

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151315	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/04/2014
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NAME OF PROVIDER OR SUPPLIER CAMERON MEMORIAL COMMUNITY HOSPITAL INC	STREET ADDRESS, CITY, STATE, ZIP CODE 416 E MAUMEE ST ANGOLA, IN 46703
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C000000	<p>The visit was for a Federal Critical Access Hospital re-certification survey.</p> <p>Facility Number: 005037</p> <p>Survey Date: 02/03-04/14</p> <p>Surveyors: Brian Montgomery, RN Public Health Nurse Surveyor</p> <p>Linda Plummer, RN Public Health Nurse Surveyor</p> <p>Lynnette Smith, BS MLT (ASCP) Medical Surveyor 3</p> <p>QA: cloughlin 02/11/14</p>	C000000		
C000272	<p>485.635(a)(2) PATIENT CARE POLICIES The policies are developed with the advice of a group of professional personnel that includes one or more doctors of medicine or osteopathy and one or more physician assistants, nurse practitioners, or clinical nurse specialists, if they are on staff under the provisions of §485.631(a)(1); at least one member is not a member of the CAH staff.</p> <p>Based on document review and</p>	C000272	The house-wide patient care	05/14/2014

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

TITLE

(X6) DATE

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

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	<p>interview, the facility failed to assure that its patient care policies were developed with the advice of a group that included at least one doctor of medicine (MD) or osteopathy (DO) and one or more physician assistants, nurse practitioners or clinical nurse specialists for 4 patient care policies.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. Review of the policy/procedure Policy Management (effective date 2-14) failed to indicate a requirement or process assuring that at least one MD or DO participated with new patient care policy development and the policy/procedure failed to document any MD or DO participation with its development and/or approval. The policy/procedure failed to indicate, if applicable, the criteria for any policies not subject to the requirement. 2. During an interview on 2-04-14 at 1105 hours, staff A4 confirmed that the policy/procedure lacked a requirement or process to validate MD or DO participation with new patient care policy development and approval, lacked evidence of MD or DO participation with its development and lacked criteria (if applicable) for excluding any policies from the group development requirement. 3. The policy/procedure titled Policy Review Rehabilitation Department (effective 6-13) indicated the following: "The policies governing physical therapy, 		<p>policy development process will be reviewed. COMPLETION DATE- 03/15/2014 The organizational process for a group of professionals that includes one or more doctors of medicine or osteopathy to develop patient care policies will be finalized-COMPLETION DATE- 04/14/2014 The policy on policies will be revised to include the new policy development process. COMPLETION DATE-05/14/2014</p>				

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	<p>occupational therapy, speech therapy and diabetic education will be reviewed annually ...no annual physician review is required ...policies requiring physician input ...are discussed with the physician prior to implementing any new procedures ..." The policy/procedure failed to ensure documentation of participation by the medical director of rehabilitation services or another MD or DO for rehab services policy development and failed to indicate physician participation with its development and approval.</p> <p>4. The policy/procedure Crash Cart Maintenance and Exchange (effective 11-13) and Code Blue Procedure, Roles and Responsibilities (effective 9-13) failed to document any MD or DO participation with its development and/or approval.</p> <p>5. During an interview on 2-04-14 at 1045 hours, the Emergency Department (ED) director A14 indicated that a committee including chief nursing officer A2, chief operating officer A3, pharmacy director A11, medical surgical director A15, nursing educator A16, materials management manager A17, and respiratory therapy manager A18 were developing a standardized crash cart for use throughout the facility including the ED. The ED director A14 confirmed that</p>			

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C000280	<p>the ED medical director or other physician was not participating with the crash cart standardization and policy development.</p> <p>485.635(a)(4) PATIENT CARE POLICIES These policies are reviewed at least annually by the group of professional personnel required under paragraph (a)(2) of this section, and reviewed as necessary by the CAH. Based on document review and interview, the facility failed to assure that its patient care policies were reviewed at least annually by a group that included at least one doctor of medicine (MD) or osteopathy (DO) and one or more physician assistants, nurse practitioners or clinical nurse specialists for its rehabilitation (physical therapy, occupational therapy and speech therapy) policies.</p> <p>Findings:</p> <p>1. The policy/procedure titled Policy Review Rehabilitation Department (effective 6-13) indicated the following: "The policies governing physical therapy, occupational therapy, speech therapy and diabetic education will be reviewed annually by the director of rehabilitation ...no annual physician review is</p>	C000280	<p>The house-wide patient care policy review process will be reviewed. COMPLETION DATE- 03/15/2014. The organizational process for a group of professionals that includes one or more doctors of medicine or osteopathy to annually review patient care policies will be finalized. COMPLETION DATE- 04/14/2014 The policy on policies will be revised to include the new review process. COMPLETION DATE-05/14/2014 Existing patient care policies will be identified and tagged. COMPLETION DATE-06/13/2014 The revised policy on policies will be fully implemented. Existing patient care policies will be routed through the new review process. COMPLETION DATE-07/13/2014</p>	07/13/2014

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C000282	<p>necessary." The policy/procedure failed to ensure documentation of annual review by the medical director of rehabilitation services or another MD or DO and failed to validate physician participation with its development or annual review.</p> <p>2. During an interview on 2-04-14 at 1100 hours, staff A4 confirmed that the rehabilitation services policy/procedure failed to require documentation of its policy/procedure review by its medical director or another MD or DO and confirmed that no documentation of an annual review by an MD or DO was available.</p> <p>485.635(b)(2) PATIENT SERVICES Laboratory services. The CAH provides, as direct services, basic laboratory services essential to the immediate diagnosis and treatment of the patient that meet the standards imposed under section 353 of the Public Health Service Act (42 U.S.C. 236a). (See the laboratory requirements specified in part 493 of this chapter.) The services provided include: (i) Chemical examination of urine by stick or tablet method or both (including urine ketones); (ii) Hemoglobin or hematocrit; (iii) Blood glucose; (iv) Examination of stool specimens for occult blood; (v) Pregnancy tests; and</p>						

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	<p>(vi) Primary culturing for transmittal to a certified laboratory.</p> <p>Based on policy and procedure review, manufacturer's recommendations, observation, and staff interview, the facility failed to ensure that no condition was created that might cause a hazard to patients related to glucometer test strips.</p> <p>Findings</p> <ol style="list-style-type: none"> review of the policy and procedure "Stat Strip Glucose Meter Patient Testing Care and Maintenance", policy number 385842, with a last "review/approved" date of 02/2013, indicated: <ol style="list-style-type: none"> on page two under "General", it reads: "Important: Test Strips are stable until the expiration date on vial. Vials should be dated when first opened. Test strips are stable for 3 months after opening or until the expiration date on vial, whichever come first..." at 2:05 PM on 2/4/14, review of the package insert for the Nova Stat Strips indicated under "storage and handling": "Expiration: The expiration date is printed on the vial of test strips. Once opened the StatStrip Test Strips are stable when stored as indicated for up to 180 days or until the expiration date, whichever comes first." at 8:35 AM on 2/4/14, while on tour 	C000282	Expiration date reminder labels placed on all glucometers.- COMPLETION DATE 02/20/2014. Policy will be changed to reflect the manufacture's guidelines- COMPLETION DATE OF 03/12/2014. Staff will be re-educated by 03/24/2014 regarding the chages and reminding staff to label vials when opened.- Director of Nursing will be the person responsible for changes and education and monitoring.	03/24/2014

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	<p>of the out patient/off site urgent care center in the company of staff member #61, the chief operations officer, and #74, the director of the urgent care center, it was observed in the nursing area that the glucometer test strips were not dated when opened, nor with an expiration date</p> <p>4. interview with staff members #61 and #74 at 8:35 AM on 2/4/14 indicated it cannot be determined when the 180 day expiration date is on the test strips at the urgent care center since the strips were not dated when opened, or with a 180 day expiration date</p> <p>5. at 11:30 AM on 2/4/14, while on tour of the Med/Surg area with staff member #61, the chief operations officer, and staff member #72, the nurse director of med/surg, it was observed that the glucometer test strips were dated as opened on 1/31/14 and dated with an expiration date of 2/28/14</p> <p>6. interview with staff members # 61 and #72 at 11:30 AM on 2/4/14 indicated the test strips were incorrectly dated as the expiration date should have been 180 days, not 30 days</p> <p>7. at 1:45 PM on 2/4/14, while on tour of the obstetrics department in the company of staff members #61, the chief operating</p>			

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C000291	<p>officer, and #75, the RN director of obstetrics, it was observed that the glucometer test strips were dated when opened on 2/1/14 and dated with an expiration date of 3/1/14</p> <p>8. interview with staff members #61 and #75 at 1:45 PM on 2/4/14 indicated the test strips are actually good for 180 days after opening, not 30 days</p> <p>9. interview with the infection control preventionist, staff member #65, at 12:25 PM on 2/4/14, indicated:</p> <p>a. the policy 385842, listed in 1. above, does not match the manufacturer's package insert recommendations for 180 day stability after opening</p> <p>b. nursing staff are not following either the policy for 90 day (3 month) expiration, or 180 days, per the manufacturer</p> <p>c. the urgent care center failed to follow the policy in dating the test strips at all after opening</p> <p>485.635(c)(3) SERVICES PROVIDED THRU AGREEMENT/ARRANGEMENT The CAH maintains a list of all services furnished under arrangements or agreements. The list describes the nature</p>				

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C000396	<p>and scope of the services provided. Based on document review and interview, the facility failed to maintain a list of all contracted services, including the nature and scope of services provided for 16 of 66 contracted services.</p> <p>Findings:</p> <ol style="list-style-type: none"> The list of contracted services failed to indicate a description or scope of service for 3 of 3 listed emergency department services, 1 of 14 laboratory services, 2 of 13 pharmacy services, 5 of 12 radiology services, 2 of 14 rehabilitation services, 1 of 3 respiratory therapy services, and 2 of 7 surgical services. During an interview on 2-04-14 at 1340 hours, the director of performance improvement A20 confirmed that the indicated services listed under the categories of laboratory, pharmacy, radiology, and rehabilitation lacked a description or nature and scope of services provided. <p>485.645(d)(6) COMPREHENSIVE CARE PLANS [The CAH is substantially in compliance with the following SNF requirements contained in subpart B of part 483 of this chapter: Comprehensive assessment,</p>			C000291	<p>The current list of contracted services will be reviewed to identify gaps in those listed as well as the presence of a description or scope of service for each. COMPLETION DATE 03/14/2014 A comprehensive list of all contracts will be completed. COMPLETION DATE 04/14/2014 Each contracted service listed will indicate a description or scope of service. COMPLETION DATE-05/14/2014</p>		05/14/2014

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	<p>comprehensive care plan, and discharge planning (§483.20(b), (k), and (l), except that the CAH is not required to use the resident assessment instrument (RAI) specified by the State that is required under §483.20(b), or to comply with the requirements for frequency, scope, and number of assessments prescribed in §413.343(b)).]</p> <p>Comprehensive care plans (§483.20(k)(2))</p> <p>"A comprehensive care plan must be-</p> <p>(i) Developed within 7 days after completion of the comprehensive assessment;</p> <p>(ii) Prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and</p> <p>(iii) Periodically reviewed and revised by a team of qualified persons after each assessment."</p> <p>Based on policy and procedure review, patient medical record review, and staff interview, the facility failed to ensure that the patient's physician participated with care planning and care conferences as part of the interdisciplinary team.</p> <p>Findings: 1. review of the policy and procedure "Swing Bed Care Conference", policy number 533636, with a</p>	C000396	Policy will be revised to reflect changes regarding physician involvement in comprehensive care plans. (COMPLETION DATE 03/12/2014) Staff will be re-educated on the changes in the policy and improving documentation with a (COMPLETION DATE OF 03-24-2014). Care Coordinator will be responsible for the changes to the policy and educating staff members and	03/24/2014

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	<p>"review/approved" date of 08/2013, indicated:</p> <p>a. under "Procedure", it reads: "...1. Conferences will be held on a mutually agreeable schedule for the Rehab Center staff, Nursing staff, Discharge Planner, and patient's significant others/family if indicated..."</p> <p>2. review of two open swing bed patient medical records at 3:15 PM on 2/4/14, indicated:</p> <p>a. pt. #5:</p> <p>A. was admitted to swing bed status on 1/30/14</p> <p>B. had a care conference on 2/3/14</p> <p>C. lacked any documentation that the patient's physician participated in the development of the care plan and/or the care conference</p> <p>b. pt. #6:</p> <p>A. was admitted to swing bed status on 1/30/14</p> <p>B. had a care conference on 2/3/14</p> <p>C. had documentation in the minutes of the care conference that read: "...Dr. [named] notified of plan."</p> <p>3. interview with staff member #72, the RN (registered nurse) manager/director of med/surg, at 3:30 PM on 2/4/14, indicated:</p> <p>a. the physician never attends care conferences as they are so busy</p>		communication with physicians.	

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S000000	<p>b. physicians are involved in patient care decisions, but documentation does not show this</p> <p>c. it was unknown that physician attendance was required at the care conferences</p> <p>d. documentation is lacking that would indicate the attending physician is involved in care planning and care conferences</p> <p>e. the facility policy does not include language to indicate the inclusion of physician participation in care conferences and planning</p> <p>The visit was for a licensure survey.</p> <p>Facility Number: 005037</p> <p>Survey Date: 02/03-04/14</p> <p>Surveyors: Brian Montgomery, RN Public Health Nurse Surveyor</p> <p>Linda Plummer, RN Public Health Nurse Surveyor</p> <p>Lynnette Smith, BS MLT (ASCP) Medical Surveyor 3</p>	S000000		

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S000394	<p>QA: cloughlin 02/11/14</p> <p>410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1(f)(3)</p> <p>(f) The governing board is responsible for services delivered in the hospital whether or not they are delivered under contracts. The governing board shall insure the following:</p> <p>(3) That the hospital maintains a list of all contracted services, including the scope and nature of the services provided. Based on document review and interview, the facility failed to maintain a list of all contracted services, including the scope and nature of services provided for 16 of 66 contracted services.</p> <p>Findings:</p> <p>1. The list of contracted services failed to indicate a description or scope of service for 3 of 3 listed emergency department services, 1 of 14 laboratory services, 2 of 13 pharmacy services, 5 of 12 radiology services, 2 of 14 rehabilitation services, 1 of 3 respiratory therapy services, and 2 of 7 surgical</p>	S000394	<p>The current list of contracted services will be reviewed to identify gaps in those listed as well as the presence of a description or scope of service for each. COMPLETION DATE- 03/15/2014 A comprehensive list of all contracts will be completed. COMPLETION DATE 04/14/2014 Each contracted service listed will indicate a description or scope of service. COMPLETION DATE-05/14/2014</p>	05/14/2014

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S000508	<p>services.</p> <p>2. During an interview on 2-04-14 at 1340 hours, director of performance improvement A20 confirmed that the indicated services listed under the categories of laboratory, pharmacy, radiology, and rehabilitation lacked a description or scope and nature of services provided.</p> <p>410 IAC 15-1.5-1 DIETETIC SERVICES 410 IAC 15-1.5-1(b)(1)(A)(B)</p> <p>(b) The food and dietetic service shall have the following:</p> <p>(1) A full-time employee who: (A) serves as director of the food and dietetic services; and (B) is responsible for the daily management of the dietary services.</p> <p>Based on policy and procedure review, observation, and interview, the food service director failed to ensure the implementation of its policy related to the cleaning of a nursing unit refrigerator in the medical/surgical unit.</p> <p>Findings: 1. review of the policy and procedure "Temperatures Of Refrigerators And Freezers, 3011", policy number 420066, with a last "review/approved" date of</p>	S000508	<p>Policy is being revised by Infection Prevention Nurse to clearly define who is responsible for the refrigerator cleaning. This policy will be hospital wide. There will also be a cleaning log added to track when the refrigerators have been cleaned.</p> <p>COMPLETION DATE 03/12/2014. Staff will be re-educated by 03/24/2014 by the Infection Prevention Nurse. Senior Director of Nursing in collaboration with Infection Prevention Nurse will monitor compliance.</p>	03/24/2014

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	<p>04/2013, indicated:</p> <p>a. under "Policy", it reads: "...Pantry refrigerator/freezer units in Med Surg, Ambulatory and OB (obstetrics) are cleaned as spills occur, and on a weekly basis (weekend...position)."</p> <p>2. at 11:45 AM on 2/4/14, while on tour of the medical/surgical nursing unit in the company of staff member #61, the chief operations officer, and #72, the RN (registered nurse) med/surg director, it was observed in the pantry that the patient refrigerator was dirty with crumbs/debris on the bottom shelf of the freezer and on the lowest shelf of the door of the refrigerator</p> <p>3. interview at 12:32 PM on 2/4/14 with staff member #73, the food services director, indicated:</p> <p>a. the policy listed in 1. above is a food services policy and signed off by this staff member</p> <p>b. there is no checklist/log or documentation that would show the last time the med/surg refrigerator was cleaned</p> <p>c. the refrigerators listed in the policy in 1. above are to be cleaned by dietary staff every Sunday</p> <p>4. interview with staff member #61 at 1:00 PM on 2/4/14 indicated the</p>			

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S000570	<p>med/surg refrigerator did not appear to have been cleaned two days ago</p> <p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2 (f)(1)(A)(b)(C)(D)(E) (f) The hospital shall establish an infection control committee to monitor and guide the infection control program in the facility as follows: (1) The infection control committee shall be a hospital or medical staff committee that meets at least quarterly, with membership that includes, but is not limited to, the following: (A) The person directly responsible for management of the infection surveillance, prevention and control program. (B) A representative from the medical staff. (C) A representative from nursing service. (D) A representative from administration. (E) Consultants from other appropriate services within the hospital, as needed.</p> <p>Based on the review of infection control committee meeting minutes and interview, the infection control committee failed to ensure that a representative from administration was present for 3 of 4 meetings held in 2013.</p> <p>Findings: 1. review of the infection control</p>	S000570	Process to assure a representative of the Administration team will be present at each Infection Control committee meetings has been implemented. The COO is responsible for compliance with this standard. The CNO has been added as a standing member to the committee. The Director of Quality is a current member. Both are members of	02/05/2014			

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S000592	<p>meeting minutes for 2013 indicated:</p> <p>a. meetings were held on 1/26/13, 5/21/13, 8/28/13 and 11/26/13</p> <p>b. an administrative representative was only in attendance at the 5/21/13 meeting</p> <p>2. interview with staff member #61, the chief operating officer, at 10:45 AM on 2/4/14, indicated that after review of the 2013 infection control meeting minutes, an administrative representative was at only one of the four meetings</p> <p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(f)(3)(D)(i)</p> <p>(f) The hospital shall establish an infection control committee to monitor and guide the infection control program in the facility as follows: (3) The infection control committee responsibilities shall include, but not be limited to, the following:</p> <p>(D) Reviewing and recommending changes in procedures, policies, and programs which are pertinent to infection control. These include, but are not limited to, the following:</p> <p>(i) Sanitation. Based on document review, manufacturer's product recommendation, and staff interview, the infection control committee failed to indicate the approval of environmental services housekeeping</p>	S000592	<p>the Senior Administrative team. In the event that neither can attend the meeting they will notify the COO and arrange for another member of the Senior Administrative team to attend.</p> <p>Finding 1. Review and update the current Infection Prevention policy and "Disinfectants Hour-wide and Department Specific List" related to the disinfectant/clean agent selection process. The</p>	03/31/2014			

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	<p>products and failed to ensure the posting of correct disinfectant solution dilution instructions for housekeeping staff in the surgery housekeeping closet.</p> <p>Findings:</p> <ol style="list-style-type: none"> review of the policy and procedure "Disinfectants: House-wide and Department Specific List", policy number 739158, with a last "review/approved" date of 02/2014, indicated: <ol style="list-style-type: none"> on page two under "Housekeeping", it reads: "Various cleaning agents used: Including all listed throughout various depts." at 2:50 PM on 2/3/14, while on tour of the surgery department in the company of staff members #63, the RN (registered nurse) senior director of nursing, and #66, the RN surgery director, it was observed in the housekeeping closet, a document posted titled: "Solution Chart for Hyperfect Disinfectant...1 1/4 oz per 1 gal" (gallon) interview with staff members #63 and #66 indicated the Hyperfect had been discontinued and now staff were using a Neutrafect product review of the gallon jug of Neutrafect at 3:00 PM on 2/3/14, indicated on the label that 2 oz per gallon is required for 		<p>Infection Prevention Committee will review the list and policy (Completion date 02/25/2014) with the final policy approved by 03/24/2014. An educational plan will be developed and implemented by 03/31/2014 for all applicable staff. Findings 2-6. the solution chart for Hyperfect was replaced (02/03/2014) with correct hospital grade disinfectant (Neutrafect) solution and mixing instructions staff have been educated on this issue.</p>	

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	<p>proper dilution of the product for optimal disinfection</p> <p>5. interview with staff member #71, the environmental services manager, at 10:30 AM on 2/4/14, indicated:</p> <ul style="list-style-type: none"> a. the Hyperfect product was discontinued "roughly" Feb. 2012 b. the product used after the Hyperfect was Genefect until "roughly" April 2013 c. the Neutrafect product has been in use since about May 2013 d. the Genefect and Neutrafect products have the same dilution ratio <p>6. interview with staff member #65, the infection preventionist, at 10:55 AM and 12:25 PM on 2/4/14 indicated:</p> <ul style="list-style-type: none"> a. there is no documentation to show that the infection control committee approved all of the changes in disinfection products through out 2012 and 2013 b. the instructions for the Hyperfect product, found in the surgery housekeeping closet, indicated a different dilution than the product being currently utilized c. it cannot be determined that the housekeeper is using the current product to its full potential of disinfection if it isn't at full strength with the dilution process d. it is possible that the surgery 			

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S001118	<p>housekeeper has incorrectly mixed the disinfectant product since Feb. 2012, or at least May 2013</p> <p>e. the policy related to housekeeping products does not specifically list the products approved for use by the infection control committee</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 policy and procedure review, manufacturer's recommendations, observation, and staff interview, the facility failed to ensure that no condition was created that might cause a hazard to patients, staff, or visitors related to glucometer test strips, dirty refrigerators, and dusty blanket warmers.</p> <p>Findings 1. review of the policy and procedure "Stat Strip Glucose Meter Patient Testing</p>	S001118	Findings 1-4. Expiration date reminder labels placed on all glucose test strips of expiration date- COMPLETION DATE 02/20/2014. Policy will be changed to reflect the manufacture's guidelines- COMPLETION DATE OF 03/12/2014. Staff will be re-educated by 03/24/2014 regarding the changes and reminding staff to label vials when opened.- Director of Nursing will be the person responsible for changes and education. Findings	03/24/2014			

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	<p>Care and Maintenance", policy number 385842, with a last "review/approved" date of 02/2013, indicated:</p> <p>a. on page two under "General", it reads: "Important: Test Strips are stable until the expiration date on vial. Vials should be dated when first opened. Test strips are stable for 3 months after opening or until the expiration date on vial, whichever come first..."</p> <p>2. at 2:05 PM on 2/4/14, review of the package insert for the Nova Stat Strips indicated under "storage and handling": "Expiration: The expiration date is printed on the vial of test strips. Once opened the StatStrip Test Strips are stable when stored as indicated for up to 180 days or until the expiration date, whichever comes first."</p> <p>3. at 8:35 AM on 2/4/14, while on tour of the out patient/off site urgent care center in the company of staff member #61, the chief operations officer, and #74, the director of the urgent care center, it was observed in the nursing area that the glucometer test strips were not dated when opened, nor with an expiration date</p> <p>4. interview with staff members #61 and #74 at 8:35 AM on 2/4/14 indicated it cannot be determined when the 180 day expiration date is on the test strips at the</p>		<p>10-15. Policy will be revised by Infection Prevention Coordinator-COMPLETION DATE OF 03/12/2014. Policy will be a house wide policy on refridgerator cleaning monthly and as needed. The Temperature Log will be revised to include documenting when refrigerator is cleaned. Staff will be re-educated by the Infection Prevention Nurse on these changes- COMPLETION DATE-03/24/2014.</p> <p>Findings 16-23 Facilities Director is responsible for this standard. Plan of Correction An organization wide policy covering all warming cabinets will be established and implemented. The policy and procedure will include routine preventive maintenance and cleaning protocols consistent with the manufacturer's recommendations as described in equipment owner's manual. Preventive maintenance and cleaning activities will be documented, archived and available for inspection. COMPLETION DATE: 3/12/2014</p>				

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	<p>urgent care center since the strips were not dated when opened, or with a 180 day expiration date</p> <p>5. at 11:30 AM on 2/4/14, while on tour of the Med/Surg area with staff member #61, the chief operations officer, and staff member #72, the nurse director of med/surg, it was observed that the glucometer test strips were dated as opened on 1/31/14 and dated with an expiration date of 2/28/14</p> <p>6. interview with staff members # 61 and #72 at 11:30 AM on 2/4/14 indicated the test strips were incorrectly dated as the expiration date should have been 180 days, not 30 days</p> <p>7. at 1:45 PM on 2/4/14, while on tour of the obstetrics department in the company of staff members #61, the chief operating officer, and #75, the RN director of obstetrics, it was observed that the glucometer test strips were dated when opened on 2/1/14 and dated with an expiration date of 3/1/14</p> <p>8. interview with staff members #61 and #75 at 1:45 PM on 2/4/14 indicated the test strips are actually good for 180 days after opening, not 30 days</p> <p>9. interview with the infection control</p>						

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	<p>preventionist, staff member #65, at 12:25 PM on 2/4/14, indicated:</p> <ul style="list-style-type: none"> a. the policy 385842, listed in 1. above, does not match the manufacturer's package insert recommendations for 180 day stability after opening b. nursing staff are not following either the policy for 90 day (3 month) expiration, or 180 days, per the manufacturer c. the urgent care center failed to follow the policy in dating the test strips at all after opening <p>10. review of the policy and procedure "Temperatures Of Refrigerators And Freezers, 3011", policy number 420066, with a last "review/approved" date of 04/2013, indicated:</p> <ul style="list-style-type: none"> a. under "Policy", it reads: "...Pantry refrigerator/freezer units in Med Surg, Ambulatory and OB (obstetrics) are cleaned as spills occur, and on a weekly basis (weekend...position)." <p>11. at 8:40 AM on 2/4/14, while on tour of the off site urgent care center in the company of staff members #61, the chief operating officer, and #74, the director of the urgent care center, it was observed in the nursing station that the medication refrigerator was dirty and had hairs on the bottom shelf of the refrigerator</p>			

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	<p>12. at 8:45 AM on 2/4/14, staff members #61 and #74 agreed that the refrigerator was dirty, needed cleaning, and is not on a routine cleaning schedule</p> <p>13. at 3:35 PM on 2/3/14, while on tour of the ED (emergency department) in the company of staff members #61, the chief operating officer, and #67, the ED director, it was observed in the quiet room pantry refrigerator that the area under the vegetable drawers was dirty with crumbs and debris</p> <p>14. staff members #61 and #67 agreed at 3:35 PM on 2/3/14 that the refrigerator was dirty and that nursing staff are responsible for cleaning the refrigerator</p> <p>15. interview with staff member #65, the infection preventionist, at 10:55 AM on 2/4/14, indicated:</p> <ul style="list-style-type: none"> a. the dietary staff are only responsible for the refrigerators listed in policy number 420066, listed in 10. above b. nursing staff are responsible for all other refrigerators c. currently, there is no policy related to the cleaning of refrigerators in either the off site location or within the hospital <p>16. review of the facility policy and procedure "Warming Cabinets", policy number 553498, with a last</p>			

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	<p>"review/approved" date of 08/2013, indicated that the cleaning of warming cabinets is not addressed in the policy</p> <p>17. review of the Blickman blanket warmer user manual indicated: a. in section "5.0 Routine Preventative Maintenance", on page 14, it reads: "5.2 Product Cleaning 5.2.1 Regular cleaning is important to maintain the appearance of stainless steel equipment...5.2.2 Shelves, Sloping Top etc. can be cleaned with a solution of liquid dishwashing detergent and water..."</p> <p>18. review of the Skytron owner's manual indicated: a. on page 7, under "Operation", it reads: "...Cleaning The exterior and interior of the cabinet should be cleaned regularly using a mild soap and water solution..."</p> <p>19. at 2:15 PM on 2/3/14, while on tour of the outpatient/pre op area of surgery in the company of staff members #61, the chief operations officer, and #66, the surgery director, it was noted that the Blickman blanket warmer had an accumulation of dust under the plenum (lower shelf)</p> <p>20. at 2:35 PM on 2/3/14, while on tour of the surgery area in the company of</p>			

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	<p>staff members #61, the chief operations officer, and #66, the surgery director, it was observed in the substerile room that the Skytron blanket warmer #A2243 was dusty under the plenum</p> <p>21. at 3:45 PM on 2/3/14 while on tour of the ED in the company of staff members #61, the chief operating officer, and #67, the ED director, it was observed that the Blickman blanket warmer in trauma room #2 had a large accumulation of dust on the top of the plenum and under the plenum</p> <p>22. interview with staff member #61 while touring the surgery area and the ED indicated that the blanket warmers were dusty as indicated above</p> <p>23. interview with the bio med director, staff member #70, at 9:35 AM on 2/4/14 indicated:</p> <ul style="list-style-type: none"> a. it was thought that the blanket warmers were being cleaned, but there is no log or documentation of this process b. the current policy on warmers does not indicate that manufacturer's recommendations, related to routine cleaning, is addressed c. it cannot be determined the last time the blanket warmers were cleaned on the inside to decrease the amount of dust, or lint, present 			

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S001164	<p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8(d)(2)(B)</p> <p>(d) The equipment requirements are as follows: (2) There shall be sufficient equipment and space to assure the safe, effective, and timely provision of the available services to patients, as follows:</p> <p>(B) There shall be evidence of preventive maintenance on all equipment.</p> <p>Based on observation and interview, the facility failed to perform preventive maintenance (PM) ensuring a safe working environment for 3 environmental services equipment.</p> <p>Findings:</p> <p>1. On 2-03-14 at 1130 hours, staff A2 and A3 were requested to provide documentation of recent PM for floor scrubbing equipment and none was provided prior to exit.</p> <p>2. During a tour on 2-03-14 at 1600 hours in a basement equipment room, a Minuteman 170 rpm floor buffer was observed with a broken strain relief and electrical tape repair to retain the power cord to the upright handle. The buffer</p>	S001164	Facilities Director is responsible for this standard. Plan of Correction- A preventive maintenance policy and procedure will be established and implemented on all floor care equipment including those cited. The inspection and preventive maintenance of all floor care equipment will be added to the inventory of all other equipment and machinery scheduled PM's. The inspection, PM, and repair of all floor care equipment will be documented. Documentation will be filed and available for inspection. COMPLETION DATE 03/1/14	03/01/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151315	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/04/2014
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S001168	<p>indicated that the last maintenance was performed 11-11-06. Additional equipment observed in the area included an IDS high speed burnisher with indication of last PM dated 11-11-06 and a Tennant 170 rpm floor buffer with indication of last PM dated 11-06-06. Staff A8 was requested to provide documentation of recent PM and none was provided prior to exit.</p> <p>3. During an interview on 2-03-14 at 1601 hours, staff A8 confirmed that the equipment had not been maintained.</p> <p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 150-1.5-8 (d)(3)</p> <p>(d) The equipment requirements are as follows:</p> <p>(3) Defibrillators shall be discharged at least in accordance with manufacturers recommendations and a discharge log with initialed entries shall be maintained.</p> <p>Based on document review, observation and interview, the facility failed to develop and maintain its policy/procedure and perform defibrillator inspection and testing in accordance with the manufacturer's recommendations for 1 defibrillator.</p>	S001168	Crash Cart Check/Defibrillator Check policy will be revised to reflect changes according to manufacturer's guidelines- COMPLETION DATE 03/24/2014. Staff will be re-educated by the Clinical Nurse Specialist- COMPLETION DATE 03/31/2014. The Chief Nursing Officer is responsible for compliance with this standard.	03/31/2014

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	<p>Findings:</p> <p>1. The Phillips M4735A HeartStart XL Defibrillator/Monitor (2006) operators manual indicated the following: "Operational Checks ...Perform these checks ...along with visual inspection of the device and all cables, controls, accessories and supplies. Also regularly check expiration dates of all supplies, such as multifunction defib electrode pads ...The Shift/System Check report lists the results of the test and additional checks that you should do. Perform each of these checks and record the results ..."</p> <p>2. The policy/procedure Defibrillation (approved 6-13) failed to indicate the following: A. perform a visual inspection of the device for visible signs of damage (page 11-2) B. check expiration dates of all supplies including multifunction defib electrode pads (page 11-2) D. test every shock delivery method that is used with the unit [page 11-3] - if you use both external paddles (page 11-4) and pads (page 11-5), test both E. the additional checks indicated in Figure 11-2 under the heading Qty/Check List and on the Shift/System Check report printed out by each defibrillator on completion of the self-test in accordance</p>		The CNO will work in collaboration with biomedical engineering to assure compliance.				

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	<p>with the guidelines for check completion (page 11-6).</p> <p>3. During a tour on 2-03-14 at 1440 hours, the following condition was observed on the rehabilitation unit: expired multifunction defib pads with the statement 'use by 2-14' on the crash cart. No documentation observed with the crash cart including the daily inspection report indicated that the additional checks were performed per manufacturer's recommendations.</p> <p>4. During an interview on 2-03-14 at 1401 hours, staff A7 and A12 confirmed that the defib pads had expired and confirmed that no documentation indicated that the additional checks were performed.</p> <p>5. During an interview on 2-04-14 at 0930 hours, staff A8 reviewed the operators manual for the Phillips M4735A defibrillator and confirmed that the policy/procedure failed to indicate the additional checks to be performed.</p>			