

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 153037	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 07/28/2015
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NAME OF PROVIDER OR SUPPLIER SOUTHERN INDIANA REHABILITATION HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 3104 BLACKISTON BLVD NEW ALBANY, IN 47150
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S 0000 Bldg. 00	<p>This visit was for a hospital State licensure survey.</p> <p>Dates of survey: 7/27/15 to 7/28/15</p> <p>Facility number: 006205</p> <p>QA: cjl 08/13/15</p> <p>IDR Committee met on 08-25-15: Tag S0838 deleted. JL</p>	S 0000		
S 0406 Bldg. 00	<p>410 IAC 15-1.4-2 QUALITY ASSESSMENT AND IMPROVEMENT 410 IAC 15-1.4-2(a)(1)</p> <p>(a) The hospital shall have an effective, organized, hospital-wide, comprehensive quality assessment and improvement program in which all areas of the hospital participate. The program shall be ongoing and have a written plan of implementation that evaluates, but is not limited to, the following:</p> <p>(1) All services, including services furnished by a contractor. Based on document review and interview, the hospital failed to ensure that the quality assessment and improvement (QAPI) program included 2 directly provided services (animal</p>	S 0406	<p>1. Quality measures have been developed for the directly provided service animal therapy, the 2 contracted services (laundry & Peripherally Inserted Central</p>	08/01/2015

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>therapy & audiology), 2 contracted services (laundry & Peripherally Inserted Central Catheter (PICC)), and 1 function (transcription) in its evaluation within the past 4 quarters.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. Review of the document titled 2015 PERFORMANCE IMPROVEMENT PLAN, indicated an objective to be: To ensure and foster efforts to continually meet the needs of all customers via an organized, hospital-wide program. The document also indicated: Each clinical department or program...is required to have at least one performance improvement measure. The plan was approved 2/19/15. 2. Review of the last 4 quarters of QAPI meeting minutes lacked evidence of program monitoring or activity for the directly provided services of animal therapy & audiology, the contracted services of laundry & PICC line insertion, and the function of transcription. 3. On 7/28/15 at 4:10pm, A1, director of quality management, confirmed animal therapy, audiology, laundry, PICC line insertion and transcription were not included in QAPI evaluations or 		<p>Catheter (PICC)), and transcription function. There was a misunderstanding during the survey and we do not offer audiology services. Data will be collected each month to track and evaluate these services. A report will be presented to the Quality Council. All monitors were started on August 1, 2015.</p> <ol style="list-style-type: none"> 2. The deficiency will not recur in the future because these items will be added to the Quality Council reporting schedule. 3. The Director of Quality Management will be responsible assuring these monitors get reported at Quality Council. 	

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S 0912 Bldg. 00	<p>monitoring.</p> <p>410 IAC 15-1.5-6 NURSING SERVICE</p> <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 document review, observation and interview, the nurse executive failed</p>	S 0912	1. Nursing staff was educated on the rounding policy during unit meetings	08/17/2015

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	<p>to implement policy/procedure on hourly rounding.</p> <p>Findings:</p> <p>1. While touring the inpatient rehabilitation unit on 7/27/2015, at 1300 hours, accompanied by staff member #A18, it was noted that patient rounding forms, just inside patient room doors, were not being signed. In all rooms observed where there were patients, it appeared the the hourly sheets were signed fairly regularly between midnight and 0600 hours, but none had signatures for the day shift.</p> <p>2. Hospital policy Patient Care Management, last reviewed October, 2011, section VI, policy 6.000, Hourly Rounding, indicated that rounding is defined as frequently scheduled rounds to proactively address the four basic "P's" of patient needs: Pain, Positioning, P.O. fluid intake offering and Potty, in addition to an environmental scan to assure close proximity of patient items and patient safety. Managers will review the rounding logs daily and perform weekly observations and audits. D. Staff are to document the hourly round on the log before leaving the patient's room.</p> <p>3. In interview on 7/2/2015 at 1500</p>		<p>the week of August 17 -21, 2015.</p> <p>2. Director of Nursing will monitor rounding logs to prevent recurrence in the future.</p> <p>3. Director of Nursing will be responsible.</p>	

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S 1118 Bldg. 00	<p>hours, staff member #A18 concurred that the policy was not being followed.</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 document review, observation, and interview, the facility failed to follow its procedure regarding the medical and storage refrigerators on the hospital in-patient unit and created a condition that may result in a hazard by unsecured storage of 6 small compressed gas tanks and 1 large gas cylinder/tank.</p> <p>Findings: 1. While on tour of the unit on 7/27/2015 at 1300 hours, it was observed that the medical refrigerator temperature log for July, 2015 indicated that refrigerator</p>	S 1118	<p>1. The patient food refrigerator log was revised to devote in red, bold letters that temperatures out of range are to be reported to Maintenance. All refrigerator logs have been revised to reflect the temperature ranges in Fahrenheit. Staff received training in documentation and reporting of temperatures out of range on 8/24/15. 2. Director of Support Services will monitor refrigerator logs to prevent recurrence in the future. 3. Director of Support Services will be responsible.</p> <p>1. The storing of Freon was added to the Maintenance Refrigerant Policy 1.18 on 8/17/15. The general storage of gas cylinders was added</p>	08/24/2015

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	<p>temperatures recorded were between -2 and +1 degrees centigrade, for each day of the month of 7/2015. The log indicated that the range for temperatures should range between 2 and 8 degrees centigrade. All temperatures were written with black ink. The temperature log indicates that out of range temperatures were to be written in red ink and reported to facility management.</p> <p>2. The storage refrigerator freezer temperature log for July, 2015, indicated that the temperatures ranged from -7 degrees to -12 degrees Celsius. The temperature log for storage refrigerator indicated that the freezer temperature should be maintained between -12 to -18 degrees Celsius, and temperatures that fall outside of perimeters are to be reported to Maintenance, at extension #104. The storage refrigerator temperature log for July, 2015, indicated that the temperature is to be maintained at 2 to 5 degrees Celsius. The temperatures recorded ranged between 34 to 39 degrees Farenheidt. There is no conversion table available and staff don't know if temperatures are out of range or not.</p> <p>3. In the area of the temperature logs where it indicates what action was taken if the temperatures were not in correct</p>		<p>to the Environment of Care Manual Policy 6.1 (Hazardous Materials and Waste Management) on 8/21/15.</p> <p>2. Compliance will be monitored during the Comprehensive Health and Safety Inspection.</p> <p>3. Director of Support Services will be responsible for monitoring.</p>	

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	<p>range, all were blank.</p> <p>4. Staff member #A18, covering unit manager, indicated that the out of range temperatures had not been reported to facility management. Staff member #A8, director of support services, indicated that the out of range temperatures had not been reported to maintenance.</p> <p>5. On 7/27/15 between 2:00pm and 3:45pm, during tour of the main campus, in the presence of A8, Director of Support Services, and A5, Assistant Director of Support Services, in the maintenance shop, 6 small unsecured compressed gas tanks were observed sitting on the floor. A5 indicated the tanks to hold Freon gas. In the maintenance shop office, a large gas cylinder tank was observed upright on the floor beside the desk, unsecured. A5 indicated the tank to contain helium. The policy and procedure (P&P) for storage of gases/tanks was requested.</p> <p>6. On 7/28/15 at 10:45am, A5 indicated the hospital did not have a P&P for storing Freon. The general P&P for compressed gas/cylinder storage was requested at that time. No further documentation was received prior to exit.</p>			

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S 1150 Bldg. 00	<p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8 (c)(9)</p> <p>(c) In new construction, renovations and additions, the hospital site and facilities, or nonlicensed facilities acquired for the purpose of providing hospital services, shall meet the following:</p> <p>(9) All back flow prevention devices shall be installed as required by 327 IAC 8-10 and the current edition of the Indiana plumbing code. Such devices shall be listed as approved by the department.</p> <p>Based on observation and interview, the hospital failed to install back flow prevention devices in 3 areas where a hose was connected to a water spigot above a basin (an equipment room sink and a shower/tub).</p> <p>Findings:</p> <p>1. On 7/27/15 between 2:00pm and 3:45pm, during tour of the main campus, in the presence of A8, Director of Support Services, and A5, Assistant Director of Support Services, in the equipment room, a hose was observed connected to a sink spigot without a back flow prevention device and in the in-patient rehabilitation therapy area was a hand held shower/hose connected to a spigot without a back flow prevention</p>	S 1150	<p>1. A backflow preventer was installed on the equipment room sink on 8/17/15. The hose in the therapy area tub shall be removed and replaced with a spray head by Maintenance by 8/27/15. Maintenance will install a back flow preventer in the shower at an off-site bathroom shower by 8/27/15.</p> <p>2. Equipment has been replaced to prevent recurrence.</p> <p>3. Director of Support Services will be responsible for equipment being replaced.</p>	08/27/2015

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S 1164 Bldg. 00	<p>device.</p> <p>2. On 7/28/15 during tour of rehabilitation off-site 1, between 8:45am and 10:00am, in the presence of O1, Off-site 1 Outpatient Rehabilitation Supervisor, and O2, Off-site 1 Pediatric Team Leader, the following was observed in the facility bathroom: a hand held shower with a hose connected to a water spigot in the shower/tub without a back flow preventer.</p> <p>3. On 7/28/15 at 11:30am, A5 indicated back flow prevention devices were not installed on the equipment room hose/spigot, the in-patient rehabilitation hand held shower, or the Off-site 1 bathroom shower hose/spigot and that the architecture of those areas did not contain a back flow prevention device in the plumbing.</p> <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</p>			

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	<p>preventive maintenance on all equipment.</p> <p>Based on document review, observation, and interview, the hospital failed to provide evidence of preventive maintenance (PM) for 12 pieces of equipment (audiometer, dishwasher, stove/range, toaster, small electric wheelchair, 3 adaptive seating chairs, 3 walkers, and a Flag House squeeze device).</p> <p>Findings:</p> <ol style="list-style-type: none"> Review of the policy & procedure (P&P) titled PREVENTIVE MAINTENANCE indicated the Hospital will maintain a preventive maintenance program for all facilities and equipment... The P&P was approved 11/3/14. On 7/27/15 at 10:00am during opening conference, A3, Chief Executive Officer, was provided with a list requesting documentation of preventive maintenance for various equipment including, but not limited to: audiometer and dishwasher. On 7/28/15 during tour of rehabilitation off-site 1, between 8:45am and 10:00am, in the presence of O1, Off-site 1 Outpatient Rehabilitation Supervisor, and O2, Off-site 1 Pediatric 	S 1164	<ol style="list-style-type: none"> All 12 pieces of equipment will be tagged and assessed by Maintenance per Preventative Maintenance Policy by 8/27/15. Deficiency will not recur since the equipment will be listed on the Preventative Maintenance schedule. Director of Support Services will be responsible for the Preventative Maintenance. 	08/27/2015

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S 1172 Bldg. 00	<p>Team Leader, the following was observed: a dishwasher, a range, a toaster, a small electric pediatric wheelchair, 3 adaptive seating chairs, 3 walkers and a Flag House squeeze device. Evidence of PM was requested.</p> <p>4. On 7/28/15 at 1:40pm, A5, Assistant Director of Support Services, indicated the facility did not have documentation of PM for the requested dishwasher, range, toaster, wheelchair, adaptive chairs, walkers, squeeze device, or audiometer.</p> <p>410 IAC 15-1.5-8 PHYSICAL PLANT 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 document review, observation, and interview, the hospital failed to</p>	S 1172	1. Stove and all other surfaces were	08/24/2015

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	<p>maintain cleanliness of 4 rehabilitation off-site kitchen appliances (range top burners, oven, dishwasher, & toaster), kitchen drawers and 1 piece of equipment (child's electric wheelchair).</p> <p>Findings:</p> <p>1. Review of the document titled PROCEDURE FOR KP DUTIES, indicated kitchen cleaning duties were assigned to be done daily. Cleaning tasks indicated in the document lacked evidence of recommendation or requirement to clean range top/burners, inside oven, toaster, or inside dishwasher. The document lacked indication of date of implementation.</p> <p>2. On 7/28/15 during tour of rehabilitation off-site 1, between 8:45am and 10:00am, in the presence of O1, Off-site 1 Outpatient Rehabilitation Supervisor, and O2, Off-site 1 Pediatric Team Leader, the following was observed: in the kitchen of the rehabilitation area in the 4 burner trays of a range, there was black hardened and loose debris inside each; inside the oven was a large chunk of black debris and accumulation of crumb type debris throughout, as well as blackened debris around the door gasket; inside a dishwasher, around the door gasket was</p>		<p>added to the daily kitchen cleaning items as a reminder to staff. Child's electric wheelchair was donated to Supplies Overseas on 8/20/15.</p> <p>2. A daily cleaning log will be completed and initialed by the person assigned to clean the stove and all other surfaces.</p> <p>3. Pediatric Team Leader will be responsible for monitoring the daily cleaning log.</p>	

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	<p>dirt/debris accumulation and in the basin was brownish spots and debris in the drain basket; an electric toaster atop the counter contained heavy crumb type debris in the bottom and brownish drip type stains on the outside; 4 kitchen drawers were observed with dust and debris in the inside bottoms of the drawers. In the clean storage room of the facility was a small child's electric wheel chair with noted rust and whitish dried droplet type debris.</p> <p>3. On 7/28/15 between 8:45am and 10:00am, O2 indicated the kitchen area is to be cleaned daily by staff and the child's wheelchair was a donation being held until pick-up for storage at the main campus. O2 indicated the facility did not have a policy related to cleaning of the appliances/equipment.</p>			