist for Gero-Psych 2</p>		<p>method of checking specific to the machine. The new Policy and Procedure is near completion. In addition a standard work document for checking each specific machine is be developed and will be laminated and secured to each cart holding the Defibrillator or AED. Re-education of staff will take place no later than November 30 housewide. The patient safety coordinator iw working with the CNS staff to complete the policy and education curriculum. The CNO is responsible for this standard. 11-14-11ADDENDUM ALL UNITS ARE REQUIRED TO SUBMIT THEIR DAILY MONITROING LOGS TO THE PATIENT SAFETY COORDINATOR. THE COORDINATOR SENDS OUT A REPORT WEEKLY TO EXECUTIVE DIRECTORS, DIRECTORS AND MANAGERS WITH DETAIL OF ANY UNIT NOT AT 100% COMPLINACE. THESE REPORTS GO TO THE HOSPITAL SAFETY AND QUALITY COMMITTEE AND ULTIMATELY TO THE BOARD OF DIRECTORS. THE CNO IS ULTIMATELY RESPONSIBLE FOR COMPLIANCE WITH THIS STANDARD.</p>		

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	<p>South Unit dated 9/19/11 through 9/21/11, indicated under the column titled AED, "Checked flashing black hourglass present and 2 unexpired batteries."</p> <p>5. While on tour of the Gero-Psych 2 South Unit, on 9/21/11 at approximately 9:00 AM, accompanied by Personnel P8, it was observed that the AED on the crash cart was a Welch Allyn AED 10. It was not the model that has the flashing black hourglass symbol.</p> <p>6. Review of manual titled, "AED 10 User Manual" on 9/21/11 at 11:00 AM, indicated under Verifying Readiness section, "To ensure the readiness of the Welch Allyn AED 10, it is important to respond immediately to low battery status indicators...Check the battery readiness by verifying the defibrillator's status indicator, located to the left of the device green power button, is in a 'ready to use' state (solid black icon). If the status indicator is flashing a red circle with a slash through it, this indicates a 'Low Battery' situation."</p> <p>7. Personnel P8 was interviewed on 9/22/11 at 12:20 PM, and confirmed the above-mentioned defibrillators are not being checked according to manufacturer's recommendations and according to facility policy and procedure.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150058	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/22/2011
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NAME OF PROVIDER OR SUPPLIER MEMORIAL HOSPITAL OF SOUTH BEND	STREET ADDRESS, CITY, STATE, ZIP CODE 615 N MICHIGAN ST SOUTH BEND, IN46601
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S1172	<p>And the checklist for the AED 10 in the Gero-Psych 2 South Unit is not accurate because that model does not have a flashing black hourglass symbol.</p> <p>410 IAC 15-1.5-8(e)(1)(A)(B)(C)</p> <p>(e) The building or buildings, including fixtures, walls, floors, ceiling, and furnishings throughout, shall be kept clean and orderly in accordance with current standards of practice as follows:</p> <p>(1) Environmental services shall be provided in such a way as to guard against transmission of disease to patients, health care workers, the public, and visitors by using the current principles of the following:</p> <p>(A) Asepsis (B) Cross-infection; and (C) Safe practice.</p> <p>Based on policy review, observation, and interview, the facility failed to implement its policy related to the storage of cardboard boxes directly on the floor, in two OR (operating room) storage rooms and failed to guard against transmission of disease to patients, health care workers, the public, and visitors by failing to disinfect surfaces according to facility policy and procedure in 1 of 11 (Oncology) areas toured.</p>	S1172	S1172 All staff including surgical services have been reminded of the policy on storage of any items directly on the floor. The policy was reviewed and determined to be appropriate. Regular safety rounds are being added to inspect all areas for appropriate storage of all equipment and supplies. On the nursing units where patient servers are located the unit directors have been assigned the responsibility to inspect the patient servers regularly to assure they are clean and orderly	10/22/2011

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	<p>Findings:</p> <ol style="list-style-type: none"> At 5:00 PM on 9/21/11, review of the policy and procedure "General Safety Guidelines", indicated in section III., "General Storage Regulations", "Storage on the floor is not acceptable unless the item is usually on the floor...Cardboard boxes may not be stored on the floor..." At 9:45 AM on 9/20/11, it was observed in the OR area, while touring in the company of staff member NM, in two separate storage rooms/closets, that cardboard boxes were being stored on the floor Interview with staff member NM at 10:00 AM on 9/20/11 indicated it was unknown that cardboard boxes were being stored on the floor in these two areas While on tour of the Oncology Unit, on 9/20/11 at approximately 1:09 PM, accompanied by Personnel P6 and P17, the following was observed in patient rooms 1026, 1028, 1033 and 1040: messy, unorganized patient server/closets with unnecessary medical equipment, needles, package wrappers, and/or wadded up isolation gown. Review of Environmental Services Terminal Cleaning Procedure on 9/22/11 		<p>and do not contain excess or expired supplies or equipment. The CNO is responsible for assuring compliance with this standard. 11-14-11 ALL INCIDENTS OF NON-COMPLINACE WITH THIS STANDARD ARE REPORTED TO THE HOSPITAL SAFETY AND QUALITY COMMITTEE AND ULTIMATELY UP TO THE BOARD OF DIRECTORS AND MEC.</p>	

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	<p>at 12:15 PM, indicated:</p> <ul style="list-style-type: none"> a. Ensure that all unnecessary medical equipment has been removed from room. b. Remove all waste and soiled linen thoroughly vacuum all surfaces above eye level. c. Damp wipe/sanitize all furniture and horizontal surfaces with germicidal solution... <p>6. Review of Environmental Services Discharge Cleaning on 9/22/11 at 12:19 PM, indicated "4. Sanitize all surfaces..."</p> <p>7. Personnel P17 was interviewed on 9/20/11 at 1:50 PM, and confirmed the above-mentioned patient servers/closets are not being cleaned and disinfected according to facility policy and procedure.</p>				