

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  151303	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  09/25/2013
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NAME OF PROVIDER OR SUPPLIER  ST VINCENT JENNINGS HOSPITAL INC	STREET ADDRESS, CITY, STATE, ZIP CODE 301 HENRY ST NORTH VERNON, IN 47265
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S000000	<p>This visit was for a State hospital licensure survey.</p> <p>Dates: 9/23/13 through 9/25/2013</p> <p>Facility Number: 005108</p> <p>Surveyors: Albert Daeger, CFM, SFPIO Medical Surveyor</p> <p>Saundra Nolfi, RN PH Nurse Surveyor</p> <p>QA: claughlin 10/29/13</p>	S000000		

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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S000278	<p>410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1(b)(2)(A)(B)(C)(D)</p> <p>(b) The governing board is responsible for the conduct of the medical staff. The governing board shall do the following: (2) Ensure that: (A) the requests of practitioners, for appointment or reappointment to practice in the hospital, are acted upon, with the advice and recommendation of the medical staff; (B) reappointments are acted upon at least biennially; (C) practitioners are granted privileges consistent with their individual training, experience, and other qualifications; and (D) this process occurs within a reasonable period of time, as specified by the medical staff bylaws.</p> <p>Based on documentation review, the facility failed to ensure 3 of 4 credentialed Allied Health Care Practitioners (AHP) were privileged for the hospital as defined by the Medical Staff By-Laws (#24, 25, and 26).</p> <p>Findings included:</p> <p>1. Medical Staff By-laws (last approved 5/16/2013) Article VIII section 8.3 states, "The standards</p>	S000278	<p>Discussion at Medical Staff Meeting on 10-17-13 on deficiency referencing credentialed files for Allied Health Care Practitioners. Further discussion between Hospital Administrator, President of Medical Staff and consultation with system office. Credentialing of Allied Health on the agenda for Medical Staff Meeting on 11-14-13. Recommendation will be made to place documentation in Allied Health current credentialing file regarding their credentialed and not privileged status will be presented at the Medical Staff Meeting for approval. Allied Health personnel</p>	11/15/2013			

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	<p>and criteria for the qualifications, duties, responsibilities, and privileges and the monitoring of AHP conduct shall be those established by the MEC and approved by the Board." The by-laws references all health care workers are required to have hospital privileges unless the reason a person who has been credentialed does not need hospital privileges is noted by the Medical Staff.</p> <p>2. Review of credential files for Allied Health Care Practitioners #24, 25, and 26 did not evidence that the health care practitioners were granted privileges to work in the hospital.</p> <p>3. The facility was unable to provide any documentation noting why the 3 allied health care practitioners did not have hospital privileges.</p>		<p>that are office based only and do not provide care within the hospital and do not have privileges for the Hospital, will have documentation placed in their current credentialing file regarding their credentialed and not privileged status. Administrative Assistant will be responsible as she prepares credentialing files for appointment and reappointment. Documentation will be placed in file 11-15-13 if approved by the Medical Staff. 11-20-13 Revised response: It was discussed at the Medical Staff Executive Committee on 11/14/13 that a letter with the following statement be placed in each Allied Health file requiring no privileges and also noted in the minutes of the meetings moving forward. It has been determined by the Medical Staff Executive Committee that blank practitioner be credentialed as part of the Medical Staff at St. Vincent Jennings Hospital but does not need hospital privileges due to no work in the Hospital being performed. The letter was signed and dated on 11-15-13 by the President of the Medical Staff and placed in the credential files of the Allied Health practitioners that do not require hospital privileges.</p>		

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S000318	<p>410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1(c)(6)(F)</p> <p>(c) The governing board is responsible for managing the hospital. The governing board shall do the following: (6) Require that the chief executive officer develops policies and programs for the following:</p> <p>(F) Ensuring cardiopulmonary resuscitation (CPR) competence in accordance with current standards of practice and hospital policy for all health care workers, including contract and agency personnel, who provide direct patient care. Based on policy review, the facility failed to ensure a definition of direct patient care, thus assuring which employees are required to provide CPR competency.</p> <p>Findings included:</p> <p>1. CPR policy #410993 (last approved 3/2013) states, "In keeping with the Core Value of Wisdom, all associates (full and part time) having direct patient care contact must successfully</p>	S000318	The policy for hospital associates was corrected to include which employees and/or what criteria is needed for the employees considered exempt for having CPR competency. The revision to this policy went to the PACC (Patient Area Care Committee) on October 21, 2013 and was approved. This policy will be reviewed annually to determine that the appropriate individuals are identified in the policy. The Chief Nursing Officer and the PACC committee will be responsible for the above. The deficiency was corrected and was approved through PACC on 10-21-2013. The policy for physicians was corrected to include which physicians and/or	10/22/2013			

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S000406	<p>complete BLS training bi-annually." The policy lacked which employees and/or what criteria is needed for the employees considered exempt from having CPR competency.</p> <p>410 IAC 15-1.4-2 QUALITY ASSESSMENT AND IMPROVEMENT 410 IAC 15-1.4-2(a)(1)</p> <p>(a) The hospital shall have an effective, organized, hospital-wide, comprehensive quality assessment and improvement program in which all areas of the hospital participate. The program shall be ongoing and have a written plan of implementation that evaluates, but is not limited to, the following:</p> <p>(1) All services, including services furnished by a contractor.</p> <p>Based on document review and staff interview, the facility failed to ensure 9 services provided by contractors were included as part of its comprehensive quality assessment and improvement (QA&amp;I) program.</p>	S000406	<p>what criteria is needed for CPR competency. The revision to this policy went to Medical Staff on October 17, 2013 and was approved. This policy will be reviewed annually to determine that the appropriate physicians are identified in the policy. The Administrative Assistant will be responsible for the above. The deficiency and policy put in place on 10-22-2013.</p> <p>Discussion at Patient Safety/Quality meeting 10-29-13 regarding reievow of contracts with direct or indirect impact on patient care quality.All contracts with direct of indirect impact on patient care quality have been reviewed and placed on a "Contracted Services" Quality list which will be presented on an annual basis to the Quality Committee, Medical</p>	11/25/2013	

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	<p>Findings included:</p> <ol style="list-style-type: none"> <li>The hospital's Quality Improvement Plan (last approved 9/2012) implements all service with direct or indirect impact on patient care quality shall be reviewed under the quality improvement program.</li> <li>Review of the facility's QA&amp;I program indicated it did not include contracted services Psychology-Telepsychology; Rehab-Inpatient; Rehab-Outpatient; Speech Pathology; Ambulance Service; Housekeeping; Nuclear Medicine; Occupational Therapy and Transcription Service.</li> <li>At 11:00 AM on 9/25/2013, staff member #1 indicated the QAPI committee has not identified issues that need to be evaluated regarding ambulance service. The staff member indicated housekeeping services</li> </ol>		<p>Staff and Board of Directors. Contracted Services Quality list will be presented to Medical Staff at their 11-14-13 for approval and then to the Hospital Board of Directors on 11-25-13 for approval. Data gathering will begin on 1-1-2014 for the first quarter of the calendar year. The Quality Coordinator will be responsible.</p>		

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	only reports biohazard, pest control and trash pickup issues to the QAPI Committee. The contracted services Psychology-Telepsychology; Rehab-Inpatient; Rehab-Outpatient; Speech Pathology; Nuclear Medicine; Occupational Therapy do not report any quality assurance issues to the QAPI Committee. The hospital Transcription Service is transcribed in Indianapolis and the staff member could not locate any documentation that evaluates the Transcription Services.			

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S000596	<p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(f)(3)(D)(iii)</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>(iii) Cleaning, disinfection, and sterilization.</p> <p>Based on document review and staff interview, the facility failed to ensure chemical Cidex OPA was used according to the manufacturer's recommendations and per policies for the Radiology Department.</p> <p>Findings included:</p> <p>1. Cidex OPA manufacturer sheet requires: 1) The user should be adequately trained in the demonstration and disinfection of semi-critical medical devices and the handling of liquid chemical</p>	S000596	<p>The GUS rinse container has been replaced with a water tub that holds 9 liters of water. The tub is filled with 9 liters of water by rinsing the transvaginal probe with 3 different volumes of water for at least 1 minute each time. The staff that uses the system has been educated and we will continue to do education that will require staff using the transvaginal probe to sign off monthly and send to Imaging Manager. The Imaging Manager will be responsible. The deficiency was corrected on 9/26/13. 11-20-13 Revised response: The GUS rinse container for the transvaginal probe has been replaced with a rinse tub that will hold greater than 9 liters of water. The process is to fill the rinse tub with</p>	09/26/2013

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	<p>germicides, 2) Manual rinsing procedure - thoroughly rinse the semi-critical medical device by immersing it completely in 2 gallons of water 3 times. Each time should be done for a minimum of 1 minute. Always use fresh water each time this step is done.</p> <p>2. The Cleaning of Ultrasound Equipment policy #US 170.01 (last approved 6/2012) indicates the probes are to be rinsed in the container of fresh water in the wall-mounted GUS ventilation system. The tube on the wall only holds 1 liter of water; therefore, the GUS system for rinsing vaginal probes does not comply with Cidex OPA manufacturing rinsing requirements for semi-critical equipment.</p> <p>3. At 2:00 PM on 9/24/2013, staff member #9 indicated the rinsing of the vaginal probes the hospital utilizes does not comply with the manufacturer's rinsing procedure</p>		<p>with at least 9 liters of water, place the transvaginal probe in the water to rinse for at least 1 minute and then empty the rinse water from the tub. The rinse tub is then refilled with at least 9 more liters of water, again placing the transvaginal probe in the water for the second time to rinse for at least 1 minute and then empty the rinse water from the tub. The rinse tub is then refilled for a third time with at least 9 more liters of water, again placing the transvaginal probe in the water for the third time to rinse for at least 1 minute and then emptying the rinse water from the tub. The transvaginal probe is now ready for the next procedure. Staff that uses this system has been educated and will continue to do education that will require the staff using the transvaginal probe to sign off monthly. The Imaging Manager will be responsible. The deficiency was corrected on 9-26-13.</p>				

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S000608	<p>for Cidex OPA.</p> <p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(f)(3)(D)(ix)</p> <p>(f) The hospital shall establish an infection control committee to monitor and guide the infection control program in the facility as follows: (3) The infection control committee responsibilities shall include, but not be limited to, the following: (D) Reviewing and recommending changes in procedures, policies, and programs which are pertinent to infection control. These include, but are not limited to, the following:</p> <p>(ix) Requirements for personal hygiene and attire appropriate for work settings.</p> <p>Based on documentation review, observation, and staff interview, the facility failed to maintain a clean sink for hand washing and for the use of an eye washing system.</p> <p>Findings included:</p> <p>1. The Dimension Xpand clinical</p>	S000608	The waste tubing was removed from the exterior of the sink and attached to the drain below the sink in a secure cabinet. The removal of the exterior tube corrected the excessive lime build up. The sink was designated as a "Dirty Sink" due to workflow needs of the laboratory. The paper towel dispenser and hand soap dispenser were removed from above the sink with signage of "Dirty Sink" posted for that sink. The separate eyewash unit remains adjacent to the sink.	10/02/2013
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	<p>chemistry system's operating manual states, "Warning: The waste tubing is biohazard."</p> <p>2. At 9/24/2013 at 12:42 PM, the Laboratory Department was toured. A double bay stainless steel sink was observed mounted on a work counter with an eye wash spraying system mounted to the left of the double bay sink. The clear plastic tubing was exiting the Dimension Xpand clinical chemistry system. This plastic tubing was observed draining into the left bay of the small double bay sink. This tube contains biohazard waste. The sink was observed with a paper towel dispenser and a detergent dispenser on the wall directly behind the double bay sink. The sink was heavily soiled with lime and other debris.</p> <p>3. At 1:15 PM on 9/24/2013, staff member #4 indicated the sink was a dirty sink; however, staff do use it for hand washing. The staff</p>		<p>Eyewash is only done through this free standing eyewash that is not part of the "Dirty Sink". The Plant Operations and Laboratory Managers are responsible. Corrected 10-2-13</p>	

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S000672	<p>member indicated a sink in the employee restroom and in the patient care area have hand washing lavatories with a sign on the wall noting they were clean sinks. The staff member confirmed hand washing practices and possible eye flushing were being conducted in a dirty sink.</p> <p>410 IAC 15-1.5-3 LABORATORY SERVICES 410 IAC 15-1.5-3(e)</p> <p>(e) All nursing and other hospital personnel performing out-of-laboratory testing shall have annually updated performance certification maintained in the employee file for the procedures being performed. Based on policy and procedure review, personnel file review, and interview, the facility failed to ensure all staff who performed out of lab testing had annual glucometer competency in 4 of 11 files reviewed (#P3, P5, P6, and P14).</p> <p>Findings included:</p> <p>1. The facility policy "Quality Testing Glucose Monitor", approved 06/2013,</p>	S000672	Hospital associates that are required to have documentation of yearly glucometer training will complete this training by November 30, 2013. Completion of yearly competencies is ultimately the associate's responsibility; however, the Department Managers will monitor their associates learning/competencies and hold the associates accountable. The Department Managers and	11/30/2013

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	<p>indicated, "5. Each RN/LPN, UC [registered nurse, licensed practical nurse, unit clerk/aide] shall have documented inservice of operating the Glucose Meter used in their individual unit and will show acceptable return demonstration of efficiency in usage at least annually."</p> <p>2. The personnel file for staff member #P3, an LPN hired 02/04/02, lacked documentation of an annual glucometer competency.</p> <p>3. The personnel file for staff member #P5, an aide hired 10/12/11, lacked documentation of an annual glucometer competency.</p> <p>4. The personnel file for staff member #P6, an RN hired 12/19/95, lacked documentation of an annual glucometer competency.</p> <p>5. The personnel file for staff member #P14, an agency RN hired 07/13/13, lacked documentation of any glucometer competency.</p> <p>6. At 2:00 PM on 09/25/13, staff member #A1 confirmed the missing training from the personnel files and indicated he/she thought the agency performed this for their staff, but was</p>		Human Resources will be responsible for the oversight of competencies.		

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S000765	<p>told it was up to the facility to provide it.</p> <p>410 IAC 15-1.5-4 MEDICAL RECORD SERVICES 410 IAC 15-1.5-4(g)(1)</p> <p>(g) A short stay record form used for inpatients hospitalized for less than forty-eight (48) hours, observation patients, ambulatory care patients and ambulatory surgery patients shall document and contain, but not be limited to, the following:</p> <p>(1) Identification data. Based on policy and procedure review, medical record review, and interview, the facility failed to ensure an Acute Short Stay History &amp; Physical, including a final diagnosis, was dictated for 3 of 4 patients who expired less than 24-hours after admission (#17, N19, and N20).</p> <p>Findings included:</p> <p>1. The facility policy "Documentation Guidelines", approved 04/2013, indicated, "Records shall be completed and authenticated within 30 days following patient discharge. ...An Acute Short Stay History &amp; Physical: In the case of an Acute Care visit of 24 hours or less; or, an Observation Stay, a Short Stay Summary may be dictated or hand written legibly, and be accompanied by a</p>	S000765	<p>Discussion at Medical Staff Meeting on 10-17-13. Policy will be reviewed and brought back to Medical Staff on 11-14-13. Policy and education will then be given to all medical staff members who provide hospital care. Death charts from Medical Surgical Unit will be reviewed for compliance. Chief Nursing Officer will be responsible. Deficiency will be corrected by 11-30-13.</p>	11/30/2013

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	<p>Final Progress Note in lieu of a Discharge Summary. Must include the condition of the patient on discharge. Must include final diagnosis. Must be dictated for all deaths."</p> <p>2. The medical record for patient #N17, who was triaged in the emergency department at 1635 on 06/23/13 and expired on the unit at 0227 on 06/24/13, lacked documentation of an Acute Short Stay History &amp; Physical or discharge summary or note.</p> <p>3. The medical record for patient #N19, who was triaged in the emergency department at 1922 on 12/06/12 and expired on the unit at 0047 on 12/06/12, lacked documentation of an Acute Short Stay History &amp; Physical or discharge summary or note.</p> <p>4. The medical record for patient #N20, who was triaged in the emergency department at 1545 on 11/09/12 and expired on the unit at 0600 on 11/10/12, indicated a dictated History &amp; Physical, but lacked a discharge summary or final note.</p> <p>5. At 1:30 PM on 09/25/13, staff member #A19 confirmed the missing forms and documentation on the death records reviewed.</p>						

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S000912	<p>410 IAC 15-1.5-6 NURSING SERVICE 410 IAC 15-15-6 (a)(2)(B)(i)(ii) (iii)(iv)(v)</p> <p>(a) The hospital shall have an organized nursing service that provides twenty-four (24) hour nursing service furnished or supervised by a registered nurse. The service shall have the following:</p> <p>(2) A nurse executive who is: (B) responsible for the following: (i) The operation of the services, including, but not limited to, determining the types and numbers of nursing personnel and staff necessary to provide care for all patient care areas of the hospital. (ii) Maintaining a current nursing service organization chart. (iii) Maintaining current job descriptions with reporting responsibilities for all nursing staff positions. (iv) Ensuring that all nursing personnel meet annual in-service requirements as established by hospital and medical staff policy and procedure, and federal and state requirements. (v) Establishing the standards of nursing care and practice in all settings in which nursing care is provided in the hospital.</p> <p>Based on medical record review, policy and procedure review, observation, and interview, the nurse executive failed to</p>	S000912	1,2,3,4,5,6 Emergency Room nursing staff will be re-educated on assessment, reassessment, need for intervention and	11/30/2013			

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	<p>ensure pain assessments were done according to policy for 4 of 4 pediatric patients (#N13, N14, N15, and N16) and failed to ensure patients at risk for falls were identified according to protocol for 3 of 3 inpatients (#N1, N2, and N3).</p> <p>Findings included:</p> <ol style="list-style-type: none"> <li>1. Review of the medical record for patient #N13, a 22-month old admitted through the emergency department (ED) on 08/13/13, indicated a drawing of a face in the area for the initial pain assessment in the ED and lacked any pain reassessment upon discharge from the ED in the space provided on the form.</li> <li>2. Review of the medical record for patient #N14, a 5-year old admitted through the emergency department on 02/20/13, indicated a lack of an initial pain assessment in the designated area of the ED form.</li> <li>3. Review of the medical record for patient #N15, a 10-month old admitted through the emergency department on 04/08/13, indicated a drawing of a face in the area for the initial pain assessment in the ED and lacked any pain reassessment upon discharge from the ED in the space provided on the form.</li> </ol>		<p>documentation of pediatric pain from admission to the Emergency Room to discharge from the Emergency Room. A six month chart review will be conducted on pediatric patients. Chief Nursing Officer will be responsible. Re-education of nursing staff will be completed by 11-30-13 and chart review will begin. 7,8,9 Falls Prevention policy was reviewed and revised on 10-2-13 to include the use of yellow armbands. The policy was read, reviewed and initialed by staff on the Medical Surgical Unit. The Nurse manager of the department will monitor for compliance of yellow armbands, yellow stars and high fall risk stickers and hold associates accountable if the policy is not being adhered to. The Medical Surgical Nurse Manager will be responsible. This deficiency was corrected on October 31, 2013</p>				

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	<p>A nursing assessment from 0035 on 04/09/13 indicated a pain rating of 8 out of 10, but lacked any documentation of any pain relief interventions.</p> <p>4. Review of the medical record for patient #N16, an 8-year old admitted through the emergency department on 06/03/13, indicated a lack of an initial pain assessment in the designated area of the ED form and lacked any pain reassessment upon discharge from the ED in the space provided on the form.</p> <p>5. The facility policy "Pain Management", approved 03/2013, indicated, "4. Assessment: ...Children may also be difficult to assess. Therefore, to assist in participation of the patient in pain management a variety of standardized pain assessment tools are available for implementation of process. ...5. Initial Assessment: ...Screen patient for the presence/absence of pain at the time of admission or presentation for care except for brief clinic visits. ...5. Reportable/Conditions/Notify M.D.: ...4. Determine any need for interventions with a patient report of 5/10 or higher on the Pain Scale or the FACES Scale."</p> <p>6. At 1:30 PM on 09/25/13, staff member #A19 confirmed the lack of</p>			

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	<p>documentation and indicated the use of the FACES Scale should be to determine a pain level of 1-10, not to draw a picture of a face.</p> <p>7. The facility policy "Falls Prevention", approved 03/2013, indicated, " Patients classified as having a high risk for falls will be provided with all the low risk interventions and the required interventions listed below: ...4. Yellow star on door or door frame. 5. Yellow non-skid footies when out of bed."</p> <p>8. During the tour of the Med/Surg unit at 1:45 PM on 09/23/13, accompanied by staff member #A1, yellow stars were observed on the door frames of rooms 109, 111, and 112. The patients in those rooms were visited with staff member #A11, a nurse on the unit, and all of them lacked yellow arm bands.</p> <p>9. At 1:55 PM on 09/23/13, staff members #A1 and A11 indicated it was protocol to use yellow armbands on fall risk patients to further identify them to all departments of the hospital. Yellow armbands were observed on the unit in the secretary's drawer.</p>			

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S001014	<p>410 IAC 15-1.5-7 PHARMACEUTICAL SERVICES 410 IAC 15-1.5-7(c)</p> <p>(c) In order to provide patient safety, the director of pharmacy shall develop and implement written policies and procedures for the appropriate selection, control, labeling, storage, use, monitoring, and quality assurance of all drugs and biologicals.</p> <p>Based on observation, policy and procedure review, and interview, the facility failed to follow its pharmacy policy regarding multidose medications.</p> <p>Findings included:</p> <p>1. During the tour of the Med/Surg unit at 1:45 PM on 09/23/13, accompanied by staff member #A1, three of three open, but not dated, Novolog Flexpens were observed in the medication area labeled for three current inpatients.</p> <p>2. The facility policy "Multiple Dose Vials (with preservatives)", approved 08/2013, indicated, "b. A '28 day' future expiration date (or shorter date as recommended by manufacturer or pharmacist) must be applied to all insulin 'pen' devices at the time of dispensing from pharmacy or retrieval from automated dispensing cabinet and upon accessing/withdrawing first dose."</p>	S001014	<p>The policy "Multiple Dose Vials" has been read, reviewed and initiated by the staff in the Medical Surgical Department. Staff were re-educated related to the policy and procedure. Nurses are responsible for labeling multi dose vials when removed from the automated medication dispensing machine for use. Nurses and pharmacy staff are responsible for removing and discarding any multi dose vial that are open and not labeled. Corrected by 11-30-13</p>	11/30/2013

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S001118	<p>3. At 2:05 PM on 09/23/13, staff member #A11, a nurse on the unit, indicated the insulin pens should be dated when first opened and discarded within 30 days.</p> <p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8 (b)(2)</p> <p>(b) The condition of the physical plant and the overall hospital environment shall be developed and maintained in such a manner that the safety and well-being of patients are assured as follows:</p> <p>(2) No condition shall be created or maintained which may result in a hazard to patients, public, or employees.</p> <p>Based on documentation review, observation and staff interview, the facility failed to maintain the hospital environment and equipment in such a manner that the safety and well-being of patients, visitors, and/or staff are assured in four (3) instances: Power Plant, Med Surg Dump Station, and Surgery Soiled Dump Station and failed to ensure a safe environment for patients by following facility policy and</p>	S001118	<p>2. Plant Operations installed two mobile eyewash stations on 10-9-13 in the Mechanical Room area, one located next to where the Chem-Aqua 999 is added to the boiler water and one located in the Generator Room where the engine batteries aare located. These stations aare rated for 15 minutes of flush. The inspection cycle, permanufacture, is on a monthly routine. This will be completed by Operation staff and documented in the Mechanical Room Office. Plant Operations Manager is responsible for oversite of the documentation. Completed on 10-9-134. Plant</p>	11/30/2013

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	<p>manufacturer's recommendations regarding warming fluids and checking emergency supplies/equipment.</p> <p>Findings included:</p> <p>1. Hazardous Material Response Policy #SAF 57.03 (Last approved 9/2012) states, St. Vincent Jennings Hospital to fully comply with OSHA. OSHA defines a hazardous chemical as any chemical which is physical or health hazard. If an employee comes in contact with minor exposure that the employee report to the Emergency Department; however, prior to departing the area where the incident occurred, the associate should flush their eyes with water for a minimum of 15 minutes.</p> <p>2. At 1:45 PM on 9/23/2013, the Power Plant was toured. The Power station was observed with a 32-ounce saline water bottle mounted on the wall. The Power</p>		<p>Operations installed an eyewash station on 10-9-13 in the Med-Surg Dump Station closet that is rated for 15 minutes of flush. This is where Environmental Services may manually mix cleaners/chemicals needed to perform their task. The inspection cycle, per manufacture, on a monthly basis by Environmental Services staff. Environmental Services will be responsible for eyewash documentation of inspections. The Environmental Services Team Lead will be responsible for over site of the documentation. Completed on 10-9-135. Plan Operation installed an eyewash unit on 10-9-13 to one of the faucets located in the Surgery Soiled Dum Station Area. This is a faucet mount unit that meets the 15 minute flush and will be inspected, per manufacture, on a weekly basis. Surgery staff will be responsible for weekly test of operation and documentation. The Surgery Nurse Manager will be responsible for over site of the documentation. Completed on 10-9-13.6. 7. 8. Policy for checking the Medical Surgical Crash Cart was revised on 10-22-13 to include the monthly inspection of equipment and to check for expired supplies by the staff on the Medical Surgical Department. Documentation by Med Surg staff is to be made on the log sheet daily to attest to the integrity of the lock.</p>		

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	<p>Station has generators that require the batteries to be filled if needed weekly and Chem-aqua 999 testing chemical for the boilers. The Chem-aqua 999 and the batteries both require a minimum of 15-minutes of flushing of eyes if they get exposed with the chemical or acid from the batteries. The water bottle does not meet the required 15-minute eye flushing.</p> <p>4. At 3:00 PM on 9/23/2013, the Med Surg Dump Station was inspected. The room was observed where housekeeping dilutes chemicals in their mop buckets. The housekeeping staff utilizes concentrated Lime-away. The manufacturer's label specifies if the chemical comes into contact with a person's eyes, the eyes must be flushed with water for at least 15-minutes. The Med Surg Dump Station was observed with a 32-ounce saline water bottle mounted on the wall. However, the water bottle does not meet the</p>		<p>Pharmacy is responsible for checking the pharmaceuticals monthly and documenting on the crash cart log sheet that they have checked the cart and shall enter a new tag number on the log sheet. The Med-Surg Department Manager will be responsible for auditing the log sheets and making sure that they are complete and accurate. Completed on 10-22-13.9A. The ultrasound gel, footies, and patient wipes were removed from the Olympic Warmette in the clean storage room in the Emergency Room the day the deficiency was noted. A daily temperature log was implemented with the manufacturer's acceptable range for temperature. Emergency Room staff was educated on its use. The Chief Nursing Officer will be responsible for monitoring. Completed on 9-26-13.9B. Broselow pediatric emergency kits were ordered and replaced the outdated kits on the pediatric crash cart. Blue locks were placed on the kits to ensure integrity of the bags. Integrity of the Broselow kit locks are checked on a daily basis when the integrity of the crash cart lock is checked. Chief Nursing Officer will be responsible for monitoring the crash cart check log. Corrected on 10-11-13.9C. As per Pharmacy policy of "Inspection of Medication Storage Areas" the Pharmacy is</p>	

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	<p>required 15-minute eye flushing.</p> <p>5. At 4:00 PM on 9/23/2013, the Surgery Soiled Decontamination room was inspected. The room was observed without an eye washing system. The staff in the room utilizes concentrated Aseptizyne and Renuzyme. The chemicals are diluted in the room. Both chemicals require a minimum of 15-minutes of eye flushing with water. The room did not have an eye wash station that meets the emergency needs if the chemical would come into contact with someone's eye.</p>		<p>responsible for performing monthly inspections for outdated medications - which includes Code Cart Medications. Discussion with Pharmacist has occurred. Emergency Room nursing staff has been re-educated on monthly inspection of the crash cart equipment and supplies. The Chief Nursing Officer is responsible for monitoring the crash cart check list. Corrected on 10-1-13.9D. As per Pharmacy policy of "Inspection of Medication Storage Areas" the Pharmacy is responsible for performing monthly inspections for outdated medications - which includes Code Cart Medications. Discussion with the Pharmacist has occurred. Emergency Room nursing staff has been re-education on monthly inspection of the crash cart equipment and supplies. The Chief Nursing Officer is responsible for monitoring the crash cart check list. Corrected on 10-1-13.10. A daily temperature log was implemented with the manufacturer's acceptable range for temperature. Emergency Room staff was educated on its use. The Chief Nursing Officer will be responsible for monitoring. Completed on 9-26-13. Emergency Room nursing staff has been re-educated on monthly inspection of the crash cart</p>		

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			<p>equipment and supplies. The Chief Nursing Officer is responsible for monitoring the crash cart check list. Corrected 10-1-13.11A&amp;B. Date all fluids placed in the warmer. Parental Solutions warmed in their plastic outer wrap may be stored in warmer for 14 days at temperatures not exceeding 104 degrees. Parental solutions and intravenous fluids shall not exceed 104 degrees. Staff was educated on change, never to be heated above 104 degrees. Do not re-warm fluids. If all of warmed solution is not used, after taken out of warmer, it is to be disposed of and not returned to warming cabinet. A daily log will continue to be kept, with temperatures not to exceed 104 degrees as indicated by the policy and manufacturer guidelines. The Surgery Nurse Manager will be responsible for monitoring the daily log. Completed on 10-1-13.12. As per Pharmacy policy of "Inspection of Medication Storage Areas" the Pharmacy is responsible for performing monthly inspections for outdated medications - which includes Code Cart Medications. Discussion with Pharmacist has occurred. The Surgery Nurse Manager is responsible for monitoring the crash cart check list. Corrected 10-1-1313. The policy was changed to include the monthly inspection of equipment and to check for expired</p>	

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			<p>products. This has been added to the log sheet and will be completed monthly. Department managers will be responsible for monitoring the log sheets and making sure that they are complete and accurate. Changes to the log sheet will be completed by 11-30-13.14. As per Pharmacy policy of "Inspection of Medication Storage Areas" the Pharmacy is responsible for performing monthly inspections for outdated medications - which includes Code Cart Medications. Discussion with Pharmacist has occurred. The Pharmacist or Pharmacy Technician is responsible for monthly inspection of outdated medications of all code cart medications and emergency drug boxes. Corrected 10-1-13.15, 16. Date all fluids placed in the warmer. Parental Solutions warmed in their plastic outer wrap may be stored in warmer for 14 days at temperatures not exceeding 104 degrees. Parental solutions and intravenous fluids shall not exceed 104 degrees. Staff was educated on change, never to be heated above 104 degrees. Do not re-warm fluids. If all of warmed solution is not used, after taken out of warmer, it is to be disposed of and not returned to warming cabinet. A daily log will continue to be kept, with temperatures not to exceed 104 degrees as indicated by the policy</p>	

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	6. During the tour of the Med/Surg unit at 1:45 PM on 09/23/13, accompanied by staff member #A1, the emergency crash cart was opened and 3 of 3 packages of gauze sponges were observed with expiration dates of		and manufacturer guidelines. The Surgery Nurse Manager will be responsible for monitoring the daily log. Corrected on 10-1-13. 17. The ultrasound gel was removed from the blanket warmer in the Emergency Department. Ultrasound gel will no longer be heated in the Emergency Department. The Chief Nursing Officer will be responsible for monitoring the daily log. Corrected on 9-26-13.18. Date all fluids placed in the warmer. Parental Solutions warmed in their plastic outer wrap may be stored in warmer for 14 days at temperatures not exceeding 104 degrees. Parental solutions and intravenous fluids shall not exceed 104 degrees. Staff was educated on change, never to be heated above 104 degrees. Do not re-warm fluids. If all of warmed solution is not used, after taken out of warmer, it is to be disposed of and not returned to warming cabinet. A daily log will continue to be kept, with temperatures not to exceed 104 degrees as indicated by the policy and manufacturer guidelines. The Surgery Nurse Manager will be responsible for monitoring the daily log. Corrected on 10-1-13.		

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	<p>11/2010 and 12/2012. The Crash Cart/Emergency Box Inspection Log on the cart indicated, "Please do not break the seal, except for emergency use or monthly pharmacy inspection. On the 1st of each month please open cart &amp; make sure all equipment is working (i.e. light on laryngoscope) and no expired products. Document accordingly." The logs indicated pharmacy checked outdates on 08/01/13 and put a new seal on and that same seal was on when opened for the check on 09/23/13. The log indicated once daily checks had been done by nursing staff.</p> <p>7. At 1:55 PM on 09/23/13, staff member #A11, a nurse on the unit, indicated checks were done daily by nursing staff to determine the integrity of the seals and he/she thought the night shift staff opened the cart to check the supplies.</p> <p>8. At 2:55 PM on 09/23/13, pharmacy staff member #A12 indicated he/she opened and checked the emergency carts monthly, but only checked the medications, not the other supplies.</p> <p>9. During the tour of the Emergency Department (ED) at 3:00 PM on 09/23/13, accompanied by staff member #A1, the following observations were</p>			

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	<p>made:</p> <p>A. An Olympic Warmette in the clean storage room containing blankets, packages of patient wipes, footies, and a plastic container of ultrasound gel, registered 140 degrees Fahrenheit (F). A manufacturer's label on the unit indicated, "Do not exceed 120 degrees Fahrenheit for blankets."</p> <p>B. Broselow pediatric emergency kits on a shelf in the trauma room with items expiring in 2011 and 2012. The red/orange kit had been opened and was without its locking seal.</p> <p>C. The logs for the pediatric crash cart inspections lacked documentation of any checks for 14 days in August 2013 indicated only once a day checks for the other days in August and September. The logs lacked documentation of monthly pharmacy checks and indicated the same seal was on from 07/17/13 through the inspection on 09/23/13.</p> <p>D. The logs for the hallway crash cart lacked documentation of any checks for 14 days in August 2013 and for 12 days so far in September with only once a day checks for the other days. The log indicated the same seal number from 07/18/13 through 09/10/13 with no pharmacy checks during that time.</p> <p>10. At 3:50 PM on 09/23/13, staff member #A13, a nurse in the ED,</p>						

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	<p>indicated the temperature of the warming unit was not monitored and he/she was unsure about the crash cart checks.</p> <p>11. During the tour of the surgical department at 3:55 PM on 09/23/13, accompanied by staff member #A5, the following observations were made:</p> <p>A. A Steris Amsco warmer in Operating Room #1, registering 114 degrees F. in the top cabinet with intravenous (IV) and irrigation fluids, and 119 degrees F. in the bottom cabinet with blankets. Four bags of IV fluid were dated 10/7 on their plastic overwrap. A sign was taped on the warmer which indicated, "IV/Parenteral Solutions warmed in their plastic outer wrap may be stored in warmer for 14 days at temperatures not exceeding 104 degrees or 72 hours at 150 degrees."</p> <p>B. The Warming Cabinet Temperature Log for September 2013 indicated the temperature in the top cabinet ranged between 112 and 115 degrees F. and the bottom cabinet ranged between 117 and 120 degrees F.</p> <p>C. The crash cart inspection logs indicated a pharmacy check on 06/06/13 and a new seal was put on and documentation indicated that same seal was on until pharmacy performed another check on 09/23/13.</p>			

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	<p>12. At 4:10 PM on 09/23/13, staff member #A5 indicated the IV solutions were dated for 14 days in the warmer and indicated the pharmacy staff checked all of the supplies in the crash carts.</p> <p>13. The facility policy "Crash Cart", approved 03/2013, indicated, "The Emergency Department, Surgery, and Med/Surg (Inpatient) nurses are responsible for checking the tamper proof seal on the cart at the beginning of each shift."</p> <p>14. The facility policy "Delivery and Storage of Medications Outside of the Pharmacy Department", approved 08/2013, indicated, "II. Non-Pharmacy Areas: A. The Pharmacy manager or designee will perform monthly inspections in non-Pharmacy areas (e.g. nursing units, ancillary departments) which store medications. The responsible individual will inspect the following in each area as applicable: 1. Code cart medications. 2. Emergency drug boxes."</p> <p>15. The facility policy "Warming of Irrigation Fluids/Intravenous Solutions", last reviewed 02/13/12, indicated, "1. Date all fluids placed in the warmer. 2.</p>			

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	<p>Parenteral Solutions warmed in their plastic outer wrap may be stored in warmer for 14 days at temperatures not exceeding 104 degrees or 72 hours at 150 degrees."</p> <p>16. Manufacturer's information regarding the fluids indicated, "Warming Recommendations for Large Volume Parenterals (Intravenous Solutions in plastic bags): IV solutions of volumes 150 ml. or greater can be warmed in their plastic overpouches to temperatures not exceeding 40 degrees C. (104 F.), and for a period no longer than 14 days."</p> <p>17. Manufacturer's information regarding the ultrasound gel indicated the variable temperature range was 90 to 120 degrees F.</p> <p>18. At 1:30 PM on 09/24/13, manufacturer's fluid warmer information was reviewed with staff member #A5 who confirmed the incorrect temperatures and indicated he/she misunderstood the temperature ranges between the IV fluids and the irrigating fluids.</p>				

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S001162	<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>Based on document review and observation, the facility failed to comply with manufacturer recommendations for the Hydrocollator located in the Physical Therapy Department.</p> <p>Findings included:</p> <p>1. The Operation Manual instructions for the use and operation of the Physical Therapy Department's Hydrocollator M-4 note the thermostats are extremely sensitive and the slightest adjustment will alter the temperature several degrees. The</p>	S001162	<p>The hydrocollator temperature was reset to meet the manufacturer temperature recommendations on 9-26-13 and the hydrocollator log was edited to reflect the recommended temperature as well. On 11-1-13, a manufacturer's manual for this equipment was obtained and is now located in a file cabinet at the registration area of the Physical Therapy Department. The recommended range of 160-165 degrees Fahrenheit has been highlighted for quick reference. On 11-1-13, the policy for this was edited to reflect the manufacturer's temperature recommendation. The hydrocollator log is posted above the hydrocollator in clear view. The temperature will be checked and logged daily by either the Team Leader or the</p>	11/01/2013

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	<p>recommended operating temperature was 160 to 166 degrees Fahrenheit. The temperature of the water should be checked before using the Steam Packs.</p> <p>2. The St. Vincent Jennings Hospital Physical Therapy Department Hydrocollator Temperature Log notes the Safety Temperature Range was 150 to 176 degrees Fahrenheit; however, this was not complying with the manufacturer's recommendations. Therefore, the 24 out of 58 days the Physical Therapy Department was open in July 2013 through September 23, 2013, the hot water temperature of the hydrocollator did not fall in the required temperature range of 160 to 166 degrees Fahrenheit.</p>		<p>Administrative Assistant in Physical Therapy. Adjustments of the thermostat will be made as fluctuations of temperature outside the recommended range occur. Maintenance will be notified of any consistent significant fluctuations to determine if repairs are necessary. The Physical Therapy Team Leader will be responsible for oversight of the temperature log.</p>	